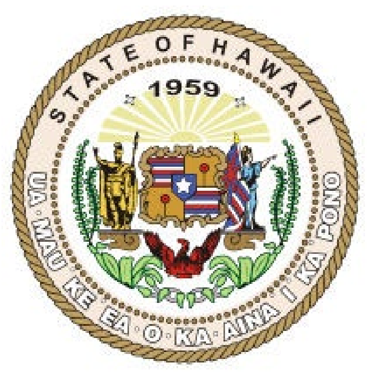
State of Hawaii

Department of Human Services

Med-QUEST Division



2024 External Quality Review Report of Results

for the

QUEST Integration Health Plans

and the

Community Care Services Program

March 2025

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1. Executive Summary

Overview

The 2024 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] 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 MQD to provide physical health and behavioral health services to Medicaid members. 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 MQD to have a serious mental illness (SMI) or serious and persistent mental illness (SPMI), and who are enrolled in a QI health plan. The MCOs and PIHP that contracted with MQD during calendar year (CY) 2024 are displayed in Table 1-1. No health plans were exempt from external quality review (EQR) in CY 2024.

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] 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, 2020.42 CFR Parts 430, 438, and 457 with revisions released (or as amended) May 10, 2024. 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 MCOs provide.

To comply with these requirements, 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') February 2023 EQR protocols when preparing this report.[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), consumer satisfaction surveys, and encounter data validation.
- Recommendations for the health plans to improve member access to care, quality of care, and timeliness of care.
- Recommendations on how the State can target goals and objectives in the Quality Strategy to better support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Medicaid beneficiaries.
- A comparative analysis of health plan performance.
- An assessment of the degree to which each health plan addressed recommendations for quality improvement made by HSAG during the previous year's EQR.

Scope of EQR Activities

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

- *Review of compliance with federal and State-specified operational standards*. HSAG conducted follow-up reviews of the health plans that were required to take corrective actions related to findings from HSAG's 2022 and 2023 compliance reviews.

[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *CMS External Quality Review (EQR) Protocols*, February 2023 Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: July 1, 2024.

- *Validation of performance measures*. HSAG validated each health plan's performance measure results for a set of Healthcare Effectiveness Data and Information Set (HEDIS)® [3] and non-HEDIS performance measures selected by 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 members' health outcomes. HSAG conducted validation of the performance measure rates following the National Committee for Quality Assurance (NCQA) HEDIS Compliance Audit™ [4] guidelines and timeline, which occurred from December 2023 through July 2024. The final audited performance measure validation results for each health plan reflected the measurement period of January 1, 2023, through December 31, 2023. HSAG provided final audit reports to the health plans and MQD in July 2024.
- *Validation of network adequacy*. MQD contracted with HSAG to conduct network adequacy validation (NAV) for the Hawaii managed care health plans. 42 CFR §438.350(a) requires states that contract with MCOs, PIHPs, and prepaid ambulatory health plans (PAHPs) to have a qualified EQRO perform an annual EQR that includes validation of network adequacy to ensure provider networks are sufficient to provide timely and accessible care to Medicaid and CHIP beneficiaries across the continuum of services. HSAG conducted NAV, validating the systems and processes, data sources, methods, and results, according to CMS EQR Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity, February 2023 (CMS EQR Protocol 4).[5]
- *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*, February 2023.[6] In CY 2024, the QI health plans submitted three PIPs each, which were reviewed and validated by HSAG. 'Ohana CCS submitted two PIPs for HSAG's review and validation. 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®)* [7] *surveys*. MQD contracted with HSAG to conduct CAHPS surveys of the adult and child QI health plan members and CHIP population to learn more about adult members' and parents'/caretakers' of child members experiences with care. The standardized survey instrument administered to adult members enrolled in the five QI health plans was the CAHPS 5.1H Adult Medicaid Health Plan Survey. The standardized survey instrument administered to parents/caretakers of child members enrolled in the five QI health plans and CHIP was the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set and the children with chronic conditions [CCC] measurement set. All adult members and parents/caretakers of sampled child members completed the surveys from February to May 2024. HSAG aggregated and produced final reports in October 2024.

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[3] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[4] NCQA HEDIS Compliance Audit™ is a trademark of the NCQA.
[5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols,* February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: July 1, 2024.
[6] Ibid.
[7] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

- *Home and Community-Based Services (HCBS) CAHPS survey*. MQD contracted with HSAG to conduct HCBS CAHPS surveys of adult QI health plan members to learn more about members' perceptions and experiences to evaluate the quality of healthcare services provided to eligible adult members. The standardized survey instrument administered to adult members of the QI health plans was the HCBS CAHPS survey without the Supplemental Employment module. Members completed the surveys from July to September 2024. HSAG will provide the final report to MQD in April 2025.
- *Encounter data validation (EDV).* HSAG and MQD initiated an EDV study in 2023. This study focused on evaluating the extent to which the encounter data in MQD's database were complete, accurate, and submitted by the QI health plans in a timely manner through a comparative analysis between MQD's electronic encounter data and the actuarial files submitted by the health plans to MQD's contracted actuary, Milliman. Based on the findings from the comparative analysis, HSAG provided each health plan with a data discrepancy report. HSAG then provided technical assistance to the health plans so that they could better identify the root cause(s) of the discrepancies and take appropriate actions to improve MQD's encounter data quality. Lastly, HSAG provided best practice recommendations to MQD in reference to MQD's encounter data submission companion guides and requirements.

Overall Summary of Health Plan Performance

Compliance Monitoring Review

CY 2024 began the third year of a three-year cycle of compliance reviews for the QI health plans and the CCS program.

For the 2024 reevaluation of health plan compliance, HSAG used a monitoring tool to assess and document the health plans' implementation of corrective actions in any standards where deficiencies had been identified during the 2022 and 2023 compliance reviews.

Findings, Conclusions, and Recommendations

Table 1-2 illustrates each health plan's individual performance on resolving its corrective action plan (CAP) areas and a statewide total for the six health plans overall.

Table 1-2—Total CAPs and Resolved CAPs by Health Plan and by Standard

Standard Name	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI	'Ohana CCS	Total # of CAPs per Standard
Assurances of Adequate Capacity and Services	NA	NA	3	NA	NA	NA	**3**
Availability of Services	NA	NA	2	1	NA	1	**4**
Confidentiality	NA	NA	NA	NA	NA	NA	**0**
Coordination and Continuity of Care	2	1	1	2	NA	NA	**6**

Standard Name	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI	'Ohana CCS	Total # of CAPs per Standard
Coverage and Authorization of Services	4	1	NA	7	NA	4	**16**
Credentialing	2	1	NA	1	NA	1	**5**
Enrollee Information	4	4	2	4	2	4	**20**
Enrollee Rights and Protections	1	NA	1	1	1	1	**5**
Enrollment and Disenrollment	NA	NA	NA	NA	NA	NA	**0**
Grievance and Appeal System	2	5	1	NA	1	NA	**9**
Health Information Systems	NA	NA	NA	NA	NA	NA	**0**
Provider Selection	NA	NA	NA	NA	NA	NA	**0**
Practice Guidelines	NA	NA	NA	NA	NA	NA	**0**
Quality Assessment and Performance Improvement	NA	NA	NA	NA	NA	NA	**0**
Subcontractual Relationships and Delegation	NA	1	1	NA	NA	NA	**2**
Total # of CAPs and Resolved CAPs by Health Plan:	**15/15**	**13/13**	**11/11**	**16/16**	**4/4**	**11/11**	**70/70**

Numerator = # of CAPs "closed" and found compliant during follow-up review.
Denominator = Total # of CAPs required for the standard following the 2022 or 2023 compliance review.
NA = Not Applicable. Reevaluation was not necessary as the health plan achieved 100 percent for the standard.

The health plans' CAP implementation resulting from HSAG's 2022 and 2023 compliance reviews was monitored by HSAG and MQD. Following completion of its CAPs, each health plan submitted documentation for HSAG's desk review to ensure that the deficiencies were resolved, and that compliance was attained. As needed, health plans were provided additional technical assistance and monitoring until they were compliant with each standard. The results of each reevaluation were provided to the health plan and MQD as a record of how the deficiencies were addressed. All five QI health plans and 'Ohana CCS successfully completed all CAPs.

CY 2025 will begin a new three-year cycle of compliance reviews for all the QI health plans and the CCS program.

Validation of Performance Measures—NCQA HEDIS Compliance Audits

HSAG, an NCQA-Licensed Organization (LO), performed independent audits of the performance measure results calculated by the QI health plans and CCS program using NCQA's standard audit methodology in alignment with *HEDIS Measurement Year (MY) 2023 Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures*.[8] The audit procedures were also consistent with the CMS

[8] National Committee for Quality Assurance. *HEDIS Measurement Year 2023 Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures.* Washington, DC: NCQA; 2022.

protocol for performance measure validation (PMV): *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023.[9] The health plans that contracted with MQD during MY 2023 for the QI and CCS programs underwent separate NCQA HEDIS Compliance Audits for these programs. Each audit incorporated a detailed evaluation of the health plans' information system (IS) capabilities and their ability to process, store, analyze, and report medical, member, practitioner, and vendor data, which is essential for reporting accurate and reliable performance measure results. In addition, HSAG used NCQA's HEDIS Determination (HD) standards to assess the health plans' algorithmic compliance and oversight of outsourced or delegated reporting functions.

The NCQA HEDIS Compliance Audit for the CCS program evaluated compliance with IS and HD standards in reporting a set of HEDIS performance measures relevant to behavioral health. The measurement period was MY 2023 (January 1, 2023, through December 31, 2023), and the audit activities were conducted concurrently with the HEDIS MY 2023 health plan data collection and reporting processes, which allows auditors to detect errors in data collection processes while there is time for the health plans to correct their methods and minimize the possibility of biased rates.

For MY 2023 reporting, the State selected a set of performance measures from NCQA's *HEDIS Measurement Year 2023 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 2024 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 2024 Reporting; CMS' Measures for Medicaid Long Term Services and Supports Plans, Technical Specifications and Resource Manual, April 2024,* and NCQA's *HEDIS & Measurement Year 2023, 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 2023 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 31 measures for the QI population, yielding a total of 123 measure indicators. 'Ohana CCS was required to report on six measures, yielding 25 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)

[9] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: July 1, 2024.

Findings, Conclusions, and Recommendations

NCQA HEDIS Compliance Audits

HSAG evaluated each QI and CCS health plan's measure data collection and reporting processes to determine compliance with NCQA's IS and HD standards during the MY 2023 NCQA HEDIS Compliance Audits. HSAG determined all five of the QI health plans and the CCS program to be *fully compliant* with all NCQA HEDIS IS and HD standards, which included NCQA's IS standard L for assessing case management data for LTSS measures. 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 rates were determined to be *Reportable*.

Performance Measure Results

HSAG analyzed the HEDIS MY 2023 performance measure results for each health plan, and where applicable, HSAG compared the results to NCQA's 2023 Quality Compass®,[10] national Medicaid health maintenance organization (HMO) percentiles for HEDIS MY 2022 (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/Expected [O/E] Ratio—Total, Hemoglobin A1c (HbA1c) Poor Control [>9%],* and *Ambulatory Care—Emergency Department Visits)*, HSAG reversed the order of the benchmarks for performance level evaluation to be consistently applied.[11]

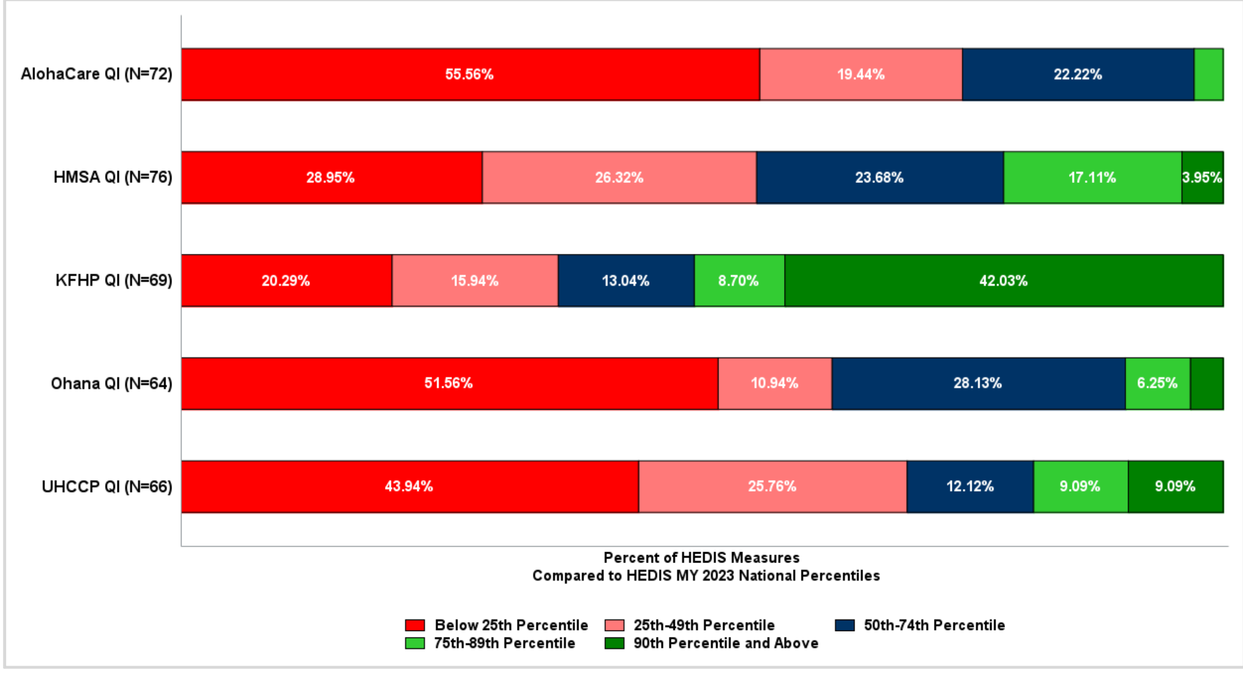
Additionally, HSAG analyzed the results for four CMS *Adult Core Set* measures, one CMS *Child Core Set* measure, two NCQA LTSS measures, and one CMS LTSS measure. Of note, these measures do not have applicable benchmarks for comparison.

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 2023 performance compared to benchmarks, where applicable. HSAG analyzed results from 23 performance measures for HEDIS MY 2023 (a total of 98 indicator rates), of which 78 indicators were comparable to benchmarks. Of note, all the health plans had at least one measure indicator or more receive a status of *NA* (i.e., small denominator).

[10] Quality Compass® is a registered trademark of the NCQA.
[11] 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 2023, with 44 of 69 (63.77 percent) measure rates ranking at or above the 50th percentile, including six rates (8.70 percent) meeting or exceeding the 75th percentile and 29 rates (42.03 percent) meeting or exceeding the 90th percentile. Conversely, 25 of KFHP QI's measure rates (36.23 percent) fell below the 50th percentile, 14 of which (20.29 percent) fell below the 25th percentile, suggesting that some opportunities for improvement exist.

HMSA QI was the second-highest performing health plan, with 34 of 76 (44.74 percent) measure rates ranking at or above the 50th percentile, with 13 of these rates (17.11 percent) ranking at or above the 75th percentile, and three of these rates (3.95 percent) ranking at or above the 90th percentile. Conversely, 42 of HMSA QI's 76 (55.27 percent) measure rates ranked below the 50th percentile, with 22 of these rates (28.95 percent) falling below the 25th percentile.

For 'Ohana QI, 24 out of 64 (37.50 percent) measure rates met or exceeded the 50th percentile, with four of these rates (6.25 percent) ranking at or above the 75th percentile, and two of these rates (3.12 percent) ranking at or above the 90th percentile. Conversely, 40 of 'Ohana QI's 64 (62.50 percent) measure rates fell below the 50th percentile, with 33 of these rates (51.56 percent) falling below the 25th percentile.

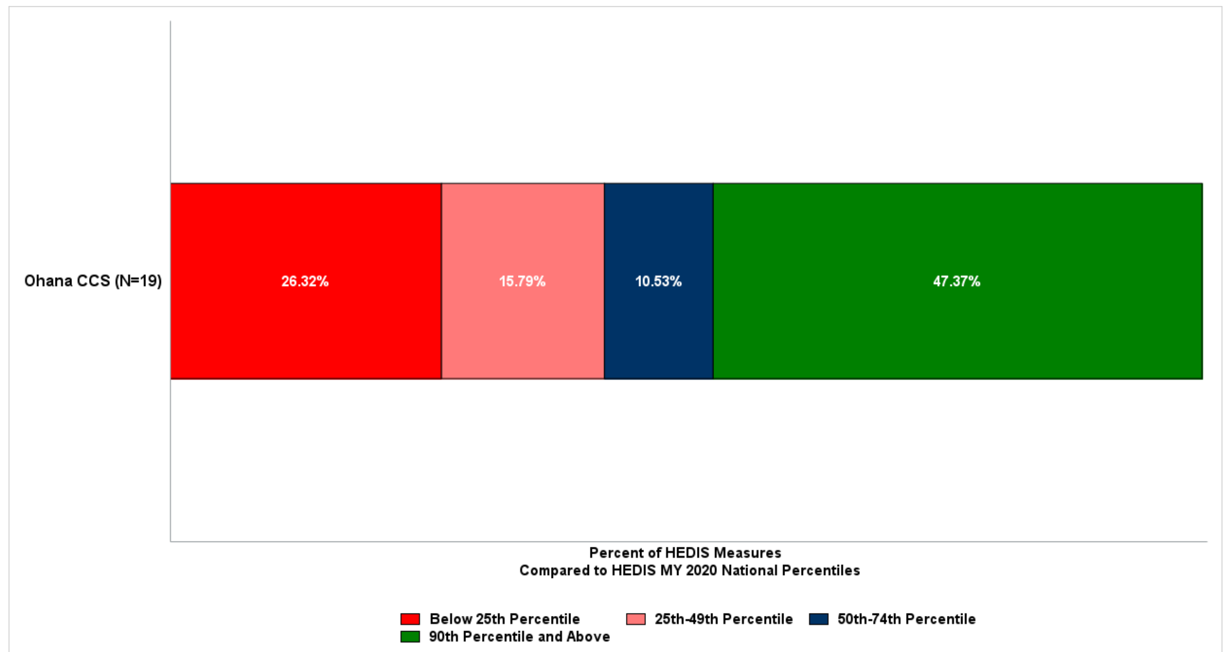
For UHC CP QI, 46 of 66 (69.70 percent) measure rates ranked below the 50th percentile, with 29 of these rates (43.94 percent) falling below the 25th percentile. Conversely, UHC CP QI met or exceed the 50th percentile for 20 measure rates (30.30 percent), with six of these rates (9.09 percent) meeting or

exceeding the 75th percentile, and six of these rates (9.09 percent) meeting or exceeding the 90th percentile.

AlohaCare QI was the lowest-performing plan for HEDIS MY 2023, with 54 of 72 measure rates (75.0 percent) falling below the 50th percentile, with 40 of these rates (55.56 percent) falling below the 25th percentile. Conversely, AlohaCare QI met or exceeded the 50th percentile for 18 measure rates (25.0 percent), with two of these rates (2.78 percent) ranking at or above the 75th percentile.

Figure 1-2 displays ‘Ohana CCS’ HEDIS MY 2023 performance compared to benchmarks, where applicable. HSAG analyzed results from 23 performance measures for HEDIS MY 2023 (a total of 97 indicator rates), of which 19 indicators were comparable to benchmarks. Of note, ‘Ohana CCS had at least one measure indicator receive a status of *NA* (i.e., small denominator) 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 11 of 19 (57.90 percent) measure rates ranking at or above the 50th percentile, including nine rates (47.37 percent) that met or exceeded the 90th percentile. Additionally, ‘Ohana CCS met four MQD Quality Strategy targets in HEDIS MY 2023. Conversely, eight of 19 (42.11 percent) measure rates fell below the 50th percentile, including five rates (26.32 percent) that fell below the 25th percentile.

Recommendations for improvement are presented in the health plan-specific results sections of this report. Overall, HSAG recommends that each health plan target the lower-scoring measure rates for improvement. Each health plan should identify relevant trends and key drivers related to low performance, coupled with data analysis and drill-down evaluations of noncompliant cases.

Validation of Network Adequacy

Based on the MQD-defined network adequacy standards, HSAG worked with MQD to define the network adequacy indicators, which HSAG then validated. The indicators are metrics used to assess adherence to the quantitative network adequacy standards required and set forth by the State. MQD identified network adequacy indicators to be validated for the reporting period of CY 2024.

By assessing statewide network adequacy results and reporting processes, HSAG identified the following areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement.

Findings, Conclusions, and Recommendations

Overall, the health plans had well-defined processes and procedures in place to ensure efficient and accurate collection of member and provider data to support network adequacy calculation and reporting. The health plans demonstrated dedicated efforts to identify gaps in provider networks throughout their service areas and identify ways to improve the accessibility and timeliness of care for members.

For the Access and Availability standard, all health plans did not meet MQD's requirements for any of the indicators. HSAG recommends that the health plans conduct an in-depth review of the provider categories for which the health plans did not meet the Access and Availability requirements, with the goal of determining whether the failure to meet the requirements was the result of a lack of providers or a lack of updated provider data.

HSAG identified that MQD's contracted language for identifying members with SMI and/or SPMI did not include the referenced Microsoft Excel-based workbook, which defines qualifying SMI and/or SPMI International Classification of Diseases, Tenth Revision (ICD-10) diagnostic codes in alignment with required network adequacy indicators. HSAG recommends that MQD routinely evaluate, update, and distribute required ICD-10 diagnostic codes to ensure standardization and consistency in reporting network adequacy indicators specific to Provider Ratios for those with an SMI and/or SPMI diagnosis.

MQD provided templates with missing indicators for health plan reporting on MQD-defined network adequacy standards, including Time and Distance, Provider Ratios, Mandatory Provider Types, and Access and Availability. HSAG has noted that there is a misalignment between the reporting template and the contractual language for the standards. HSAG recommends that MQD review its reporting template against the contractual language to align with and more accurately reflect the MQD-desired indicators to ensure consistent and accurate reporting by the health plans.

Performance Improvement Projects

In CY 2024, HSAG validated three PIPs for each of the five QUEST Integration health plans and two PIPs for one PIHP—'Ohana CCS. The PIP topics for the QI health plans were a nonclinical PIP: *Behavioral Health Coordination*, and two clinical PIPs: *Plan All-Cause Readmissions* and *Screening for*

Depression and Follow-Up Plan. The PIP topics for 'Ohana CCS were a nonclinical PIP: *Behavioral Health Coordination*, and a clinical PIP: *7-Day 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 2024 submission, the health plans progressed to the Outcomes stages of the PIPs and submitted Steps 1 through 8 in the PIP Submission Form. For the *Screening for Depression and Follow-Up Plan* PIP, the QI health plans submitted the Design stage (Steps 1 through 6) in the PIP Submission Form.

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

- For the *Behavioral Health Coordination* PIP, all five QI health plans received a *High Confidence* level rating for overall confidence in adherence to acceptable methodology. Three QI health plans received a *High Confidence* level rating, one health plan received a *Moderate Confidence* level rating, and one health plan received a *No Confidence* level rating for overall confidence in achievement of significant improvement.
- For the *Plan All-Cause Readmissions* PIP, all five QI health plans received a *High Confidence* level rating for overall confidence in adherence to acceptable methodology. Three QI health plans received a *Moderate Confidence* level rating, and two health plans received a *No Confidence* level rating for overall confidence in achievement of significant improvement.
- For the *Screening for Depression and Follow-Up Plan* PIP, all five QI health plans received a *High Confidence* level rating for overall confidence in adherence to acceptable methodology. The QI health plans had not progressed to reporting and analyzing data or conducting quality improvement activities. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle.
- 'Ohana CCS received a *High Confidence* level rating for overall confidence in adherence to acceptable methodology for both PIPs. For the *Behavioral Health Coordination* PIP, 'Ohana CCS received a *High Confidence* level rating for overall confidence in achievement of significant improvement, and the *7-Day Follow-Up After Emergency Department Visit for Mental Illness* PIP received a *No Confidence* level rating for overall confidence in achievement of significant improvement.

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

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

Health Plan Name	Validation Rating 1: Overall Confidence in Adherence to Acceptable Methodology for All Phases of the PIP			Validation Rating 2: Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Behavioral Health Coordination						
AlohaCare QI	100%	100%	*High Confidence*	100%	100%	*High Confidence*
HMSA QI	100%	100%	*High Confidence*	33%	100%	*Moderate Confidence*
KFHP QI	100%	100%	*High Confidence*	33%	100%	*No Confidence*
‘Ohana QI	100%	100%	*High Confidence*	100%	100%	*High Confidence*
UHC CP QI	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Plan All-Cause Readmissions						
AlohaCare QI	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
HMSA QI	100%	100%	*High Confidence*	33%	100%	*No Confidence*
KFHP QI	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
‘Ohana QI	100%	100%	*High Confidence*	33%	100%	*No Confidence*
UHC CP QI	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
Screening for Depression and Follow-Up Plan						
AlohaCare QI	100%	100%	*High Confidence*	*Not Assessed*[4]		
HMSA QI	100%	100%	*High Confidence*	*Not Assessed*[4]		

Health Plan Name	Validation Rating 1			Validation Rating 2		
	Overall Confidence in Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
KFHP QI	100%	100%	*High Confidence*	*Not Assessed*[4]		
‘Ohana QI	100%	100%	*High Confidence*	*Not Assessed*[4]		
UHC CP QI	100%	100%	*High Confidence*	*Not Assessed*[4]		

1 **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) 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 **Confidence Level**— Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.
4 **Not Assessed**—HSAG did not assess Step 9, as the QI health plans only reported the Design stage.

Health plan-specific performance for PIP outcomes were as follows:

Behavioral Health Coordination

The third quarter of CY 2023 was the Remeasurement 2 period for this PIP, and the PIP included two performance indicators. AlohaCare QI, ‘Ohana QI, and UHC CP QI achieved statistically significant improvement over the baseline during Remeasurement 2 for both performance indicators. HMSA QI achieved statistically significant improvement in the Performance Indicator 1 rate; however, a decline from the baseline rate was noted in the Performance Indicator 2 rate. KFHP QI had a decline in performance over the baseline for both performance indicators.

Plan All-Cause Readmissions

CY 2023 was the Remeasurement 2 period for this PIP, and the PIP includes one performance indicator. AlohaCare QI, KFHP QI, and UHC CP QI achieved statistically nonsignificant improvement in the Remeasurement 2 rate over the baseline. HMSA QI and ‘Ohana QI demonstrated a decline in performance over the baseline with an increase in the observed readmission rate.

Screening for Depression and Follow-Up Plan

The health plans had not progressed to reporting remeasurement outcomes in the 2024 validation.

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

PIP Topic	Validation Rating 1			Validation Rating 2		
	Overall Confidence in Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Behavioral Health Coordination	100%	100%	*High Confidence*	100%	100%	*High Confidence*
7-Day Follow-Up After Emergency Department Visit for Mental Illness	100%	100%	*High Confidence*	33%	100%	*No Confidence*

[1] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) 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] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

For the *Behavioral Health Coordination* PIP outcomes, 'Ohana CCS sustained statistically significant improvement over the baseline in the Performance Indicator 1 rate and documented a rate of 100 percent for Performance Indicator 2 for the baseline and both remeasurement periods.

'Ohana CCS reported Remeasurement 2 data for the *7-Day Follow-up After Emergency Department Visit for Mental Illness* PIP. The health plan achieved statistically nonsignificant decline over the baseline.

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

- The health plans should continually work on the PIPs throughout the year.

- For the *Screening for Depression and Follow-Up Plan* PIP, the health plans must ensure that the interventions are implemented in a timely manner to impact outcomes during the remeasurement period.
- The health plans must revisit 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.
- For the PIPs that did not demonstrate improvement, the health plans should consider the use of quality improvement science-based tools, such as process mapping with failure modes and effects analysis (FMEA), for causal/barrier analysis and consider additional interventions to drive improvement.
- The health plans must evaluate each intervention listed in the barriers/interventions table for effectiveness.
- The health plans should collect the intervention effectiveness data more frequently (e.g., monthly, quarterly), unlike the annual performance indicator data. This would help the health plans understand intervention effectiveness and make any updates to the interventions in a timely manner to impact remeasurement outcomes.
- Intervention effectiveness data must guide next steps for each individual intervention.
- The health plans should reference the PIP Completion Instructions to ensure that all requirements have been addressed when completing the PIP Submission Form.
- The health plan must address the validation feedback associated with any *Met* score and the *Partially Met* and *Not Met* comments in the next annual submission. The health plans should seek technical assistance from HSAG and MQD throughout the PIP process to address any questions or concerns.

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

The primary objective of the adult Medicaid CAHPS survey was to obtain information effectively and efficiently on the levels of experience with the Hawaii adult Medicaid members' health plan and healthcare services. HSAG administered the CAHPS 5.1 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set to adult Medicaid members enrolled in each of the QI health plans who met age and enrollment criteria. Results were provided at both plan-specific and statewide aggregate levels.

The primary objective of the statewide child Medicaid CAHPS survey and the Hawaii CHIP CAHPS survey was to obtain information effectively and efficiently on the levels of experience with the parents/caretakers of the statewide child Medicaid population (i.e., children enrolled in the QI health plans and Hawaii CHIP) and the Hawaii CHIP population to provide to MQD and to meet the State's obligation for CAHPS measure reporting to CMS. HSAG administered the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set (with the CCC measurement set) to a statewide sample of child Medicaid members and a statewide sample of Hawaii CHIP members who met age and enrollment criteria. Results were provided to MQD in a statewide aggregate report.

Findings, Conclusions, and Recommendations

Table 1-5 presents the 2024 scores for the QI Program (i.e., combined results of the five QI health plans) compared to the 2023 NCQA adult Medicaid national averages and the corresponding 2022 top-box scores.[12,13] Additionally, the overall member experience ratings (i.e., star ratings) resulting from the comparison of the QI Program's 2024 top-box scores to NCQA's 2023 Quality Compass®[14] Benchmark and Compare Quality Data are displayed below.[15]

Table 1-5—QI Program Adult CAHPS Results

Measure	2022 Scores	2024 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	61.65%	63.92%	★★★
Rating of All Health Care	58.42%	57.72%	★★★
Rating of Personal Doctor	65.06%	66.02%	★★
Rating of Specialist Seen Most Often	70.07%	67.13%	★★★
Composite Measures			
Getting Needed Care	79.23%	79.28%	★★
Getting Care Quickly	75.85%	76.87%	★★
How Well Doctors Communicate	90.56%	91.77%	★★
Customer Service	84.68%	87.90%	★
Individual Item Measure			
Coordination of Care	81.67%	86.70% ▲	★★★
Medical Assistance With Smoking and Tobacco Use Cessation Measure Items			
Advising Smokers and Tobacco Users to Quit	72.98%	69.14%	★★
Discussing Cessation Medications	53.56%	51.28%	★★★
Discussing Cessation Strategies	51.59%	49.32%	★★★

A cell highlighted in green represents the score is statistically significantly higher than the 2023 NCQA adult Medicaid national average.
A cell highlighted in red represents the score is statistically significantly lower than the 2023 NCQA adult Medicaid national average.
▲ *Indicates the 2024 score is statistically significantly higher than the 2022 score.*
▼ *Indicates the 2024 score is statistically significantly lower than the 2022 score.*

[12] The QI Program 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.

[13] The adult population was last surveyed in 2022; therefore, the 2024 adult CAHPS scores are compared to the corresponding 2022 scores.

[14] Quality Compass® is a registered trademark of NCQA.

[15] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2023.* Washington, DC: NCQA, September 2023.

Measure	2022 Scores	2024 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*			

Comparison of the QI Program's 2024 scores to the 2023 NCQA adult Medicaid national averages revealed the following summary results:

- The QI Program scored statistically significantly higher than the national average on one measure, *Rating of Health Plan*.
- The QI Program scored statistically significantly lower than the national average on one measure, *Getting Care Quickly*.

Comparison of the QI Program aggregate's 2024 scores to the corresponding 2022 scores revealed the following summary results:

- The QI Program scored was statistically significantly higher than the 2022 score on one measure, *Coordination of Care*.
- The QI Program did not score statistically significantly lower than the 2022 scores for any measure.

Comparison of the QI Program's 2024 scores to the 2023 NCQA child Medicaid Quality Compass data revealed the following:

- The QI Program did not score at or above the 75th percentile for any measures.
- The QI Program scored at or between the 50th and 74th percentiles on six measures: *Rating of Health Plan, Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Coordination of Care*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*.
- The QI Program scored at or between the 25th and 49th percentiles on five measures: *Rating of Personal Doctor*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, and *Advising Smokers and Tobacco Users to Quit*.
- The QI Program scored below the 25th percentile on one measure, *Customer Service.*

Table 1-6 presents the 2024 percentage of top-box responses (i.e., top-box scores) for the general Hawaii CHIP population (i.e., all children in the general child sample only [not the CCC supplemental sample]) compared to the 2023 NCQA general child Medicaid national averages and the corresponding 2023 top-box scores.[16,17] Additionally, the overall member experience ratings (i.e., star ratings) resulting from the

[16] For the NCQA general child Medicaid national averages, the source for data contained in this publication is Quality Compass® 2023 data. National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2023*. Washington, DC: NCQA, September 2023.

[17] NCQA national averages for the general child Medicaid population were used for comparative purposes, since NCQA does not publish separate benchmarking data for CHIP; therefore, caution should be exercised when interpreting these results.

comparison of the 2024 top-box scores to NCQA's 2023 Quality Compass Benchmark and Compare Quality Data are displayed below.

Table 1-6—General Hawaii CHIP CAHPS Results

	2023 Scores	2024 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	75.40%	74.60%	★★★
Rating of All Health Care	65.53%	70.59%	★★★
Rating of Personal Doctor	77.72%	78.13%	★★★
Rating of Specialist Seen Most Often	76.67%+	72.34%+	★★★
Composite Measures			
Getting Needed Care	78.89%	78.05%	★
Getting Care Quickly	78.48%	80.75%	★
How Well Doctors Communicate	95.65%	95.75%	★★★★
Customer Service	89.13%+	88.06%+	★★★
Individual Item Measure			
Coordination of Care	87.04%	85.92%+	★★★

A cell highlighted in green represents the score is statistically significantly higher than the 2023 NCQA general child Medicaid national average.
A cell highlighted in red represents the score is statistically significantly lower than the 2023 NCQA general child Medicaid national average.
▲ *Indicates the 2024 score is statistically significantly higher than the 2023 score.*
▼ *Indicates the 2024 score is statistically significantly lower than the 2023 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 general Hawaii CHIP population's 2024 scores to the 2023 NCQA child Medicaid national averages revealed the following summary results:

- The general Hawaii CHIP population scored statistically significantly higher than the national average on one measure, *How Well Doctors Communicate.*
- The general Hawaii CHIP population did not score statistically significantly lower than the national averages for any measure.

Comparison of the CHIP population's 2024 scores to the corresponding 2023 scores revealed the following summary results:

- The general Hawaii CHIP population did not statistically significantly higher or lower than the 2023 scores for any measure.

Comparison of the general Hawaii CHIP population's 2024 scores to the 2023 NCQA child Medicaid Quality Compass data revealed the following:

- The general Hawaii CHIP population scored at or between the 75th and 89th percentile on one measure, *How Well Doctors Communicate*.
- The general Hawaii CHIP population scored at or between the 50th and 74th percentiles on six measures: *Rating of Health Plan, Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Customer Service*, and *Coordination of Care*.
- The general Hawaii CHIP population scored below the 25th percentiles on two measures: *Getting Needed Care* and *Getting Care Quickly*.

Table 1-7 presents the 2024 percentage of top-box responses (i.e., top-box scores) for the CCC Hawaii CHIP population (i.e., children in the general child sample and CCC supplemental sample whose parents/caretakers answered affirmatively to specific survey items that were used to determine which members had chronic conditions) compared to the 2023 NCQA CCC Medicaid national averages.[18,19] Additionally, the overall member experience ratings (i.e., star ratings) resulting from the comparison of the 2024 top-box scores to NCQA's 2023 Quality Compass Benchmark and Compare Quality Data are displayed below.[20]

Table 1-7—CCC Hawaii CHIP CAHPS Results

	2024 Scores	Star Ratings
Global Ratings		
Rating of Health Plan	71.35%	★★★★
Rating of All Health Care	67.57%	★★★
Rating of Personal Doctor	80.65%	★★★★
Rating of Specialist Seen Most Often	59.09%$^{+}$	★
Composite Measures		
Getting Needed Care	83.17%	★★
Getting Care Quickly	89.30%$^{+}$	★★

[18] For the NCQA CCC Medicaid national averages, the source for data contained in this publication is Quality Compass® 2023 data. National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2023*. Washington, DC: NCQA, September 2023.

[19] NCQA national averages for the CCC Medicaid population were used for comparative purposes, since NCQA does not publish separate benchmarking data for CHIP; therefore, caution should be exercised when interpreting these results.

[20] Since this is the first year parents/caretakers of Hawaii CHIP members in the State of Hawaii were administered the CAHPS Survey with the CCC measurement set, trend results are unavailable for the CCC population.

	2024 Scores	Star Ratings
How Well Doctors Communicate	96.63%	★★★★
Customer Service	86.27%+	★★
Individual Item Measure		
Coordination of Care	90.12%+	★★★★★
CCC Composite and Item Measures		
Access to Specialized Services	83.06%+	★★★★★
Family-Centered Care (FCC): Personal Doctor Who Knows Child	91.94%	★★★
Coordination of Care for Children with Chronic Conditions	79.90%+	★★★★
FCC: Getting Needed Information	89.80%	★★
Access to Prescription Medicines	94.17%	★★★★★

A cell highlighted in green represents the score is statistically significantly higher than the 2023 NCQA CCC Medicaid national average.
A cell highlighted in red represents the score is statistically significantly lower than the 2023 NCQA CCC Medicaid national average.
+ 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 CCC Hawaii CHIP population's 2023 scores to the 2023 NCQA CCC Medicaid national averages revealed the following summary results:

- The CCC Hawaii CHIP population scored statistically significantly higher than the national averages on three measures: *How Well Doctors Communicate*, *Access to Specialized Services*, and *Access to Prescription Medicines*.
- The CCC Hawaii CHIP population scored statistically significantly lower than the national average on one measure, *Rating of Specialist Seen Most Often*.

Comparison of the CCC Hawaii CHIP population's 2024 scores to the 2023 NCQA CCC Medicaid Quality Compass data revealed the following:

- The CCC Hawaii CHIP population scored at or above the 90th percentiles on three measures: *Coordination of Care*, *Access to Specialized Services,* and *Access to Prescription Medicines.*
- The CCC Hawaii CHIP population scored at or between the 75th and 89th percentiles on four measures: *Rating of Health Plan*, *Rating of Personal Doctor*, *How Well Doctors Communicate*, and *Coordination of Care for Children with Chronic Conditions*.
- The CCC Hawaii CHIP population scored at or between the 50th and 74th percentiles on two measures: *Rating of All Health Care* and *FCC: Personal Doctor Who Knows Child*.
- The CCC Hawaii CHIP population scored between the 25th and 49th percentiles on four measures: *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, and *FCC: Getting Needed Information*.

- The CCC Hawaii CHIP population scored below the 25th percentile on one measure, *Rating of Specialist Seen Most Often*.

Table 1-8 presents the 2024 percentage of top-box responses (i.e., top-box scores) for the general child statewide population (i.e., all children in the general child sample only [not the CCC supplemental sample]) compared to the 2023 NCQA general child Medicaid national averages. Additionally, the overall member experience ratings (i.e., star ratings) resulting from the comparison of the 2024 top-box scores to NCQA's 2023 Quality Compass Benchmark and Compare Quality Data are displayed below.[21,22]

Table 1-8—General Child Statewide CAHPS Results

Measure	2024 Scores	Star Ratings
Global Ratings		
Rating of Health Plan	73.45%	★★★
Rating of All Health Care	76.51%	★★★★★
Rating of Personal Doctor	80.18%	★★★★
Rating of Specialist Seen Most Often	76.19%+	★★★★
Composite Measures		
Getting Needed Care	80.76%+	★★
Getting Care Quickly	79.32%	★
How Well Doctors Communicate	95.81%	★★★★
Customer Service	81.25%+	★
Individual Item Measure		
Coordination of Care	80.77%+	★

A cell highlighted in green represents the score is statistically significantly higher than the 2023 NCQA general child Medicaid national average.
A cell highlighted in red represents the score is statistically significantly lower than the 2023 NCQA general child Medicaid national average.
+ 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

[21] For the NCQA general child Medicaid national averages, the source for data contained in this publication is Quality Compass® 2023 data. National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2023*. Washington, DC: NCQA, September 2023.

[22] Since this is the first year parents/caretakers of a statewide population of child members were administered the CAHPS Survey for the State of Hawaii, trend results are unavailable for the general child population.

Comparison of the general child statewide population's 2024 scores to the 2023 NCQA child Medicaid national averages revealed the following summary results:

- The general child statewide population scored statistically significantly higher than the national average on one measure, *Rating of All Health Care*.
- The general child statewide population did not score statistically significantly lower than the national averages for any measure.

Comparison of the general child statewide population's 2024 scores to the 2023 NCQA child Medicaid Quality Compass data revealed the following:

- The general child statewide population scored at or above the 90th percentile on one measure, *Rating of All Health Care*.
- The general child statewide population scored at or between the 75th and 89th percentiles on three measures: *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *How Well Doctors Communicate*.
- The general child statewide population scored at or between the 50th and 74th percentile on one measure, *Rating of Health Plan*.
- The general child statewide population scored at or between the 25th and 49th percentile on one measure, *Getting Needed Care*
- The general child statewide population scored below the 25th percentiles on three measures: *Getting Needed Care*, *Getting Care Quickly*, and *Coordination of Care*.

Table 1-9 presents the 2024 percentage of top-box responses (i.e., top-box scores) for the CCC statewide population (i.e., children in the general child sample and CCC supplemental sample whose parents/caretakers answered affirmatively to specific survey items that were used to determine which members had chronic conditions) compared to the 2023 NCQA CCC Medicaid national averages. Additionally, the overall member experience ratings (i.e., star ratings) resulting from the comparison of the 2024 top-box scores to NCQA's 2023 Quality Compass Benchmark and Compare Quality Data are displayed below. [23,24]

Table 1-9—CCC Statewide CAHPS Results

Measure	2024 Scores	Star Ratings
Global Ratings		
Rating of Health Plan	65.45%	★

[23] For the NCQA CCC Medicaid national averages, the source for data contained in this publication is Quality Compass® 2023 data. National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2023*. Washington, DC: NCQA, September 2023.

[24] Since this is the first year parents/caretakers of a statewide population of child members were administered the CAHPS Survey for the State of Hawaii, trend results are unavailable for the CCC population.

Measure	2024 Scores	Star Ratings
Rating of All Health Care	66.39%	★★
Rating of Personal Doctor	72.41%	★
Rating of Specialist Seen Most Often	68.75%+	★★
Composite Measures		
Getting Needed Care	85.59%+	★★★
Getting Care Quickly	79.67%+	★
How Well Doctors Communicate	94.03%	★★★
Customer Service	84.21%+	★
Individual Item Measure		
Coordination of Care	85.71%+	★★★
CCC Composite and Item Measures		
Access to Specialized Services	72.71%+	★★★
FCC: Personal Doctor Who Knows Child	91.22%+	★★★
Coordination of Care for Children with Chronic Conditions	83.58%+	★★★★★
FCC: Getting Needed Information	86.07%	★
Access to Prescription Medicines	90.83%	★★★

A cell highlighted in green represents the score is statistically significantly higher than the 2023 NCQA CCC Medicaid national average.
A cell highlighted in red represents the score is statistically significantly lower than the 2023 NCQA CCC Medicaid national average.
+ 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 CCC statewide population's 2024 scores to the 2023 NCQA CCC Medicaid national averages revealed the following summary results:

- The CCC statewide population did not score statistically significantly higher than the national averages for any measure.
- The CCC statewide population scored statistically significantly lower than the national average on one measure, *Getting Care Quickly*.

Comparison of the CCC statewide population's 2024 scores to the 2023 NCQA CCC Medicaid Quality Compass data revealed the following:

- The CCC statewide population scored at or above the 90th percentile on one measure, *Coordination of Care for Children with Chronic Conditions*.

- The CCC statewide population scored at or between the 50th and 74th percentiles on six measures: *Getting Needed Care*, *How Well Doctors Communicate*, *Coordination of Care*, *Access to Specialized Services*, *FCC: Personal Doctor Who Knows Child*, and *Access to Prescription Medicines*.
- The CCC statewide population scored at or between the 25th and 49th percentile on two measures: *Rating of All Health Care* and *Rating of Specialist Seen Most Often.*
- The CCC statewide population scored below the 25th percentiles on five measures: *Rating Health Plan*, *Rating of Personal Doctor*, *Getting Care Quickly*, *Customer Service*, and *FCC: Getting Needed Information*.

Recommendations for improvement are presented in the health 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.

Home and Community-Based Services CAHPS Survey

The primary objective of the HCBS CAHPS survey is to gather direct feedback from Medicaid members receiving HCBS services about their experiences and the quality of the LTSS they receive. HSAG administered the HCBS CAHPS Survey to eligible adult members enrolled in all five QI health plans. The survey provides state Medicaid agencies with standard individual experience metrics for HCBS programs that are applicable to all populations served by these programs, including elderly and people with one or more disabilities (e.g., physical disabilities, cognitive disabilities, intellectual impairments, or disabilities due to mental illness). Results were provided at both plan-specific and statewide aggregate levels.

Findings, Conclusions, and Recommendations

Table 1-10 presents the 2024 percentage of top-box responses (i.e., top-box scores) for the Hawaii HCBS Program compared to the Agency for Healthcare Research and Quality's (AHRQ's) 2024 CAHPS Database benchmarks and the corresponding 2023 top-box scores to determine if the results were statistically significantly different.[25,26,27]

[25] HSAG recalculated the 2023 mean scores to top-box scores for HCBS CAHPS Database benchmark comparability. Therefore, the 2023 results in this report will not match previous reports.

[26] Agency for Healthcare Research and Quality. The CAHPS Databases. *The CAHPS® Home and Community-Based Services (HCBS) Survey Database 2024 Chartbook*. Available at: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/cahps-database/2024-hcbs-chartbook.pdf. Accessed on: Jan 15, 2025.

[27] The 2024 HCBS CAHPS Database benchmarks represent survey data collected from January 1 to December 31, 2022. Caution should be exercised when comparing the 2024 HCBS CAHPS Database benchmarks to the Hawaii HCBS Program 2024 results, which represent survey data collected from July 23, 2024, to September 15, 2024.

Table 1-10—Hawaii HCBS Program Results

Measure	2023 Top-Box Scores	2024 Top-Box Scores
Global Ratings		
Rating of Personal Assistance and Behavioral Health Staff	76.69%	77.67%
Rating of Homemaker	70.90%+	75.75%+
Rating of Case Manager	70.15%	70.45%
Composite Measures		
Reliable and Helpful Staff	77.59%	78.84%
Staff Listen and Communicate Well	76.56%	83.14% ▲
Helpful Case Manager	86.28%	86.63%
Choosing the Services that Matter to You	71.00%	70.63%
Transportation to Medical Appointments	68.02%	68.60%
Personal Safety and Respect	89.24%	91.11%
Planning Your Time and Activities	53.23%	54.27%
Recommendation Measures		
Recommend Personal Assistance/Behavioral Health Staff	74.09%	74.25%
Recommend Homemaker	59.45%+	75.88%+
Recommend Case Manager	68.02%	71.65%
Unmet Need and Physical Safety Measures		
No Unmet Need in Dressing/Bathing	35.75%+	35.02%+
No Unmet Need in Meal Preparation/Eating	27.00%+	25.49%+
No Unmet Need in Medication Administration	53.76%+	NA
No Unmet Need in Toileting	94.88%	95.65%
No Unmet Need with Household Tasks	NA	39.92%+
Not Hit or Hurt by Staff	100.00%	100.00%

A cell highlighted in green represents the score is statistically significantly higher than the 2024 CAHPS Database benchmark.
A cell highlighted in red represents the score is statistically significantly lower than the 2024 CAHPS Database benchmark.
▲ *Indicates the 2024 score is statistically significantly higher than in previous year.*
▼ *Indicates the 2024 score is statistically significantly lower than in previous year.*
\+ *Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.*
Results based on fewer than 11 respondents were suppressed and noted as "NA".

Comparison of the Hawaii HCBS Program's 2024 scores to AHRQ's 2024 CAHPS Database benchmark revealed the following summary results:

- The Hawaii HCBS Program scored statistically significantly lower than AHRQ's 2024 CAHPS Database benchmarks on nine measures: *Rating of Case Manager, Reliable and Helpful Staff, Staff Listen and Communicate Well, Helpful Case Manager, Choosing the Services that Matter to You,*

Transportation to Medical Appointments, Personal Safety and Respect, Planning Your Time and Activities, and *Recommend Personal Assistance/Behavioral Health Staff*.

- The Hawaii HCBS Program did not score statistically significantly higher than the CAHPS database benchmarks on any measure.

Comparison of the Hawaii HCBS Program's 2024 scores to the corresponding 2023 scores revealed the following summary results:

- The Hawaii HCBS Program scored statistically significantly higher than the 2023 score on one measure, *Staff Listen and Communicate Well*.
- The 2024 Hawaii HCBS Program did not score statistically significantly lower than the 2023 scores for any measure.

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

Encounter Data Validation

In alignment with the CMS EQR *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023,[28] HSAG conducted the following three evaluation activities for the EDV activity:

- Comparative analysis—evaluation of MQD's electronic encounter data completeness and accuracy through a comparative analysis between MQD's electronic encounter data and the actuarial files submitted by the QI health plans to MQD's contracted actuary, Milliman. This activity corresponds to Activity 3 in the CMS EQR Protocol 5: Analyze Electronic Encounter Data.
- Technical assistance with the QI health plans regarding the findings from the comparative analysis so that the health plans can identity the root cause(s) of any issues and take appropriate actions to improve MQD's encounter data quality.
- Best practice recommendations to MQD regarding encounter data submission companion guides and requirements.

HSAG included encounter data with dates of service from CY 2022 in the comparative analysis.

[28] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5: Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 17, 2024.

Findings, Conclusions, and Recommendations

HSAG evaluated the record-level data completeness of MQD's encounter data by investigating the record omission (i.e., in Milliman-submitted data but not in MQD-submitted data or underreporting to MQD) and record surplus (i.e., in MQD-submitted data but not in Milliman-submitted data or underreporting to Milliman) in MQD's data compared to the data submitted by the QI health plans to Milliman. Throughout the comparative analysis section, lower rates indicate better performance for omission, surplus, and discrepancy rates.

Table 1-11 displays the QI health plans' performance by encounter type. The left half circle in the table is for the record omission rate and the right half circle is for the record surplus rate. The green shade indicates a rate of less than 5.0 percent (i.e., better record completeness) while the red shade indicates a rate higher than 5.0 percent (i.e., relatively poor performance).

Table 1-11—Summary for Record Omission and Surplus Rates

Encounter Data Type	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Institutional	Record Surplus <5.0%	Record Omission <5.0%	Both >5.0%	Both >5.0%	Both >5.0%
Professional	Record Surplus <5.0%	Record Omission <5.0%	Record Surplus <5.0%	Both >5.0%	Both >5.0%
Pharmacy	Both >5.0%	Record Surplus <5.0%	Both >5.0%	Both <5.0%	Both >5.0%

Both <5.0% | Record Omission <5.0% | Record Surplus <5.0% | Both >5.0%

Except pharmacy encounters for 'Ohana QI, all QI health plans should improve their encounter data completeness for institutional, professional, and pharmacy encounters, since all health plans had either a record omission or a record surplus rate that was above 5.0 percent (i.e., relatively poor performance) for each encounter type.

HSAG also evaluated the element-level discrepancy of MQD's encounter data by assessing records that were present in both MQD's and Milliman's data with different non-missing values for a given data element. Table 1-12 shows the number of data elements with a discrepancy rate greater than 5.0 percent (i.e., relatively poor performance) for each health plan by encounter type.

Table 1-12—Number of Data Elements With Discrepancy Rates Greater Than 5.0 Percent

Encounter Type	Number of Data Elements	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Institutional	38	9	11	10	12	14
Professional	27	5	7	10	8	9
Pharmacy	17	1	4	5	4	4

For all health plans, the matched records largely contained similar values between the MQD-submitted and Milliman-submitted data. In addition, all health plans had at least one data element for each encounter type that they should work on to improve their data element accuracy values. Among the health plans, AlohaCare QI had the fewest data elements with discrepancies across the three encounter types and UHC CP QI had the most.

After completing the comparative analysis, HSAG documented the findings in the health plan-specific data discrepancy reports and then distributed them to the health plans, along with data samples to assist the health plans with their internal investigations. Based on the health plans' internal investigations, the health plans provided written responses to the data discrepancy reports noting the potential root cause(s) and action plans, if applicable. HSAG, Milliman, and MQD then reviewed the written responses and followed up with the health plans for any further clarification. Lastly, HSAG distributed the final data discrepancy reports to the health plans, Milliman, and MQD to document the action items agreed upon by the health plans, Milliman, and MQD.

The health plans should work on the action items noted in the final data discrepancy reports to improve encounter data completeness and accuracy so that the encounter data submitted to the Hawaii Prepaid Medicaid Management Information System (HPMMIS) in CY 2025 accurately reflect data needed for the CY 2026 rate-setting activities. In addition, all health plans should utilize the three-year encounter file that MQD will provide monthly to ensure the data it submits to the HPMMIS are processed and submitted correctly. All health plans should review any discrepancies within the file with MQD to reconcile any differences.

2. Introduction

Purpose of the Report

As required by 42 CFR §438.364,[29] 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, PIHP, or PAHP.
- For each EQR-related activity conducted in accordance with §438.358:
  - Objectives
  - Technical methods of data collection and analysis
  - The data and a description of data obtained, including validated performance measurement, any outcomes data and results from quantitative assessments, for each activity conducted with §438.358(b)(1)(i), (ii) and (iv).
  - Conclusions drawn from the data
- An assessment of each MCO's, PIHP's, or PAHP'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, or PAHP, 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, or PAHPs, 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, or PAHP has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.
- The names of the MCOs exempt from EQR by the State, including the beginning date of the current exemption period, or that no MCOs are exempt, as appropriate.

[29] 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, 42 CFR Parts 430, 438, and 457 with revisions released (or as amended) May 10, 2024. Final Rule. Available at: https://www.federalregister.gov/agencies/centers-for-medicare-medicaid-services. Accessed on: July 1, 2024.

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, or PAHP's compliance with federal standards and associated state-specific requirements, when applicable. The EQR technical report must include information on the reviews conducted within the previous three-year period to determine the health plans' compliance with the standards established by the State.

Performance Measure Validation

In accordance with 42 CFR §438.330(c), states must require that MCOs, PIHPs, and PAHPs, submit performance measurement data as part of the MCOs', PIHPs', and PAHPs' 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, and PAHP performance measures (as required by the state) or MCO, PIHP, and PAHP 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 MQD-selected performance measures calculated and submitted by the MCOs and the PIHP.

Network Adequacy Validation

In accordance with 42 CFR §438.68, states that contract with MCOs, PIHPs, or PAHPs must develop and enforce network adequacy standards. Validating network adequacy is one of the mandatory external quality review activities described at 42 CFR §438.358(b)(1). The EQR technical report must include information on the validation of MCO, PIHP, and PAHP network adequacy during the preceding 12 months.

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, and PAHPs 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).

Encounter Data Validation

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

Technical Assistance

At the state's direction, the EQRO may provide technical guidance to groups of MCOs, PIHPs, or PAHPs 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, 2024, through December 31, 2024, this report provides:

- A description of Hawaii's Medicaid service delivery system.
- A description of MQD's Quality Strategy and evaluation of the Quality Strategy effectiveness.
- 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 and optional activities, as set forth in 42 CFR §438.358:
  - Mandatory activities:
    - Compliance monitoring reviews
    - Validation of performance measures
    - Validation of network adequacy
    - Validation of PIPs
  - Optional activities:
    - Administration of consumer surveys
    - Validation of encounter data
- 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 *400,000*[30] *individuals in the State of Hawaii. 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."*[31] 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 QUEST Expanded Access (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, 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

[30] All Medicaid enrollment statistics cited in this section are as of November 2024, as cited in the Eligibility Enrollment Snapshot provided by MQD.
[31] Hawaii Department of Human Services, Med-QUEST Division. Mission Statement. Available at: https://medquest.hawaii.gov/en/about/mission-statement.html. Accessed on: July 1, 2024.

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 contracted 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.

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 SMI or SPMI. '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 69,000 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 46,000 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 QExA plan, then in July 2012 also as a QUEST plan. ‘Ohana QI currently provides services to over 32,000 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 52,000 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[32]

In accordance with 42 CFR §438.340, each state contracting with an MCO, PIHP, or PAHP must draft and implement a written quality strategy for assessing and improving the quality of healthcare and services furnished by the MCO, PIHP, or PAHP. In keeping *with* the requirements specified, the Hawaii Quality Strategy was submitted and reviewed by CMS in 2023. 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 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, 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, 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.

HOPE activities are organized into four strategic focus areas, which include multiple targeted initiatives to promote integrated health systems and payment reform initiatives, and three foundational building blocks, which directly support the four strategic areas and also enhance overall system performance as presented in Table 2-1. The HOPE initiative guides the Quality Strategy.

[32] Hawai’i Quality Strategy 2023. State of Hawaii, Department of Human Services, Med-QUEST Division. Available at: https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/quality-strategy/MQD%20Quality%20Strategy%202023.FINAL.pdf. Accessed on: July 1, 2024.

Table 2-1—HOPE Goals, Strategic Areas, and Building Blocks

Goals	Healthy Families, Healthy Communities, Achieving the Triple Aim—Better Health, Better Care, Sustainable Costs			
Strategies	1. Invest in primary care, prevention, and health promotion	2. Improve outcomes for high-need, high-cost individuals	3. Payment reform and alignment	4. Support community driven initiatives
Foundational Building Blocks	1. Use data and analytics to drive transformation and improve outcomes			
	2. Increase workforce capacity			
	3. Accountability, performance measurement and evaluation			

The Quality Strategy is centered on the four HOPE strategic areas and then organized into seven overarching goals. Each goal contains one or more objectives for a total of 17 objectives. Most objectives are cross-cutting as they achieve more than one of MQD's goals. Cross-cutting objectives allow for a non-siloed and more effective and efficient approach to achieving the HOPE vision. Each objective is generally tied to more than one HOPE strategy and works to advance Hawaii's progress across several goal areas simultaneously.

Quality Strategy Goals and Objectives

The Quality Strategy's identified goals and objectives focus on improving health outcomes of Hawaii Medicaid members and maintaining and improving the managed care delivery system. The goals and supporting objectives are measurable and take into consideration all populations served by the QI and CCS programs. Refer to Table 2-2 for a detailed description of the objectives and performance measures used to support each goal.

Table 2-2—Quality Strategy Goals and Objectives

Goals	Objectives
Goal 1: Advance primary care, prevention, and health promotion	**Objective 1:** Enhance timely and comprehensive pediatric care
	Objective 2: Reduce unintended pregnancies, and improve pregnancy-related care
	Objective 3: Increase utilization of adult preventive screenings in the primary care setting
	Objective 4: Expand adult primary care preventive services
Goal 2: Integrate behavioral health with physical health across the continuum of care	**Objective 5:** Promote behavioral health integration and build behavioral health capacity
	Objective 6: Support specialized behavioral health services for serious intellectual/developmental

Goals	Objectives
	disorders, mental illness, and substance use disorders (SUDs)
Goal 3: Improve outcomes for high-need, high-cost individuals	**Objective 7:** Provide appropriate care coordination for populations with special health care needs
	Objective 8: Provide team-based care for beneficiaries with high needs high-cost conditions
	Objective 9: Advance care at the end of life
	Objective 10: Provide supportive housing to homeless beneficiaries with complex health needs
Goal 4: Support community initiatives to improve population health	**Objective 11:** Assess and address social determinants of health needs
Goal 5: Enhance care in LTSS settings	**Objective 12:** Enhance community integration/reintegration of LTSS beneficiaries
	Objective 13: Enhance nursing facility and HCBS; prevent or delay progression to nursing facility level of care
Goal 6: Maintain access to appropriate care	**Objective 14:** Maintain or enhance access to care
	Objective 15: Increase coordination of care and decrease inappropriate care
Goal 7: Align payment structures to improve health outcomes	**Objective 16:** Align payment structures to support work on social determinants of health
	Objective 17: Align payment structures to enhance quality and value of care

Each of the 17 objectives is tied to initiatives and interventions used to drive improvements within and across the goals and objectives set forth in the Quality Strategy. To assess the impact of these interventions and continue to identify opportunities for improving the quality of care delivered under Medicaid managed care, and in compliance with the requirements set forth in 42 CFR §438.340(b)(3), these interventions are tied to a set of metrics by which progress is assessed. This approach provides for data-driven decision making to identify gaps, formulate solutions, and prioritize quality initiatives.

MQD uses several mechanisms to monitor and enforce health plan compliance with the standards set forth throughout the Quality Strategy, and to assess the quality and appropriateness of care provided to Medicaid managed care members. The following sections provide an overview of the key mechanisms MQD uses to enforce these standards and to identify ongoing opportunities for improvement.

Quality Initiatives

Hawaii has implemented a series of initiatives aligned closely to the Quality Strategy and designed to build a person-centered, coordinated system of care that addresses both medical and non-medical drivers of health. These initiatives drive progress toward the Quality Strategy goals and objectives, and are discussed below.

Health Equity and Social Determinants of Health

Given the unique geography and diversity that exists in Hawaii, one of MQD's priorities is reducing health disparities and assessing and addressing social determinants of health (SDOH). Socio-economic status, discrimination, education, neighborhood and physical environment, employment, housing, food security and access to healthy food choice, access to transportation, social support networks and connection to culture, as well as access to healthcare are all determinants of health. The health of population groups, including that of Native Hawaiians and Pacific Islanders, is affected differently by these factors, leading to disparities in health outcomes. MQD, in partnership with the health plans, has developed an SDOH Transformation Plan that will act as a roadmap for identifying, evaluating, and addressing health disparities. The health plans are currently in the early implementation stages of the Plan and focusing on the collection, analysis, and use of demographic and SDOH data.

Additionally, as part of managed care reporting, health plans are required to analyze performance measure data by various strata, including geography, race/ethnicity, and English language proficiency, and develop tailored quality improvement activities that are then monitored over time for efficacy and impact. Health plans also have developed and implemented SDOH quality activities as part of their quality assurance and program improvement (QAPI) programs.

Lastly, MQD has four key financial strategies to encourage health plans to work on SDOH, including exploring capitation methodology reform to incorporate SDOH, allowances for the creation of alternative payment models to support community-clinical partnerships, the Advancing Primary Care initiative, and pay for performance incentives. The Advancing Primary Care initiative defines and measures primary care spend using four definitions of primary care spend with the intention of setting investment targets within each category.

Community Integration Services (CIS)

The CIS program provides members who have physical and/or behavioral health needs and are homeless, or at risk of homelessness, with various housing services that are likely to ameliorate their physical or behavioral health needs. The benefits include pre-tenancy supports, tenancy sustaining services, housing quality and safety improvement services, legal assistance, and house payments, including a one-time payment for a security deposit and/or first month's rent. MQD is looking to expand upon this program through its 1115 waiver renewal to include medical respite. MQD evaluates the CIS program on an ongoing basis through rapid cycle assessments (RCAs); MQD recently released updated implementation guidelines to lessen administrative burdens related to the program's implementation based on health plan and provider feedback.

Long-Term Services and Supports (LTSS)

Medicaid members meeting eligibility criteria can receive long-term care services in a nursing facility or HCBS. To ensure quality care and equitable access to services, MQD developed an HCBS Quality Strategy that addresses six areas of performance: Administrative Authority, Level of Care, Person-Centered Service Plan, Qualified Providers, Health and Welfare, and Financial Accountability. MQD established priority goals and performance measures tied to specific HCBS requirements. The health plans are required to report the HCBS performance measures, and MQD monitors the results quarterly. The performance measures associated with HCBS program assurances have a threshold of 86 percent. Any performance measure with less than 86 percent triggers further analysis and implementation of quality improvement activities.

Behavioral Health Integration

MQD, health plans, and DOH agencies work collaboratively to integrate primary care with behavioral health, support the utilization of a Coordinated Addiction Resource Entry System (CARES), and enhance the use of Screening, Brief Intervention, and Referral to Treatment (SBIRT). MQD uses performance and quality measurement as well as financial incentive programs to support advancements in behavioral healthcare and integration. Beginning in CY 2022, MQD contracted with HSAG to facilitate collaborative workgroups related to the two PIP topics: *Behavioral Health Coordination* and *Plan All-Cause Readmissions.* HSAG continued facilitating these workgroups during CY 2024 and monitored the health plans' progress toward goals of workgroup charters, provided training on quality improvement strategies, facilitated meetings, and provided ongoing support as the health plans completed quality improvement activities.

Quality-Based Payment Programs

MQD maintains several quality-based payment programs to enhance the quality and value of care provided across various settings. The MCO pay for performance (P4P) program is a withhold-based program used to incentivize quality, improvement, and progress in selected performance measures and implementation of new initiatives. Beyond P4P measures, there are additional financial levers that support the State's strategy, such as the Advancing Primary Care initiative. MQD also encourages the health plans to align payment structures through value-based purchasing (VBP) strategies to enhance quality and value of care. Finally, MQD uses quality metrics in its auto-assignment algorithm to further reward health plan performance.

MQD's Hospital P4P and Nursing Facility P4P programs are administered in close partnership with the Healthcare Association of Hawaii (HAH). Measures are selected in partnership with the facilities to accelerate progress across various MQD quality objectives.

Contract Compliance

MQD intends to achieve the Quality Strategy goals and objectives through managed care contracts for the provision of covered services to eligible Medicaid and Children's Health Insurance Program (CHIP)

members for necessary medical, behavioral health, and LTSS in a fully risk-based, managed care environment. Through quality assurance and quality improvement oversight activities, MQD monitors the health plans to ensure they are operating in accordance with the contract. New reporting packages and key performance indicators were developed and implemented in 2021. When contract requirements are not met, MQD may initiate corrective action processes or may impose sanctions for non-performance or violations of contract requirements.

EQR Activities

MQD regularly monitors the effectiveness of health plans in achieving the Quality Strategy goals through EQR activities and reports. 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, CAHPS surveys, provider survey, encounter data validation, and technical assistance to MQD and health plans.

Actions on EQR Recommendations

In accordance with 42 CFR §438.364(a)(4), the 2023 EQR technical report included recommendations for how MQD can target goals and objectives in the Quality Strategy to better support improvement in the quality of, access to, and timeliness of health services furnished to Medicaid managed care members. Table 2-3 includes the recommendations made to MQD in support of the Quality Strategy goals and the subsequent actions taken by MQD to support program improvement and progress toward meeting the goals of the Quality Strategy. The State's responses regarding implemented improvement activities were edited for grammatical and stylistic changes only.

Table 2-3—EQRO Recommendations and State Actions

2023 EQRO Recommendations	2024 MQD Actions
Goal 1: Advance primary care, prevention, and health promotion. **Objective 1:** Enhance timely and comprehensive pediatric care. **Objective 2:** Reduce unintended pregnancies and improve pregnancy-related care. **Objective 3:** Increase utilization of adult preventive screenings in the primary care setting. **Objective 4:** Expand adult primary care preventive services. **Recommendation:** Adult and pediatric preventive care measure rates continue to show considerable room for improvement. To target improvement in Goal 1, HSAG recommends that MQD consider requiring the health plans	Through MQD's comprehensive QAPI report template, health plans are required to implement several quality improvement activities to address different areas of health services, including adult and pediatric preventive care. The QAPI reports were submitted by the health plans and reviewed by MQD quarterly. MQD continues to include access to care measures *Child and Adolescent Well-Care Visits (WCV)* and *Well-Child Visits in the First 30 Months of Life (W30)* in the State's MCO Pay for Performance Program. Finally, MQD included the SDOH Collaborative as part of the Hospital Pay for Performance program, where hospitals are required to implement social risk factors

2023 EQRO Recommendations	2024 MQD Actions
to implement improvement activities to increase utilization of adult and pediatric preventive care services.	screening on Medicaid members to improve health equity across the state of Hawaii, identifying areas of opportunity through the collection and analysis of both clinical health data and social risk factor screening data, and development of community standards of care for those patients with identified SDOH needs.
Goal 5: Enhance care in LTSS settings. **Objective 12:** Enhance community integration/reintegration of LTSS beneficiaries. **Objective 13:** Enhance nursing facility and HCBS; prevent or delay progression to nursing facility level of care. **Recommendation:** Since only one-third of Quality Strategy targets were met for Goal 5, HSAG recommends that technical assistance be provided to support the health plans in calculating the managed long-term services and supports (MLTSS) measures, as reporting year (RY) 2023 was only the second year that health plans reported rates for these complex measures.	MQD actively works and collaborates with the EQRO and health plans on enhancing the Health Functional Assessment tool to ensure alignment with MLTSS measure requirements.
Goal 6: Maintain access to appropriate care. **Objective 14:** Maintain or enhance access to care. **Recommendation:** Given that the Quality Strategy performance measures for Goal 6 span several care settings, Medicaid beneficiary populations, and include both physical and behavioral health services, HSAG recommends that MQD focus on one area for improvement that corresponds with the State's current managed care program priorities. Lower-performing measures that could benefit from quality improvement activities or initiatives include SUD treatment measures, nursing facility measures, and CAHPS measures.	To address Objective 14: Maintain or enhance access to care, MQD included the provider directory data quality as a process measure under the MCO Pay for Performance Program, where MCOs are required to enhance their processes in ensuring accurate provider directories for their Medicaid members. In addition to this, MQD included the SUD-related measure *Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement* as part of the auto assignment incentive program. In 2021, CMS granted the State of Hawaii with an exception regarding the medication-assisted treatment (MAT) requirements based on the fact that Hawaii does not have a sufficient provider network to furnish one or more of the required MAT benefit components. This exception is in effect until September 30, 2025. MQD continues to look for opportunities to increase the MAT provider network so that the MAT services are available on every island,

2023 EQRO Recommendations	2024 MQD Actions
	and MQD can be compliant with this federal requirement. One option is to work with the Federally Qualified Health Centers (FQHCs) to be onboarded as MAT providers for MQD.
Goal 7: Align payment structures to improve health outcomes. **Objective 16:** Align payment structures to support work on SDOH. **Objective 17:** Align payment structures to enhance quality and value of care. **Recommendation:** To target improvement in Goal 7, HSAG recommends that MQD consider revising the Hospital P4P and Nursing Facility P4P program goals and associated measures and performance targets. While the process measures achieved a rating of *Met*, none of the performance measures met the RY 2023 statewide targets.	MQD is in the process of revamping the Hospital P4P and Nursing Facility P4P programs. MQD met with the Healthcare Association of Hawaii and started the discussion of having a consultant to provide technical support for the 2025/2026 quality program planning.

Evaluation of Quality Strategy Effectiveness

To track the progress of achieving goals and objectives outlined in the Quality Strategy, HSAG developed a Hawaii Medicaid Goals Tracking Table, as shown in Appendix B. The table comprises the metrics included in the Hawaii Quality Strategy 2023 Measures Appendix and is categorized by the State's associated goals and objectives, along with MY 2023 performance measure targets and results. MQD identifies the baseline performance measure rate (if applicable/available) and the target rate, which is based on a goal of 1 percent improvement each year.

Table 2-4 summarizes the statewide performance measure results and Quality Strategy targets met as shown in Appendix B—Hawaii Medicaid Goals Tracking Table.

Table 2-4—MY 2023 Quality Strategy Goals Statewide Summary of Performance

	Goal 1	Goal 2	Goal 3	Goal 4	Goal 5	Goal 6	Goal 7
Number of rates reported	58	28	50	6	14	71	17
Rates with an established target	56	27	49	6	14	68	17
Rates achieving the target	**27**	**17**	**22**	**5**	**8**	**29**	**7**

	Goal 1	Goal 2	Goal 3	Goal 4	Goal 5	Goal 6	Goal 7
Percentage of rates achieving the target	**48.21%**	**62.96%**	**44.90%**	**83.33%**	**57.14%**	**42.65%**	**41.18%**

Table 2-5 summarizes QI health plan performance relative to MQD Quality Strategy targets. Detailed information can be found in Section 4. Comparative Analysis of Health Plan Performance.

Table 2-5—Percentage of MQD Quality Strategy Targets Met or Exceeded for QI Population

	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Total MQD Targets Met	**14**	**22**	**35**	**16**	**19**
Percent MQD Targets Met	**27.08%**	**45.83%**	**72.92%**	**33.33%**	**39.58%**

Table 2-6 summarizes CCS' performance relative to MQD Quality Strategy targets.

Table 2-6—Percentage of MQD Quality Strategy Targets Met or Exceeded for CCS

	'Ohana CCS
Total MQD Targets Met	**5**
Percent MQD Targets Met	**55.56%**

Strengths and Recommendations

Strengths

MQD's Quality Strategy provides the roadmap to achieve its vision of healthy families and healthy communities. MQD continually monitors, assesses, and implements strategies to improve access to quality care. Overall, the Quality Strategy represents an effective tool for measuring and improving the quality of Hawaii's QI and CCS programs.

The results of the compliance review, PIP, HEDIS, and NAV audit activities indicate that the health plans have established an operational foundation to support the quality of, access to, and timeliness of care and service delivery.

The Hawaii Medicaid managed care program has made significant progress toward achieving Goal 4—Support community initiatives to improve population health, as five of the six MLTSS Quality Strategy statewide targets were achieved in RY 2024. Similarly, improvement was noted in Goal 5—Enhance care in LTSS settings, with more than 50 percent of the statewide Quality Strategy targets met. While progress was made in the reporting of these measures, MLTSS measure rates among some health plans remain low and indicate continued room for improvement.

Progress was also made toward achieving Goal 2—Integrate behavioral health with physical health across the continuum of care, as performance measure results indicate that nearly two-thirds of the

established Quality Strategy statewide targets were achieved. MQD initiatives, health plan contract requirements, and behavioral health care coordination activities will support continued improvement in this program area.

At the health plan level, KFHP QI and ‘Ohana CCS met more than half of the RY 2024 Quality Strategy targets. AlohaCare QI, ‘Ohana QI, and UHC CP QI have the greatest room for improvement, as they met one-third or less of the Quality strategy targets.

Recommendations

Quality Strategy Goal 1, Goal 3, Goal 6, and Goal 7 have the greatest room for improvement, as performance measure results revealed that less than 50 percent of targets were met. The EQRO has identified the following recommendations to target improvement:

- While there was an increase in the number of Quality Strategy targets met from RY 2023 to RY 2024, adult and pediatric preventive care measures rates continue to show considerable room for improvement. To target improvement in Goal 1—Advance primary care, prevention, and health promotion, HSAG recommends that MQD consider requiring the health plans to conduct a PIP focusing on adult or pediatric preventive care services.
- All nine of the Prevention Quality Indicator (PQI) measure targets associated with Goal 3—Improve outcomes for high-need, high-cost individuals, showed an increase in the RY 2024 rates (PQI measures are inverse measures where lower rates indicate better performance). HSAG recommends that MQD consider requiring the health plans to conduct a root-cause analysis or other study to determine why avoidable hospital admissions increased. Timely and effective outpatient care, along with care coordination for members with special healthcare needs, will support continued improvement in this program area.
- As the Quality Strategy performance measures for Goal 6—Maintain access to appropriate care, span several care settings, Medicaid beneficiary populations, and include both physical and behavioral health services, HSAG recommends that MQD focus on one area for improvement that corresponds with the State’s current managed care program priorities. Lower-performing measures that could benefit from quality improvement activities or initiatives include SUD treatment measures, potentially avoidable hospital admission measures, and LTSS rebalancing and utilization measures.
- To target improvement in Goal 7—Align payment structures to improve health outcomes, HSAG recommends that MQD continue to evaluate its current incentive programs and make adjustments that support MQD priorities or implement other value-based payment models that aim to increase care coordination, quality, and health outcomes.

3. Assessment of Health Plan Performance

Introduction

This section of the report describes the results of HSAG's 2024 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, or PAHP 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.[33]
- **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).[34]
- **Timeliness**—NCQA defines "timeliness" relative to utilization decisions as follows:

[33] 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, 42 CFR Parts 430, 438, and 457 with revisions released (or as amended) May 10, 2024, Final Rule. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438. Accessed on: July 1, 2024.

[34] Ibid.

> "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[35] NCQA further discusses the intent of this standard as being to minimize any disruption in the provision of healthcare. HSAG extends this definition of timeliness to include other managed care provisions that impact services to beneficiaries and that require timely response by the MCO—e.g., processing expedited appeals and providing timely follow-up care. The Agency for Healthcare Research and Quality (AHRQ) indicates that "timeliness is the health care system's capacity to provide health care quickly after a need is recognized."[36] Timeliness includes the interval between identifying a need for specific tests and treatments and receiving those services.[37]

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 2024 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 MQD.

AlohaCare QUEST Integration (AlohaCare QI) Results

Compliance Monitoring Review

The 2024 compliance monitoring review activity included follow-up reviews of the health plans' required corrective actions implemented to address deficiencies noted during the 2022 and 2023 reviews.

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[35] National Committee for Quality Assurance. 2024 Standards and Guidelines for Accreditation of Health Plans.

[36] Agency for Healthcare Research and Quality. National Healthcare Quality and Disparities Reports. Elements of Access to Health Care: Timeliness. Available at: https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/access/elements3.html. Accessed on: July 1, 2024.

[37] Ibid.

Findings

Table 3-1 presents the scores from HSAG's 2022 and 2023 compliance reviews, the number of CAPs required, the number of CAPs closed, and the results of the 2024 follow-up reviews of AlohaCare QI.

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

Standard Name	Standard Review Year	Compliance Review Score	# of CAPs Required	# of CAPs Closed	2024 Final Follow-Up Review Score
Assurances of Adequate Capacity and Services	2022	100%	0	NA	100%
Availability of Services	2022	100%	0	NA	100%
Confidentiality	2022	100%	0	NA	100%
Coordination and Continuity of Care	2022	90%	2	2	100%
Coverage and Authorization of Services	2022	92%	4	4	100%
Credentialing	2023	98%	2	2	100%
Enrollee Information	2022	89%	4	4	100%
Enrollee Rights and Protections	2022	94%	1	1	100%
Enrollment and Disenrollment	2023	100%	0	NA	100%
Grievance and Appeal System	2022	97%	2	2	100%
Health Information Systems	2023	100%	0	NA	100%
Provider Selection	2023	100%	0	NA	100%
Practice Guidelines	2023	100%	0	NA	100%
Quality Assessment and Performance Improvement	2023	100%	0	NA	100%
Subcontractual Relationships and Delegation	2023	100%	0	NA	100%
Totals			**15**	**15**	**100%**

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

Strengths

The 2022 compliance review revealed that AlohaCare QI had deficiencies in five of the eight standards reviewed. During 2023 and 2024, AlohaCare QI completed 13 corrective action items to bring them into full compliance. To address the Coordination and Continuity of Care deficiencies, AlohaCare QI retrained its health coordinators, implemented weekly reminders for outstanding health and functional assessments, and conducted monthly care coordination file audits. Additionally, HSAG conducted follow-up file reviews on a sample of care coordination files in 2024. HSAG found that all files were fully compliant with the care coordination requirements. To address deficiencies in the Coverage and Authorization of Services and Grievance and Appeal System standards, AlohaCare QI updated policies and procedures, as well as its provider manual. Finally, to address deficiencies in the Enrollee Information and Enrollee Rights and Protections standards, AlohaCare QI updated policies and

procedures, the member handbook, the provider directory, and the member portal on its website to ensure all required information was present.

Since AlohaCare QI performed well during the 2023 compliance review, only two corrective action items needed to be completed in 2024. To address the Credentialing standard deficiencies, AlohaCare QI retrained its credentialing staff and conducted weekly audits of individual practitioner and organizational provider applications to ensure all required documents and verifications were in the credentialing file. Additionally, HSAG conducted follow-up file reviews on a sample of organizational provider credentialing files. HSAG found that all records were fully compliant with the organizational provider credentialing requirements.

Areas for Improvement

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

Recommendations

HSAG recommends that AlohaCare QI review the revised Medicaid managed care rules released in 2024 and implement operational changes, as applicable, to ensure continued compliance.

Validation of Performance Measures—NCQA HEDIS Compliance Audits

NCQA HEDIS Compliance Audit Findings

HSAG's review team assessed AlohaCare QI's IS capabilities and its ability to process data for reporting accurate performance measure rates. AlohaCare QI was found to be fully compliant with all HEDIS IS standards, including IS standard L for assessing case management data for LTSS measures. This demonstrated that AlohaCare QI had effective IS processes and control procedures in place for reporting the required performance measure rates. AlohaCare QI presented seven supplemental data sources for consideration to use for supplementing its MY 2023 performance measure rates. HSAG determined one data source to be nonstandard supplemental data, and the remaining six were determined to be standard supplemental data. No concerns were identified, and all seven supplemental data sources were approved for HEDIS MY 2023 reporting.

AlohaCare QI was required to undergo convenience sample validation for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Body Mass Index (BMI) Percentile—Total* and *Immunization for Adolescents—Combination 1* indicators, as they were new to the scope of the audit for MY 2023, as well as all medical record exclusions. All *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile—Total, Immunization for Adolescents—Combination 1,* and medical record exclusion cases successfully passed the validation process. The final statistical medical record review validation (MRRV) was conducted for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—*

BMI Percentile—Total, Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition—Total, Cervical Cancer Screening, Immunization for Adolescents—Combination 2, as well as all medical record exclusions. All selected cases passed the final MRRV without any critical errors.

All measures under the scope of the audit were determined to be *Reportable*. AlohaCare QI was determined to be fully compliant with all IS standards; therefore, HSAG did not have any recommendations for AlohaCare QI.

Access and Risk-Adjusted Utilization Performance Measure Results

AlohaCare QI's Access and Risk-Adjusted Utilization performance measure results are shown in Table 3-2.

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

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	—	52.19%	—	★
45–64 Years	—	66.29%	—	★
65 Years and Older	—	73.73%	—	★★
Total	—	58.72%	—	★
Ambulatory Care				
Emergency Department Visits	456.03	467.74	2.57%	★★★★
Outpatient Visits	3,008.45	2,890.18	-3.93%	★
Asthma in Younger Adults Admission Rate*				
*Asthma in Younger Adults Admission Rate**	—	2.95	—	NC
Heart Failure Admission Rate*				
18–64 Years	46.19	41.39	-10.39%	NC
65 Years and Older	158.70	117.25	-26.12%	NC
Total (18 Years and Older)	56.59	48.63	-14.07%	NC
Plan All-Cause Readmissions				
*Index Total Stays—Observed Readmissions—Total**	7.47%	7.39%	-1.08%	NC
Expected Readmissions—Total	9.97%	9.87%	-0.98%	NC
*Index Total Stays—O/E Ratio—Total**	0.7499	0.7485	-0.19%	NC

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by 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 health 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 2023 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*

The *Ambulatory Care—Emergency Department Visits* measure indicator rate met the 75th percentile. All other measure indicators in this domain did not meet or exceed the 50th percentile or did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented.

AlohaCare QI met the MQD-established Quality Strategy target for *Plan All-Cause Readmissions—Index Total Stays—O/E Ratio—Total.* No other MQD Quality Strategy targets were met in this domain.

Children's Preventive Health Performance Measure Results

AlohaCare QI's Children's Preventive Health performance measure results are shown in Table 3-3.

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

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Child and Adolescent Well-Care Visits				
Child and Adolescent Well-Care Visits	40.26%	42.51%	5.59%	★
Childhood Immunization Status				
Combination 3	50.36%	44.04%	-12.56%	★
Combination 7	43.31%	37.71%	-12.92%	★
Combination 10	29.93%	25.06%	-16.26%	★★
Diphtheria, Tetanus, Pertussis (DTaP)	54.50%	52.55%	-3.57%	★
Hepatitis A	70.32%	67.15%	-4.50%	★
Hepatitis B	75.43%	63.75%	-15.48%	★
Haemophilus Influenzae Type B (HiB)	72.99%	67.88%	-7.00%	★
Influenza	43.07%	38.20%	-11.30%	★★
Inactivated Polio Vaccine (IPV)	74.94%	69.34%	-7.47%	★
Measles, Mumps, Rubella (MMR)	69.83%	67.88%	-2.79%	★
Pneumococcal Conjugate	56.69%	51.34%	-9.44%	★
Rotavirus	60.34%	54.01%	-10.48%	★
Varicella-Zoster Virus (VZV)	70.80%	67.64%	-4.47%	★
Immunizations for Adolescents				
Combination 1 (Meningococcal; Tetanus, Diphtheria, Pertussis [Tdap])	—	59.85%	—	★
Combination 2 (Meningococcal, Tdap, Human Papillomavirus [HPV])	—	32.12%	—	★★

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Meningococcal Serogroups A, C, W, Y	—	61.80%	—	★
Tdap	—	61.56%	—	★
HPV	—	33.33%	—	★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents				
BMI Percentile Documentation—3–11 Years	—	83.92%	—	★★★
BMI Percentile Documentation—12–17 Years	—	77.56%	—	★★
BMI Percentile Documentation—Total	—	81.51%	—	★★★
Counseling for Nutrition—3–11 Years	—	75.69%	—	★★★
Counseling for Nutrition—12–17 Years	—	73.08%	—	★★★
Counseling for Nutrition—Total	—	74.70%	—	★★★
Counseling for Physical Activity—3–11 Years	—	73.33%	—	★★★
Counseling for Physical Activity—12–17 Years	—	73.72%	—	★★★
Counseling for Physical Activity—Total	—	73.48%	—	★★★
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	57.82%	56.03%	-3.10%	★★
Well-Child Visits for Age 15 Months to 30 Months of Life—Two or More Well-Child Visits	56.19%	57.47%	2.28%	★

— Indicates that the health 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 2023 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*

All *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* measure indicators with the exception of *BMI Percentile Documentation—12–17 Years* met or exceeded the 50th percentile. All other measure indicators in this domain did not meet or exceed the 50th percentile for MY 2023.

AlohaCare QI did not meet the MQD-established Quality Strategy targets in this domain.

Women's Health Performance Measure Results

AlohaCare QI's Women's Health performance measure results are shown in Table 3-4.

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

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Cervical Cancer Screening				
Cervical Cancer Screening	50.36%	47.69%	-5.31%	★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	77.37%	73.48%	-5.03%	★
Postpartum Care	73.24%	76.64%	4.65%	★★
Prenatal and Postpartum Care: Under 21 Years of Age (Child Core)				
Timeliness of Prenatal Care: Under 21 Years of Age	—	63.91%	—	NC
Postpartum Care: Under 21 Years of Age	—	65.41%	—	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 health 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 2023 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*

No measure indicators in this domain met or exceeded the 50th percentile. The *Prenatal and Postpartum Care: Under 21 Years of Age (Child Core)* measure indicators did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented.

AlohaCare QI did not meet the MQD-established Quality Strategy targets in this domain.

Care for Chronic Conditions Performance Measure Results

AlohaCare QI's Care for Chronic Conditions performance measure results are shown in Table 3-5.

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

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Asthma Medication Ratio				
5–11 Years	—	75.00%	—	★★

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
12–18 Years	—	53.49%	—	★
19–50 Years	—	48.08%	—	★
51–64 Years	—	58.89%	—	★★
Total (5–64 Years)	—	54.07%	—	★
Total—5–18 Years (Child Core)	—	63.86%	—	NC
Total—19–64 Years (Adult Core)	—	51.34%	—	NC
Blood Pressure Control for Patients With Diabetes				
Blood Pressure Control for Patients With Diabetes	60.10%	54.74%	-8.91%	★
Concurrent Use of Opioids and Benzodiazepines*				
18–64 Years	9.27%	10.84%	16.93%	NC
65 Years and Older	6.38%	7.58%	18.69%	NC
Total (18 Years and Older)	8.88%	10.35%	16.58%	NC
Controlling High Blood Pressure				
18–64 Years	52.12%	49.49%	-5.04%	NC
65–85 Years	54.81%	49.14%	-10.34%	NC
Total	52.80%	49.39%	-6.45%	★
Eye Exam for Patients With Diabetes				
Eye Exam for Patients With Diabetes	52.80%	54.74%	3.69%	★★★
Hemoglobin A1c Control for Patients With Diabetes				
HbA1c Control (<8.0%)—18–64 Years	—	40.80%	—	NC
HbA1c Control (<8.0%)-65–75 Years	—	56.47%	—	NC
HbA1c Control (<8.0%)—Total	52.31%	44.04%	-15.81%	★
*HbA1c Poor Control (>9.0%)—18–64 Years**	—	50.31%	—	NC
*HbA1c Poor Control (>9.0%)—65–75 Years**	—	36.47%	—	NC
*HbA1c Poor Control (>9.0%)—Total**	38.93%	47.45%	21.87%	★

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by 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 health 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 2023 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*

Eye Exam for Patients With Diabetes met or exceeded the 50th percentile. No other measure indicators in this domain met or exceeded the 50th percentile for MY 2023. Several measure indicators in this domain did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented.

AlohaCare QI met the MQD-established Quality Strategy target for *Concurrent Use of Opioids and Benzodiazepines—Total (18 Years and Older).* No other MQD Quality Strategy targets were met in this domain.

Behavioral Health Performance Measure Results

AlohaCare QI's Behavioral Health performance measure results are shown in Table 3-6.

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

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	64.55%	61.41%	-4.86%	★★★
Antidepressant Medication Management				
Effective Acute Phase Treatment—18–64 Years	—	53.39%	—	NC
Effective Acute Phase Treatment—65 Years and Older	—	75.00%	—	NC
Effective Acute Phase Treatment—Total	59.41%	54.81%	-7.75%	★
Effective Continuation Phase Treatment—18–64 Years	—	35.89%	—	NC
Effective Continuation Phase Treatment—65 Years and Older	—	56.25%	—	NC
Effective Continuation Phase Treatment—Total	42.92%	37.22%	-13.29%	★
Follow-Up After Emergency Department Visit for Mental Illness				
7-Day Follow-Up—6–17 Years	40.00%	22.50%	-43.75%	★
7-Day Follow-Up—18–64 Years	30.77%	30.95%	0.60%	★★
7-Day Follow-Up—65 Years and Older	—	NA	—	NC
7-Day Follow-Up—Total	31.75%	30.49%	-3.95%	★
30-Day Follow-Up—6–17 Years	50.00%	40.00%	-20.00%	★
30-Day Follow-Up—18–64 Years	43.08%	45.83%	6.40%	★★
30-Day Follow-Up—65 Years and Older	—	NA	—	NC
30-Day Follow-Up—Total	43.65%	45.74%	4.78%	★
Follow-Up After Emergency Department Visit for Substance Use				
7-Day Follow-Up—13–17 Years	—	NA	—	NC

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
7-Day Follow-Up—18 Years and Older	25.68%	27.10%	5.53%	★★★
7-Day Follow-Up—Total	24.70%	26.98%	9.24%	★★★
7-Day Follow-Up—-18–64 Years (Adult Core)	—	27.22%	—	NC
7-Day Follow-Up—65 Years and Older (Adult Core)	—	NA	—	NC
30-Day Follow-Up—13–17 Years	—	NA	—	NC
30-Day Follow-Up—18 Years and Older	39.04%	39.69%	1.65%	★★★
30-Day Follow-Up—Total	37.55%	39.29%	4.64%	★★★
30-Day Follow-Up—18–64 Years (Adult Core)	—	39.56%	—	NC
30-Day Follow-Up—65 Years and Older (Adult Core)	—	NA	—	NC
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase—Total	—	49.18%	—	★★★★
Continuation and Maintenance Phase—Total	—	47.37%	—	★
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation—Total—13–17 Years	27.63%	31.08%	12.48%	★
Initiation—Total—18–64 Years	—	41.02%	—	★★
Initiation—Total—65 Years and Older	—	45.26%	—	★★★
Initiation—Total	36.57%	40.95%	11.98%	★★
Engagement—Total—13–17 Years	1.32%	5.41%	310.81%	★
Engagement—Total—18–64 Years	—	9.13%	—	★
Engagement—Total—65 Years and Older	—	5.84%	—	★★★
Engagement—Total	6.85%	8.80%	28.42%	★
Screening for Depression and Follow-Up Plan				
12–17 Years	31.63%	41.51%	31.23%	NC
18–64 Years	19.65%	29.09%	48.00%	NC
65 Years and Older	20.33%	28.92%	42.28%	NC
Total (12 Years and Older)	22.28%	31.77%	42.57%	NC
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
1–11 Years	—	NA	—	NC
12–17 Years	—	NA	—	NC
Total	—	NA	—	NC
Use of Pharmacotherapy for Opioid Use Disorder				
Rate 1: Total	57.18%	55.15%	-3.56%	NC
Rate 2: Buprenorphine	34.73%	33.58%	-3.30%	NC

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Rate 3: Oral Naltrexone	0.78%	0.98%	25.16%	NC
Rate 4: Long-Acting, Injectable Naltrexone	—	0.25%	—	NC
Rate 5: Methadone	24.28%	22.06%	-9.16%	NC

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by 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 health 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 2023 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*

All HEDIS measure indicators for *Follow-Up After Emergency Department Visit for Substance Use* met or exceeded the 50th percentile. Two of the *Initiation and Engagement of Substance Use Disorder Treatment* measure indicators met or exceeded the 50th percentile. Additionally, *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* met or exceeded the 50th percentile, and *Follow-Up Care for Children Prescribed (ADHD Medication—Initiation Phase—Total* met or exceeded the 75th percentile. All other measure indicators in this domain either did not meet the 50th percentile or did not have national benchmarks to compare for MY 2023.

AlohaCare QI met the MQD-established Quality Strategy target for the *Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total; Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase—Total; Initiation and Engagement of Substance Use Disorder Treatment—Initiation—Total; Screening for Depression and Follow-Up Plan—Total (12 Years and Older);* and *Use of Pharmacotherapy for Opioid Use Disorder—Rate 1, Rate 2,* and *Rate 5* measure indicators. No other MQD Quality Strategy targets were met for this domain.

Long-Term Services and Supports Performance Measure Results

AlohaCare QI's Long-Term Services and Supports performance measure results are shown in Table 3-7.

Table 3-7—AlohaCare QI's Results for QI Measures Under Long-Term Services and Supports

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
LTSS Comprehensive Assessment and Update				
Assessment of Core Elements Documented	78.13%	47.92%	-38.67%	NC
Assessment of Supplemental Elements Documented	78.13%	47.92%	-38.67%	NC
LTSS Comprehensive Care Plan and Update				
Care Plan With Core Elements Documented	69.79%	66.67%	-4.48%	NC
Care Plan With Supplemental Elements Documented	69.79%	66.67%	-4.48%	NC
LTSS Minimizing Institutional Length of Stay				
Observed Rate	7.62%	4.66%	-38.86%	NC
Risk-Adjusted Rate	26.95%	31.36%	16.38%	NC
O/E Ratio	0.2829	0.1486	-47.47%	NC

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

AlohaCare QI met the established MQD targets for *LTSS Comprehensive Assessment and Update—Assessment of Core Elements Documented, Assessment of Supplemental Elements Documented, LTSS Comprehensive Care Plan and Update—Care Plan With Core Elements Documented,* and *Care Plan With Supplemental Elements Documented.* The measures in this domain did not have applicable benchmarks; therefore, no comparison to national benchmarks is presented.

Strengths

Based on HSAG's analyses of AlohaCare QI's 72 indicator rates comparable to benchmarks, 18 indicator rates (25 percent) ranked at or above the 50th percentile, with two of these rates (2.78 percent) ranking at or above the 75th percentile. Additionally, AlohaCare QI met 14 MQD Quality Strategy targets for MY 2023.

Areas for Improvement

Conversely, 54 of AlohaCare QI's measure rates comparable to benchmarks (75 percent) fell below the 50th percentile, with 24 rates (33.3 percent) falling below the 25th percentile, suggesting significant opportunities for improvement across most domains of care.

Recommendations

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:

- Within the Children's Preventive Health domain, the following recommendations were identified:
  - Regarding the *Child and Adolescent Well-Care Visits* measure, HSAG recommends that AlohaCare QI incentivize providers, members, and parents to complete visits; encourage teen-centered care through privacy and confidentiality; promote well-visits on social media or perform other outreach; and develop partnerships with community stakeholders.[38]
  - Regarding the *Total Childhood Immunization Status* measure, HSAG recommends that AlohaCare QI provide education to providers and members about the importance of vaccination for disease prevention and encourage vaccination at every opportunity, including mild illness visits.
  - Regarding the *Well-Child Visits in the First 30 Months of Life* measure*,* HSAG recommends that AlohaCare QI identify performance improvement efforts to improve well-child visits, drawing from other states' performance improvement initiatives. For instance, California and Virginia have focused on delays in newborn enrollment data, and Missouri and Texas focused on beneficiary barriers and implemented interventions such as utilizing patient portals and phone outreach.[39] HSAG recommends that that AlohaCare QI identify other barriers to care and conduct a focus group on identifying abilities to address barriers.
- Within the Women's Health domain, the following recommendations were identified:
  - Regarding the *Cervical Cancer Screening* measure, HSAG recommends that AlohaCare QI consider utilizing one-on-one interactions with a healthcare professional, such as community health workers (CHWs), which have been shown to improve cervical cancer screening.[40] Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness. In addition, HSAG recommends that AlohaCare QI provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is lack of knowledge.
  - Regarding the *Prenatal and Postpartum Care* measure, HSAG recommends that AlohaCare QI consider whether there are disparities/SDOH within AlohaCare QI's population that contribute to lower access to care. Upon identification of a root cause, HSAG recommends that AlohaCare QI implement appropriate interventions to reduce barriers to care. Strategies could include providing expanded access appointments outside of business hours to accommodate work schedules or childcare needs. Many appointments can be made via telehealth; therefore, ensuring members

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[38] Centers for Medicare & Medicaid Services. Paving the Road to Good Health Strategies for Increasing Medicaid Adolescent Well-Care Visits. Available at: https://www.medicaid.gov/medicaid/benefits/downloads/paving-the-road-to-good-health.pdf. Accessed on: Jan 6, 2025.

[39] Centers for Medicare & Medicaid Services. Well-Child Care. Available at: https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/well-child-care/index.html. Accessed on: Jan 6, 2025.

[40] Popalis ML, Ramirez SI, Leach KM, et al. Improving cervical cancer screening rates: a scoping review of resources and interventions. *Cancer Causes Control*. 2022 Nov;33(11):1325–1333.

have access to this option could potentially increase performance on this measure. Further, HSAG recommends that AlohaCare QI identify payment structure types that will incentivize quality care. Bundling payments may cause disincentives for postpartum care, as providers might receive the same payment regardless of whether the member attends the postpartum visit.[41]

- Within the Care for Chronic Conditions domain, the following recommendations were identified:
  - Regarding the *Controlling High Blood Pressure* measure, HSAG recommends that AlohaCare QI identify trends within the data to identify which demographic groups and regions report lower blood pressure. HSAG recommends providing coverage for automated home blood pressure monitors for patients, while educating members about the benefits of this approach.[42] Further, HSAG recommends providing incentives to members and providers to encourage blood pressure control.
- Within the Behavioral Health domain, the following recommendations were identified:
  - Regarding the *Follow-Up After Hospitalization for Mental Illness* measure, HSAG recommends that AlohaCare QI consider effective interventions to reduce repeat hospitalizations for people with mental illness, such as Critical Time Intervention (CTI), Assertive Community Treatment (ACT), case management, and focusing on co-occurring substance abuse disorders.[43]

Validation of Network Adequacy

HSAG evaluated and assessed the data methods that AlohaCare QI used to calculate results generated for each network adequacy indicator in the scope of the 2024 NAV activities. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that AlohaCare QI used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator.

Findings

Based on the results of the information systems capability assessment (ISCA) combined with the virtual audit and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the health plan's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each health plan according to Table 3-8.

[41] Centers for Medicare & Medicaid Services. Lessons Learned About Payment Strategies to Improve Postpartum Care in Medicaid and CHIP. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/postpartum-payment-strategies.pdf. Accessed on: Dec 18, 2024.

[42] Centers for Disease Control and Prevention. The Surgeon General's Call to Action to Control Hypertension. Available at: https://www.cdc.gov/high-blood-pressure/php/cta/index.html. Accessed on: Dec 26, 2024.

[43] Kreyenbuhl J, Nossel IR, Dixon LB. Disengagement from mental health treatment among individuals with schizophrenia and strategies for facilitating connections to care: a review of the literature. *Schizophrenia Bulletin*. 2009 Jul;35(4):696–703.

Table 3-8—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*
10.0% to 49.9%	*Low Confidence*
Less than 10% and/or any *Not Met* element has significant bias on the results	*No Confidence*

No indicators were designated as *Low Confidence* or *No Confidence* for AlohaCare QI.

HSAG determined that AlohaCare QI was not compliant with network adequacy requirements for the Access and Availability standard. MQD required at least 80 percent of members to be provided an appointment within the designated time frame for the Behavioral Health, Primary Care Provider (PCP) Adult Sick Visits, and PCP Visits provider types. MQD required at least 60 percent of members to be provided an appointment within the designated time frame for the Urgent Care and PCP Pediatric Sick Visits and Visits with Specialists or Non-Emergency Hospital Stays provider types. Compliance was determined based on the health plan meeting the State's Access and Availability indicators. All indicators were calculated by MQD. Results are presented by provider type in Table 3-9.

Table 3-9—AlohaCare QI Network Adequacy Access and Availability Compliance

Provider Type	Indicator	Compliance
Urgent Care and PCP Pediatric Sick Visits	Appointments within twenty-four (24) hours	*Not Met*
Visits with Specialists or Non-Emergency Hospital Stays*	Appointments within four (4) weeks or of sufficient timeliness to meet medical necessity	*Not Met*
Behavioral Health (routine visits for adults and children)	Appointment within twenty-one (21) days	*Not Met*
PCP Adult Sick Visits	Appointment within seventy-two (72) hours	*Not Met*
PCP Visits (routine visits for adults and children)	Appointments within twenty-one (21) days	*Not Met*

* MQD confirmed that in CY 2024, Visits with Specialists only included OB/GYN.

HSAG determined that AlohaCare QI was compliant with network adequacy requirements for the Provider Ratios standard for all provider types. Compliance was determined based on the health plan meeting the State's Provider Ratio indicators. All indicators were calculated by MQD. Results are presented by provider type in Table 3-10.

Table 3-10—AlohaCare QI Network Adequacy Provider Ratios Compliance

Provider Type	Ratio	Results	Compliance
Hospitals on Oahu	5	11	*Met*
Hospital on Kauai	1	4	*Met*
Hospital on Lanai	1	1	*Met*
Hospital on Maui	1	2	*Met*
Hospital on Molokai	1	1	*Met*
Hospitals on Hawaii (one in East Hawaii and one in West Hawaii)	2	7	*Met*
Other Behavioral Health Providers to include Psychologists, Licensed Mental Health Counselors, Licensed Clinical Social Workers, and Advanced Practice Registered Nurses (APRNs)—Behavioral Health for members with an SMI or SPMI diagnosis	1:100	1:4	*Met*
Behavioral Health Psychiatrists for members with an SMI or SPMI diagnosis. In geographic areas with a demonstrated shortage of qualified physicians, a psychiatric APRN who has the authority to prescribe medications (APRN-Rx) may assume the role of psychiatrist.	1:150	1:30	*Met*
PCPs	1:300	1:21	*Met*

HSAG determined that AlohaCare QI was compliant with network adequacy requirements for the Mandatory Provider Types standard for 13 of 16 indicators (81.25 percent). Compliance was determined based on the health plan meeting the State's Mandatory Provider Type indicators, which includes one servicing provider within each provider type. All indicators were calculated by MQD. Compliant results are presented by provider type in Table 3-11, and noncompliant results are presented in Table 3-12.

Table 3-11—AlohaCare QI Network Adequacy Mandatory Provider Types Compliance

Provider Type	Compliance
Home Health Agencies and Hospices	*Met*
LTSS Providers	*Met*
Durable Medical Equipment (DME)	*Met*
Case Management Agencies	*Met*
Laboratories which have either a Clinical Laboratory Improvement Amendments (CLIA) 1988 certificate or a waiver of a certificate of registration	*Met*
Optometrists	*Met*
Physical and Occupational Therapists, Audiologists, and Speech-Language Pathologists	*Met*
Providers of lodging and meals associated with obtaining necessary medical care	*Met*

Provider Type	Compliance
Sign language interpreters and interpreters for languages other than English	*Met*
Physician Specialists, including but not limited to Cardiologists, Endocrinologists, General Surgeons, Geriatricians, Hematologists, Infectious Disease Specialists, Nephrologists, Neurologists, Obstetricians/Gynecologists (OB/GYNs), Oncologists, Ophthalmologists, Orthopedists, Otolaryngologists, Pediatric Specialists, Plastic and Reconstructive Surgeons, Pulmonologists, Radiologists, and Urologists	*Met*
Behavioral Health Providers: Licensed Therapists, Counselors, and Certified Substance Abuse Counselors (CSACs)	*Met*
Emergency Transportation Providers (both ground and air)	*Met*
Non-Emergency Transportation Providers (both ground and air)	*Met*

Table 3-12—AlohaCare QI Network Adequacy Mandatory Provider Types Noncompliance

Provider Type	Compliance
Peer Support Specialists certified by the Adult Mental Health Division (AMHD) as a part of its Hawaii certified peer specialist program or a program that meets the criteria established by AMHD	*Not Met*
Licensed Dietitians	*Not Met*
Community Health Workers	*Not Met*

During the NAV review period, HSAG determined that the Access and Availability provider types in Table 3-13 were not required by MQD, resulting in an *Unable to Validate* designation for each associated provider type.

Table 3-13—AlohaCare QI Network Adequacy Mandatory Provider Types *Unable to Validate* Indicators

Provider Type
State-Licensed Special Treatment Facilities for the provision of substance abuse therapy/treatment
Physician Assistants (PAs)
Community Paramedics (CPs)

HSAG determined that AlohaCare QI was compliant with network adequacy requirements for a subset of the Time and Distance indicators. MQD required at least 85 percent of members to have access to the providers within the associated time or distance parameters. Compliance was determined based on the health plan meeting the State's Time and Distance indicators for both Urban and Rural classifications. All indicators were calculated by MQD. Results are presented by provider type and urbanicity in Table 3-14, and noncompliant results are presented in Table 3-15.

Table 3-14—AlohaCare QI Network Adequacy Time and Distance ≥85% Compliance by Urbanicity

Provider Type	Urbanicity	Compliance
PCPs (Adult and Pediatric)	Urban	*Met*
	Rural	*Met*
Specialists (Adult and Pediatric)	Urban	*Met***
	Rural	*Met***
OB/GYN	Urban	*Met*
	Rural	*Met*
Adult day care/adult day health	Urban	*Met*
Hospitals	Urban	*Met*
	Rural	*Met*
Behavioral Health Provider (Adult and Pediatric)	Urban	*Met*
	Rural	*Met*
LTSS Providers	Urban	*Met*
	Rural	*Met*
24-Hour Pharmacy	Urban	*Met*
Pharmacies	Urban	*Met*
	Rural	*Met*
Emergency Services Facilities	Urban	*NA**
	Rural	*NA**

* Due to misalignment between the MQD-provided reporting template and contractual standards, the health plan did not report for this indicator.
** *Met* for a subset of provider types.

Table 3-15—AlohaCare QI Network Adequacy Time and Distance < 85% Noncompliance by Urbanicity

Provider Type	Urbanicity	Compliance
Pediatric Specialists	Urban	*Not Met*
	Rural	*Not Met*
Geriatricians	Urban	*Not Met*
Endocrinologists	Rural	*Not Met*
Hematologists	Rural	*Not Met*
Infectious Disease Specialists	Rural	*Not Met*
Otolaryngologists	Rural	*Not Met*

During the NAV review period, HSAG determined that the Access and Availability provider types in Table 3-16 were not required by MQD, resulting in an *Unable to Validate* designation for each associated indicator.

Table 3-16—AlohaCare QI Network Adequacy Time and Distance *Unable to Validate* Indicators

Provider Type	Urbanicity	Indicator
Emergency Services Facilities	Urban	Within 30 minute driving time
	Rural	Within 60 minute driving time

Strengths

HSAG identified the following strengths related to NAV for AlohaCare QI:

- AlohaCare QI used one data system across enrollment, claims, and provider data management, facilitating accuracy and completeness of data.
- AlohaCare QI implemented multiple strategies to support its members and provider network, including access to care grants to support community-based innovations that improve access to healthcare, peer-to-peer provider consultations to reduce the need for referrals to specialists for care, and expedited and provisional credentialing to onboard providers.

Areas for Improvement

No opportunities for improvement were identified related to the systems, processes, data submissions, and monitoring activities AlohaCare QI had in place to inform network adequacy reporting.

Recommendations

While HSAG had no recommendations related to AlohaCare QI's processes for producing the network adequacy results, HSAG recommends that AlohaCare QI continue to monitor and address any gaps in its provider network.

Validation of Performance Improvement Projects

In CY 2024, AlohaCare QI continued the two PIPs initiated in 2022. The selected PIP topics were *Behavioral Health Coordination* and *Plan All-Cause Readmissions*. For the CY 2024 submission, the health plan progressed to the Design, Implementation, and Outcomes stages of the PIPs and submitted Steps 1 through 8 in the PIP Submission Form. The PIPs were assessed for improvement in outcomes in Step 9.

In CY 2024, AlohaCare QI also submitted a new PIP: *Screening for Depression and Follow-Up Plan*. For this PIP, AlohaCare QI progressed to the Design stage of the PIP and submitted Steps 1 through 6 in the PIP submission form.

Table 3-17 displays the topics, progression status, and measurement periods reported for the PIPs.

Table 3-17—CY 2024 AlohaCare QI PIP Topics and Status

PIP Topic	PIP Progression Status	Baseline Measurement Period	Measurement Period Reported in CY 2024
Behavioral Health Coordination	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	07/01/2021 to 09/30/2021	07/01/2023 to 09/30/2023 (Remeasurement 2)
Plan All-Cause Readmissions	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	CY 2021	CY 2023 (Remeasurement 2)
Screening for Depression and Follow-Up Plan	PIP Design Stage (Steps 1 through 6)	01/01/2024 to 12/31/2024	Not Applicable

The focus of the nonclinical *Behavioral Health Coordination* PIP is to integrate care between the Department of Health (DOH) Behavioral Health Services Administration divisions, ‘Ohana 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 SMI and SPMI, developmental disabilities, and other chronic issues. The methodology for this PIP was defined by 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 *Plan All-Cause Readmissions (PCR)* measure.

The focus of the clinical *Screening for Depression and Follow-Up Plan* PIP is to increase depression screening and documentation of a follow-up plan for members 12 years of age or older who screened positive for depression.

Findings

Table 3-18 illustrates the validation results for the three PIPs submitted by AlohaCare QI for the CY 2024 validation.

Table 3-18—CY 2024 PIP Validation Results for AlohaCare QI

PIP Topic	Validation Rating 1			Validation Rating 2		
	Overall Confidence in Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Behavioral Health Coordination	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Plan All-Cause Readmissions	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
Screening for Depression and Follow-Up Plan	100%	100%	*High Confidence*	*Not Assessed*[4]		

1 **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) 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 **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.
4 **Not Assessed**—HSAG did not assess Step 9, as the QI health plans only reported the Design stage.

The *Behavioral Health Coordination* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *High Confidence* level rating that the PIP achieved significant improvement.

The *Plan All-Cause Readmissions* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *Moderate Confidence* level rating that the PIP achieved significant improvement.

The *Screening for Depression and Follow-Up Plan* PIP was validated through the first six steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. AlohaCare QI had not progressed to reporting remeasurement data, and therefore the PIP was not assessed for Validation Rating 2 (i.e., overall confidence that the PIP achieved significant improvement).

Design (Steps 1-6)

Behavioral Health Coordination

The health plan met 100 percent of the requirements in the Design stage for the *Behavioral Health Coordination* PIP. AlohaCare QI documented the PIP design accurately. AlohaCare QI's data collection process was methodologically sound; however, the data collection processes to capture the combined reviews and data sharing with the DOH Behavioral Health Services Administration divisions were not defined. At the time of the PIP submission in March 2024, the health plan was awaiting approval of the Data Sharing Agreement (DSA) by the DOH Behavioral Health Services Administration divisions. The DSA was finalized and executed in December 2024 and is effective as of January 1, 2025.

Plan All-Cause Readmissions

The health plan met 100 percent of the requirements in the Design stage. The selected PIP topic was required by MQD, and the health 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.

Screening for Depression and Follow-Up Plan

The health plan met 100 percent of the requirements in the Design stage, Steps 1 through 6. The selected PIP topic was required by MQD. 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 CMS Child Core Set *Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)* measure and the CMS Adult Core Set *Screening for Depression and Follow-Up Plan (CDF-AD)* measure. AlohaCare QI's data collection process was also found to be methodologically sound.

Implementation (Steps 7-8)

Behavioral Health Coordination

The health plan reported and analyzed the Remeasurement 2 rates for the two performance indicators. AlohaCare QI documented its quality improvement efforts, which included partnering with other health plans and working with its leadership team to determine a workflow for ongoing communication and information sharing. AlohaCare QI also drafted and shared the DSA with the DOH Behavioral Health Services Administration divisions.

Plan All-Cause Readmissions

The health plan accurately reported and analyzed the Remeasurement 2 rate for the performance indicator. AlohaCare QI conducted appropriate quality improvement processes to identify barriers, and it

deployed logical interventions linked to the identified barriers. The interventions appeared to positively impact performance indicator outcomes. AlohaCare QI included an evaluation of effectiveness for each intervention and appropriate next steps for the interventions.

Screening for Depression and Follow-Up Plan

The health plan had not progressed to reporting and analyzing data or conducting quality improvement activities.

Outcomes (Step 9)

Behavioral Health Coordination

The health plan reported third quarter of CY 2023 as the Remeasurement 2 period for this PIP. The health plan achieved statistically significant improvement over the baseline during the Remeasurement 2 period for both performance indicators.

Plan All-Cause Readmissions

The health plan reported CY 2023 as the Remeasurement 2 period for this PIP. The health plan achieved nonstatistically significant improvement in the Remeasurement 2 rate over the baseline.

Screening for Depression and Follow-Up Plan

The health plan had not progressed to reporting remeasurement outcomes. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle.

Analysis of Results

Table 3-19 displays the data that the health plan reported for the *Behavioral Health Coordination* PIP.

Table 3-19—Outcomes for the *Behavioral Health Coordination* PIP

Performance Indicator	Baseline (07/01/2021–09/30/2021)		Remeasurement 1 (07/01/2022–09/30/2022)		Remeasurement 2 (07/01/2023–09/30/2023)		Sustained Improvement
Percent of shared members with eligible trigger events who received a combined review in the past three months.	N: 9	12.0%	N: 49	33.0%*	N: 129	41.7%*	*Yes*
	D: 82		D: 148		D: 309		
Percent of shared members whose data are actively shared at a regular frequency with partner agencies.	N: 0	0.0%	N: 19	2.0%*	N: 48	4.4%*	*Yes*
	D: 933		D: 973		D: 1,102		

*Rate demonstrates statistically significant improvement over the baseline rate.
N–Numerator D–Denominator
HSAG rounded percentages to the first decimal place.

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. For Remeasurement 1, the Performance Indicator 1 rate increased to 33.0 percent. For Remeasurement 2, the rate was 41.7 percent, which represents a statistically significant increase of 29.7 percentage points over the baseline.

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 baseline year 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. For Remeasurement 1, the Performance Indicator 2 rate increased to 2.0 percent, and for Remeasurement 2, the rate was 4.4 percent, which represents a statistically significant increase of 4.4 percentage points over the baseline. AlohaCare QI documented that during Remeasurement 2, it continued to share daily data reports with 'Ohana CCS for shared members who were hospitalized for medical reasons. The data sharing for members who are high utilizers of ED visits began in January 2023. Data sharing between the health plan and the DOH Behavioral Health Services Administration divisions had not yet started and was pending the approval of the DSA by the concerned authorities.

During Remeasurement 2, both performance indicators sustained statistically significant improvement in performance.

Table 3-20 displays the data that the health plan reported for the *Plan All-Cause Readmissions* PIP.

Table 3-20—Outcomes for the *Plan All-Cause Readmissions* PIP

Performance Indicator	Baseline (01/01/2021–12/31/2021)		Remeasurement 1 (01/01/2022–12/31/2022)		Remeasurement 2 (01/01/2023–12/31/2023)		Sustained Improvement
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	8.9%	N: 161	7.5%	N:169	7.4%	*Not Assessed*
	D: 2,000		D: 2,154		D:2,287		

N–Numerator D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline 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, and for Remeasurement 1, the performance indicator rate decreased to 7.5 percent. For Remeasurement 2, the rate was 7.4 percent, which represents a statistically nonsignificant improvement

of 1.5 percentage points compared to the baseline rate. The health plan was not assessed for sustained improvement because it had not achieved statistically significant improvement during Remeasurement 1.

Table 3-21 will display the data for the *Screening for Depression and Follow-Up Plan* PIP once AlohaCare QI reports performance indicator results.

Table 3-21—Performance Indicator Results for the *Screening for Depression and Follow-Up Plan* PIP

Performance Indicator	Baseline (01/01/2024–12/31/2024)		Remeasurement 1 (01/01/2025–12/31/2025)		Sustained Improvement
1. Percentage of members ages 12 to 17 screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter.					
2. Percentage of members aged 18 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and, if positive, a follow-up plan is documented on the date of the eligible encounter.					

Barriers/Interventions

The identification and prioritization of barriers through causal/barrier analysis and the selection of appropriate active interventions to address these barriers are necessary steps to improve outcomes. AlohaCare QI's choice of interventions, combination of intervention types, and sequence of implementing the interventions are essential to the health plan's overall success in achieving the desired outcomes for the PIP.

Table 3-22 displays the barriers and interventions as documented by the health plan for the *Behavioral Health Coordination* and *Plan All-Cause Readmissions* PIPs. Barriers and interventions for the *Screening for Depression and Follow-Up Plan* PIP will be documented when the PIP progresses to including QI activities and interventions.

Table 3-22—Interventions Implemented/Planned for AlohaCare QI PIPs

Barriers	Interventions
Behavioral Health Coordination	
Inadequate care coordination and integrated care approach among partnering agencies for shared members.	1. Drafting and executing Memorandum of Understanding (MOU) with CCS.* 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.* 4. Develop DSAs with DOH agencies. DSAs were submitted to DOH agencies in December 2022 for their review/approval. Based on feedback from the DOH agencies, the DSAs were revised to a single MOU to include all DOH agencies. The new MOU was submitted to DOH for review and approval in December 2023.
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. 4. Lack of knowledge on how to interpret and utilize the Predictive Analytics tool.	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. A TOC referral workflow includes notification of anticipated discharge date and supports if known. 4. Interdepartmental clinical rounds and behavioral health rounds (two per week) to discuss discharge dates, needs, risks, community resources, and ways to prevent member readmissions. Each member will have a change in condition assessment performed by health coordinators/community health workers within three days of discharge. 5. Utilize Risk Scores obtained from the Predictive Analytics tool to determine if a higher risk score is an accurate indicator of readmission.
Screening for Depression and Follow-Up Plan	

* The documented interventions are required by MQD.

Strengths

- For all three PIPs, AlohaCare QI received an overall *High Confidence* level rating for overall confidence in adherence to acceptable methodology for all phases of the PIP for Steps 1 through 8. For the *Behavioral Health Coordination* PIP, AlohaCare QI received an overall *High Confidence* level rating for overall confidence that the PIP achieved significant improvement for Step 9.
- For the *Behavioral Health Coordination* PIP, during Remeasurement 2, the health plan sustained statistically significant improvement in the rates of both performance indicators.
- For the *Plan All-Cause Readmissions* PIP, the health plan achieved statistically nonsignificant improvement in the performance indicator rate over the baseline with a decrease in the observed readmission rate.
- For the *Screening for Depression and Follow-Up Plan* PIP, the health plan designed a scientifically sound project that was supported by using key research principles.

Areas for Improvement

- For the *Behavioral Health Coordination* PIP, the health plan had continued data sharing with ‘Ohana CCS; however, the data sharing with DOH Behavioral Health Services Administration divisions will begin in 2025.
- For the *Plan All-Cause Readmissions* PIP, AlohaCare QI must expand the successful interventions to realize a statistically significant improvement in the performance indicator rate.

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 performance indicator rates to at least one decimal place for each measurement period.
- For the *Screening for Depression and Follow-Up* PIP:
  - The health plan must ensure that the interventions are implemented in a timely manner to impact outcomes during the remeasurement period.
- The health plan must 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 the use of quality improvement science-based tools, such as process mapping with FMEA, for causal/barrier analysis.
- The health plan must evaluate each intervention listed in the barriers/interventions table for effectiveness.

- The health plan should collect the intervention effectiveness data more frequently (e.g., monthly or quarterly), unlike the annual performance indicator data. This would help AlohaCare QI understand intervention effectiveness and make any updates to the interventions in a timely manner to impact remeasurement outcomes.
- Intervention effectiveness data must guide next steps for each individual intervention.

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 3-23 presents the 2024 scores for AlohaCare QI compared to the 2023 NCQA adult Medicaid national averages, the corresponding 2022 scores, and the QI Program (i.e., combination of the five QI health plans).[44,45] Additionally the overall member experience ratings (i.e., star ratings) resulting from the comparison of AlohaCare QI's 2024 scores to NCQA's 2023 Quality Compass Benchmark and Compare Quality Data are displayed below.[46]

Table 3-23—Adult Medicaid CAHPS Results for AlohaCare QI

Measure	2022 Scores	2024 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	59.80%	63.60%	★★★
Rating of All Health Care	55.95%	53.08%	★★
Rating of Personal Doctor	64.10%	68.52%	★★★
Rating of Specialist Seen Most Often	70.64%	64.10%+	★★
Composite Measures			
Getting Needed Care	79.19%	80.29%	★★
Getting Care Quickly	75.55%	75.63%+	★
How Well Doctors Communicate	90.66%	90.82%	★
Customer Service	83.86%	88.13%+	★★
Individual Item Measure			
Coordination of Care	78.95%+	87.32%+	★★★★

[44] The adult population was last surveyed in 2022; therefore, the 2024 adult CAHPS scores are compared to the corresponding 2022 scores.
[45] National Committee for Quality Assurance. *HEDIS® Measurement Year 2023*, *Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2023.
[46] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2023.* Washington, DC: NCQA, September 2023.

Measure	2022 Scores	2024 Scores	Star Ratings
Medical Assistance With Smoking and Tobacco Use Cessation Measure Items			
Advising Smokers and Tobacco Users to Quit	65.41%	69.11%	★★
Discussing Cessation Medications	49.46%	50.41%	★★★
Discussing Cessation Strategies	47.03%	47.97%	★★★

A cell highlighted in green represents the score is statistically significantly higher than the 2023 NCQA adult Medicaid national average.
A cell highlighted in red represents the score is statistically significantly lower than the 2023 NCQA adult Medicaid national average.
▲ *Indicates the 2024 score is statistically significantly higher than the 2022 score.*
▼ *Indicates the 2024 score is statistically significantly lower than the 2022 score.*
↑ *Indicates the QI health plan's 2024 score is statistically significantly higher than the QI Program.*
↓ *Indicates the QI health plan's 2024 score is statistically significantly lower than the QI Program.*
+ *Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.*
Star Ratings based on percentiles:
★★★★★ *90th or Above* ★★★★ *75th-89th* ★★★ *50th-74th* ★★ *25th-49th* ★ *Below 25th*

Strengths

- For AlohaCare QI's adult Medicaid population, the *Coordination of Care* measure met or exceeded the 75th percentile.
- Of the nine MQD member satisfaction Quality Strategy target measures—*Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Coordination of Care*—AlohaCare QI's member experience rating for *Rating of Health Plan*, *Rating of Personal Doctor*, and *Coordination of Care* exceeded the RY 2024 target.

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 3-24 provides a summary of the key drivers identified for AlohaCare QI.

Table 3-24—AlohaCare QI Key Drivers of Member Experience Analysis

Survey Item	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	—	✓	—
Q6. Received appointment for a checkup or routine care as soon as needed	✓	—	—
Q15. Personal doctor spent enough time	—	—	✓

Survey Item	Key Drivers		
	Rating of Health Plan	*Rating of All Health Care*	*Rating of Personal Doctor*
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	✓	—	NA

NA *Indicates that this question was not evaluated for this measure.*
— *Indicates the survey item is not strongly correlated with the measure or that the item did not perform poorly (i.e., not a key driver).*

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

- Respondents reported not always receiving care as soon as they needed when care was needed right away.
- Respondents reported not receiving an appointment for a checkup or routine care as soon as they needed.

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

- 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 spend enough time with them.
- 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.

Recommendations

HSAG recommends that AlohaCare QI explore what may be driving lower experience scores and develop initiatives designed to improve quality and access to care, including a focus on improving adult members' overall experiences with their health plan, overall healthcare, the specialist they see most often, customer service, and getting needed care in a timely manner.

Home and Community-Based CAHPS Survey

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

Findings

Table 3-25 presents the 2024 top-box scores for AlohaCare QI compared to the Hawaii HCBS Program (i.e., combination of the five QI health plans) scores, AHRQ's 2024 CAHPS Database benchmarks, and the corresponding 2023 scores.[47,48,49]

Table 3-25—HCBS Survey Results for AlohaCare QI

Measure	2023 Scores	2024 Scores
Global Ratings		
Rating of Personal Assistance and Behavioral Health Staff	66.07%+	83.72%+ ▲
Rating of Homemaker	NA	60.00%+
Rating of Case Manager	70.77%+	62.69%+
Composite Measures		
Reliable and Helpful Staff	80.54%+	82.47%+
Staff Listen and Communicate Well	76.11%+	86.66%+
Helpful Case Manager	89.96%+	86.93%+
Choosing the Services that Matter to You	68.95%+	73.83%+
Transportation to Medical Appointments	63.10%+	70.51%+
Personal Safety and Respect	88.17%+	89.92%+
Planning Your Time and Activities	52.23%+	53.71%+
Recommendation Measures		
Recommend Personal Assistance/Behavioral Health Staff	61.40%	75.61%+
Recommend Homemaker	NA	71.43%+
Recommend Case Manager	69.23%+	65.08%+
Unmet Need and Physical Safety Measures		
No Unmet Need in Dressing/Bathing	NA	NA
No Unmet Need in Meal Preparation/Eating	NA	NA
No Unmet Need in Medication Administration	NA	NA
No Unmet Need in Toileting	91.30%+	90.00%+
No Unmet Need with Household Tasks	NA	NA

[47] For this report, only the composite measure scores are displayed. For more detailed results of the items within the composite measures, please see the 2024 Hawaii HCBS CAHPS Survey full report.

[48] Agency for Healthcare Research and Quality. *The CAHPS® Home and Community-Based Services (HCBS) Survey Database 2024 Chartbook*. January 2024. Available at: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/cahps-database/2024-hcbs-chartbook.pdf. Accessed on: Jan 15, 2025.

[49] The 2024 HCBS CAHPS Database benchmarks represent survey data collected from January 1 to December 31, 2022. Caution should be exercised when comparing the 2024 HCBS CAHPS Database benchmarks to the Hawaii HCBS Program 2024 results, which represent survey data collected from July 23, 2024, to September 15, 2024.

Measure	2023 Scores	2024 Scores
Not Hit or Hurt by Staff	100.00%+	100.00% +

A cell highlighted in green represents the score is statistically significantly higher than the 2024 CAHPS Database benchmark.
A cell highlighted in red represents the score is statistically significantly lower than the 2024 CAHPS Database benchmark.
▲ *Indicates the 2024 score is statistically significantly higher than the 2023 score.*
▼ *Indicates the 2024 score is statistically significantly lower than the 2023 score.*
↑ *Indicates the QI health plan's score is statistically significantly higher than the Hawaii HCBS Program.*
↓ *Indicates the QI health plan's score is statistically significantly lower than the Hawaii HCBS Program.*
+ *Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.*
Results based on fewer than 11 respondents were suppressed and noted as "NA".

Strengths

- For AlohaCare QI, the *Rating of Personal Assistance and Behavioral Health Staff* measure scored statistically significantly higher in 2024 than in 2023.

Areas for Improvement

- For AlohaCare QI, the *Rating of Case Manager* measure was statistically significantly lower than AHRQ's 2024 CAHPS Database benchmark.

Recommendations

HSAG recommends that AlohaCare QI explore what may be driving lower experience scores and develop initiatives designed to improve quality of care, including a focus on improving adult members' overall experiences with their case manager.

Encounter Data Validation

HSAG evaluated the extent to which the encounter data in MQD's database were complete, accurate, and submitted by AlohaCare QI in a timely manner through a comparative analysis between MQD's electronic encounter data and the actuarial files submitted by AlohaCare QI to MQD's contracted actuary, Milliman.

Findings

Table 3-26 illustrates the percentage of records present in the Milliman-submitted files that were not found in the MQD-submitted files (record omission or underreporting to MQD) and the percentage of records present in the MQD-submitted files but not present in the Milliman-submitted files (record surplus or underreporting to Milliman). Lower rates indicate better performance for both record omission and record surplus.

Table 3-26—Record Omission and Surplus by Encounter Type

Encounter Type	Record Omission (Underreporting to MQD)	Record Surplus (Underreporting to Milliman)
Institutional	87.5%	0.6%
Professional	7.6%	2.6%
Pharmacy	9.1%	9.1%

Note: Lower rates indicate better performance.
Red text indicates rates higher than 5.0 percent.

Element-level discrepancy was limited to those records present in both data sources with values present in both data sources. Records with values missing from both data sources were not included in the denominator. The numerator was the number of records with different non-missing values for a given data element. Lower data element discrepancy rates indicate that the values populated for a data element in the MQD-submitted encounter data were more accurate. As such, for the discrepancy indicator, lower rates indicate better performance**.** Table 3-27 to Table 3-29 present the data element discrepancy rates for each encounter type.

Table 3-27—Element Discrepancy by Key Data Element for Institutional Encounters

Key Data Element	Discrepancy Rate
Member, Date of Service, and Provider	
Member Identification (ID)	0.0%
Member Date of Birth	0.0%
Detail First Date of Service	0.6%
Detail Last Date of Service	0.6%
Billing Provider National Provider Identifier (NPI)	0.0%
Billing Provider Type	15.9%
Servicing Provider NPI	0.1%
Servicing Provider ID	0.5%
Payment Information	
Allowed Amount	19.2%
Billed Amount	0.4%
Coordination of Benefits (COB) Amount	6.7%
Coinsurance Amount	0.0%
Copay Amount	0.0%
Deductible Amount	0.0%
MCO Paid Amount	<0.1%

Key Data Element	Discrepancy Rate
Value Code Amount	0.1%
Diagnosis Codes, Procedure Codes, and Drug Information	
Admission Diagnosis Code	0.0%
Primary Diagnosis Code	0.0%
All Secondary Diagnosis Codes	10.6%
All Surgical Procedure Codes	0.0%
Procedure Code	3.4%
Procedure Code Modifiers	1.0%
Units of Service	0.3%
National Drug Code (NDC)	5.2%
Other Data Elements	
Admission Date	0.0%
Admission Source	<0.1%
Admission Type	0.5%
Diagnosis Related Group (DRG) Code	0.0%
Discharge Date	—
Discharge Status	98.0%
Encounter Flag	0.0%
MCO Paid Date	0.0%
Occurrence Span Codes	92.4%
Present on Admission (POA) Code	—
All Secondary POA Codes	100%
Revenue Code	0.2%
Type of Bill (TOB) Code	9.4%
Value Codes	0.0%

— indicates that the denominator was zero.
Red text indicates rates higher than 5.0 percent.

Table 3-28—Element Discrepancy by Key Data Element for Professional Encounters

Key Data Element	Discrepancy Rate
Member, Date of Service, and Provider	
Member ID	<0.1%
Member Date of Birth	<0.1%
Detail First Date of Service	0.6%

Key Data Element	Discrepancy Rate
Detail Last Date of Service	0.6%
Billing Provider NPI	<0.1%
Billing Provider Type	70.5%
Servicing Provider NPI	<0.1%
Servicing Provider ID	2.0%
Payment Information	
Allowed Amount	17.1%
Billed Amount	4.5%
COB Amount	0.4%
Coinsurance Amount	0.0%
Copay Amount	0.0%
Deductible Amount	0.0%
MCO Paid Amount	4.0%
Patient Paid Amount	<0.1%
Diagnosis Codes, Procedure Codes, and Drug Information	
Primary Diagnosis Code	5.9%
All Secondary Diagnosis Codes	33.2%
Procedure Code	5.0%
Procedure Code Modifiers	0.7%
Units of Service	0.7%
NDC	1.6%
Other Data Elements	
Admission Date	77.1%
Discharge Date	—
Encounter Flag	0.0%
Place of Service (POS) Code	0.1%
MCO Paid Date	<0.1%

— indicates that the denominator was zero.
Red text indicates rates higher than 5.0 percent.

Table 3-29—Element Discrepancy by Key Data Element for Pharmacy Encounters

Key Data Element	Discrepancy Rate
Member and Date of Service	
Member ID	<0.1%
Date of Service	0.0%

Key Data Element	Discrepancy Rate
Payment Information	
Billed Amount	0.0%
COB Amount	0.0%
Coinsurance Amount	0.0%
Copay Amount	0.0%
Deductible Amount	0.0%
Dispensing Fee	94.5%
Ingredient Cost	0.0%
MCO Paid Amount	0.0%
Patient Paid Amount	0.0%
Drug Information	
NDC	0.0%
Dispensing Quantity	0.0%
Days' Supply	0.0%
New or Refill Flag	0.0%
Number of Refills	0.0%
Other Data Elements	
MCO Paid Date	<0.1%

— indicates that the denominator was zero.
Red text indicates rates higher than 5.0 percent.

Strengths

- Record surplus rates for institutional and professional encounters were below 5.0 percent. This indicates that encounters in the Milliman-submitted data could largely be identified in the MQD-submitted data.
- All but nine institutional encounter data elements, all but five professional encounter data elements, and all but one pharmacy encounter data element had a discrepancy rate less than 5.0 percent. This indicates that records which could be matched between the MQD-submitted and the Milliman-submitted data largely contained the same values.

Areas for Improvement

- The record omission rates for all encounter types were high. Institutional encounters had the highest record omission rate at 87.5 percent, while professional and pharmacy encounters had record omission rates of 7.6 percent and 9.1 percent, respectively. Additionally, the record surplus pharmacy encounter rate was high at 9.1 percent.

- Although matched records largely contained similar values between the MQD-submitted and the Milliman-submitted data, AlohaCare QI should ensure the following data elements have accurate values:
  - Institutional encounters: Billing Provider Type, Allowed Amount, COB Amount, All Secondary Diagnosis Codes, NDC, Discharge Status, Occurrence Span Codes, All Secondary POA Codes, and TOB Code.
  - Professional encounters: Billing Provider Type, Allowed Amount, Primary Diagnosis Code, All Secondary Diagnosis Codes, and Admission Date.
  - Pharmacy encounters: Dispensing Fee.

Recommendations

- AlohaCare QI should review and work on the action items noted in the data discrepancy report.
- AlohaCare QI should utilize the three-year encounter file that MQD will provide monthly to ensure the data it submits to HPMMIS are processed and submitted correctly. AlohaCare QI should review any discrepancies within the file with MQD to reconcile any differences.
- AlohaCare QI should continue to work with MQD and Milliman to ensure data submitted to HPMMIS in CY 2025 accurately reflect data needed for the CY 2026 rate-setting activities.

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

As a result of the 2022 and 2023 compliance reviews, AlohaCare QI had 15 corrective action items to address during 2023 and 2024. AlohaCare QI took the necessary steps to plan interventions; update policies, procedures, and member and provider information; and make operational changes to address the deficiencies found. As a result of its CAP interventions, AlohaCare QI was found to be fully compliant with all standards during 2024.

The results of the NAV activities revealed that AlohaCare QI had well-defined processes and procedures in place to ensure efficient and accurate collection of member and provider data to support network adequacy calculation and reporting. AlohaCare QI demonstrated efforts to identify gaps in provider

networks throughout its service areas and identify ways to improve the accessibility and timeliness of care for members.

Overall, more than three quarters (75.0 percent) of AlohaCare QI's performance measure rates fell below the 50th percentile across all domains, with many (33.3 percent) falling below the 25th percentile. While some measures showed improvement from MY 2022, AlohaCare QI's performance suggests several areas in need of improvement, including the Children's Preventive Health and Behavioral Health domains. Only 14 of AlohaCare QI's measure rates met MQD Quality Strategy targets.

AlohaCare QI's CAHPS results illustrate opportunities for improvement in members' satisfaction. While none of the measures scored statistically significantly lower in 2024 than in 2022 and none of the measures scored statistically significantly lower than the 2023 NCQA adult Medicaid national averages, the following seven measures were below the 50th percentiles: *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Advising Smokers and Tobacco Users to Quit*. 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 three of the nine measures MQD selected for monitoring within its Quality Strategy met or exceeded the RY 2024 target, AlohaCare QI should focus improvement efforts on the *Getting Care Quickly* and *How Well Doctors Communicate* measures, which fell below the 25th percentile.

AlohaCare QI's HCBS CAHPS Survey results illustrated positive results and opportunities for improvement in members' experience. While none of the measures scored statistically significantly higher than the Hawaii HCBS Program or AHRQ's 2024 CAHPS Database benchmark, the *Rating of Personal Assistance and Behavioral Health Staff* measure scored statistically significantly higher than the 2023 score. Additionally, while none of the measures scored statistically significantly lower than the 2023 scores or Hawaii HCBS Program, the *Rating of Case Manager* measure scored statistically significantly lower than AHRQ's 2024 CAHPS Database benchmark, indicating a need for AlohaCare QI to implement strategies to ensure members have access to high-quality care.

The EDV activities revealed that AlohaCare QI should improve its encounter data completeness for institutional, professional, and pharmacy encounters, since either the record omission or the record surplus rate for each encounter type was above 5.0 percent (i.e., relatively poor performance). In addition, although matched records largely contained similar values between the MQD-submitted and the Milliman-submitted data, AlohaCare QI had at least one data element for each encounter type that it should work on to improve its accuracy. Submitting accurate and complete encounter data assists MQD in monitoring issues concerning quality of care and access to care, as well as setting up proper capitation rates starting in CY 2026 with CY 2025 data.

AlohaCare QI progressed to the Outcomes stage of the two PIPs that were initiated in CY 2022 and the Design stage for the new PIP initiated in CY 2024. The PIPs 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 a *High Confidence* level rating for both overall confidence in adherence to acceptable methodology for all phases of the PIP and overall confidence that

the PIP achieved significant improvement. For both remeasurement periods, the health plan achieved statistically significant improvement in the rates of both performance indicators. The health plan continued data sharing with ‘Ohana CCS; however, the data sharing with DOH Behavioral Health Services Administration divisions would begin in 2025.

For the *Plan All-Cause Readmissions* PIP, AlohaCare QI received a *High Confidence* level rating for overall confidence in adherence to acceptable methodology for all phases of the PIP and a *Moderate Confidence* rating for overall confidence that the PIP achieved significant improvement. The documented PIP design and data were accurate. The health plan conducted appropriate quality improvement processes and participated in the Readmissions Collaborative workgroup to identify barriers, and it deployed interventions that were logically linked to the identified barriers. For both remeasurement periods, the health plan achieved statistically nonsignificant improvement in the performance indicator rate over the baseline with a decrease in the observed readmission rate.

For the *Screening for Depression and Follow-Up Plan* PIP, AlohaCare QI received a *High Confidence* level rating for adherence to acceptable methodology for the PIP design. The health plan designed a scientifically sound project that was supported by using key research principles.

Hawaii Medical Service Association QUEST Integration (HMSA QI) Results

Compliance Monitoring Review

The 2024 compliance monitoring review activity included follow-up reviews of the health plans' required corrective actions implemented to address deficiencies noted during the 2022 and 2023 reviews.

Findings

Table 3-30 presents the scores from HSAG's 2022 and 2023 compliance reviews, the number of CAPs required, the number of CAPs closed, and the results of the 2024 follow-up reviews of HMSA QI.

Table 3-30—Standards, Compliance Scores, and CAPs—HMSA QI

Standard Name	Standard Review Year	Compliance Review Score	# of CAPs Required	# of CAPs Closed	2024 Final Follow-Up Review Score
Assurances of Adequate Capacity and Services	2022	100%	0	NA	**100%**
Availability of Services	2022	100%	0	NA	**100%**
Confidentiality	2022	100%	0	NA	**100%**
Coordination and Continuity of Care	2022	95%	1	1	**100%**
Coverage and Authorization of Services	2022	98%	1	1	**100%**
Credentialing	2023	99%	1	1	**100%**
Enrollee Information	2022	89%	4	4	**100%**
Enrollee Rights and Protections	2022	100%	0	NA	**100%**
Enrollment and Disenrollment	2023	100%	0	NA	**100%**
Grievance and Appeal System	2022	92%	5	5	**100%**
Health Information Systems	2023	100%	0	NA	**100%**
Provider Selection	2023	100%	0	NA	**100%**
Practice Guidelines	2023	100%	0	NA	**100%**
Quality Assessment and Performance Improvement	2023	100%	0	NA	**100%**
Subcontractual Relationships and Delegation	2023	92%	1	1	**100%**
Totals			**13**	**13**	**100%**

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

Strengths

The 2022 compliance review revealed that HMSA QI had deficiencies in four of the eight standards reviewed. During 2023 and 2024, HMSA QI completed 11 corrective action items to bring them into full

compliance. To address the Coordination and Continuity of Care deficiencies, HMSA QI developed new dashboards to monitor and evaluate improvement, retrained all staff members on appropriate and timely documentation, and audited all care coordination cases for three months. Additionally, HSAG conducted follow-up file reviews on a sample of care coordination files in 2024. HSAG found that all files were fully compliant with the care coordination requirements. To address deficiencies in the Coverage and Authorization of Services and Grievance and Appeal System standards, HMSA QI updated internal procedures and templates, trained staff members on new processes, and performed audits to validate compliance. Finally, to address deficiencies in the Enrollee Information standard, HMSA QI updated its policies, the member handbook, and the provider directory, and developed a frequently asked questions (FAQ) document for members to ensure compliance.

HMSA QI performed well during the 2023 compliance review, with only two corrective action items that needed to be completed in 2024. To address the Credentialing standard deficiencies, HMSA QI revised its recredentialing workflows and procedures, trained all impacted departments on revised workflows and procedures, and audited samples to validate compliance. To address the Subcontractual Relationships and Delegation standard, HMSA QI updated its policies and procedures to identify and classify delegates and monitor and audit each of its subcontractors.

Areas for Improvement

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

Recommendations

HSAG recommends that HMSA QI review the revised Medicaid managed care rules released in 2024 and implement operational changes, as applicable, to ensure continued compliance.

Validation of Performance Measures—NCQA HEDIS Compliance Audits

NCQA HEDIS Compliance Audit Findings

HSAG's review team assessed HMSA QI's IS capabilities and its ability to process data for reporting accurate performance measure rates. HMSA QI was found to be fully compliant with all HEDIS IS standards, including IS standard L for assessing case management data for the LTSS measures. This demonstrated that HMSA QI had effective IS processes and control procedures in place for reporting the required performance measure rates. HMSA QI presented 10 supplemental data sources for consideration to use for supplementing its MY 2023 performance measure rates. HSAG determined four data sources to be nonstandard supplemental data; the remaining six were considered standard supplemental data. HSAG reviewed all data sources and conducted primary source verification on the four nonstandard data sources. No concerns were identified, and all 10 supplemental data sources were approved for HEDIS MY 2023 reporting.

Since there were new hybrid measures under the scope of the audit, HMSA QI was required to undergo convenience sample validation for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile—Total* and *Immunization for Adolescents—Combination 1* measures. HMSA QI successfully passed the validation for all cases reviewed. The final MRRV was conducted for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents, Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)*, and *Immunizations for Adolescents—Combination 2* measures. All selected cases passed the final MRRV without any critical errors.

All measures under the scope of the audit were determined to be *Reportable.* HMSA QI was determined to be fully compliant with all IS standards; therefore, HSAG did not have any recommendations for HMSA QI.

Access and Risk-Adjusted Utilization Performance Measure Results

HMSA QI's Access and Risk-Adjusted Utilization performance measure results are shown in Table 3-31.

Table 3-31—HMSA QI's Results for QI Measures Under Access and Risk-Adjusted Utilization

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	—	63.48%	—	★
45–64 Years	—	76.15%	—	★★
65 Years and Older	—	76.29%	—	★★
Total	—	68.54%	—	★★
Ambulatory Care				
Emergency Department Visits	406.28	414.98	2.14%	★★★★
Outpatient Visits	3,424.32	3,296.57	-3.73%	★★
Asthma in Younger Adults Admission Rate*				
*Asthma in Younger Adults Admission Rate**	—	2.53	—	NC
Heart Failure Admission Rate*				
18–64 Years	27.57	27.92	1.28%	NC
65 Years and Older	97.06	73.79	-23.97%	NC
Total (18 Years and Older)	32.32	31.40	-2.85%	NC
Plan All-Cause Readmissions				
*Index Total Stays—Observed Readmissions—Total**	8.29%	7.91%	-4.58%	NC
Expected Readmissions—Total	9.68%	9.68%	-0.02%	NC
*Index Total Stays—O/E Ratio—Total**	0.8564	0.8173	-4.56%	NC

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by 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 health 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 2023 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*

The *Ambulatory Care—Emergency Department Visits* measure indicator rate met the 75th percentile. All other measure indicators in this domain did not meet or exceed the 50th percentile, or did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented.

HMSA QI met the MQD-established Quality Strategy target for *Heart Failure Admission Rate—Total—18 Years and Older* and *Plan All-Cause Readmissions—Index Total Stays—O/E Ratio—Total.* All other MQD Quality Strategy targets were not met for this domain.

Children's Preventive Health Performance Measure Results

HMSA QI's Children's Preventive Health performance measure results are shown in Table 3-32.

Table 3-32—HMSA QI's Results for QI Measures Under Children's Preventive Health

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Child and Adolescent Well-Care Visits				
Child and Adolescent Well-Care Visits	52.41%	55.29%	5.50%	★★★★
Childhood Immunization Status				
Combination 3	58.64%	63.75%	8.71%	★★
Combination 7	49.88%	54.99%	10.24%	★★
Combination 10	35.52%	35.04%	-1.37%	★★★
DTaP	69.59%	67.40%	-3.15%	★★
Hepatitis A	78.10%	79.08%	1.25%	★★
Hepatitis B	71.53%	81.02%	13.27%	★
HiB	80.05%	82.00%	2.43%	★★
Influenza	49.64%	46.96%	-5.39%	★★★
IPV	79.81%	81.51%	2.13%	★
MMR	78.10%	80.78%	3.43%	★★
Pneumococcal Conjugate	68.37%	68.61%	0.36%	★★
Rotavirus	64.48%	66.91%	3.77%	★★
VZV	77.86%	80.54%	3.44%	★
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	—	69.10%	—	★

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Combination 2 (Meningococcal, Tdap, HPV)	—	40.88%	—	★★★
Meningococcal Serogroups A, C, W, Y	—	71.53%	—	★
Tdap	—	71.78%	—	★
HPV	—	43.07%	—	★★★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents				
BMI Percentile Documentation—3–11 Years	—	86.19%	—	★★★★
BMI Percentile Documentation—-12–17 Years	—	90.91%	—	★★★★★
BMI Percentile Documentation—Total	—	88.01%	—	★★★★
Counseling for Nutrition—3–11 Years	—	79.52%	—	★★★★
Counseling for Nutrition—12–17 Years	—	79.55%	—	★★★★
Counseling for Nutrition—Total	—	79.53%	—	★★★★
Counseling for Physical Activity-3–11 Years	—	77.14%	—	★★★★
Counseling for Physical Activity—12–17 Years	—	78.03%	—	★★★★
Counseling for Physical Activity—Total	—	77.49%	—	★★★★
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	69.57%	68.53%	-1.50%	★★★★★
Well-Child Visits for Age 15 Months to 30 Months of Life—Two or More Well-Child Visits	72.98%	73.72%	1.01%	★★★★

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by MQD.
— Indicates that the health 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 2023 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*

The *Child and Adolescent Well-Care Visits* measure rate met or exceeded the 75th percentile. Both *Well-Child Visits in the First 30 Months of Life* indicator rates met or exceeded the 75th percentile, and one met or exceeded the 90th percentile. All *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* indicator rates met or exceeded the 75th percentile, and *BMI Percentile Documentation—12–17 Years* met or exceeded the 90th percentile.

HMSA QI met MQD's established Quality Strategy target for the *Child and Adolescent Well-Care Visits, Childhood Immunization Status—Combination 3* and *Combination 7, Immunizations for Adolescents—Combination 2, Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile Documentation—Total, Well-Child Visits in the First 30 Months of Life—Six or More Well-Child Visits in the First 15 Months of Life* and *Two or More Well-Child Visits in the First 30 Months of Life*. All other MQD Quality Strategy targets were not met for this domain.

Women's Health Performance Measure Results

HMSA QI's Women's Health performance measure results are shown in Table 3-33.

Table 3-33—HMSA QI's Results for QI Measures Under Women's Health

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Cervical Cancer Screening				
Cervical Cancer Screening	57.49%	59.55%	3.58%	★★★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	77.70%	82.79%	6.54%	★★
Postpartum Care	67.54%	78.14%	15.70%	★★★
Prenatal and Postpartum Care: Under 21 Years of Age (Child Core)				
Timeliness of Prenatal Care: Under 21 Years of Age	—	63.31%	—	NC
Postpartum Care: Under 21 Years of Age	—	60.79%	—	NC

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by 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 health 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 2023 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

The *Cervical Cancer Screening* measure rate and the *Prenatal and Postpartum Care—Postpartum Care* indicator rate met or exceeded the 50th percentile. The *Prenatal and Postpartum Care: Under 21 Years of Age (Child Core)* measure indicators in this domain did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented.

HMSA QI met the MQD-established Quality Strategy target for *Cervical Cancer Screening—Total*. All other MQD Quality Strategy targets were not met for this domain.

Care for Chronic Conditions Performance Measure Results

HMSA QI's Care for Chronic Conditions performance measure results are shown in Table 3-34.

Table 3-34—HMSA QI's Results for QI Measures Under Care for Chronic Conditions

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Asthma Medication Ratio				
5–11 Years	—	55.28%	—	★
12–18 Years	—	50.86%	—	★
19–50 Years	—	42.04%	—	★
51–64 Years	—	49.41%	—	★
Total (5–64 Years)	—	46.97%	—	★
Total Child Core Set (5–18 Years)	—	53.43%	—	NC
Total Adult Core Set (19–64 Years)	—	44.56%	—	NC
Blood Pressure Control for Patients With Diabetes				
Blood Pressure Control for Patients With Diabetes	56.97%	64.06%	12.45%	★★★
Concurrent Use of Opioids and Benzodiazepines*				
18–64 Years	13.28%	13.65%	2.83%	NC
65 Years and Older	9.80%	9.29%	-5.22%	NC
Total (18 Years and Older)	13.06%	13.32%	1.97%	NC
Controlling High Blood Pressure				
18–64 Years	57.51%	58.64%	1.96%	NC
65–85 Years	50.79%	62.96%	23.96%	NC
Total	56.48%	59.51%	5.36%	★★
Eye Exam for Patients With Diabetes				
Eye Exam for Patients With Diabetes	59.66%	59.41%	-0.41%	★★★★
Hemoglobin A1c Control for Patients With Diabetes				
HbA1c Control (<8.0%)—18–64 Years	—	53.58%	—	NC
HbA1c Control (<8.0%)—65–75 Years	—	66.67%	—	NC
HbA1c Control (<8.0%)—Total	54.52%	55.50%	1.79%	★★★
*HbA1c Poor Control (>9.0%)—18–64 Years**	—	38.40%	—	NC
*HbA1c Poor Control (>9.0%)—65–75 Years**	—	25.00%	—	NC
*HbA1c Poor Control (>9.0%)—Total**	37.16%	36.43%	-1.97%	★★★

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by 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 health 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 2023 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*

Blood Pressure Control for Patients With Diabetes, HbA1c Control (<8.0%)—Total, and *HbA1c Poor Control (>9.0%)—Total* all met or exceeded the 50th percentile. Additionally, *Eye Exam for Patients With Diabetes* met the 75th percentile. All other measure indicators in this domain did not meet or exceed the 50th percentile for MY 2023. All other measure indicators in this domain did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented.

HMSA QI met the MQD-established Quality Strategy target for *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)—Total* and *Blood Pressure Control for Patients With Diabetes*. All other MQD Quality Strategy targets were not met for this domain.

Behavioral Health Performance Measure Results

HMSA QI's Behavioral Health performance measure results are shown in Table 3-35.

Table 3-35—HMSA QI's Results for QI Measures Under Behavioral Health

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	58.62%	59.03%	0.70%	★★
Antidepressant Medication Management				
Effective Acute Phase Treatment—18–64 Years	—	65.94%	—	NC
Effective Acute Phase Treatment—65 Years and Older	—	67.92%	—	NC
Effective Acute Phase Treatment—Total	61.39%	66.00%	7.52%	★★★
Effective Continuation Phase Treatment—18–64 Years	—	46.97%	—	NC
Effective Continuation Phase Treatment—65 Years and Older	—	50.94%	—	NC
Effective Continuation Phase Treatment—Total	44.64%	47.08%	5.47%	★★★
Follow-Up After Emergency Department Visit for Mental Illness				
7-Day Follow-Up—6–17 Years	49.30%	34.00%	-31.03%	★
7-Day Follow-Up—18–64 Years	40.36%	25.37%	-37.14%	★

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
7-Day Follow-Up—65 Years and Older	21.95%	NA	-47.44%	NC
7-Day Follow-Up—Total	40.86%	26.21%	-35.87%	★
30-Day Follow-Up—6–17 Years	60.56%	46.67%	-22.95%	★
30-Day Follow-Up—18–64 Years	53.29%	42.78%	-19.72%	★★
30-Day Follow-Up—65 Years and Older	36.59%	NA	-57.95%	NC
30-Day Follow-Up—Total	53.63%	42.67%	-20.45%	★
Follow-Up After Emergency Department Visit for Substance Use				
7-Day Follow-Up—13–17 Years	17.02%	21.05%	23.68%	★★★
7-Day Follow-Up—18 Years and Older	32.96%	26.87%	-18.47%	★★★
7-Day Follow-Up—Total	32.38%	26.64%	-17.73%	★★★
7-Day Follow-Up—18–64 Years (Adult Core)	—	27.37%	—	NC
7-Day Follow-Up—65 Years and Older (Adult Core)	—	14.81%	—	NC
30-Day Follow-Up—13–17 Years	29.79%	38.60%	29.57%	★★★
30-Day Follow-Up—18 Years and Older	46.54%	42.36%	-8.98%	★★★
30-Day Follow-Up—Total	45.93%	42.21%	-8.10%	★★★
30-Day Follow-Up—18–64 Years (Adult Core)	—	42.89%	—	NC
30-Day Follow-Up—65 Years and Older (Adult Core)	—	29.63%	—	NC
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase—Total	—	47.18%	—	★★★
Continuation and Maintenance Phase—Total	—	59.15%	—	★★★
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation—Total—13–17 Years	41.00%	41.97%	2.36%	★★
Initiation—Total—18–64 Years	—	33.73%	—	★
Initiation—Total—65 Years and Older	—	30.82%	—	★
Initiation—Total	35.47%	33.96%	-4.26%	★
Engagement—Total—13–17 Years	16.74%	23.36%	39.56%	★★★★★
Engagement—Total—18–64 Years	—	11.24%	—	★★
Engagement—Total—65 Years and Older	—	3.93%	—	★★
Engagement—Total	11.96%	11.39%	-4.71%	★★
Screening for Depression and Follow-Up Plan				
12–17 Years	47.92%	47.16%	-1.59%	NC
18–64 Years	27.27%	25.29%	-7.26%	NC
65 Years and Older	25.75%	24.23%	-5.87%	NC

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Total (12 Years and Older)	31.53%	29.79%	-5.52%	NC
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
1–11 Years	—	NA	—	NC
12–17 Years	—	43.33%	—	★
Total	—	45.71%	—	★
Use of Pharmacotherapy for Opioid Use Disorder				
Rate 1: Total	67.68%	57.90%	-14.44%	NC
Rate 2: Buprenorphine	53.03%	38.13%	-28.10%	NC
Rate 3: Oral Naltrexone	3.03%	1.41%	-53.40%	NC
Rate 4: Long-Acting, Injectable Naltrexone	1.01%	0.27%	-73.37%	NC
Rate 5: Methadone	12.63%	19.91%	57.65%	NC

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by 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 health 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 2023 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*

All indicator rates for the *Antidepressant Medication Management, Follow-Up After Emergency Department Visit for Substance Use*, and *Follow-Up Care for Children Prescribed ADHD Medication* measures met or exceeded the 50th percentile. Additionally, *Initiation and Engagement of Substance Use Disorder Treatment—Engagement—Total—13–17 Years* met or exceeded the 90th percentile. All other measure indicators in this domain either did not meet the 50th percentile or did not have national benchmarks to compare for MY 2023.

HMSA QI met the MQD-established Quality Strategy target for *Antidepressant Medication Management—Effective Acute Phase Treatment—Total* and *Effective Continuation Phase Treatment—Total, Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total, Screening for Depression and Follow-Up Plan—Total (12 Years and Older),* and *Use of Pharmacotherapy for Opioid Use Disorder—Rate 1, Rate 2,* and *Rate 3.* All other MQD Quality Strategy targets were not met for this domain.

Long-Term Services and Supports Performance Measure Results

HMSA QI's Long-Term Services and Supports performance measure results are shown in Table 3-36.

Table 3-36—HMSA QI's Results for QI Measures Under Long-Term Services and Supports

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
LTSS Comprehensive Assessment and Update				
Assessment of Core Elements Documented	0.00%	26.04%	—	NC
Assessment of Supplemental Elements Documented	0.00%	18.75%	—	NC
LTSS Comprehensive Care Plan and Update				
Care Plan With Core Elements Documented	0.00%	2.08%	—	NC
Care Plan With Supplemental Elements Documented	0.00%	2.08%	—	NC
LTSS Minimizing Institutional Length of Stay				
Observed Rate	NA	NA	—	NC
Risk-Adjusted Rate	NA	NA	—	NC
O/E Ratio	NA	NA	—	NC

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by MQD.
NA indicates that the QI health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
NC indicates that 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 health 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.

For the *LTSS Minimizing Institutional Length of Stay* measure, HMSA 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. The measures in this domain did not have applicable benchmarks; therefore, no comparison to national benchmarks is presented.

HMSA QI met the MQD-established Quality Strategy targets for *LTSS Comprehensive Assessment and Update—Assessment of Core Elements Documented* and *LTSS Comprehensive Assessment and Update—Assessment of Supplemental Elements Documented.* All other MQD Quality Strategy targets were not met for this domain.

Strengths

Based on HSAG's analyses of HMSA QI's 76 measure rates comparable to benchmarks, 34 measure rates (44.76 percent) ranked at or above the 50th percentile, with 13 of these rates (17.11 percent) ranking at or above the 75th percentile and three rates (3.95 percent) ranking at or above the 90th percentile. Additionally, HMSA QI met 22 MQD Quality Strategy targets for MY 2023.

Areas for Improvement

Conversely, 42 of HMSA QI's measure rates (55.26 percent) comparable to benchmarks fell below the 50th percentile, with 22 rates (28.95 percent) falling below the 25th percentile, suggesting significant opportunities for improvement.

Recommendations

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:

- Within the Children's Preventive Health domain, the following measure-level recommendations were identified:
  - Regarding the *Childhood Immunization Status* measure, HSAG recommends that HMSA QI provide education to providers and members about the importance of vaccination for disease prevention and encourage vaccination at every opportunity, including mild illness visits.[50]
  - Regarding the *Well-Child Visits in the First 30 Months of Life* measure, HSAG recommends that HMSA QI identify performance improvement efforts to improve well-child visits, drawing from other states' performance improvement initiatives. For instance, California and Virginia have focused on delays in newborn enrollment data, and Missouri and Texas focused on beneficiary barriers and implemented interventions such as utilizing patient portals and phone outreach. HSAG recommends that HMSA QI identify other barriers to care and conduct a focus group on identifying abilities to address barriers.[51]
- Within the Women's Health the following measure-level recommendations were identified:
  - Regarding the *Prenatal and Postpartum Care* measure, HSAG recommends that HMSA QI consider whether there are disparities/SDOH within HMSA QI's population that contribute to lower access to care. Upon identification of a root cause, HSAG recommends that HMSA QI implement appropriate interventions to reduce barriers to care. Strategies could include providing expanded access appointments outside of business hours to accommodate work schedules or childcare needs. Many appointments can be made via telehealth; therefore, ensuring members have access to this option could potentially increase performance on this measure. Further, HSAG recommends that HMSA QI identify payment structure types that will incentivize quality care. Bundling payments may cause disincentives for postpartum care, as providers might receive the same payment regardless of whether the member attends the postpartum visit.[52]

[50] Anderson, EL. Recommended solutions to the barriers to immunization in children and adults. *Missouri Medicine.* 2014; vol. 111,4: 344–348.

[51] Centers for Medicare & Medicaid Services. Well-Child Care. Available at: https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/well-child-care/index.html. Accessed on: Jan 6, 2025.

[52] Centers for Medicare & Medicaid Services. Lessons Learned About Payment Strategies to Improve Postpartum Care in Medicaid and CHIP. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/postpartum-payment-strategies.pdf. Accessed on: Dec 18, 2024.

Validation of Network Adequacy

HSAG evaluated and assessed the data methods that HMSA QI used to calculate results generated for each network adequacy indicator in the scope of the 2024 NAV activities. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that HMSA QI used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator.

Findings

Based on the results of the ISCA combined with the virtual audit and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the health plan's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each health plan according to Table 3-37.

Table 3-37—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*
10.0% to 49.9%	*Low Confidence*
Less than 10% and/or any *Not Met* element has significant bias on the results	*No Confidence*

No indicators were designated as *Low Confidence* or *No Confidence* for HMSA QI.

HSAG determined that HMSA QI was not compliant with network adequacy requirements for the Access and Availability standard. MQD required at least 80 percent of members for the Behavioral Health, PCP Adult Sick Visits, and PCP Visits provider types to be provided an appointment within the designated time frame. MQD required at least 60 percent of members for the Urgent Care and PCP Pediatric Sick Visits and Visits with Specialists or Non-Emergency Hospital Stays provider types to be provided an appointment within the designated time frame. Compliance was determined based on the health plan meeting the State's Access and Availability indicators. All indicators were calculated by MQD. Results are presented by provider type in Table 3-38.

Table 3-38—HMSA QI Network Adequacy Access and Availability Compliance

Provider Type	Indicator	Compliance
Urgent Care and PCP Pediatric Sick Visits	Appointments within twenty-four (24) hours	*Not Met*

Provider Type	Indicator	Compliance
Visits with Specialists or Non-Emergency Hospital Stays*	Appointments within four (4) weeks or of sufficient timeliness to meet medical necessity	*Not Met*
Behavioral Health (routine visits for adults and children)	Appointment within twenty-one (21) days	*Not Met*
PCP Adult Sick Visits	Appointment within seventy-two (72) hours	*Not Met*
PCP Visits (routine visits for adults and children)	Appointments within twenty-one (21) days	*Not Met*

* MQD confirmed that in CY 2024, Visits with Specialists only included OB/GYN.

HSAG determined that HMSA QI was compliant with network adequacy requirements for the Provider Ratios standard for eight of nine provider types (88.88 percent). Compliance was determined based on the health plan meeting the State's Provider Ratio indicators. All indicators were calculated by MQD. Results are presented by provider type in Table 3-39.

Table 3-39—HMSA QI Network Adequacy Provider Ratios Compliance

Provider Type	Ratio	Results	Compliance
Hospitals on Oahu	5	18	*Met*
Hospital on Kauai	1	3	*Met*
Hospital on Lanai	1	1	*Met*
Hospital on Maui	1	2	*Met*
Hospital on Molokai	1	3	*Met*
Hospitals on Hawaii (one in East Hawaii and one in West Hawaii)	2	7	*Met*
Other Behavioral Health Providers to include Psychologists, Licensed Mental Health Counselors, Licensed Clinical Social Workers, and APRNs—Behavioral Health for members with an SMI or SPMI diagnosis	1:100	1:72	*Met*
Behavioral Health Psychiatrists for members with an SMI or SPMI diagnosis. In geographic areas with a demonstrated shortage of qualified physicians, a psychiatric APRN-Rx may assume the role of psychiatrist.	1:150	1:836	*Not Met*
Primary Care Physicians	1:300	1:175	*Met*

HSAG determined that HMSA QI was compliant with network adequacy requirements for the Mandatory Provider Types standard for 13 of 16 indicators (81.25 percent). Compliance was determined based on the health plan meeting the State's Mandatory Provider Type indicators, which includes one

servicing provider within each provider type. All indicators were calculated by MQD. Compliant results are presented by provider type in Table 3-40, and noncompliant results are presented in Table 3-41.

Table 3-40—HMSA QI Network Adequacy Mandatory Provider Types Compliance

Provider Type	Compliance
Home Health Agencies and Hospices	*Met*
LTSS Providers	*Met*
DME	*Met*
Case Management Agencies	*Met*
Laboratories which have either a CLIA 1988 certificate or a waiver of a certificate of registration	*Met*
Optometrists	*Met*
Physical and Occupational Therapists, Audiologists, and Speech-Language Pathologists	*Met*
Providers of lodging and meals associated with obtaining necessary medical care	*Met*
Sign language interpreters and interpreters for languages other than English	*Met*
Physician Specialists, including but not limited to Cardiologists, Endocrinologists, General Surgeons, Geriatricians, Hematologists, Infectious Disease Specialists, Nephrologists, Neurologists, OB/GYNs, Oncologists, Ophthalmologists, Orthopedists, Otolaryngologists, Pediatric Specialists, Plastic and Reconstructive Surgeons, Pulmonologists, Radiologists, and Urologists	*Met*
Behavioral Health Providers: Licensed Therapists, Counselors, and CSACs	*Met*
Emergency Transportation Providers (both ground and air)	*Met*
Non-Emergency Transportation Providers (both ground and air)	*Met*

Table 3-41—HMSA QI Network Adequacy Mandatory Provider Types Noncompliance

Provider Type	Compliance
Peer Support Specialists certified by AMHD as a part of its Hawaii certified peer specialist program or a program that meets the criteria established by AMHD	*Not Met*
Licensed Dietitians	*Not Met*
Community Health Workers	*Not Met*

During the NAV review period, HSAG determined that the Access and Availability provider types in Table 3-42 were not required by MQD, resulting in an *Unable to Validate* designation for each associated provider type.

Table 3-42—HMSA QI Network Adequacy Mandatory Provider Types *Unable to Validate Indicators*

Provider Type
State-licensed Special Treatment Facilities for the provision of substance abuse therapy/treatment
PAs
CPs

HSAG determined that HMSA QI was compliant with network adequacy requirements for a subset of the Time and Distance indicators. MQD required at least 85 percent of members to have access to the providers within the associated time or distance parameters. Compliance was determined based on the health plan meeting the State's Time and Distance indicators for both Urban and Rural classifications. All indicators were calculated by MQD. Results are presented by provider type and urbanicity in Table 3-43, and noncompliant results are presented in Table 3-44.

Table 3-43—HMSA QI Network Adequacy Time and Distance ≥85% Compliance by Urbanicity

Provider Type	Urbanicity	Compliance
PCPs (Adult and Pediatric)	Urban	*Met*
	Rural	*Met*
Specialists (Adult and Pediatric)	Urban	*Met***
	Rural	*Met***
OB/GYN	Urban	*Met*
	Rural	*Met*
Adult Day Care/Adult Day Health	Urban	*Met*
Hospitals	Urban	*Met*
	Rural	*Met*
Behavioral Health Provider (Adult and Pediatric)	Urban	*Met*
	Rural	*Met*
LTSS Providers	Urban	*Met*
	Rural	*Met*
24-Hour Pharmacy	Urban	*Met*
Pharmacies	Urban	*Met*
	Rural	*Met*

** *Met* for a subset of provider types.

Table 3-44—HMSA QI Network Adequacy Time and Distance < 85% Noncompliance by Urbanicity

Provider Type	Urbanicity	Compliance
Hematologists	Urban	*Not Met*
Pediatric Specialists	Rural	*Not Met*

Provider Type	Urbanicity	Compliance
Nephrologists	Rural	*Not Met*
Neurologists	Rural	*Not Met*
Infectious Disease Specialists	Rural	*Not Met*
Otolaryngologists	Rural	*Not Met*
Pulmonologists	Rural	*Not Met*

During the NAV review period, HSAG determined that the Access and Availability provider types in Table 3-45 were not required by MQD, resulting in an *Unable to Validate* designation for each associated indicator.

Table 3-45—HMSA QI Network Adequacy Time and Distance *Unable to Validate* Indicators

Provider Type	Urbanicity	Indicator
Emergency Services Facilities	Urban	Within 30 minute driving time
	Rural	Within 60 minute driving time

Strengths

HMSA QI had robust processes to keep provider data up to date and accurate through its quarterly attestation reminders, telephonic outreach, on-site visits to providers, and recredentialing process.

Areas for Improvement

HMSA QI indicated that the member demographic information that comes through the 834 file is considered the source of truth, regardless of when HMSA QI is informed of a change in member demographic information.

Recommendations

HSAG recommends that HMSA QI explore its system capabilities to capture updated demographic information collected through various member-level interactions that may be more current than what is provided through the 834 file. HSAG also recommends that HMSA QI continue to monitor and address any gaps in its provider network.

Validation of Performance Improvement Projects

In CY 2024, HMSA QI continued the two PIPs initiated in 2022. The selected PIP topics were *Behavioral Health Coordination* and *Plan All-Cause Readmissions*. For the CY 2024 submission, the health plan progressed to the Design, Implementation, and Outcomes stages of the PIPs and submitted

Steps 1 through 8 in the PIP Submission Form. The PIPs were assessed for improvement in outcomes in Step 9.

In CY 2024, HMSA QI also submitted a new PIP: *Screening for Depression and Follow-Up Plan*. For this PIP, HMSA QI progressed to the Design stage of the PIP and submitted Steps 1 through 6 in the PIP submission form.

Table 3-46 displays the topics, progression status, and measurement periods reported for the PIPs.

Table 3-46—CY 2024 HMSA QI PIP Topics and Status

PIP Topic	PIP Progression Status	Baseline Measurement Period	Measurement Period Reported in CY 2024
Behavioral Health Coordination	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	07/01/2021 to 09/30/2021	07/01/2023 to 09/30/2023 (Remeasurement 2)
Plan All-Cause Readmissions	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	CY 2021	CY 2023 (Remeasurement 2)
Screening for Depression and Follow-Up Plan	PIP Design Stage (Steps 1 through 6)	01/01/2024 to 12/31/2024	Not Applicable

The focus of the nonclinical *Behavioral Health Coordination* PIP is to integrate care between DOH Behavioral Health Services Administration divisions, ‘Ohana 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 SMI and SPMI, developmental disabilities, and other chronic issues. The methodology for this PIP was defined by 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 the HEDIS *PCR* measure.

The focus of the clinical *Screening for Depression and Follow-Up Plan* PIP is to increase depression screening and documentation of a follow-up plan for members 12 years of age or older who screened positive for depression.

Findings

Table 3-47 illustrates the validation results for the three PIPs submitted by HMSA QI for CY 2024 validation.

Table 3-47—CY 2024 PIP Validation Results for HMSA QI

PIP Topic	Validation Rating 1: Overall Confidence in Adherence to Acceptable Methodology for All Phases of the PIP			Validation Rating 2: Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Behavioral Health Coordination	100%	100%	*High Confidence*	33%	100%	*Moderate Confidence*
Plan All-Cause Readmissions	100%	100%	*High Confidence*	33%	100%	*No Confidence*
Screening for Depression and Follow-Up Plan	100%	100%	*High Confidence*	*Not Assessed*[4]		

1 **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) 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 **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.
4 **Not Assessed**—HSAG did not assess Step 9, as the QI health plans only reported the Design stage.

The *Behavioral Health Coordination* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. HMSA QI received *Met* scores for 100 percent of applicable evaluation elements in the Design (Steps 1–6) and Implementation (Steps 7–8) stages of the PIP. For Validation Rating 2, HSAG assigned a *Moderate Confidence* level rating that the PIP achieved significant improvement.

The *Plan All-Cause Readmissions* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. HMSA QI received *Met* scores for 100 percent of applicable evaluation elements in the Design (Steps 1–6) and Implementation (Steps 7–8) stages of the PIP. For Validation Rating 2, HSAG assigned a *No Confidence* level rating that the PIP achieved significant improvement.

The *Screening for Depression and Follow-Up Plan* PIP was validated through the first six steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. HMSA QI received *Met* scores for 100 percent of the applicable evaluation elements in the Design stage (Steps 1–6) of the PIP. HMSA QI had not progressed

to reporting remeasurement data, and therefore the PIP was not assessed for Validation Rating 2 (i.e., overall confidence that the PIP achieved significant improvement).

Design (Steps 1-6)

Behavioral Health Coordination

The health plan met 100 percent of the requirements in the Design stage, Steps 1 through 6 for the *Behavioral Health Coordination* PIP. The selected PIP topic was required by MQD. HMSA QI documented the PIP design accurately. HMSA's data collection process was methodologically sound; however, the data collection processes to capture the combined reviews and data sharing with the DOH Behavioral Health Services Administration divisions were not defined. At the time of the PIP submission, the health plan was awaiting approval of the DSA by the DOH Behavioral Health Services Administration divisions. The DSA was approved and executed in December 2024 and is effective as of January 1, 2025.

Plan All-Cause Readmissions

The health plan met the requirements in the Design stage, Steps 1 through 6. The selected PIP topic was required by MQD. 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.

Screening for Depression and Follow-Up Plan

The health plan met 100 percent of the requirements in the Design stage, Steps 1 through 6. The selected PIP topic was required by MQD. 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 CMS Child Core Set *CDF-CH* measure and CMS Adult Core Set *CDF-AD* measure. HMSA QI's data collection process was also found to be methodologically sound.

Implementation (Steps 7-8)

Behavioral Health Coordination

The health plan accurately reported and analyzed Remeasurement 2 rates for the two performance indicators. HMSA QI conducted appropriate quality improvement processes to identify barriers and deployed logical interventions linked to the identified barriers. The interventions could reasonably be expected to positively impact performance indicator outcomes. HMSA QI also drafted and shared the DSA with the DOH Behavioral Health Services Administration divisions. The DSA was approved and executed in December 2024 and is effective as of January 1, 2025.

Plan All-Cause Readmissions

The health plan accurately reported and analyzed Remeasurement 2 rates. HMSA QI conducted appropriate quality improvement processes. As part of the Readmissions Collaborative workgroup, the health plan identified barriers and deployed logical interventions linked to the identified barriers. HMSA QI included an evaluation of effectiveness for each intervention and appropriate next steps for the interventions.

Screening for Depression and Follow-Up Plan

The health plan had not progressed to reporting and analyzing data or conducting quality improvement activities.

Outcomes (Step 9)

Behavioral Health Coordination

During Remeasurement 2, the health plan achieved statistically significant improvement in the Performance Indicator 1 rate. A decline from the baseline rate was noted in the Performance Indicator 2 rate.

Plan All-Cause Readmissions

During Remeasurement 2, the health plan had a statistically nonsignificant decline in performance over the baseline.

Screening for Depression and Follow-Up Plan

The health plan had not progressed to reporting remeasurement outcomes. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle.

Analysis of Results

Table 3-48 displays the data that the health plan reported for the *Behavioral Health Coordination* PIP.

Table 3-48—Outcomes for the *Behavioral Health Coordination* PIP

Performance Indicator	Baseline (07/01/2021–09/30/2021)		Remeasurement 1 (07/01/2022–09/30/2022)		Remeasurement 2 (07/01/2023–09/30/2024)		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%	N: 21 D: 165	12.7%*	N: 67 D: 171	39.2%*	*Yes*

Performance Indicator	Baseline (07/01/2021–09/30/2021)		Remeasurement 1 (07/01/2022–09/30/2022)		Remeasurement 2 (07/01/2023–09/30/2024)		Sustained Improvement
2. Percent of shared members whose data are actively shared at a regular frequency with partner agencies.	N: 98 D: 1,071	9.2%	N: 100 D: 1,190	8.4%	N: 114 D: 1,309	8.7%	*Not Assessed*

*Rate demonstrates statistically significant improvement over the baseline rate.
N–Numerator D–Denominator
HSAG rounded percentages to the first decimal place.

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, and for Remeasurement 1, the Performance Indicator 1 rate increased to 12.7 percent. For Remeasurement 2, the rate was 39.2 percent, which represents a statistically significant increase of 37.1 percentage points over the baseline. HMSA QI documented that only formal combined reviews were counted in the numerator of the baseline rate; however, during the remeasurement periods, with system enhancements made to the health plan's care management platform Coreo Care, the health plan's care coordination team is now able to document interactions with partner agencies by selecting appropriate options from the drop-down menu. Therefore, both formal and informal combined reviews were captured.

The rate for the percentage of shared members whose data were actively shared with the partner agencies during the baseline measurement period was 9.2 percent, and for Remeasurement 1, the Performance Indicator 2 rate decreased to 8.4 percent. For Remeasurement 2, the rate was 8.7 percent, which represents a statistically nonsignificant decrease of 0.5 percentage points from the baseline. For the Performance Indicator 2 denominator, the health plan had information for shared members with the Child & Adolescent Mental Health Division (CAMHD) and 'Ohana CCS only. The health plan indicated that it is unable to accurately identify all shared members with the Adult Mental Health Division (AMHD), Alcohol and Drug Abuse Division (ADAD), or Developmental Disabilities Division (DDD) until the time when DSAs and member identification mechanisms are in place.

Table 3-49 displays the data that the health plan reported for the *Plan All-Cause Readmissions* PIP.

Table 3-49—Outcomes for the *Plan All-Cause Readmissions* PIP

Performance Indicator	Baseline (01/01/2021–12/31/2021)		Remeasurement 1 (01/01/2022–12/31/2022)		Remeasurement 2 (01/01/2023–12/31/2023)		Sustained Improvement
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: 4,298	7.7%	N: 390 D: 4,702	8.3%	N: 396 D: 5,006	7.9%	*Not Assessed*

N–Numerator D–Denominator
HSAG rounded percentages to the first decimal place.

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. For Remeasurement 1, the performance indicator rate increased to 8.3 percent. For Remeasurement 2, the rate was 7.9 percent, which represents a statistically nonsignificant increase (decline in performance) of 0.2 percentage points from the baseline. The health plan was not assessed for sustained improvement because it had not achieved statistically significant improvement during Remeasurement 1.

Table 3-50 will display the data for the *Screening for Depression and Follow-Up Plan* PIP once the health plan reports performance indicator results.

Table 3-50—Performance Indicator Results for the *Screening for Depression and Follow-Up Plan* PIP

Performance Indicator	Baseline (01/01/2024–12/31/2024)		Remeasurement 1 (01/01/2025–12/31/2025)		Sustained Improvement
1. Percentage of members ages 12 to 17 screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool and, if positive, a follow-up plan is documented on the date of the eligible encounter.					
2. Percentage of members aged 18 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and, if positive, a follow-up plan is documented on the date of the eligible encounter.					

Barriers/Interventions

Table 3-51 displays the barriers and interventions as documented by the health plan for the *Behavioral Health Coordination* and *Plan All-Cause Readmissions* PIPs. Barriers and interventions for the *Screening for Depression and Follow-Up Plan* PIP will be documented when the PIP progresses to including QI activities and interventions.

Table 3-51—Interventions Implemented/Planned for HMSA QI PIPs

Barriers	Interventions
Behavioral Health Coordination	
1. No formal data sharing agreements between health plans and the DOH agencies that would allow bi-directional exchange of data pertaining to shared member population. 2. No established group of stakeholders with regularly scheduled meetings to discuss collaboration strategies. 3. Lack of a workflow to facilitate regular and effective communication among QUEST Integration Health Plans and partnering agencies. 4. Limited capability for data capture and reporting. Reliance on information entered in text format and challenge with extracting that information for reporting. 5. Challenge in scheduling interdisciplinary team (IDT) meetings among multiple partnering agencies.	1. Drafted data sharing agreement with the partnering agencies.* 2. Established a workgroup with partnering agencies that meets at least quarterly.* 3. Developed a workflow for ongoing communication between health plan and partnering agencies.* 4. Enhancements were made to HMSA's care management system (Coreo Care) with input from the health coordination team. 5. Converted IDT meetings cadence from ad hoc to a weekly recurring schedule resulting in more collaboration opportunities among the health plan, CCS, and case management 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. 3. Members' lack of understanding of post-discharge planning. Care transition staff may not be effectively communicating with members to ensure they understood discharge instructions, medications, treatment plan, and action plan.	1. Members will be enrolled in HMSA's Event Driven Care (EDC) program and receive education from nurses via phone on the importance of managing chronic conditions, including regular visits to primary care providers, and the importance of accessing appropriate medical services. 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. (Discontinued) 3. Develop and train EDC staff on the teach-back method. Teach back is a method to improve communication skills and has been associated with improved comprehension of discharge instructions. Using this method, the EDC nurse will communicate the member's discharge instructions, medications, treatment plan, and action plan. Then, the EDC nurse will ask the member to explain back in their own words, thereby validating that the EDC nurse communicated the information to the member and checked their understanding. Staff training on the method includes an overview and sample

Barriers	Interventions
	questionnaire; a tip sheet on how to incorporate teach-back into visits with members; a training video with links to additional online resources; and an observation tool, 10 elements of competence, and coaching tips from Always Use Teach-Back.
Screening for Depression and Follow-Up Plan	

* The documented interventions are required by MQD.

Strengths

- For all three PIPs, HMSA QI received an overall *High Confidence* level rating for overall confidence in adherence to acceptable methodology for all phases of the PIP for Steps 1 through 8.
- For the *Behavioral Health Coordination* PIP, during Remeasurement 2, the health plan achieved statistically significant improvement in both performance indicator rates.
- For the *Screening for Depression and Follow-Up Plan* PIP, the health plan designed a scientifically sound project that was supported by using key research principles.

Areas for Improvement

- For the *Plan All-Cause Readmissions* PIP, for both remeasurement periods, the health plan had a statistically nonsignificant decline in performance over the baseline with an increase in the observed readmission rate.

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 *Screening for Depression and Follow-Up Plan* PIP:
  - The health plan ensure that the interventions are implemented in a timely manner to impact outcomes during the remeasurement period.
- For the *Behavioral Health Coordination* PIP:
  - HSAG recommends that the health plan document performance indicator rates to at least one decimal place for each measurement period.
- The health plan must 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 to drive improvement.

- The health plan should consider the use of quality improvement science-based tools, such as process mapping with FMEA, for causal/barrier analysis.
- The health plan must evaluate each intervention listed in the barriers/interventions table for effectiveness.
- The health plan should collect the intervention effectiveness data more frequently (e.g., monthly or quarterly) unlike the annual performance indicator data. This would help the health plan understand intervention effectiveness and make any updates to the interventions in a timely manner to impact remeasurement outcomes.
- Intervention effectiveness data must guide next steps for each individual intervention.

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 3-52 presents the 2024 scores for HMSA QI compared to the 2023 NCQA adult Medicaid national averages, the corresponding 2022 scores, and QI Program (i.e., combination of the five QI health plans).[53,54] Additionally, the overall member experience ratings (i.e., star ratings) resulting from the comparison of HMSA QI's 2024 scores to NCQA's 2023 Quality Compass Benchmark and Compare Quality Data are displayed below.[55]

Table 3-52—Adult Medicaid CAHPS Results for HMSA QI

Measure	2022 Scores	2024 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	59.05%	63.67%	★★★
Rating of All Health Care	56.77%	57.40%	★★★
Rating of Personal Doctor	61.75%	64.93%	★★
Rating of Specialist Seen Most Often	75.86%	65.38%	★★
Composite Measures			
Getting Needed Care	78.46%	77.80%	★
Getting Care Quickly	71.79%	76.75%	★★

[53] The adult population was last surveyed in 2022; therefore, the 2024 adult CAHPS scores are compared to the corresponding 2022 scores.

[54] National Committee for Quality Assurance. *HEDIS® Measurement Year 2023*, *Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2023.

[55] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2023.* Washington, DC: NCQA, September 2023.

Measure	2022 Scores	2024 Scores	Star Ratings
How Well Doctors Communicate	90.62%	92.02%	★★
Customer Service	87.45%+	86.16%+	★
Individual Item Measure			
Coordination of Care	79.38%+	89.69%+ ▲	★★★★★
Medical Assistance With Smoking and Tobacco Use Cessation Measure Items			
Advising Smokers and Tobacco Users to Quit	67.32%	68.82%+	★★
Discussing Cessation Medications	49.01%	48.91%+	★★
Discussing Cessation Strategies	47.02%	45.16%+	★★

A cell highlighted in green represents the score is statistically significantly higher than the 2023 NCQA adult Medicaid national average.
A cell highlighted in red represents the score is statistically significantly lower than the 2023 NCQA adult Medicaid national average.
▲ *Indicates the 2024 score is statistically significantly higher than the 2022 score.*
▼ *Indicates the 2024 score is statistically significantly lower than the 2022 score.*
↑ *Indicates the QI health plan's 2024 score is statistically significantly higher than the QI Program.*
↓ *Indicates the QI health plan's 2024 score is statistically significantly lower than the QI Program.*
\+ *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

- HMSA QI's adult Medicaid population, the *Coordination of Care* scored statistically significantly higher in 2024 than in 2022 and met or exceeded the 90th percentile.
- Of the nine MQD member satisfaction Quality Strategy target measures—*Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Coordination of Care*—HMSA QI's member experience rating for *Rating of Health Plan* and *Coordination of Care* exceeded the RY 2024 target.

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 3-53 provides a summary of the key drivers identified for HMSA QI.

Table 3-53—HMSA QI Key Drivers of Member Experience Analysis

Survey Item	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	✓	✓	—
Q6. Received appointment for a checkup or routine care as soon as needed	—	✓	—
Q9. Ease of getting the care, tests, or treatment needed	✓	✓	—
Q15. Personal doctor spent enough time	✓	—	✓
Q20. Received appointment with a specialist as soon as needed	—	✓	NA
Q24. Health plan's customer service gave the information or help needed	✓	✓	NA

NA *Indicates that this question was not evaluated for this measure.*
— *Indicates the survey item is not strongly correlated with the measure or that the item did not perform poorly (i.e., not a key driver).*

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

- Respondents reported not always receiving care as soon as they needed when care was needed right away.
- Respondents reported not receiving an appointment for a checkup or routine care as soon as they needed.

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

- 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 HMSA QI:

- Respondents reported that their personal doctor did not always spend enough time with them.
- Respondents reported their health plan's customer service did not provide the information or help they needed.

Recommendations

HSAG recommends that HMSA QI explore what may be driving lower experience scores and develop

initiatives designed to improve quality and access to care, including a focus on improving adult members' overall experiences with their health plan, personal doctor, overall healthcare, the specialist they see most often, customer service, getting needed care in a timely manner, and discussion of cessation strategies and medications to quit smoking/using tobacco.

Home and Community-Based CAHPS Survey

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

Findings

Table 3-54 presents the 2024 top-box scores for HMSA QI compared to the Hawaii HCBS Program (i.e., combination of the five QI health plans) scores, AHRQ's 2024 CAHPS Database benchmarks, and the corresponding 2023 scores.[56,57,58]

Table 3-54—HCBS Survey Results for HMSA QI

Measure	2023 Scores	2024 Scores
Global Ratings		
Rating of Personal Assistance and Behavioral Health Staff	52.94%+	55.56%+
Rating of Homemaker	NA	NA
Rating of Case Manager	50.00%+	80.00%+
Composite Measures		
Reliable and Helpful Staff	NA	72.14%+
Staff Listen and Communicate Well	NA	82.70%+ ▲
Helpful Case Manager	NA	NA
Choosing the Services that Matter to You	56.88%+	64.29%+
Transportation to Medical Appointments	46.92%+	75.63%+ ▲
Personal Safety and Respect	86.50%+	93.06%+
Planning Your Time and Activities	40.15%+	56.07%+ ▲
Recommendation Measures		
Recommend Personal Assistance/Behavioral Health Staff	62.50%+	72.22% +

[56] For this report, only the composite measure scores are displayed. For more detailed results of the items within the composite measure, please see the 2024 Hawaii HCBS CAHPS Survey full report.

[57] Agency for Healthcare Research and Quality. *The CAHPS® Home and Community-Based Services (HCBS) Survey Database 2024 Chartbook*. January 2024. Available at: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/cahps-database/2024-hcbs-chartbook.pdf. Accessed on: Jan 15, 2025.

[58] The 2024 HCBS CAHPS Database benchmarks represent survey data collected from January 1 to December 31, 2022. Caution should be exercised when comparing the 2024 HCBS CAHPS Database benchmarks to the Hawaii HCBS Program 2024 results, which represent survey data collected from July 23, 2024, to September 15, 2024.

Measure	2023 Scores	2024 Scores
Recommend Homemaker	NA	NA
Recommend Case Manager	23.53%+	93.75%+▲↑
Unmet Need and Physical Safety Measures		
No Unmet Need in Dressing/Bathing	NA	NA
No Unmet Need in Meal Preparation/Eating	NA	NA
No Unmet Need in Medication Administration	NA	NA
No Unmet Need in Toileting	NA	NA
No Unmet Need with Household Tasks	NA	NA
Not Hit or Hurt by Staff	100.00%+	100.00%+

A cell highlighted in green represents the score is statistically significantly higher than the 2024 CAHPS Database benchmark.
A cell highlighted in red represents the score is statistically significantly lower than the 2024 CAHPS Database benchmark.
▲ *Indicates the 2024 score is statistically significantly higher than the 2023 score.*
▼ *Indicates the 2024 score is statistically significantly lower than the 2023 score.*
↑ *Indicates the QI health plan's score is statistically significantly higher than the Hawaii HCBS Program.*
↓ *Indicates the QI health plan's score is statistically significantly lower than the Hawaii HCBS Program.*
+ *Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.*
Results based on fewer than 11 respondents were suppressed and noted as "NA".

Strengths

- For HMSA QI, the following measures scored statistically significantly higher in 2024 than in 2023:
  - *Staff Listen and Communicate Well*
  - *Transportation to Medical Appointments*
  - *Planning Your Time and Activities*
  - *Recommended Case Manager*
- For HMSA QI, the *Recommended Case Manager* measure scored statistically significantly higher than the Hawaii HCBS Program and AHRQ's 2024 CAHPS Database benchmark.

Areas for Improvement

- For HMSA QI, the *Rating of Personal Assistance and Behavioral Health Staff* measure scored statistically significantly lower than AHRQ's 2024 CAHPS Database benchmark.

Recommendations

HSAG recommends that HMSA QI explore what may be driving lower experience scores and develop initiatives designed to improve quality of care, including a focus on improving adult members' overall experiences with their personal assistance and behavioral health staff.

Encounter Data Validation

HSAG evaluated the extent to which the encounter data in MQD's database were complete, accurate, and submitted by HMSA QI in a timely manner through a comparative analysis between MQD's electronic encounter data and the actuarial files submitted by HMSA QI to MQD's contracted actuary, Milliman.

Findings

Table 3-55 illustrates the percentage of records present in the Milliman-submitted files that were not found in the MQD-submitted files (record omission or underreporting to MQD) and the percentage of records present in the MQD-submitted files but not present in the Milliman-submitted files (record surplus or underreporting to Milliman). Lower rates indicate better performance for both record omission and record surplus.

Table 3-55—Record Omission and Surplus by Encounter Type

Encounter Type	Record Omission (Underreporting to MQD)	Record Surplus (Underreporting to Milliman)
Institutional	3.9%	29.5%
Professional	2.5%	12.3%
Pharmacy	11.9%	0.4%

Note: Lower rates indicate better performance.
Red text indicates rates higher than 5.0 percent.

Element-level discrepancy was limited to those records present in both data sources with values present in both data sources. Records with values missing from both data sources were not included in the denominator. The numerator was the number of records with different non-missing values for a given data element. Lower data element discrepancy rates indicate that the values populated for a data element in the MQD-submitted encounter data were more accurate. As such, for the discrepancy indicator, lower rates indicate better performance. Table 3-56 to Table 3-58 present the data element discrepancy rates for each encounter type.

Table 3-56—Element Discrepancy by Key Data Element for Institutional Encounters

Key Data Element	Discrepancy Rate
Member, Date of Service, and Provider	
Member ID	<0.1%
Member Date of Birth	2.5%
Detail First Date of Service	2.2%
Detail Last Date of Service	2.2%
Billing Provider NPI	1.0%
Billing Provider Type	3.7%

Key Data Element	Discrepancy Rate
Servicing Provider NPI	1.0%
Servicing Provider ID	12.3%
Payment Information	
Allowed Amount	35.3%
Billed Amount	47.7%
COB Amount	10.5%
Coinsurance Amount	0.0%
Copay Amount	0.0%
Deductible Amount	0.0%
MCO Paid Amount	<0.1%
Value Code Amount	<0.1%
Diagnosis Codes, Procedure Codes, and Drug Information	
Admission Diagnosis Code	0.0%
Primary Diagnosis Code	<0.1%
All Secondary Diagnosis Codes	90.1%
All Surgical Procedure Codes	65.7%
Procedure Code	3.5%
Procedure Code Modifiers	4.5%
Units of Service	9.6%
NDC	1.0%
Other Data Elements	
Admission Date	0.0%
Admission Source	<0.1%
Admission Type	0.1%
DRG Code	—
Discharge Date	27.9%
Discharge Status	21.2%
Encounter Flag	<0.1%
MCO Paid Date	0.0%
Occurrence Span Codes	1.5%
POA Code	—
All Secondary POA Codes	90.2%
Revenue Code	1.9%
TOB Code	100%

Key Data Element	Discrepancy Rate
Value Codes	0.0%

— indicates that the denominator was zero.
Red text indicates rates higher than 5.0 percent.

Table 3-57—Element Discrepancy by Key Data Element for Professional Encounters

Key Data Element	Discrepancy Rate
Member, Date of Service, and Provider	
Member ID	<0.1%
Member Date of Birth	1.8%
Detail First Date of Service	<0.1%
Detail Last Date of Service	<0.1%
Billing Provider NPI	1.4%
Billing Provider Type	67.0%
Servicing Provider NPI	0.3%
Servicing Provider ID	3.0%
Payment Information	
Allowed Amount	28.9%
Billed Amount	0.6%
COB Amount	3.9%
Coinsurance Amount	0.0%
Copay Amount	0.0%
Deductible Amount	0.0%
MCO Paid Amount	5.5%
Patient Paid Amount	<0.1%
Diagnosis Codes, Procedure Codes, and Drug Information	
Primary Diagnosis Code	5.6%
All Secondary Diagnosis Codes	31.6%
Procedure Code	0.8%
Procedure Code Modifiers	0.1%
Units of Service	0.5%
NDC	0.7%
Other Data Elements	
Admission Date	74.6%
Discharge Date	—
Encounter Flag	19.1%

Key Data Element	Discrepancy Rate
POS Code	0.2%
MCO Paid Date	<0.1%

— indicates that the denominator was zero.
Red text indicates rates higher than 5.0 percent.

Table 3-58—Element Discrepancy by Key Data Element for Pharmacy Encounters

Key Data Element	Discrepancy Rate
Member and Date of Service	
Member ID	0.0%
Date of Service	0.0%
Payment Information	
Billed Amount	98.4%
COB Amount	3.9%
Coinsurance Amount	0.0%
Copay Amount	0.0%
Deductible Amount	0.0%
Dispensing Fee	0.0%
Ingredient Cost	99.8%
MCO Paid Amount	<0.1%
Patient Paid Amount	0.0%
Drug Information	
NDC	<0.1%
Dispensing Quantity	3.1%
Days' Supply	0.0%
New or Refill Flag	—
Number of Refills	87.9%
Other Data Elements	
MCO Paid Date	100%

— indicates that the denominator was zero.
Red text indicates rates higher than 5.0 percent.

Strengths

- Record omission rates for institutional and professional encounters were below 5.0 percent, and the record surplus rate for pharmacy encounters was below 5.0 percent. This indicates that encounters in the Milliman-submitted data could largely be identified in the MQD-submitted data for institutional

and professional encounters, while encounters in the MQD-submitted data could largely be identified in the Milliman-submitted data for pharmacy encounters.

- All but 11 institutional encounter data elements, all but seven professional encounter data elements, and all but four pharmacy encounter data elements had a discrepancy rate less than 5.0 percent. This indicates that records which could be matched between the MQD-submitted and the Milliman-submitted data largely contained the same values.

Areas for Improvement

- The record omission rate for pharmacy encounters was high at 11.9 percent, while the record surplus rates for institutional and professional encounters were high at 29.5 percent and 12.3 percent, respectively.
- Although matched records largely contained similar values between the MQD-submitted and Milliman-submitted data, HMSA QI should ensure the following data elements have accurate values:
  – Institutional encounters: Servicing Provider ID, Allowed Amount, Billed Amount, COB Amount, All Secondary Diagnosis Codes, All Surgical Procedure Codes, Units of Service, Discharge Date, Discharge Status, All Secondary POA Codes, and TOB Code.
  – Professional encounters: Billing Provider Type, Allowed Amount, MCO Paid Amount, Primary Diagnosis Code, All Secondary Diagnosis Codes, Admission Date, and Encounter Flag.
  – Pharmacy encounters: Billed Amount, Ingredient Cost. Number of Refills, and MCO Paid Date.

Recommendations

- HMSA QI should review and work on the action items noted in the data discrepancy report.
- HMSA QI should utilize the three-year encounter file that MQD will provide monthly to ensure the data it submits to HPMMIS are processed and submitted correctly. HMSA QI should review any discrepancies within the file with MQD to reconcile any differences.
- HMSA QI should continue to work with MQD and Milliman to ensure data submitted to HPMMIS in CY 2025 accurately reflect data needed for the CY 2026 rate-setting activities.

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 seven EQR activities. While follow-up on compliance monitoring review findings and NAV activities indicated that

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

As a result of the 2022 and 2023 compliance reviews, HMSA QI had 13 corrective action items to address during 2023 and 2024. HMSA QI took the necessary steps to plan interventions; update policies, procedures, and member and provider information; and make operational changes to address the deficiencies found. As a result of its CAP interventions, HMSA QI was found to be fully compliant with all standards during 2024.

The results of the NAV activities revealed that HMSA QI had well-defined processes and procedures in place to ensure efficient and accurate collection of member and provider data to support network adequacy calculation and reporting. HMSA QI demonstrated efforts to identify gaps in provider networks throughout its service areas and identify ways to improve the accessibility and timeliness of care for members.

Overall, more than half (55.26 percent) of HMSA QI's performance measures fell below the 50th percentile across all domains. While some measures showed improvement from MY 2022, HMSA QI's performance suggests several areas in need of improvement, including the Children's Preventive Health and Women's Health domains. While 22 MQD Quality Strategy targets were met in HEDIS MY 2023, HMSA QI should focus improvement efforts on Children's Preventive Health and Women's Health measures that fell below the 25th percentile.

HMSA QI's CAHPS results illustrate opportunities for improvement in members' satisfaction. While none of the measures scored statistically significantly lower in 2024 than in 2022 and none of the measures scored statistically significantly lower than the 2023 NCQA adult Medicaid national averages, the following nine 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*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*. 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 two of the nine measures MQD selected for monitoring within its Quality Strategy met or exceeded the RY 2024 target, HMSA QI should focus improvement efforts on the *Getting Needed Care* and *Customer Service* measures, which fell below the 25th percentile.

HMSA QI's HCBS CAHPS Survey results illustrated positive results and opportunities for improvement in members' experience. The following measures scored statistically significantly higher than the 2023 scores: *Staff Listen and Communicate Well*, *Transportation to Medical Appointments*, *Planning Your Time and Activities*, and *Recommended Case Manager*. The *Recommended Case Manager* measure also scored statistically significantly higher than the Hawaii HCBS Program and AHRQ's 2024 CAHPS Database benchmark. Additionally, while none of the measures scored statistically significantly lower than the 2023 scores or the Hawaii HCBS Program, the *Rating of Personal Assistance and Behavioral Health Staff* measure scored statistically significantly lower than AHRQ's 2024 CAHPS Database

benchmark*,* indicating a need for HMSA QI to implement strategies to ensure members have access to high-quality care.

The EDV activities revealed that HMSA QI should improve its encounter data completeness for institutional, professional, and pharmacy encounters, since either the record omission or the record surplus rate for each encounter type was above 5.0 percent (i.e., relatively poor performance). In addition, although matched records largely contained similar values between the MQD-submitted and the Milliman-submitted data, HMSA QI had at least one data element for each encounter type that it should work on to improve its accuracy. Submitting accurate and complete encounter data assists MQD in monitoring issues concerning quality of care and access to care, as well as setting up proper capitation rates starting in CY 2026 with CY 2025 data.

HMSA QI progressed to the Outcomes stage of the two PIPs that were initiated in CY 2022 and the Design stage for the new PIP initiated in CY 2024. The PIPs 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 a *High Confidence* level rating for overall confidence in adherence to acceptable methodology for all phases of the PIP and a *Moderate Confidence* rating for overall confidence that the PIP achieved significant improvement. Besides 'Ohana CCS and CAMHD, the health plan could not identify shared members with the remaining DOH partnering agencies. At the time of the PIP submission, the health plan was awaiting approval of the DSA by the DOH Behavioral Health Services Administration divisions. For both remeasurement periods, the health plan achieved statistically significant improvement in the Performance Indicator 1 rate; however, a decline from the baseline rate was noted in the Performance Indicator 2 rate.

For the *Plan All-Cause Readmissions* PIP, HMSA QI received a *High Confidence* level rating for overall confidence in adherence to acceptable methodology for all phases of the PIP and a *No Confidence* rating for overall confidence that the PIP achieved significant improvement. The documented PIP design and data were accurate. The health plan conducted appropriate QI processes and participated in the Readmissions Collaborative workgroup to identify barriers, and deployed interventions that were logically linked to the identified barriers. For both remeasurement periods, the health plan had statistically nonsignificant declines in performance over the baseline.

For the *Screening for Depression and Follow-Up Plan* PIP, HMSA QI received a *High Confidence* level rating for adherence to acceptable methodology for the PIP design. The health plan designed a scientifically sound project that was supported by using key research principles.

Kaiser Foundation Health Plan QUEST Integration (KFHP QI) Results

Compliance Monitoring Review

The 2024 compliance monitoring review activity included follow-up reviews of the health plans' required corrective actions implemented to address deficiencies noted during the 2022 and 2023 reviews.

Findings

Table 3-59 presents the scores from HSAG's 2022 and 2023 compliance reviews, the number of CAPs required, the number of CAPs closed, and the results of the 2024 follow-up reviews of KFHP QI.

Table 3-59—Standards, Compliance Scores, and CAPs—KFHP QI

Standard Name	Standard Review Year	Compliance Review Score	# of CAPs Required	# of CAPs Closed	2024 Final Follow-Up Review Score
Assurances of Adequate Capacity and Services	2022	50%	3	3	**100%**
Availability of Services	2022	94%	2	2	**100%**
Confidentiality	2022	100%	0	NA	**100%**
Coordination and Continuity of Care	2022	95%	1	1	**100%**
Coverage and Authorization of Services	2022	100%	0	NA	**100%**
Credentialing	2023	100%	0	NA	**100%**
Enrollee Information	2022	92%	2	2	**100%**
Enrollee Rights and Protections	2022	94%	1	1	**100%**
Enrollment and Disenrollment	2023	100%	0	NA	**100%**
Grievance and Appeal System	2022	98%	1	1	**100%**
Health Information Systems	2023	100%	0	NA	**100%**
Provider Selection	2023	100%	0	NA	**100%**
Practice Guidelines	2023	100%	0	NA	**100%**
Quality Assessment and Performance Improvement	2023	100%	0	NA	**100%**
Subcontractual Relationships and Delegation	2023	92%	1	1	**100%**
Totals			**11**	**11**	**100%**

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

Strengths

The 2022 compliance review revealed that KFHP QI had deficiencies in six of the eight standards reviewed. During 2023 and 2024, KFHP QI completed 10 corrective action items to bring them into full

compliance. To address the Availability of Services and Assurances of Adequate Capacity and Services deficiencies, KFHP QI developed a new Provider Network Adequacy (PNA) report to monitor and ensure it has an appropriate range of providers that can effectively meet the needs of members in service areas. Additionally, HSAG and MQD reviewed and approved the elements of the PNA report, and it is now being provided to MQD quarterly. To address the Coordination and Continuity of Care deficiencies, KFHP QI updated processes and staff roles to support timely completion of Health and Functional Assessments (HFAs), implemented reminders for earlier initial outreach to members, hired temporary staff members to support the care coordination staff, developed a dashboard to track and ensure the timeliness of HFA completion, and retrained staff to ensure complete documentation.

To address deficiencies in the Enrollee Information and Enrollee Rights and Protections standards, KFHP QI updated policies, the member portal, and the provider directory on its website to ensure all required information was present. Finally, to address the Grievance and Appeal System standard, KFHP QI revised a policy to clearly indicate that written consent of the member must be received for a provider or an authorized representative to file an appeal on behalf of the member.

KFHP QI performed well during 2023 compliance review, with only one corrective action item to complete in 2024. To address the Subcontractual Relationships and Delegation standard, KFHPI QI has updated policies and procedures for overseeing subcontractor performance, updated subcontractor agreements with delegates, and developed an annual review process for individual subcontractors.

Areas for Improvement

As a result of its CAP interventions, KFHP QI was found to be fully compliant with all standards and had no continuing corrective actions.

Recommendations

HSAG recommends that KFHP QI review the revised Medicaid managed care rules released in 2024 and implement operational changes, as applicable, to ensure continued compliance.

Validation of Performance Measures—NCQA HEDIS Compliance Audits

NCQA HEDIS Compliance Audit Findings

HSAG's review team assessed KFHP QI's IS capabilities and its ability to process data for reporting accurate performance measure rates. KFHP QI was found to be fully compliant with all HEDIS IS standards, as well as IS standard L for assessing case management data for LTSS measures. This demonstrated that KFHP QI had effective IS processes and control procedures in place for reporting the required performance measure rates. KFHP QI presented four supplemental data sources for consideration to use for supplementing its MY 2023 performance measure rates. HSAG determined two data sources to be nonstandard supplemental data, and the remaining two were considered standard

supplemental data. No concerns were identified, and all four supplemental data sources were approved for HEDIS MY 2023 reporting.

KFHP QI was required to undergo convenience sample validation for two new measures in the scope of the audit: *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile—Total* and *Immunization for Adolescents—Combination 1.* The final MRRV was conducted for the *Controlling High Blood Pressure, Eye Exam for Patients With Diabetes,* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care* measure indicators, as well as all medical record exclusions. All selected cases passed the final MRRV without any critical errors.

All measures under the scope of the audit were determined to be *Reportable*. Additionally, KFHP QI was determined to be fully compliant with all IS standards; therefore, HSAG 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 3-60.

Table 3-60—KFHP QI's Results for QI Measures Under Access and Risk-Adjusted Utilization

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	—	58.57%	—	★
45–64 Years	—	73.25%	—	★
65 Years and Older	—	83.76%	—	★★★
Total	—	65.75%	—	★
Ambulatory Care				
Emergency Department Visits	360.22	384.74	6.81%	★★★★★
Outpatient Visits	2,966.33	3,059.61	3.14%	★
Asthma in Younger Adults Admission Rate*				
*Asthma in Younger Adults Admission Rate**	—	2.75	—	NC
Heart Failure Admission Rate*				
18–64 Years	31.62	29.19	-7.69%	NC
65 Years and Older	109.16	116.61	6.82%	NC
Total (18 Years and Older)	38.04	37.26	-2.05%	NC
Plan All-Cause Readmissions				
*Index Total Stays—Observed Readmissions—Total**	8.79%	7.45%	-15.19%	NC
Expected Readmissions—Total	9.56%	9.69%	1.40%	NC
*Index Total Stays—O/E Ratio—Total**	0.9192	0.7690	-16.34%	NC

** A lower rate indicates better performance.*
Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by 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 health 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 2023 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*

The *Ambulatory Care—Emergency Department Visits* indicator rate met or exceeded the 90th percentile. The *Adults' Access to Preventive/Ambulatory Health Services—65 years and Older* indicator met or exceeded the 50th percentile. All other measure indicators in this domain did not meet or exceed the 50th percentile or did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented.

KFHP QI met the MQD-established Quality Strategy target for *Heart Failure Admission Rate—Total—18 Years and Older* and *Plan All-Cause Readmissions—Index Total Stays—O/E Ratio—Total.* All other MQD Quality Strategy targets were not met for this domain.

Children's Preventive Health Performance Measure Results

KFHP QI's Children's Preventive Health performance measure results are shown in Table 3-61.

Table 3-61—KFHP QI's Results for QI Measures Under Children's Preventive Health

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Child and Adolescent Well-Care Visits				
Child and Adolescent Well-Care Visits	41.15%	42.94%	4.35%	★
Childhood Immunization Status				
Combination 3	69.46%	68.65%	-1.16%	★★★
Combination 7	66.96%	65.73%	-1.84%	★★★★★
Combination 10	56.85%	52.46%	-7.73%	★★★★★
DTaP	72.39%	72.41%	0.03%	★★★
Hepatitis A	80.98%	82.34%	1.68%	★★★
Hepatitis B	86.09%	86.83%	0.87%	★★★
HiB	77.28%	82.13%	6.27%	★★
Influenza	65.11%	60.40%	-7.24%	★★★★★
IPV	84.67%	82.86%	-2.14%	★★
MMR	82.61%	83.80%	1.45%	★★
Pneumococcal Conjugate	70.87%	69.59%	-1.80%	★★

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Rotavirus	79.57%	77.95%	-2.03%	★★★★★
VZV	82.17%	83.39%	1.47%	★★
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	—	73.48%	—	★★
Combination 2 (Meningococcal, Tdap, HPV)	—	52.93%	—	★★★★★
Meningococcal Serogroups A, C, W, Y	—	74.25%	—	★
Tdap	—	75.47%	—	★
HPV	—	54.25%	—	★★★★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents				
BMI Percentile Documentation—3–11 Years	—	97.34%	—	★★★★★
BMI Percentile Documentation—-12–17 Years	—	95.71%	—	★★★★★
BMI Percentile Documentation—Total	—	96.77%	—	★★★★★
Counseling for Nutrition—3–11 Years	—	97.72%	—	★★★★★
Counseling for Nutrition—12–17 Years	—	97.86%	—	★★★★★
Counseling for Nutrition—Total	—	97.77%	—	★★★★★
Counseling for Physical Activity-3–11 Years	—	97.72%	—	★★★★★
Counseling for Physical Activity—12–17 Years	—	97.86%	—	★★★★★
Counseling for Physical Activity—Total	—	97.77%	—	★★★★★
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	70.41%	72.10%	2.40%	★★★★★
Well-Child Visits for Age 15 Months to 30 Months of Life—Two or More Well-Child Visits	73.05%	80.11%	9.66%	★★★★★

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by MQD.
— Indicates that the health 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 2023 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*

Twenty-one of 30 measure rates that could be compared to national benchmarks met or exceeded the 50th percentile, including 17 rates that ranked at or above the 90th percentile. All indicators for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents*

measure met or exceeded the 90th percentile. For *Childhood Immunization Status,* eight indicators met or exceeded the 50th percentile and four met or exceeded the 90th percentile. Both measure rates for *Well-Child Visits in the First 30 Months of Life* met or exceeded the 90th percentile.

KFHP QI met MQD's established Quality Strategy targets for the following measure indicators: *Childhood Immunization Status—Combination 3, Combination 7,* and *Combination 10; Immunizations for Adolescents—Combination 1* and *Combination 2; Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—Counseling for Nutrition, BMI Percentile Documentation,* and *Counseling for Physical Activity; Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life;* and *Well-Child Visits in the First 30 Months of Life.* All other MQD Quality Strategy targets were not met for this domain.

Women's Health Performance Measure Results

KFHP QI's Women's Health performance measure results are shown in Table 3-62.

Table 3-62—KFHP QI's Results for QI Measures Under Women's Health

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Cervical Cancer Screening				
Cervical Cancer Screening	63.61%	61.12%	-3.92%	★★★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	90.32%	90.63%	0.33%	★★★★
Postpartum Care	86.38%	85.07%	-1.52%	★★★★★
Prenatal and Postpartum Care: Under 21 Years of Age (Child Core)				
Timeliness of Prenatal Care: Under 21 Years of Age	—	77.59%	—	NC
Postpartum Care: Under 21 Years of Age	—	75.86%	—	NC

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by 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 health 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 2023 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*

All three indicator rates in this domain that could be compared to benchmarks performed at or above the 50th percentile. Additionally, the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* indicator benchmarked at or above the 75th percentile, and the *Postpartum Care* indicator benchmarked at or above the 90th percentile. The *Prenatal and Postpartum Care: Under 21 Years of Age (Child Core)*

measure indicators in this domain did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented.

KFHP QI met the MQD-established Quality Strategy targets for *Cervical Cancer Screening*, *Prenatal and Postpartum Care—Timeliness of Prenatal Care,* and *Prenatal and Postpartum Care—Postpartum Care.*

Care for Chronic Conditions Performance Measure Results

KFHP QI's Care for Chronic Conditions performance measure results are shown in Table 3-63.

Table 3-63—KFHP QI's Results for QI Measures Under Care for Chronic Conditions

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Asthma Medication Ratio				
5–11 Years	—	97.04%	—	★★★★★
12–18 Years	—	100.00%	—	★★★★★
19–50 Years	—	81.31%	—	★★★★★
51–64 Years	—	90.91%	—	★★★★★
Total (5–64 Years)	—	89.67%	—	★★★★★
Total Child Core Set (5–18 Years)	—	97.95%	—	NC
Total Adult Core Set (19–64 Years)	—	85.15%	—	NC
Blood Pressure Control for Patients With Diabetes				
Blood Pressure Control for Patients With Diabetes	66.84%	76.32%	14.17%	★★★★★
Concurrent Use of Opioids and Benzodiazepines*				
18–64 Years	7.20%	6.45%	-10.34%	NC
65 Years and Older	6.25%	7.92%	26.73%	NC
Total (18 Years and Older)	7.04%	6.77%	-3.89%	NC
Controlling High Blood Pressure				
18–64 Years	68.87%	71.43%	3.71%	NC
65–85 Years	67.94%	78.13%	14.99%	NC
Total	68.56%	73.68%	7.48%	★★★★★
Eye Exam for Patients With Diabetes				
Eye Exam for Patients With Diabetes	66.83%	71.16%	6.48%	★★★★★
Hemoglobin A1c Control for Patients With Diabetes				
HbA1c Control (<8.0%)—18–64 Years	—	55.21%	—	NC
HbA1c Control (<8.0%)—65–75 Years	—	70.07%	—	NC
HbA1c Control (<8.0%)—Total	51.41%	58.02%	12.86%	★★★★
*HbA1c Poor Control (>9.0%)—18–64 Years**	—	33.35%	—	NC

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
*HbA1c Poor Control (>9.0%)—65–75 Years**	—	20.62%	—	NC
*HbA1c Poor Control (>9.0%)—Total**	37.47%	30.94%	-17.42%	★★★★

** A lower rate indicates better performance.*
Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by 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 health 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 2023 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*

All *Asthma Medication Ratio* indicators, *Blood Pressure Control for Patients With Diabetes, Controlling High Blood Pressure—Total,* and *Eye Exam for Patients With Diabetes* indicators met or exceeded the 90th percentile. Additionally, *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)—Total* and *HbA1c Poor Control (>9.0%)—Total* met or exceeded the 75th percentile. All other measure indicators in this domain did not meet or exceed the 50th percentile for MY 2023. All other indicators in this domain could not be compared to benchmarks or did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented.

KFHP QI met the established Quality Strategy target for *Asthma Medication Ratio—Total—5–64 Years, Blood Pressure Control for Patients With Diabetes, Concurrent Use of Opioids and Benzodiazepines—Total—18 Years and Older, Controlling High Blood Pressure—Total, Eye Exam for Patients With Diabetes, Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%—Total),* and *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)—Total.*

Behavioral Health Performance Measure Results

KFHP QI's Behavioral Health performance measure results are shown in Table 3-64.

Table 3-64—KFHP QI's Results for QI Measures Under Behavioral Health

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	62.93%	68.29%	8.52%	★★★★
Antidepressant Medication Management				

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Effective Acute Phase Treatment—18–64 Years	—	72.73%	—	NC
Effective Acute Phase Treatment—65 Years and Older	—	83.87%	—	NC
Effective Acute Phase Treatment—Total	75.70%	73.52%	-2.89%	★★★★
Effective Continuation Phase Treatment—18-64 Years	—	51.35%	—	NC
Effective Continuation Phase Treatment—65 Years and Older	—	48.39%	—	NC
Effective Continuation Phase Treatment—Total	50.11%	51.14%	2.06%	★★★★
Follow-Up After Emergency Department Visit for Mental Illness				
7-Day Follow-Up—6–17 Years	51.28%	NA	0.86%	NC
7-Day Follow-Up—18–64 Years	29.95%	23.53%	-21.43%	★
7-Day Follow-Up—65 Years and Older	—	NA	—	NC
7-Day Follow-Up—Total	33.61%	29.89%	-11.08%	★
30-Day Follow-Up—6–17 Years	74.36%	NA	-16.53%	NC
30-Day Follow-Up—18–64 Years	47.59%	46.32%	-2.67%	★★
30-Day Follow-Up—65 Years and Older	—	NA	—	NC
30-Day Follow-Up—Total	51.87%	49.43%	-4.71%	★★
Follow-Up After Emergency Department Visit for Substance Use				
7-Day Follow-Up—13–17 Years	—	NA	—	NC
7-Day Follow-Up—18 Years and Older	21.05%	20.49%	-2.68%	★★
7-Day Follow-Up—Total	20.73%	20.00%	-3.50%	★★
7-Day Follow-Up—18–64 Years (Adult Core)	—	20.50%	—	NC
7-Day Follow-Up—65 Years and Older (Adult Core)	—	NA	—	NC
30-Day Follow-Up—13–17 Years	—	NA	—	NC
30-Day Follow-Up—18 Years and Older	37.89%	39.02%	2.98%	★★★
30-Day Follow-Up—Total	37.82%	38.14%	0.83%	★★★
30-Day Follow-Up—18–64 Years (Adult Core)	—	39.50%	—	NC
30-Day Follow-Up—65 Years and Older (Adult Core)	—	NA	—	NC
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase—Total	—	66.67%	—	★★★★★
Continuation and Maintenance Phase—Total	—	NA	—	NC

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation—Total—13–17 Years	26.32%	40.43%	53.62%	★★
Initiation—Total—18–64 Years	—	28.21%	—	★
Initiation—Total—65 Years and Older	—	46.15%	—	★★★
Initiation—Total	32.52%	29.92%	-7.99%	★
Engagement—Total—13–17 Years	2.63%	21.28%	708.51%	★★★★★
Engagement—Total—18–64 Years	—	6.75%	—	★
Engagement—Total—65 Years and Older	—	1.54%	—	★
Engagement—Total	6.62%	7.09%	7.05%	★
Screening for Depression and Follow-Up Plan				
12–17 Years	1.44%	1.56%	7.99%	NC
18–64 Years	5.77%	6.08%	5.36%	NC
65 Years and Older	7.47%	8.60%	15.15%	NC
Total (12 Years and Older)	5.07%	5.47%	7.89%	NC
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
1–11 Years	—	NA	—	NC
12–17 Years	—	NA	—	NC
Total	—	NA	—	NC
Use of Pharmacotherapy for Opioid Use Disorder				
Rate 1: Total	56.25%	57.38%	2.00%	NC
Rate 2: Buprenorphine	50.00%	45.90%	-8.20%	NC
Rate 3: Oral Naltrexone	—	0.00%	—	NC
Rate 4: Long-Acting, Injectable Naltrexone	—	0.00%	—	NC
Rate 5: Methadone	8.33%	14.75%	77.05%	NC

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by 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 health 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 2023 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*

The *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—18 Years and Older* and *30-Day Follow-Up—Total—13 Years and Older,* and *Initiation and Engagement of Substance Use Disorder Treatment—Initiation—Total—65 Years and Older* indicators met or exceeded the 50th percentile. All indicators for the *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* and *Antidepressant Medication Management* measures met or exceeded the 75th

percentile. The *Follow-Up Care for Children Prescribed ADHD—Initiation Phase—Total* and *Initiation and Engagement of Substance Use Disorder Treatment—Engagement—Total—13–17 Years* indicators met or exceeded the 90th percentile. All other measure indicators in this domain either did not meet the 50th percentile or did not have national benchmarks to compare for MY 2023.

KFHP QI met the MQD-established Quality Strategy Target for *Antidepressant Medication Management—Effective Acute Phase Treatment—Total* and *Effective Continuation Phase Treatment—Total; Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total; Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase—Total;* and *Use of Pharmacotherapy for Opioid Use Disorder—Rate 1* and *Rate 2.* All other MQD Quality Strategy targets were not met for this domain.

Long-Term Services and Supports Performance Measure Results

KFHP QI's Long-Term Services and Supports performance measure results are shown in Table 3-65.

Table 3-65—KFHP QI's Results for QI Measures Under Long-Term Services and Supports

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
LTSS Comprehensive Assessment and Update				
Assessment of Core Elements Documented	34.38%	44.79%	30.30%	NC
Assessment of Supplemental Elements Documented	30.21%	42.71%	41.38%	NC
LTSS Comprehensive Care Plan and Update				
Care Plan With Core Elements Documented	42.71%	35.42%	-17.07%	NC
Care Plan With Supplemental Elements Documented	40.63%	35.42%	-12.82%	NC
LTSS Minimizing Institutional Length of Stay				
Observed Rate	25.94%	28.51%	9.90%	NC
Risk-Adjusted Rate	35.22%	35.92%	1.99%	NC
O/E Ratio	0.7366	0.7937	7.76%	NC

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

The measures in this domain did not have applicable benchmarks; therefore, no comparison to national benchmarks is presented.

KFHP QI met the MQD-established Quality Strategy targets for *LTSS Comprehensive Assessment and Update—Assessment of Core Elements Documented* and *Assessment of Supplemental Elements*

Documented, LTSS Comprehensive Care Plan and Update—Care Plan With Core Elements Documented and *Care Plan With Supplemental Elements Documented,* and *LTSS Minimizing Institutional Length of Stay—Observed Rate.* All other MQD Quality Strategy targets were not met for this domain.

Strengths

Based on HSAG's analyses of KFHP QI's 69 measure rates comparable to benchmarks, 43 measure rates (62.32 percent) ranked at or above the 50th percentile, with six rates (8.7 percent) meeting or exceeding the 75th percentile and 28 rates (40.58 percent) meeting or exceeding the 90th percentile, indicating strong performance across all domains. Additionally, KFHP QI met 34 MQD Quality Strategy targets for MY 2023.

Areas for Improvement

Conversely, 26 of KFHP QI's measure rates comparable to benchmarks (37.68 percent) fell below the 50th percentile, 14 of which (20.29 percent) fell below the 25th percentile, suggesting that some opportunities for improvement exist.

Recommendations

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:

- Within the Children's Preventive Health domain, the following recommendations were identified:
  - Regarding the *Child and Adolescent Well-Care Visits* measure. HSAG recommends that KFHP QI identify performance improvement efforts to improve well-child visits, drawing from other states' performance improvement initiatives. For instance, California and Virginia have focused on delays in newborn enrollment data, and Missouri and Texas focused on beneficiary barriers and implemented interventions such as utilizing patient portals and phone outreach. HSAG recommends that KFHP QI identify other barriers to care and conduct a focus group on identifying abilities to address barriers.[59]
  - Regarding the *Childhood Immunization Status* measure, HSAG recommends that KFHP QI provide education to providers and members about the importance of vaccination for disease prevention and encourage vaccination at every opportunity, including mild illness visits.[60]

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[59] Centers for Medicare & Medicaid Services. Well-Child Care. Available at: https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/well-child-care/index.html. Accessed on: Jan 6, 2025.

[60] Anderson, EL. Recommended solutions to the barriers to immunization in children and adults. *Missouri Medicine.* 2014; vol. 111,4: 344–348.

Validation of Network Adequacy

HSAG evaluated and assessed the data methods that KFHP QI used to calculate results generated for each network adequacy indicator in the scope of the 2024 NAV activities. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that KFHP QI used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator.

Findings

Based on the results of the ISCA combined with the virtual audit and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the health plan's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each health plan according to Table 3-66.

Table 3-66—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*
10.0% to 49.9%	*Low Confidence*
Less than 10% and/or any *Not Met* element has significant bias on the results	*No Confidence*

No indicators were designated as *Low Confidence* or *No Confidence* for KFHP QI.

Due to observed gaps in quarter 1 reporting, MQD approved HSAG's assessment and validation of quarter 2 network adequacy calculation and reporting during the NAV review period.

HSAG determined that KFHP QI was not compliant with network adequacy requirements for the Access and Availability Standard. MQD required at least 80 percent of members for the Behavioral Health, PCP Adult Sick Visits, and PCP Visits provider types to be provided an appointment within the designated time frame. MQD required at least 60 percent of members for the Urgent Care and PCP Pediatric Sick Visits and Visits with Specialists or Non-Emergency Hospital Stays provider types to be provided an appointment within the designated time frame. Compliance was determined based on the health plan meeting the State's Access and Availability indicators. All indicators were calculated by MQD. Results are presented by provider type in Table 3-67.

Table 3-67—KFHP QI Network Adequacy Access and Availability Compliance

Provider Type	Indicator	Compliance
Urgent Care and PCP Pediatric Sick Visits	Appointments within twenty-four (24) hours	*Not Met*
Visits with Specialists or Non-Emergency Hospital Stays**	Appointments within four (4) weeks or of sufficient timeliness to meet medical necessity	*Not Met*
Behavioral Health (routine visits for adults and children)	Appointment within twenty-one (21) days	*Not Met*
PCP Adult Sick Visits	Appointment within seventy-two (72) hours	*Not Met*
PCP Visits (routine visits for adults and children)	Appointments within twenty-one (21) days	*Not Met*

** MQD confirmed that in CY 2024, Visits with Specialists only included OB/GYN.

HSAG determined that KFHP QI was compliant with network adequacy requirements for the Provider Ratios standard for four of nine indicators (44.44 percent). Compliance was determined based on the health plan meeting the State's Provider Ratio indicators. All indicators were calculated by MQD. Results are presented by provider type in Table 3-68.

Table 3-68—KFHP QI Network Adequacy Provider Ratios Compliance

Provider Type	Ratio	Results	Compliance
Hospitals on Oahu	5	13	*Met*
Hospital on Kauai	1	0	*Not Met*
Hospital on Lanai	1	0	*Not Met*
Hospital on Maui	1	2	*Met*
Hospital on Molokai	1	0	*Not Met*
Hospitals on Hawaii (one in East Hawaii and one in West Hawaii)	2	0	*Not Met*
Other Behavioral Health Providers to include Psychologists, Licensed Mental Health Counselors, Licensed Clinical Social Workers, and APRNs—Behavioral Health	1:100	1:31	*Met*
Behavioral Health Psychiatrists for members with an SMI or SPMI diagnosis. In geographic areas with a demonstrated shortage of qualified physicians, a psychiatric APRN-Rx may assume the role of psychiatrist.	1:150	1:261	*Not Met*
PCPs	1:300	1:115	*Met*

HSAG determined that KFHP QI was compliant with network adequacy requirements for a subset of the Mandatory Provider Types indicators. Compliance was determined based on the health plan meeting the State's Mandatory Provider Type indicators, which includes one servicing provider within each provider

type. All indicators were calculated by MQD. Compliant results are presented by provider type in Table 3-69, and noncompliant results are presented in Table 3-70.

Table 3-69—KFHP QI Network Adequacy Mandatory Provider Types Compliance

Provider Type	Compliance
Home Health Agencies and Hospices	*Met*
LTSS Providers	*Met***
DME	*Met*
Case Management Agencies	*Met*
Laboratories which have either a CLIA 1988 certificate or a waiver of a certificate of registration	*Met*
Optometrists	*Met*
Physical and Occupational Therapists, Audiologists, and Speech-Language Pathologists	*Met*
Providers of lodging and meals associated with obtaining necessary medical care	*Met*
Sign language interpreters and interpreters for languages other than English	*Met*
Physician Specialists, including but not limited to Cardiologists, Endocrinologists, General Surgeons, Geriatricians, Hematologists, Infectious Disease Specialists, Nephrologists, Neurologists, OB/GYNs, Oncologists, Ophthalmologists, Orthopedists, Otolaryngologists, Pediatric Specialists, Plastic and Reconstructive Surgeons, Pulmonologists, Radiologists, and Urologists	*Met*
Behavioral Health Providers: Licensed Therapists, Counselors, and CSACs	*Met*
Emergency Transportation Providers (both ground and air)	*Met*
Non-Emergency Transportation Providers (both ground and air)	*Met*

** *Met* for a subset of provider types.

Table 3-70—KFHP QI Network Adequacy Mandatory Provider Types Noncompliance

Provider Type	Compliance
Emergency transportation providers (both ground and air)	*Not Met*
LTSS Providers (PERS Providers)	*Not Met*
LTSS Providers (Respite Care Facilities)	*Not Met*
LTSS Providers (Environmental Accessibility Adaptations Providers)	*Not Met*
LTSS Providers (Moving Assistance Providers)	*Not Met*
LTSS Providers (Home Maintenance Providers)	*Not Met*

Provider Type	Compliance
Peer Support Specialists certified by AMHD as a part of its Hawaii certified peer specialist program or a program that meets the criteria established by AMHD	*Not Met*
Licensed Dietitians	*Not Met*
Community Health Workers	*Not Met*
Providers of lodging and meals associated with obtaining necessary medical care	*Not Met*

During the NAV review period, HSAG determined that the Access and Availability indicators in Table 3-71 were not required by MQD, resulting in an *Unable to Validate* designation for each associated indicator.

Table 3-71—KFHP QI Network Adequacy Mandatory Provider Types *Unable to Validate* Indicators

Provider Type
State-licensed Special Treatment Facilities for the provision of substance abuse therapy/treatment
PAs
CPs

HSAG determined that KFHP QI was compliant with network adequacy requirements for a subset of the Time and Distance indicators. MQD required at least 85 percent of members to have access to the providers within the associated time or distance parameters. Compliance was determined based on the health plan meeting the State's Time and Distance indicators for both Urban and Rural classifications. All indicators were calculated by MQD. Results are presented by provider type and urbanicity in Table 3-72, and noncompliant results are presented in Table 3-73.

Table 3-72—KFHP QI Network Adequacy Time and Distance ≥85% Compliance by Urbanicity

Provider Type	Urbanicity	Compliance
PCPs (Adult and Pediatric)	Urban	*Met*
	Rural	*Met*
Specialists (Adult and Pediatric)	Urban	*Met***
	Rural	*Met***
OB/GYN	Urban	*Met*
	Rural	*Met*
Adult Day Care/Adult Day Health	Urban	*Met*
	Rural	*Met*
Hospitals	Urban	*Met*
	Rural	*Met*

Provider Type	Urbanicity	Compliance
Behavioral Health Provider (Adult and Pediatric)	Urban	*Met*
	Rural	*Met*
LTSS Providers	Urban	*Met***
	Rural	*Met*
24-Hour Pharmacy	Urban	*Met*
Pharmacies	Rural	*Met*

** *Met* for a subset of provider types.

Table 3-73—KFHP QI Network Adequacy Time and Distance < 85% Noncompliance by Urbanicity

Provider Type	Urbanicity	Compliance
24-Hour Pharmacy	Urban	*Not Met*
Pharmacies	Urban	*Not Met*
Endocrinologists	Urban	*Not Met*
LTSS Providers (PERS Providers)	Urban	*Not Met*
	Rural	
LTSS Providers (Respite Care Facilities Providers)	Urban	*Not Met*
	Rural	
LTSS Providers (DME Suppliers)	Urban	*Not Met*
	Rural	
LTSS Providers (Home-Delivered Meal Providers)	Urban	*Not Met*
LTSS Providers (CCMA)	Rural	*Not Met*
Hematologists	Urban	*Not Met*
	Rural	*Not Met*
Pediatric Specialists	Rural	*Not Met*
Optometrists	Urban	*Not Met*
	Rural	*Not Met*
Nephrologists	Rural	*Not Met*
Neurologists	Rural	*Not Met*
Infectious Disease Specialists	Urban	*Not Met*
	Rural	*Not Met*
Otolaryngologists	Rural	*Not Met*
Pulmonologists	Urban	*Not Met*

Provider Type	Urbanicity	Compliance
	Rural	*Not Met*

During the NAV review period, HSAG determined that the Access and Availability indicators in Table 3-74 were not required by MQD, resulting in an *Unable to Validate* designation for each associated indicator.

Table 3-74—KFHP QI Network Adequacy Time and Distance *Unable to Validate* Indicators

Provider Type	Urbanicity	Indicator
Emergency Services Facilities	Urban	Within 30 minute driving time
	Rural	Within 60 minute driving time

Strengths

KFHP QI demonstrated the ability to maintain accurate and complete member data through its automated process to scan for 834 files every 30 minutes during business hours, use of electronic data file matches to identify existing members within the system, automated reports to identify missing and incomplete data, and the weekly 1179 file process to report updates identified by the health plan to MQD.

Areas for Improvement

HSAG identified the following opportunities for improvement related to NAV for KFHP QI:

- KFHP QI did not have specific time frames during which providers were required to update data.
- KFHP QI was still in the process of implementing a Medicaid Oversight Review board to conduct annual reviews of its delegated entity, Hawaii Permanente Medical Group (HPMG).

Recommendations

- HSAG recommends that KFHP QI establish time frames during which provider demographic changes are required to be reported to ensure that processes are in place for ongoing management and collection of updated demographic data.
- HSAG recommends that KFHP QI continue to implement monitoring activities for HPMG to monitor ongoing performance of its delegated activities.

Validation of Performance Improvement Projects

In CY 2024, KFHP QI continued the two PIPs initiated in 2022. The selected PIP topics were *Behavioral Health Coordination* and *Plan All-Cause Readmissions*. For the CY 2024 submission, the health plan progressed to the Design, Implementation, and Outcomes stages of the PIPs and submitted Steps 1 through 8 in the PIP Submission Form. The PIPs were assessed for improvement in outcomes in Step 9.

In CY 2024, KFHP QI also submitted a new PIP: *Screening for Depression and Follow-Up Plan*. For this PIP, KFHP QI progressed to the Design stage of the PIP and submitted Steps 1 through 6 in the PIP submission form.

Table 3-75 displays the topics, progression status, and measurement periods reported for the PIPs.

Table 3-75—CY 2024 KFHP QI PIP Topics and Status

PIP Topic	PIP Progression Status	Baseline Measurement Period	Measurement Period Reported in CY 2024
Behavioral Health Coordination	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	07/01/2021 to 09/30/2021	07/01/2023 to 09/30/2023 (Remeasurement 2)
Plan All-Cause Readmissions	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	CY 2021	CY 2023 (Remeasurement 2)
Screening for Depression and Follow-Up Plan	PIP Design Stage (Steps 1 through 6)	01/01/2024 to 12/31/2024	Not Applicable

The focus of the nonclinical *Behavioral Health Coordination* PIP is to integrate care between the (DOH Behavioral Health Services Administration divisions, ‘Ohana 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 SMI and SPMI, developmental disabilities, and other chronic issues. The methodology for this PIP was defined by 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.

The focus of the clinical *Screening for Depression and Follow-Up Plan* PIP is to increase depression screening and documentation of a follow-up plan for members 12 years of age or older who screened positive for depression.

Findings

Table 3-76 illustrates the validation results for the three PIPs submitted by KFHP QI for CY 2024 validation.

Table 3-76—CY 2024 PIP Validation Results for KFHP QI

PIP Topic	Validation Rating 1: Overall Confidence in Adherence to Acceptable Methodology for All Phases of the PIP			Validation Rating 2: Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Behavioral Health Coordination	100%	100%	*High Confidence*	33%	100%	*No Confidence*
Plan All-Cause Readmissions	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
Screening for Depression and Follow-Up Plan	100%	100%	*High Confidence*	*Not Assessed*[4]		

[1] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) 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] **Confidence Level**— Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

4 **Not Assessed**—HSAG did not assess Step 9, as the QI health plans only reported the Design stage.

The *Behavioral Health Coordination* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *No Confidence* level rating that the PIP achieved significant improvement.

The *Plan All-Cause Readmissions* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *Moderate Confidence* level rating that the PIP achieved significant improvement.

The *Screening for Depression and Follow-Up Plan* PIP was validated through the first six steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for

adhering to acceptable PIP methodology. KFHP QI had not progressed to reporting remeasurement data and therefore the PIP was not assessed for Validation Rating 2 (i.e., overall confidence that the PIP achieved significant improvement).

Design (Steps 1-6)

Behavioral Health Coordination

The health plan met 100 percent of the requirements in the Design stage, Steps 1 through 6. The selected PIP topic was required by MQD. KFHP QI documented the PIP design accurately and as discussed during the workgroup meetings. KFHP QI's data collection process appeared methodologically sound; however, the data collection process was not comprehensive. At the time of the PIP submission, the health plan was awaiting approval of the DSA by the DOH Behavioral Health Services Administration divisions. The DSA was finalized and executed in December 2024 and is effective as of January 1, 2025.

Plan All-Cause Readmissions

The health plan met 100 percent of the requirements in the Design stage, Steps 1 through 6. The selected PIP topic was required by MQD, and the health plan-specific 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.

Screening for Depression and Follow-Up Plan

The health plan met 100 percent of the requirements in the Design stage, Steps 1 through 6. The selected PIP topic was required by MQD. 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 CMS Child Core Set *CDF-CH* measure and CMS Adult Core Set *CDF-AD* measure. KFHP QI's data collection process was also found to be methodologically sound.

Implementation (Steps 7-8)

Behavioral Health Coordination

The health plan accurately reported and analyzed the Remeasurement 2 rates for the two performance indicators. KFHP QI conducted appropriate quality improvement processes to identify barriers and deployed logical interventions linked to the identified barriers. KFHP QI also drafted and shared the DSA with the DOH Behavioral Health Services Administration divisions. The DSA was approved and executed in December 2024 and is effective as of January 1, 2025.

Plan All-Cause Readmissions

The health plan accurately reported and analyzed Remeasurement 2 rates. KFHP QI conducted appropriate quality improvement processes. As part of the Readmissions Collaborative workgroup, the health plan identified barriers, and it deployed logical interventions linked to the identified barriers. KFHP QI included an evaluation of effectiveness for each intervention and appropriate next steps for the interventions.

Screening for Depression and Follow-Up Plan

The health plan had not progressed to reporting and analyzing data or conducting quality improvement activities.

Outcomes (Step 9)

Behavioral Health Coordination

For Remeasurement 2, the health plan had a statistically nonsignificant decline in the performance for both indicators.

Plan All-Cause Readmissions

For Remeasurement 2, the health plan achieved statistically nonsignificant improvement in the performance indicator rate over the baseline.

Screening for Depression and Follow-Up Plan

The health plan had not progressed to reporting remeasurement outcomes. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle.

Analysis of Results

Table 3-77 displays the data that the health plan reported for the *Behavioral Health Coordination* PIP.

Table 3-77—Outcomes for the *Behavioral Health Coordination* PIP

Performance Indicator	Baseline (07/01/2021–09/30/2021)		Remeasurement 1 (07/01/2022–09/30/2022)		Remeasurement 2 (07/01/2023–09/30/2023)		Sustained Improvement
1. Percent of shared members with eligible trigger events who received a combined review in the past three months.	N: 3	7.9%	N: 18	37.5%*	N: 2	5.0%	*No*
	D: 38		D: 48		D: 40		

Performance Indicator	Baseline (07/01/2021–09/30/2021)		Remeasurement 1 (07/01/2022–09/30/2022)		Remeasurement 2 (07/01/2023–09/30/2023)		Sustained Improvement
2. Percent of shared members whose data are actively shared at a regular frequency with partner agencies.	N: 84	37.7%	N: 96	20.9%	N: 78	16.4%	*Not Assessed*
	D: 223		D: 460		D: 477		

*Rate demonstrates statistically significant improvement over the baseline rate.
N–Numerator D–Denominator
HSAG rounded percentages to the first decimal place.

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 7.9 percent. Out of the 38 members with eligible trigger events, two combined reviews were for members shared with ‘Ohana CCS, and one for a member shared with CAMHD. For Remeasurement 1, the Performance Indicator 1 rate increased to 37.5 percent. The health plan documented that out of a total of 18 combined reviews, 14 reviews were completed with ‘Ohana CCS, three reviews were with CAMHD, and one review was with DDD. For Remeasurement 2, the rate was 5.0 percent, which represents a statistically nonsignificant decrease of 2.9 percentage points from the baseline. Only two combined reviews were completed, one each with ‘Ohana CCS and CAMHD. The health plan did not sustain the improvement that was achieved during Remeasurement 1.

The baseline rate for the percentage of shared members whose data were actively shared with the partner agencies during the measurement period was 37.7 percent, and for Remeasurement 1, the Performance Indicator 2 rate decreased to 20.9 percent. For Remeasurement 2, the rate was 16.4 percent, which represents a statistically nonsignificant decrease of 21.3 percentage points from the baseline. The health plan was not assessed for sustained improvement because it had not achieved improvement during Remeasurement 1.

Table 3-78 displays the data that the health plan reported for the *Plan All-Cause Readmissions* PIP.

Table 3-78—Outcomes for the *Plan All-Cause Readmissions* PIP

Performance Indicator	Baseline (01/01/2021–12/31/2021)		Remeasurement 1 (01/01/2022–12/31/2022)		Remeasurement 2 (01/01/2023–12/31/2023)		Sustained Improvement
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	7.6%	N: 74	8.8%	N: 70	7.5%	
	D: 780		D: 842		D: 939		

N–Numerator D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline 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, and for Remeasurement 1, the performance indicator rate increased to 8.8 percent. For Remeasurement 2, the rate was 7.5 percent, which represents a statistically nonsignificant decrease (improvement in performance) of 0.1 percentage point from the baseline.

Table 3-79 will display the data for the *Screening for Depression and Follow-Up Plan* PIP once KFHP QI reports performance indicator results.

Table 3-79—Performance Indicator Results for the *Screening for Depression and Follow-Up Plan* PIP

Performance Indicator	Baseline (01/01/2023–12/31/2023)		Remeasurement 1 (01/01/2024–12/31/2024)		Sustained Improvement
1. Percentage of members ages 12 to 17 screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter.					
2. Percentage of members aged 18 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and, if positive, a follow-up plan is documented on the date of the eligible encounter.					

Barriers/Interventions

Table 3-80 displays the barriers and interventions as documented by the health plan for the *Behavioral Health Coordination* and *Plan All-Cause Readmissions* PIPs. Barriers and interventions for the *Screening for Depression and Follow-Up Plan* PIP will be documented when the PIP progresses to including QI activities and interventions.

Table 3-80—Interventions Implemented/Planned for KFHP QI PIPs

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 Memorandums of Understanding (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.*

Barriers	Interventions
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 (PCCs) 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 ≥19.
Screening for Depression and Follow-Up Plan	

* The documented interventions are required by MQD.

Strengths

- For all three PIPs, KFHP QI received an overall *High Confidence* level rating for overall confidence in adherence to acceptable methodology for all phases of the PIP for Steps 1 through 8.
- For the *Plan All-Cause Readmissions* PIP, the health plan conducted appropriate quality improvement processes and participated in the Readmissions Collaborative workgroup to identify barriers, and deployed interventions that were logically linked to the identified barriers.
- For the *Screening for Depression and Follow-Up Plan* PIP designed a scientifically sound project that was supported by using key research principles.

Areas for Improvement

- For the *Behavioral Health Coordination* PIP, during Remeasurement 2, a statistically nonsignificant decline in performance for both indicators from the baseline rate. There was a marked decrease in data sharing with ‘Ohana CCS from Remeasurement 1 to Remeasurement 2.
- For the *Plan All-Cause Readmissions* PIP, the health plan had a marginal decrease in the observed readmission rate from the baseline.

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:
  – There was a marked decrease in data sharing with ‘Ohana CCS from Remeasurement 1 to Remeasurement 2. The health plan must identify the barriers to ongoing data sharing and combined reviews with ‘Ohana CCS and consider interventions to address barriers.

- For the *Screening for Depression and Follow-Up Plan* PIP:
  - The health plan must ensure that the interventions are implemented in a timely manner to impact outcomes during the remeasurement period.
- For the *Behavioral Health Coordination* PIP:
  - It appears there was a marked decrease in data sharing with ‘Ohana CCS from Remeasurement 1 to Remeasurement 2. KFHP QI must identify the barriers to ongoing data sharing and combined reviews with ‘Ohana CCS and consider interventions to address those barriers.
- 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 the use of quality improvement science-based tools, such as process mapping with FMEA, for causal/barrier analysis. The health plan must include a copy of the quality improvement tools used with the annual PIP submission.
- The health plan must evaluate each intervention listed in the barriers/interventions table for effectiveness.
- The health plan should collect the intervention effectiveness data more frequently (e.g., monthly or quarterly), unlike the annual performance indicator data. This would help the health plan understand intervention effectiveness and make any updates to the interventions in a timely manner to impact remeasurement outcomes.
- Intervention effectiveness data must guide next steps for each individual intervention.

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 3-81 presents the 2024 scores for KFHP QI compared to the 2023 NCQA adult Medicaid national averages, the corresponding 2022 scores, and the QI Program (i.e., combination of the five QI health plans).[61,62] Additionally, the overall member experience ratings (i.e., star ratings) resulting from the comparison of KFHP QI’s 2023 scores to NCQA’s 2023 Quality Compass Benchmark and Compare Quality Data are displayed below.[63]

[61] The adult population was last surveyed in 2022; therefore, the 2024 adult CAHPS scores are compared to the corresponding 2022 scores.

[62] National Committee for Quality Assurance. *HEDIS® Measurement Year 2023*, *Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2023.

[63] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2023.* Washington, DC: NCQA, September 2023.

Table 3-81—Adult Medicaid CAHPS Results for KFHP QI

Measure	2022 Scores	2024 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	62.89%	67.37%	★★★★
Rating of All Health Care	60.89%	56.73%	★★★
Rating of Personal Doctor	64.06%	62.95%	★
Rating of Specialist Seen Most Often	62.88%	65.32%	★★
Composite Measures			
Getting Needed Care	79.59%	78.71%	★★
Getting Care Quickly	78.94%	75.59%	★
How Well Doctors Communicate	90.59%	89.41%	★
Customer Service	85.11%+	88.07%	★
Individual Item Measure			
Coordination of Care	79.25%	80.41%+	★
Medical Assistance With Smoking and Tobacco Use Cessation Measure Items			
Advising Smokers and Tobacco Users to Quit	77.27%	70.30%	★★
Discussing Cessation Medications	55.92%	51.49%	★★★
Discussing Cessation Strategies	58.94%	53.47%	★★★★

A cell highlighted in green represents the score is statistically significantly higher than the 2023 NCQA adult Medicaid national average.
A cell highlighted in red represents the score is statistically significantly lower than the 2023 NCQA adult Medicaid national average.
▲ *Indicates the 2024 score is statistically significantly higher than the 2022 score.*
▼ *Indicates the 2024 score is statistically significantly lower than the 2022 score.*
↑ *Indicates the QI health plan's 2024 score is statistically significantly higher than the QI Program.*
↓ *Indicates the QI health plan's 2024 score is statistically significantly lower than the QI Program.*
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
Star Ratings based on percentiles:
★★★★★ *90th or Above* ★★★★ *75th-89th* ★★★ *50th-74th* ★★ *25th-49th* ★ *Below 25th*

Strengths

- For KFHP QI's adult Medicaid population, the *Rating of Health Plan* measure scored statistically significantly higher than the 2023 NCQA adult Medicaid national average.
- For KFHP QI's adult Medicaid population, the following measures met or exceeded the 75th percentile:
  - *Rating of Health Plan*
  - *Discussing Cessation Strategies*

- Of the nine MQD member satisfaction Quality Strategy target measures—*Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Coordination of Care*—KFHP QI's member experience rating for *Rating of Health Plan* and *Customer Service* exceeded the RY 2024 target.

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 3-82 provides a summary of the key drivers identified for KFHP QI.

Table 3-82—KFHP QI Key Drivers of Member Experience Analysis

Survey Item	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	✓	—	—
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	✓	✓	NA
Q27. Ease of filling out forms from health plan	✓	—	NA

NA *Indicates that this question was not evaluated for this measure.*
— *Indicates the survey item is not strongly correlated with the measure or that the item did not perform poorly (i.e., not a key driver).*

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

- Respondents reported not always receiving care as soon as they needed when care was needed right away.

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

- Respondents reported that their personal doctor did not always 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 provide the information or help they needed.
- Respondents reported that it was not always easy to fill out forms from their health plan.

Recommendations

HSAG recommends that KFHP QI explore what may be driving lower experience scores and develop initiatives designed to improve quality and access to care, including a focus on improving adult members' overall experiences with their health plan, personal doctor, overall healthcare, and customer service, getting needed care in a timely manner, and receiving advise on quitting smoking/using tobacco.

Home and Community-Based CAHPS Survey

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

Findings

Table 3-83 presents the 2024 top-box scores for KFHP QI compared to the Hawaii HCBS Program (i.e., combination of the five QI health plans) scores, AHRQ's 2024 CAHPS Database benchmarks, and the corresponding 2023 scores.[64,65,66]

Table 3-83—HCBS Survey Results for KFHP QI

Measure	2023 Scores	2024 Scores
Global Ratings		
Rating of Personal Assistance and Behavioral Health Staff	88.46%+	78.26%+
Rating of Homemaker	NA	NA
Rating of Case Manager	76.67%+	77.42%+
Composite Measures		
Reliable and Helpful Staff	81.81%+	77.99%+
Staff Listen and Communicate Well	84.40%+	81.76%+
Helpful Case Manager	90.83%+	86.19%+
Choosing the Services that Matter to You	81.41%+	77.29%+
Transportation to Medical Appointments	83.21%+	68.12%+▼
Personal Safety and Respect	92.11%+	90.81%+
Planning Your Time and Activities	61.77%+	56.19%+

[64] For this report, only the composite measure scores are displayed. For more detailed results of the items within the composite measure, please see the 2024 Hawaii HCBS CAHPS Survey full report.

[65] Agency for Healthcare Research and Quality. *The CAHPS® Home and Community-Based Services (HCBS) Survey Database 2024 Chartbook*. January 2024. Available at: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/cahps-database/2024-hcbs-chartbook.pdf. Accessed on: Jan 15, 2025.

[66] The 2024 HCBS CAHPS Database benchmarks represent survey data collected from January 1 to December 31, 2022. Caution should be exercised when comparing the 2024 HCBS CAHPS Database benchmarks to the Hawaii HCBS Program 2024 results, which represent survey data collected from July 23, 2024, to September 15, 2024.

Measure	2023 Scores	2024 Scores
Recommendation Measures		
Recommend Personal Assistance/Behavioral Health Staff	81.48%+	60.87%+
Recommend Homemaker	NA	NA
Recommend Case Manager	85.19%+	75.86%+
Unmet Need and Physical Safety Measures		
No Unmet Need in Dressing/Bathing	NA	NA
No Unmet Need in Meal Preparation/Eating	NA	NA
No Unmet Need in Medication Administration	NA	NA
No Unmet Need in Toileting	100.00%+	100.00%+
No Unmet Need with Household Tasks	NA	NA
Not Hit or Hurt by Staff	100.00%+	100.00%+

A cell highlighted in green represents the score is statistically significantly higher than the 2024 CAHPS Database benchmark.
A cell highlighted in red represents the score is statistically significantly lower than the 2024 CAHPS Database benchmark.
▲ *Indicates the 2024 score is statistically significantly higher than the 2023 score.*
▼ *Indicates the 2024 score is statistically significantly lower than the 2023 score.*
↑ *Indicates the QI health plan's score is statistically significantly higher than the Hawaii HCBS Program.*
↓ *Indicates the QI health plan's score is statistically significantly lower than the Hawaii HCBS Program.*
+ *Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.*
Results based on fewer than 11 respondents were suppressed and noted as "NA".

Strengths

- For KFHP QI, the *No Unmet Need in Toileting* measure scored statistically significantly higher than AHRQ's 2024 CAHPS Database benchmark.

Areas for Improvement

- For KFHP QI, the *Transportation to Medical Appointments* measure scored statistically significantly lower in 2024 than in 2023.
- For KFHP QI, the *Recommend Personal Assistance/Behavioral Health Staff* measure scored statistically significantly lower than AHRQ's 2024 CAHPS Database benchmark.

Recommendations

HSAG recommends that KFHP QI explore what may be driving lower experience scores and develop initiatives designed to improve quality and access to care, including a focus on improving adult members' overall experiences with personal assistance and behavioral health staff, and receiving transportation to medical appointments.

Encounter Data Validation

HSAG evaluated the extent to which the encounter data in MQD's database were complete, accurate, and submitted by KFHP QI in a timely manner through a comparative analysis between MQD's electronic encounter data and the actuarial files submitted by KFHP QI to MQD's contracted actuary, Milliman.

Findings

Table 3-84 illustrates the percentage of records present in the Milliman-submitted files that were not found in the MQD-submitted files (record omission or underreporting to MQD) and the percentage of records present in the MQD-submitted files but not present in the Milliman-submitted files (record surplus or underreporting to Milliman). Lower rates indicate better performance for both record omission and record surplus.

Table 3-84—Record Omission and Surplus by Encounter Type

Encounter Type	Record Omission (Underreporting to MQD)	Record Surplus (Underreporting to Milliman)
Institutional	45.7%	10.0%
Professional	22.8%	4.2%
Pharmacy	6.4%	8.9%

Note: Lower rates indicate better performance.
Red text indicates rates higher than 5.0 percent.

Element-level discrepancy was limited to those records present in both data sources with values present in both data sources. Records with values missing from both data sources were not included in the denominator. The numerator was the number of records with different non-missing values for a given data element. Lower data element discrepancy rates indicate that the values populated for a data element in the MQD-submitted encounter data were more accurate. As such, for the discrepancy indicator, lower rates indicate better performance. Table 3-85 to Table 3-87 present the data element discrepancy rates for each encounter type.

Table 3-85—Element Discrepancy by Key Data Element for Institutional Encounters

Key Data Element	Discrepancy Rate
Member, Date of Service, and Provider	
Member ID	<0.1%
Member Date of Birth	3.1%
Detail First Date of Service	0.8%
Detail Last Date of Service	0.8%
Billing Provider NPI	0.0%
Billing Provider Type	0.0%
Servicing Provider NPI	99.9%

Key Data Element	Discrepancy Rate
Servicing Provider ID	88.6%
Payment Information	
Allowed Amount	16.3%
Billed Amount	8.0%
COB Amount	20.3%
Coinsurance Amount	<0.1%
Copay Amount	0.2%
Deductible Amount	0.0%
MCO Paid Amount	1.5%
Value Code Amount	3.4%
Diagnosis Codes, Procedure Codes, and Drug Information	
Admission Diagnosis Code	0.0%
Primary Diagnosis Code	0.0%
All Secondary Diagnosis Codes	1.2%
All Surgical Procedure Codes	8.1%
Procedure Code	0.9%
Procedure Code Modifiers	1.5%
Units of Service	0.4%
NDC	1.3%
Other Data Elements	
Admission Date	0.0%
Admission Source	2.0%
Admission Type	<0.1%
DRG Code	3.9%
Discharge Date	0.5%
Discharge Status	0.0%
Encounter Flag	79.0%
MCO Paid Date	<0.1%
Occurrence Span Codes	—
POA Code	0.0%
All Secondary POA Codes	5.6%
Revenue Code	0.5%
TOB Code	12.6%
Value Codes	6.3%

— indicates that the denominator was zero.
Red text indicates rates higher than 5.0 percent.

Table 3-86—Element Discrepancy by Key Data Element for Professional Encounters

Key Data Element	Discrepancy Rate
Member, Date of Service, and Provider	
Member ID	<0.1%
Member Date of Birth	3.3%
Detail First Date of Service	0.5%
Detail Last Date of Service	0.5%
Billing Provider NPI	0.0%
Billing Provider Type	89.7%
Servicing Provider NPI	<0.1%
Servicing Provider ID	11.6%
Payment Information	
Allowed Amount	80.8%
Billed Amount	17.4%
COB Amount	18.8%
Coinsurance Amount	<0.1%
Copay Amount	0.1%
Deductible Amount	0.0%
MCO Paid Amount	9.5%
Patient Paid Amount	0.1%
Diagnosis Codes, Procedure Codes, and Drug Information	
Primary Diagnosis Code	1.8%
All Secondary Diagnosis Codes	28.1%
Procedure Code	8.9%
Procedure Code Modifiers	1.7%
Units of Service	2.5%
NDC	3.7%
Other Data Elements	
Admission Date	68.8%
Discharge Date	87.4%
Encounter Flag	0.0%
POS Code	0.3%
MCO Paid Date	0.6%

— indicates that the denominator was zero.
Red text indicates rates higher than 5.0 percent.

Table 3-87—Element Discrepancy by Key Data Element for Pharmacy Encounters

Key Data Element	Discrepancy Rate
Member and Date of Service	
Member ID	0.1%

Key Data Element	Discrepancy Rate
Date of Service	0.0%
Payment Information	
Billed Amount	13.9%
COB Amount	0.3%
Coinsurance Amount	0.0%
Copay Amount	0.0%
Deductible Amount	0.0%
Dispensing Fee	79.2%
Ingredient Cost	<0.1%
MCO Paid Amount	13.8%
Patient Paid Amount	0.0%
Drug Information	
NDC	<0.1%
Dispensing Quantity	98.6%
Days' Supply	<0.1%
New or Refill Flag	<0.1%
Number of Refills	100%
Other Data Elements	
MCO Paid Date	<0.1%

— indicates that the denominator was zero.
Red text indicates rates higher than 5.0 percent.

Strengths

- The record surplus rate for professional encounters was below 5.0 percent. This indicates that encounters in the MQD-submitted data could largely be identified in the Milliman-submitted data.
- All but 10 institutional encounter data elements, all but 10 professional encounter data elements, and all but five pharmacy encounter data elements had a discrepancy rate less than 5.0 percent. This indicates that records which could be matched between the MQD-submitted and the Milliman-submitted data largely contained the same values.

Areas for Improvement

- The record omission rates for all encounter types were high. Institutional encounters had the highest record omission rate at 45.7 percent, while professional and pharmacy encounters had record omission rates of 22.8 percent and 6.4 percent, respectively. Additionally, the record surplus rates for institutional and pharmacy encounters were high at 10.0 percent and 8.9 percent, respectively.
- Although matched records largely contained similar values between the MQD-submitted and the Milliman-submitted data, KFHP QI should ensure the following data elements have accurate values:

- Institutional encounters: Servicing Provider NPI, Servicing Provider ID, Allowed Amount, Billed Amount, COB Amount, All Surgical Procedure Codes, Encounter Flag, All Secondary POA Codes, TOB Code, and Value Codes.
- Professional encounters: Billing Provider Type, Servicing Provider ID, Allowed Amount, Billed Amount, COB Amount, MCO Paid Amount, All Secondary Diagnosis Codes, Procedure Code, Admission Date, and Discharge Date.
- Pharmacy encounters: Billed Amount, Dispensing Fee, MCO Paid Amount, Dispensing Quantity, and Number of Refills.

Recommendations

- KFHP QI should review and work on the action items noted in the data discrepancy report.
- KFHP QI should utilize the three-year encounter file that MQD will provide monthly to ensure the data it submits to HPMMIS are processed and submitted correctly. KFHP QI should review any discrepancies within the file with MQD to reconcile any differences.
- KFHP QI should continue to work with MQD and Milliman to ensure data submitted to HPMMIS in CY 2025 accurately reflect data needed for the CY 2026 rate-setting activities.

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 seven EQR activities. As a result of the 2022 and 2023 compliance reviews, KFHP QI had 11 corrective action items to address during 2023 and 2024. KFHP QI took the necessary steps to plan interventions; update policies, procedures, and member and provider information; and make operational changes to address the deficiencies found. As a result of its CAP interventions, KFHP QI was found to be fully compliant with all standards during 2024.

KFHP QI continued to show strong performance in quality, timeliness, and access to care measures. Overall, more than half (62.32 percent) of KFHP QI's measure rates ranked at or above the 50th percentile across all domains, with nearly half (49.28 percent) of the measure rates ranking at or above the 75th percentile. Conversely, 26 of KFHP QI's measure rates (37.68 percent) fell below the 50th percentile. KFHP QI's performance demonstrated a few areas for improvement, including the Behavioral Health domain. KFHP QI's measure rates met 34 MQD Quality Strategy targets.

The results of the NAV activities revealed that KFHP QI demonstrated the ability to maintain accurate and complete member data through various automated processes and reports. However, as similarly

noted during the compliance review activities, NAV revealed that KFHP QI did not have a process implemented to oversee HPMG, which was delegated provider network management responsibilities.

KFHP QI's CAHPS results illustrate opportunities for improvement in members' satisfaction. While none of the measures scored statistically significantly lower in 2024 than in 2022 and none of the measures scored statistically significantly lower than the 2023 NCQA adult Medicaid national averages, the following eight 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*, *Coordination of Care*, and *Advising Smokers and Tobacco Users to Quit*. 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 two of the nine measures MQD selected for monitoring within its Quality Strategy met or exceeded the RY 2024 target, KFHP QI should focus improvement efforts on the *Rating of Personal Doctor*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Coordination of Care* measures, which fell below the 25th percentile.

KFHP QI's HCBS CAHPS Survey results illustrated positive results and opportunities for improvement in members' experience. While none of the measures scored statistically significantly higher than the 2023 scores or the Hawaii HCBS Program, the *No Unmet Need in Toileting* measure scored statistically significantly higher than AHRQ's 2024 CAHPS Database benchmark. Additionally, while none of the measures scored statistically significantly lower than the Hawaii HCBS Program, the *Transportation to Medical Appointments* measure scored statistically significantly lower than the 2023 score, and the *Recommend Personal Assistance/Behavioral Health Staff* measure scored statistically significantly lower than AHRQ's 2024 CAHPS Database benchmark, indicating a need for KFHP QI to implement strategies to ensure members have access to high-quality care.

The EDV activities revealed that KFHP QI should improve its encounter data completeness for institutional, professional, and pharmacy encounters, since either the record omission or the record surplus rate for each encounter type was above 5.0 percent (i.e., relatively poor performance). In addition, although matched records largely contained similar values between the MQD-submitted and the Milliman-submitted data, KFHP QI had at least one data element for each encounter type that it should work on to improve its accuracy. Submitting accurate and complete encounter data assists MQD in monitoring issues concerning quality of care and access to care, as well as setting up proper capitation rates starting in CY 2026 with CY 2025 data.

KFHP QI progressed to the Outcomes stage of the two PIPs initiated in CY 2022 and the Design stage for the new PIP initiated in CY 2024. 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 *High Confidence* level rating for overall confidence in adherence to acceptable methodology for all phases of the PIP and a *No Confidence* level rating for overall confidence that the PIP achieved significant improvement. During Remeasurement 2, the health plan had a statistically nonsignificant decline in performance for both indicators. At the time of the PIP

submission, the health plan was awaiting approval of the DSA by the DOH Behavioral Health Services Administration divisions.

For the *Plan All-Cause Readmissions* PIP, KFHP QI received a *High Confidence* level rating for overall confidence in adherence to acceptable methodology for all phases of the PIP and a *Moderate Confidence* rating for overall confidence that the PIP achieved significant improvement. The documented PIP design and data were accurate. The health plan conducted appropriate QI processes and participated in the Readmissions Collaborative workgroup to identify barriers, and deployed interventions that were logically linked to the identified barriers. During Remeasurement 2, the health plan had a marginal decrease in the observed readmission rate from the baseline.

For the *Screening for Depression and Follow-Up Plan* PIP, KFHP QI received a *High Confidence* level rating for adherence to acceptable methodology for the PIP design. The health plan designed a scientifically sound project that was supported by using key research principles.

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

Compliance Monitoring Review

The 2024 compliance monitoring review activity included follow-up reviews of the health plans’ required corrective actions implemented to address deficiencies noted during the 2022 and 2023 reviews.

Findings

Table 3-88 presents the scores from HSAG’s 2022 and 2023 compliance reviews, the number of CAPs required, the number of CAPs closed, and the results of the 2024 follow-up reviews of ‘Ohana QI.

Table 3-88—Standards, Compliance Scores, and CAPs—‘Ohana QI

Standard Name	Standard Review Year	Compliance Review Score	# of CAPs Required	# of CAPs Closed	2024 Final Follow-Up Review Score
Assurances of Adequate Capacity and Services	2022	100%	0	NA	**100%**
Availability of Services	2022	97%	1	1	**100%**
Confidentiality	2022	100%	0	NA	**100%**
Coordination and Continuity of Care	2022	90%	2	2	**100%**
Coverage and Authorization of Services	2022	89%	7	7	**100%**
Credentialing	2023	99%	1	1	**100%**
Enrollee Information	2022	84%	4	4	**100%**
Enrollee Rights and Protections	2022	94%	1	1	**100%**
Enrollment and Disenrollment	2023	100%	0	NA	**100%**
Grievance and Appeal System	2022	100%	0	NA	**100%**
Health Information Systems	2023	100%	0	NA	**100%**
Provider Selection	2023	100%	0	NA	**100%**
Practice Guidelines	2023	100%	0	NA	**100%**
Quality Assessment and Performance Improvement	2023	100%	0	NA	**100%**
Subcontractual Relationships and Delegation	2023	100%	0	NA	**100%**
Totals			**16**	**16**	**100%**

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

Strengths

The 2022 compliance review revealed that ‘Ohana QI had deficiencies in five of the eight standards reviewed. During 2023 and 2024, ‘Ohana QI completed 15 corrective action items to bring them into full compliance.

To address the Coordination and Continuity of Care deficiencies, ‘Ohana QI updated its care management system to automatically save and mail completed Health Action Plans (HAPs), developed a manual process for mailing the HAPs as a back-up to the automated process, and is auditing random files monthly to ensure the HAP is shared with providers. HSAG conducted follow-up file reviews on a sample of care coordination files in 2024 and found that all files included evidence that the health plan shared member information with involved providers to avoid duplication of services and coordinate the care of members. To further emphasize full compliance, ‘Ohana QI implemented a report reflecting all HAPs due within 30 days, conducted weekly audits to monitor timeliness of initial and upcoming HAPs, and created a position to validate that HAPs have been fully completed and saved.

To address the deficiencies in the Coverage and Authorization of Services and Availability of Services standards, ‘Ohana QI updated policies and procedures to define medically necessary services and address time frames for authorization decisions, and updated the provider manual to reflect timely access standards for routine and follow-up behavioral health visits. Additionally, ‘Ohana QI updated notice of adverse benefit determination (NABD) policies, procedures, and templates to ensure timely and accurate NABD letters and notices. To address the Enrollee Information and Enrollee Rights and Protections standard, ‘Ohana QI updated its policies, member portal, member handbook, and provider directory to ensure all required information was present.

‘Ohana QI performed well during 2023 compliance review, with only one corrective action item to complete in 2024. To address the Credentialing standard, HSAG conducted follow-up file reviews on a sample of organizational provider credentialing and recredentialing files. HSAG found that all files were fully compliant with the verification of licensing requirements, accreditation status, and exclusions.

Areas for Improvement

As a result of its CAP interventions, ‘Ohana QI was found to be fully compliant with all standards and had no continuing corrective actions.

Recommendations

HSAG recommends that ‘Ohana QI review the revised Medicaid managed care rules released in 2024 and implement operational changes, as applicable, to ensure continued compliance.

Validation of Performance Measures—NCQA HEDIS Compliance Audits

NCQA HEDIS Compliance Audit Findings

HSAG's review team assessed 'Ohana QI's IS capabilities and its ability to process data for reporting accurate performance measure rates. 'Ohana QI was found to be fully compliant with all HEDIS IS standards, as well as IS standard L for assessing case management data for LTSS measures. This demonstrated that 'Ohana QI had effective IS processes and control procedures for reporting the required performance measure rates. 'Ohana QI presented 18 supplemental data sources for consideration to use for supplementing its MY 2023 performance measure rates. HSAG determined seven data sources to be standard supplemental data, and the remaining 11 were considered nonstandard supplemental data. 'Ohana QI withdrew three of the 18 supplemental data sources, leaving eight standard data sources and seven nonstandard data sources. No concerns were identified, and the eight standard and seven nonstandard data sources were approved for HEDIS MY 2023 reporting.

'Ohana QI was required to undergo convenience sample validation for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile—Total* and the *Immunization for Adolescents—Combination 1* indicators, as they were new to the scope of the audit for MY 2023. All convenience sample and medical record exclusion cases successfully passed the validation process. The final statistical MRRV was conducted for the *Long-Term Services and Supports Comprehensive Assessment and Update—Assessment of Core Elements Documented* and *Assessment of Supplemental Elements Documented, Long-Term Services and Supports Comprehensive Care Plan and Update—Care Plan with Core Elements* and *Care Plan with Supplemental Elements* indicators, as well as all medical record exclusions. All selected cases passed the final MRRV without any critical errors.

All measures under the scope of the audit were determined to be *Reportable*. 'Ohana QI was determined to be fully compliant with all IS standards, including IS standard L for assessing case management data; therefore, HSAG 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 3-89.

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

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	—	48.95%	—	★
45–64 Years	—	68.40%	—	★
65 Years and Older	—	80.72%	—	★★★
Total	—	60.70%	—	★

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Ambulatory Care				
Emergency Department Visits	514.57	560.91	9.00%	★★★
Outpatient Visits	4,114.03	4,097.03	-0.41%	★★★
Asthma in Younger Adults Admission Rate*				
*Asthma in Younger Adults Admission Rate**	—	2.71	—	NC
Heart Failure Admission Rate*				
18–64 Years	55.20	72.61	31.53%	NC
65 Years and Older	110.11	196.03	78.04%	NC
Total (18 Years and Older)	63.11	91.17	44.46%	NC
Plan All-Cause Readmissions				
*Index Total Stays—Observed Readmissions—Total**	9.94%	10.56%	6.27%	NC
Expected Readmissions—Total	11.83%	11.89%	0.50%	NC
*Index Total Stays—O/E Ratio—Total**	0.8401	0.8885	5.76%	NC

** A lower rate indicates better performance.*
Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by 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 health 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 2023 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*

The *Ambulatory Care—Emergency Department Visits* and *Outpatient Visits* indicators met or exceeded the 50th percentile. Additionally, the *Adults' Access to Preventive/Ambulatory Health Services—65 Years and Older* indicator rate met or exceeded the 50th percentile. All other measure indicators in this domain did not meet or exceed the 50th percentile or did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented.

'Ohana QI met the MQD-established Quality Strategy targets for *Plan All-Cause Readmissions—Index Total Stays— O/E Ratio—Total.* All other MQD Quality Strategy targets were not met for this domain.

Children's Preventive Health Performance Measure Results

'Ohana QI's Children's Preventive Health performance measure results are shown in Table 3-90.

Table 3-90—'Ohana QI's Results for QI Measures Under Children's Preventive Health

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Child and Adolescent Well-Care Visits				
Child and Adolescent Well-Care Visits	26.41%	36.67%	38.84%	★
Childhood Immunization Status				
Combination 3	36.50%	36.72%	0.60%	★
Combination 7	31.87%	29.25%	-8.22%	★
Combination 10	25.06%	19.70%	-21.39%	★
DTaP	44.53%	46.87%	5.26%	★
Hepatitis A	60.34%	66.57%	10.32%	★
Hepatitis B	59.12%	60.00%	1.48%	★
HiB	60.10%	62.69%	4.31%	★
Influenza	40.15%	38.81%	-3.34%	★★
IPV	62.77%	63.58%	1.29%	★
MMR	58.64%	67.46%	15.05%	★
Pneumococcal Conjugate	45.99%	47.46%	3.21%	★
Rotavirus	52.55%	47.16%	-10.26%	★
VZV	58.15%	65.97%	13.45%	★
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	—	50.15%	—	★
Combination 2 (Meningococcal, Tdap, HPV)	—	23.72%	—	★
Meningococcal Serogroups A, C, W, Y	—	54.05%	—	★
Tdap	—	51.95%	—	★
HPV	—	25.23%	—	★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents				
BMI Percentile Documentation—3–11 Years	—	84.62%	—	★★★
BMI Percentile Documentation—-12–17 Years	—	78.40%	—	★★★
BMI Percentile Documentation—Total	—	82.73%	—	★★★
Counseling for Nutrition—3–11 Years	—	72.73%	—	★★★
Counseling for Nutrition—12–17 Years	—	67.20%	—	★★
Counseling for Nutrition—Total	—	71.05%	—	★★★
Counseling for Physical Activity-3–11 Years	—	70.98%	—	★★★
Counseling for Physical Activity—12–17 Years	—	67.20%	—	★★
Counseling for Physical Activity—Total	—	69.83%	—	★★★

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
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	33.24%	58.24%	75.24%	★★
Well-Child Visits for Age 15 Months to 30 Months of Life—Two or More Well-Child Visits	36.68%	58.16%	58.55%	★

— Indicates that the health 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 2023 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

Seven of the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents* indicators met or exceeded the 50th percentile. All other measure indicators in this domain did not meet or exceed the 50th percentile or did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented.

'Ohana QI did not meet the MQD-established Quality Strategy targets for this domain.

Women's Health Performance Measure Results

Ohana QI's Women's Health performance measure results are shown in Table 3-91.

Table 3-91—'Ohana QI's Results for QI Measures Under Women's Health

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Cervical Cancer Screening				
Cervical Cancer Screening	41.36%	40.63%	-1.76%	★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	67.02%	66.99%	-0.04%	★
Postpartum Care	66.67%	69.28%	3.92%	★
Prenatal and Postpartum Care: Under 21 Years of Age (Child Core)				
Timeliness of Prenatal Care: Under 21 Years of Age	—	NA	—	NC
Postpartum Care: Under 21 Years of Age	—	NA	—	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 health 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 2023 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

None of the measure indicators rates in this domain met or exceeded the 50th percentile. The *Prenatal and Postpartum Care: Under 21 Years of Age (Child Core)* indicators did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented.

'Ohana QI did not meet the MQD-established Quality Strategy targets for this domain.

Care for Chronic Conditions Performance Measure Results

'Ohana QI's Care for Chronic Conditions performance measure results are shown in Table 3-92.

Table 3-92—'Ohana QI's Results for QI Measures Under Care for Chronic Conditions

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Asthma Medication Ratio				
5–11 Years	—	NA	—	NC
12–18 Years	—	NA	—	NC
19–50 Years	—	50.77%	—	★
51–64 Years	—	41.82%	—	★
Total (5–64 Years)	—	44.36%	—	★
Total Child Core Set (5–18 Years)	—	NA	—	NC
Total Adult Core Set (19–64 Years)	—	46.67%	—	NC
Blood Pressure Control for Patients With Diabetes				
Blood Pressure Control for Patients With Diabetes	52.80%	57.91%	9.68%	★
Concurrent Use of Opioids and Benzodiazepines*				
18–64 Years	19.26%	16.51%	-14.28%	NC
65 Years and Older	18.72%	21.30%	13.78%	NC
Total (18 Years and Older)	19.14%	17.66%	-7.73%	NC
Controlling High Blood Pressure				
18–64 Years	52.73%	56.72%	7.75%	NC
65–85 Years	63.24%	56.64%	-10.42%	NC
Total	56.20%	56.69%	0.87%	★★
Eye Exam for Patients With Diabetes				
Eye Exam for Patients With Diabetes	53.28%	57.18%	7.31%	★★★
Hemoglobin A1c Control for Patients With Diabetes				
HbA1c Control (<8.0%)—18–64 Years	—	54.41%	—	NC

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
HbA1c Control (<8.0%)—65–75 Years	—	59.76%	—	NC
HbA1c Control (<8.0%)—Total	46.23%	55.47%	20.00%	★★★
*HbA1c Poor Control (>9.0%)—18–64 Years**	—	35.26%	—	NC
*HbA1c Poor Control (>9.0%)—65–75 Years**	—	34.15%	—	NC
*HbA1c Poor Control (>9.0%)—Total**	41.36%	35.04%	-15.29%	★★★

** A lower rate indicates better performance.*
Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by 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 health 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 2023 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*

Eye Exam for Patients With Diabetes, Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)—Total and *HbA1c Poor Control (>9.0%)—Total* met or exceeded the 50th percentile. All other measure indicators in this domain either did not meet the 50th percentile or did not have national benchmarks to compare for MY 2023.

'Ohana QI met the MQD-established Quality Strategy target for both *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)—Total* and *HbA1c Poor Control (>9.0%)—Total*. All other MQD Quality Strategy targets were not met for this domain.

Behavioral Health Performance Measure Results

'Ohana QI's Behavioral Health performance measure results are shown in Table 3-93.

Table 3-93—'Ohana QI's Results for QI Measures Under Behavioral Health

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	75.21%	74.47%	-0.99%	★★★★★
Antidepressant Medication Management				
Effective Acute Phase Treatment—18–64 Years	—	64.76%	—	NC

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Effective Acute Phase Treatment—65 Years and Older	—	88.57%	—	NC
Effective Acute Phase Treatment—Total	60.75%	67.94%	11.83%	★★★★
Effective Continuation Phase Treatment—18–64 Years	—	46.26%	—	NC
Effective Continuation Phase Treatment—65 Years and Older	—	65.71%	—	NC
Effective Continuation Phase Treatment—Total	48.12%	48.85%	1.53%	★★★★
Follow-Up After Emergency Department Visit for Mental Illness				
7-Day Follow-Up—6–17 Years	—	NA	—	NC
7-Day Follow-Up—18–64 Years	47.00%	37.50%	-20.21%	★★★
7-Day Follow-Up—65 Years and Older	—	NA	—	NC
7-Day Follow-Up—Total	48.34%	37.76%	-21.89%	★★
30-Day Follow-Up—6–17 Years	—	NA	—	NC
30-Day Follow-Up—18–64 Years	63.00%	55.88%	-11.30%	★★★
30-Day Follow-Up—65 Years and Older	—	NA	—	NC
30-Day Follow-Up—Total	64.35%	56.12%	-12.79%	★★★
Follow-Up After Emergency Department Visit for Substance Use				
7-Day Follow-Up—13–17 Years	—	NA	—	NC
7-Day Follow-Up—18 Years and Older	30.18%	29.67%	-1.71%	★★★
7-Day Follow-Up—Total	30.09%	29.08%	-3.34%	★★★
7-Day Follow-Up—18–64 Years (Adult Core)	—	28.82%	—	NC
7-Day Follow-Up—65 Years and Older (Adult Core)	—	NA	—	NC
30-Day Follow-Up—13–17 Years	—	NA	—	NC
30-Day Follow-Up—18 Years and Older	45.12%	46.33%	2.68%	★★★★
30-Day Follow-Up—Total	44.98%	45.42%	0.98%	★★★★
30-Day Follow-Up—18–64 Years (Adult Core)	—	45.49%	—	NC
30-Day Follow-Up—65 Years and Older (Adult Core)	—	NA	—	NC
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase—Total	—	NA	—	NC
Continuation and Maintenance Phase—Total	—	NA	—	NC
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation—Total—13–17 Years	—	NA	—	NC

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Initiation—Total—18–64 Years	—	34.13%	—	★
Initiation—Total—65 Years and Older	—	40.22%	—	★★
Initiation—Total	32.66%	34.33%	5.11%	★
Engagement—Total—13–17 Years	—	NA	—	NC
Engagement—Total—18–64 Years	—	8.59%	—	★
Engagement—Total—65 Years and Older	—	11.96%	—	★★★★★
Engagement—Total	6.70%	8.80%	31.35%	★
Screening for Depression and Follow-Up Plan				
12–17 Years	19.19%	17.82%	-7.16%	NC
18–64 Years	9.54%	11.57%	21.29%	NC
65 Years and Older	26.71%	24.06%	-9.90%	NC
Total (12 Years and Older)	13.80%	14.71%	6.64%	NC
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
1–11 Years	—	NA	—	NC
12–17 Years	—	NA	—	NC
Total	—	NA	—	NC
Use of Pharmacotherapy for Opioid Use Disorder				
Rate 1: Total	54.04%	59.18%	9.51%	NC
Rate 2: Buprenorphine	20.35%	21.72%	6.74%	NC
Rate 3: Oral Naltrexone	0.70%	0.75%	6.74%	NC
Rate 4: Long-Acting, Injectable Naltrexone	0.00%	0.00%	—	NC
Rate 5: Methadone	35.44%	38.95%	9.91%	NC

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by 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 health 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 2023 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*

All indicators for the *Antidepressant Medication Management* and *Follow-Up After Emergency Department Visit for Substance Use* measures met or exceeded the 50th percentile. Three indicator rates for the *Follow-Up After Emergency Department Visit for Mental Illness* measure met or exceeded the 50th percentile. Additionally, *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* and *Initiation and Engagement of Substance Use Disorder Treatment—Engagement—*

Total—65 Years and Older met or exceeded the 90th percentile. All other measure indicators in this domain either did not meet the 50th percentile or did not have national benchmarks to compare for MY 2023.

'Ohana QI met the MQD-established Quality Strategy Target for *Adherence to Antipsychotic Medications for Individuals With Schizophrenia; Antidepressant Medication Management—Effective Acute Phase Treatment—Total* and *Effective Continuation Phase Treatment—Total; Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total; Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total;* and *Use of Pharmacotherapy for Opioid Use Disorder—Rate 1* and *Rate 5*. All other MQD Quality Strategy targets were not met for this domain.

Long-Term Services and Supports Performance Measure Results

'Ohana QI's Long-Term Services and Supports performance measure results are shown in Table 3-94.

Table 3-94—'Ohana QI's Results for QI Measures Under Long-Term Services and Supports

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
LTSS Comprehensive Assessment and Update				
Assessment of Core Elements Documented	19.79%	50.00%	152.63%	NC
Assessment of Supplemental Elements Documented	17.71%	47.92%	170.59%	NC
LTSS Comprehensive Care Plan and Update				
Care Plan With Core Elements Documented	8.33%	50.00%	500.00%	NC
Care Plan With Supplemental Elements Documented	8.33%	42.71%	412.50%	NC
LTSS Minimizing Institutional Length of Stay				
Observed Rate	1.40%	1.40%	0.19%	NC
Risk-Adjusted Rate	37.73%	37.87%	0.37%	NC
O/E Ratio	0.0371	0.0371	-0.18%	NC

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

The measures in this domain did not have applicable benchmarks; therefore, no comparison to national benchmarks is presented.

'Ohana QI met the MQD-established Quality Strategy target for *LTSS Comprehensive Assessment and Update—Assessment of Core Elements Documented* and *Assessment of Supplemental Elements*

Documented, and *LTSS Comprehensive Care Plan and Update—Care Plan With Core Elements Documented* and *Care Plan With Supplemental Elements Documented.* All other MQD Quality Strategy targets were not met for this domain.

Strengths

Based on HSAG's analyses of 'Ohana QI's 64 measure rates comparable to benchmarks, 24 indicators (37.50 percent) met or exceeded the 50th percentile, four indicators (6.25 percent) ranked at or above the 75th percentile, and two indicators (3.13 percent) met or exceeded the 90th percentile. Additionally, 'Ohana QI met 16 MQD Quality Strategy targets for MY 2023.

Areas for Improvement

Conversely, 40 measure rates comparable to benchmarks (62.50 percent) ranked below the 50th percentile, with 33 measure rates (51.56 percent) falling below the 25th percentile, suggesting considerable opportunities for improvement across all domains.

Recommendations

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:

- Within the Children's Preventive Health domain, the following recommendations were identified:
  - Regarding the *Child and Adolescent Well-Care Visits* measure*,* HSAG recommends that 'Ohana QI promote teen-centered care by reminding providers of the need for using teen-appropriate language, treating teens as important partners in their care, and ensuring confidentiality and privacy. Further, HSAG recommends that 'Ohana QI and providers develop partnerships with community stakeholders such as schools.[67] HSAG also recommends that 'Ohana QI conduct provider education about encouraging preventive care when members are seen for sickness, sports physicals, and other reasons. Additionally, HSAG recommends that health plans promote well-visits on social media, through emails, or personalized outreach. Finally, HSAG recommends that 'Ohana QI incentivize providers, members, and parents to complete visits.
  - Regarding the *Childhood Immunization Status* measure, HSAG recommends that 'Ohana QI provide education to providers and members about the importance of vaccination for disease prevention and encourage vaccination at every opportunity, including mild illness visits.[68]
  - Regarding the *Well-Child Visits in the First 30 Months of Life* measure, HSAG recommends that 'Ohana QI identify performance improvement efforts to improve well-child visits, drawing from

[67] Centers for Medicare & Medicaid Services. Paving the Road to Good Health: Strategies for Increasing Medicaid Adolescent Well-Care Visits. Available at: https://www.medicaid.gov/medicaid/benefits/downloads/paving-the-road-to-good-health.pdf. Accessed on: Dec 18, 2024.

[68] Anderson, EL. Recommended solutions to the barriers to immunization in children and adults. *Missouri Medicine.* 2014; vol. 111,4: 344–348.

other states' performance improvement initiatives. For instance, California and Virginia have focused on delays in newborn enrollment data, and Missouri and Texas focused on beneficiary barriers and implemented interventions such as utilizing patient portals and phone outreach. HSAG recommends that health plans identify other barriers to care and conduct a focus group on identifying abilities to address barriers.[69]

- Within the Women's Health domain, the following recommendations were identified:
  - Regarding the *Cervical Cancer Screening* measure, HSAG recommends that 'Ohana QI consider utilizing one-on-one interactions with a healthcare professional, such as CHWs, which have been shown to improve cervical cancer screening.[70] Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness. In addition, HSAG recommends that 'Ohana QI provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is lack of knowledge.
  - Regarding the *Prenatal and Postpartum Care* measure, HSAG recommends that 'Ohana QI consider whether there are disparities/SDOH within 'Ohana QI's population that contribute to lower access to care. Upon identification of a root cause, HSAG recommends that 'Ohana QI implement appropriate interventions to reduce barriers to care. Strategies could include providing expanded access appointments outside of business hours to accommodate work schedules or childcare needs. Many appointments can be made via telehealth; therefore, ensuring members have access to these options could potentially increase performance in this measure. Further, HSAG recommends that 'Ohana QI identify payment structure types that will incentivize quality care. Bundling payments may cause disincentives for postpartum care, as providers might receive the same payment regardless of whether the member attends the postpartum visit.[71]
- Within the Chronic Conditions domain, the following recommendations were identified:
  - Regarding the *Controlling High Blood Pressure* measure, HSAG recommends that 'Ohana QI identify trends within the data to identify which demographic groups and regions report lower blood pressure. HSAG recommends providing coverage for automated home blood pressure monitors for patients, while educating members about the benefits of this approach.[72] Further, HSAG recommends providing incentives to members and providers to encourage blood pressure control.
- Within the Behavioral Health domain, the following recommendations were identified:
  - Regarding the *Follow-Up After Hospitalization for Mental Illness* measure, HSAG recommends that 'Ohana QI consider effective interventions to reduce repeat hospitalizations for people with

[69] Centers for Medicare & Medicaid Services. Well-Child Care. Available at: https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/well-child-care/index.html. Accessed on: Jan 6, 2025.

[70] Popalis ML, Ramirez SI, Leach KM, et al. Improving cervical cancer screening rates: a scoping review of resources and interventions. *Cancer Causes Control*. 2022 Nov;33(11):1325–1333.

[71] Centers for Medicare & Medicaid Services. Lessons Learned About Payment Strategies to Improve Postpartum Care in Medicaid and CHIP. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/postpartum-payment-strategies.pdf. Accessed on: Dec 18, 2024.

[72] Centers for Disease Control and Prevention. The Surgeon General's Call to Action to Control Hypertension. Available at: https://www.cdc.gov/high-blood-pressure/php/cta/index.html. Accessed on: Dec 26, 2024.

mental illness, such as CTI, ACT, case management, and focusing on co-occurring substance abuse disorders.[73]

Validation of Network Adequacy

HSAG evaluated and assessed the data methods that ‘Ohana QI used to calculate results generated for each network adequacy indicator in the scope of the 2024 NAV activities. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG’s overall confidence that ‘Ohana QI used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator.

Findings

Based on the results of the ISCA combined with the virtual audit and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the health plan’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each health plan according to Table 3-95.

Table 3-95—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*
10.0% to 49.9%	*Low Confidence*
Less than 10% and/or any *Not Met* element has significant bias on the results	*No Confidence*

No indicators were designated as *Low Confidence* or *No Confidence* for ‘Ohana QI.

HSAG determined that ‘Ohana QI was not compliant with network adequacy requirements for the Access and Availability Standard. MQD required at least 80 percent of members for the Behavioral Health, PCP Adult Sick Visits, and PCP Visits provider types to be provided an appointment within the designated time frame. MQD required at least 60 percent of members for the Urgent Care and PCP Pediatric Sick Visits and Visits with Specialists or Non-Emergency Hospital Stays provider types to be provided an appointment within the designated time frame. Compliance was determined based on the

[73] Kreyenbuhl J, Nossel IR, Dixon LB. Disengagement from mental health treatment among individuals with schizophrenia and strategies for facilitating connections to care: a review of the literature. *Schizophrenia Bulletin*. 2009 Jul;35(4):696–703.

health plan meeting the State's Access and Availability indicators. All indicators were calculated by MQD. Results are presented by provider type in Table 3-96.

Table 3-96—'Ohana QI Network Adequacy Access and Availability Compliance

Provider Type	Indicator	Compliance
Urgent Care and PCP Pediatric Sick Visits	Appointments within twenty-four (24) hours	*Not Met*
Visits with Specialists or Non-Emergency Hospital Stays**	Appointments within four (4) weeks or of sufficient timeliness to meet medical necessity	*Not Met*
Behavioral Health (routine visits for adults and children)	Appointment within twenty-one (21) days	*Not Met*
PCP Adult Sick Visits	Appointment within seventy-two (72) hours	*Not Met*
PCP Visits (routine visits for adults and children)	Appointments within twenty-one (21) days	*Not Met*

** MQD confirmed that in CY 2024, Visits with Specialists only included OB/GYN.

HSAG determined that 'Ohana QI was compliant with network adequacy requirements for the Provider Ratios standard for all but one provider type. Compliance was determined based on the health plan meeting the State's Provider Ratio indicators. All indicators were calculated by MQD. Results are presented by provider type in Table 3-97.

Table 3-97—'Ohana QI Network Adequacy Provider Ratios Compliance

Provider Type	Ratio	Results	Compliance
Hospitals on Oahu	5		*Met*
Hospital on Kauai	1		*Met*
Hospital on Lanai	1		*Not Met*
Hospital on Maui	1		*Met*
Hospital on Molokai	1		*Met*
Hospitals on Hawaii (one in East Hawaii and one in West Hawaii)	2		*Met*
Other Behavioral Health Providers to include Psychologists, Licensed Mental Health Counselors, Licensed Clinical Social Workers, and APRNs—Behavioral Health for members with an SMI or SPMI diagnosis	1:100		*Met*
Behavioral Health Psychiatrists for members with an SMI or SPMI diagnosis. In geographic areas with a demonstrated shortage of qualified physicians, a	1:150		*Met*

Provider Type	Ratio	Results	Compliance
psychiatric APRN-Rx may assume the role of psychiatrist.			
PCPs	1:300		*Met*

HSAG determined that ‘Ohana QI was compliant with a subset of network adequacy requirements for the Mandatory Provider Type indicators. Compliance was determined based on the health plan meeting the State’s Mandatory Provider Type indicators, which includes one servicing provider within each provider type. All indicators were calculated by MQD. Compliant results are presented by provider type in Table 3-98, and noncompliant results are presented in Table 3-99.

Table 3-98—‘Ohana QI Network Adequacy Mandatory Provider Types Compliance

Provider Type	Compliance
Home Health Agencies and Hospices	*Met*
LTSS Providers	*Met*
DME	*Met*
Case Management Agencies	*Met*
Laboratories which have either a CLIA 1988 certificate or a waiver of a certificate of registration	*Met*
Optometrists	*Met*
Physical and Occupational Therapists, Audiologists, and Speech-Language Pathologists	*Met*
Physician Specialists, including but not limited to Cardiologists, Endocrinologists, General Surgeons, Geriatricians, Hematologists, Infectious Disease Specialists, Nephrologists, Neurologists, OB/GYNs, Oncologists, Ophthalmologists, Orthopedists, Otolaryngologists, Pediatric Specialists, Plastic and Reconstructive Surgeons, Pulmonologists, Radiologists, and Urologists	*Met*
Behavioral Health Providers: Licensed Therapists, Counselors, and CSACs	*Met*
Emergency Transportation Providers (both ground and air)	*Met*
Non-Emergency Transportation Providers (both ground and air)	*Met*

Table 3-99—‘Ohana QI Network Adequacy Mandatory Provider Types Noncompliance

Provider Type	Compliance
Non-Emergency Transportation Providers (both ground and air)	*Not Met**
Emergency Transportation Providers (both ground and air)	*Not Met*
Sign language interpreters and interpreters for languages other than English	*Not Met*

Provider Type	Compliance
Providers of lodging and meals associated with obtaining necessary medical care	*Not Met*
Community Health Workers	*Not Met*

* Did not meet for non-emergency ground transportation

During the NAV review period, HSAG determined that the Access and Availability provider types in Table 3-100 were not required by MQD, resulting in an *Unable to Validate* designation for each associated provider type.

Table 3-100—'Ohana QI Network Adequacy Mandatory Provider Types *Unable to Validate* Indicators

Provider Type
State-Licensed Special Treatment Facilities for the provision of substance abuse therapy/treatment
PAs
CPs

HSAG determined that 'Ohana QI was compliant with a subset of network adequacy requirements for the Time and Distance indicators. MQD required at least 85 percent of members to have access to the providers within the associated time or distance parameters. Compliance was determined based on the health plan meeting the State's Time and Distance indicators for both Urban and Rural classifications. All indicators were calculated by MQD. Results are presented by provider type and urbanicity in Table 3-101, and noncompliant results are presented in Table 3-102.

Table 3-101—'Ohana QI Network Adequacy Time and Distance ≥85% Compliance by Urbanicity

Provider Type	Urbanicity	Compliance
PCPs (Adult and Pediatric)	Urban	*Met*
	Rural	*Met*
Specialists (Adult and Pediatric)	Urban	*Met*
	Rural	*Met***
OB/GYN	Urban	*Met*
	Rural	*Met*
Adult Day Care/Adult Day Health	Urban	*Met*
	Rural	*Met*
Hospitals	Urban	*Met*
	Rural	*Met*
Behavioral Health Provider (Adult and Pediatric)	Urban	*Met*
	Rural	*Met*
LTSS Providers	Urban	*Met***
	Rural	*Met*

Provider Type	Urbanicity	Compliance
24-Hour Pharmacy	Urban	*Met*
Pharmacies	Urban	*Met*
	Rural	*Met*
Emergency Services Facilities	Urban	*NA**
	Rural	*NA**

* Due to misalignment between the MQD-provided reporting template and contractual standards, the health plan did not report for this indicator.

** *Met* for a subset of provider types

Table 3-102—'Ohana QI Network Adequacy Time and Distance < 85% Noncompliance by Urbanicity

Provider Type	Urbanicity	Compliance
LTSS Providers (Personal Care Assistance Providers)	Urban	*Not Met*
Geriatricians	Rural	*Not Met*
Pediatric Specialists	Rural	*Not Met*
Pulmonologists	Rural	*Not Met*
Plastic and Reconstructive Surgeons	Rural	*Not Met*
Otolaryngologists	Rural	*Not Met*

During the NAV review period, HSAG determined that the Access and Availability provider types in Table 3-103 were not required by MQD, resulting in an *Unable to Validate* designation for each associated indicator.

Table 3-103—'Ohana QI Network Adequacy Time and Distance *Unable to Validate* Indicators

Provider Type	Urbanicity	Indicator
Emergency Services Facilities	Urban	Within 30 minute driving time

Strengths

HSAG identified the following strengths related to NAV for 'Ohana QI:

- 'Ohana QI demonstrated the ability to maintain accurate and complete member data through the use of a data file matching process of the 834 file to identify existing members within the system, automated reports to identify missing and incomplete data, and systems capabilities to update demographic information collected through various member-level interactions more current than what is provided through the 834 file.

- ‘Ohana QI maintained detailed process documentation for creation of the network adequacy report by extracting robust data and cleaning processes to ensure business continuity of the network adequacy reporting process.

Areas for Improvement

No specific opportunities were identified related to the data collection and management processes ‘Ohana QI had in place to inform network adequacy standard and indicator calculations.

Recommendations

While HSAG had no recommendations related to ‘Ohana QI’s processes for producing the network adequacy results, HSAG recommends that ‘Ohana QI continue to monitor and address any gaps in its provider network.

Validation of Performance Improvement Projects

In CY 2024, ‘Ohana QI continued the two PIPs initiated in 2022. The selected PIP topics were *Behavioral Health Coordination* and *Plan All-Cause Readmissions*. For the CY 2024 submission, the health plan progressed to the Design, Implementation, and Outcomes stages of the PIPs and submitted Steps 1 through 8 in the PIP Submission Form. The PIPs were assessed for improvement in outcomes in Step 9.

In CY 2024, ‘Ohana QI also submitted a new PIP: *Screening for Depression and Follow-Up Plan*. For this PIP, ‘Ohana QI progressed to the Design stage of the PIP and submitted Steps 1 through 6 in the PIP submission form.

Table 3-104 displays the topics, progression status, and measurement periods reported for the PIPs.

Table 3-104—CY 2024 ‘Ohana QI PIP Topics and Status

PIP Topic	PIP Progression Status	Baseline Measurement Period	Measurement Period Reported in CY 2024
Behavioral Health Coordination	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	07/01/2021 to 09/30/2021	07/01/2023 to 09/30/2023 (Remeasurement 2)
Plan All-Cause Readmissions	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	CY 2021	CY 2023 (Remeasurement 1)
Screening for Depression and Follow-Up Plan	PIP Design (Steps 1 through 6)	01/01/2024 to 12/31/2024	Not Applicable

The focus of the nonclinical *Behavioral Health Coordination* PIP is to integrate care between the DOH Behavioral Health Services Administration divisions, 'Ohana 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 SMI and SPMI, developmental disabilities, and other chronic issues. The methodology for this PIP was defined by 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 the HEDIS *PCR* measure.

The focus of the new clinical *Screening for Depression and Follow-Up Plan* is to increase depression screening and documentation of a follow-up plan for members 12 years of age or older who screened positive for depression.

Findings

Table 3-105 illustrates the validation results for the three PIPs submitted by 'Ohana QI for CY 2024 validation.

Table 3-105—CY 2024 PIP Validation Results for 'Ohana QI

PIP Topic	Validation Rating 1			Validation Rating 2		
	Overall Confidence in Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Behavioral Health Coordination	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Plan All-Cause Readmissions	100%	100%	*High Confidence*	33%	100%	*No Confidence*
Screening for Depression and Follow-Up Plan	100%	100%	*High Confidence*	*Not Assessed*[4]		

[1] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) 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] **Confidence Level**— Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

4 **Not Assessed**—HSAG did not assess Step 9, as the QI health plans only reported the Design stage.

The *Behavioral Health Coordination* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *High Confidence* level rating that the PIP achieved significant improvement.

The *Plan All-Cause Readmissions* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *No Confidence* level rating that the PIP achieved significant improvement.

The *Screening for Depression and Follow-Up Plan* PIP was validated through the first six steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. 'Ohana QI had not progressed to reporting remeasurement data and therefore the PIP was not assessed for Validation Rating 2 (i.e., overall confidence that the PIP achieved significant improvement).

Design (Steps 1-6)

Behavioral Health Coordination

The health plan met 100 percent of the evaluation elements in the Design stage, Steps 1 through 6. The selected PIP topic was required by MQD. 'Ohana QI documented the PIP design accurately. 'Ohana QI's data collection process as documented was methodologically sound; however, the data collection processes to capture the combined reviews and data sharing with the DOH Behavioral Health Services Administration divisions were not defined. At the time of the PIP submission, the health plan was awaiting approval of its DSA with the DOH Behavioral Health Services Administration divisions. The DSA was finalized and executed in December 2024 and is effective as of January 1, 2025.

Plan All-Cause Readmissions

The health plan met 100 percent of the requirements in the Design stage, Steps 1 through 6. The selected PIP topic was required by MQD, and the health plan-specific 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.

Screening for Depression and Follow-Up Plan

The health plan met 100 percent of the requirements in the Design stage, Steps 1 through 6. The selected PIP topic was required by MQD. '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 CMS Child Core Set *CDF-CH* measure and CMS Adult Core Set *CDF-AD* measure. ‘Ohana QI's data collection process was also found to be methodologically sound.

Implementation (Steps 7-8)

Behavioral Health Coordination

The health plan accurately reported and analyzed the Remeasurement 2 rates for the two performance indicators. ‘Ohana QI conducted appropriate quality improvement processes to identify barriers, and it deployed logical interventions linked to the identified barriers. ‘Ohana QI also drafted and shared the DSA with the DOH Behavioral Health Services Administration divisions. The DSA was approved and executed in December 2024 and is effective as of January 1, 2025.

Plan All-Cause Readmissions

The health plan conducted appropriate quality improvement processes to identify barriers and deployed logical interventions linked to the identified barriers as part of the Readmissions Collaborative Workgroup. ‘Ohana QI included an evaluation of effectiveness for each intervention and appropriate next steps for the interventions.

Screening for Depression and Follow-Up Plan

The health plan has not progressed to reporting and analyzing data or conducting QI activities.

Outcomes (Step 9)

Behavioral Health Coordination

During Remeasurement 2, the health plan achieved statistically significant improvement in both performance indicator rates over the baseline.

Plan All-Cause Readmissions

During Remeasurement 2, the health plan had a statistically nonsignificant decline in performance compared to the baseline.

Screening for Depression and Follow-Up Plan

The health plan had not progressed to reporting remeasurement outcomes. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle.

Analysis of Results

Table 3-106 displays the data that the health plan reported for the *Behavioral Health Coordination* PIP.

Table 3-106—Outcomes for the *Behavioral Health Coordination* PIP

Performance Indicator	Baseline (07/01/2021–09/30/2021)		Remeasurement 1 (07/01/2022–09/30/2022)		Remeasurement 2 (07/01/2023–09/30/2023)		Sustained Improvement
1. Percent of shared members with eligible trigger events who received a combined review in the past three months.	N: 2	1.7%	N: 40	37.0%*	N: 59	30.9%*	*Yes*
	D: 113		D: 108		D: 191		
2. Percent of shared members whose data are actively shared at a regular frequency with partner agencies.	N: 113	2.4%	N: 65	1.4%	N: 277	10.7%*	*Not Assessed*
	D: 4,797		D: 4,563		D: 2,589		

*Rate demonstrates statistically significant improvement over the baseline rate.
N–Numerator D–Denominator
HSAG rounded percentages to the first decimal place.

The baseline rate for the percentage of shared members with eligible trigger events who received a combined review during the baseline measurement period was 1.7 percent, and for Remeasurement 1, the Performance Indicator 1 rate increased to 37.0 percent. For Remeasurement 2, the rate was 30.9 percent, which represents a statistically significant increase of 29.2 percentage points over the baseline. The health plan sustained improvement during Remeasurement 2.

The baseline rate for the percentage of shared members whose data were actively shared with the partner agencies during the measurement period was 2.4 percent, and for Remeasurement 1, the Performance Indicator 2 rate decreased to 1.4 percent. For Remeasurement 2, the rate was 10.7 percent, which represents a statistically significant increase of 8.3 percentage points over the baseline. The health plan was not assessed for sustained improvement because it had not achieved statistically significant improvement during Remeasurement 1.

Table 3-107 displays the data that the health plan reported for the *Plan All-Cause Readmissions* PIP.

Table 3-107—Outcomes for the *Plan All-Cause Readmissions* PIP

Performance Indicator	Baseline (01/01/2021–12/31/2021)		Remeasurement 1 (01/01/2022–12/31/2022)		Remeasurement 2 (01/01/2023–12/31/2023)		Sustained Improvement
The observed Plan All-Cause Readmission Rate for all QUEST Integration members	N: 133	9.6%	N: 102	9.9%	N: 105	10.6%	*Not Assessed*

Performance Indicator	Baseline (01/01/2021–12/31/2021)		Remeasurement 1 (01/01/2022–12/31/2022)		Remeasurement 2 (01/01/2023–12/31/2023)		Sustained Improvement
ages 18–64 years of age with an unplanned acute readmission for any diagnosis within 30 days	D: 1,384		D: 1,026		D: 994		

N–Numerator D–Denominator
HSAG rounded percentages to the first decimal place.

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. For Remeasurement 1, there was a decline in performance, and the readmission rate increased to 9.9 percent. For Remeasurement 2, the performance indicator rate was 10.6 percent, which represents a statistically nonsignificant increase (decline in performance) of 1.0 percentage point from the baseline.

The baseline measurement period is CY 2024 for the *Screening for Depression and Follow-Up Plan* PIP; however, the health plan was to submit Steps 1 through 6 (Design stage) only for the 2024 annual validation. Once performance indicator outcomes are reported, the table below will display the performance indicator results.

Table 3-108 will display the data for the *Screening for Depression and Follow-Up Plan* PIP once the health plan reports performance indicator results.

Table 3-108—Performance Indicator Results for the *Screening for Depression and Follow-Up Plan* PIP

Performance Indicator	Baseline (01/01/2024–12/31/2024)		Remeasurement 1 (01/01/2025–12/31/2025)		Sustained Improvement
1. Percentage of members ages 12 to 17 screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter.					
2. Percentage of members aged 18 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and, if positive, a follow-up plan is					

Performance Indicator	Baseline (01/01/2024–12/31/2024)		Remeasurement 1 (01/01/2025–12/31/2025)		Sustained Improvement
documented on the date of the eligible encounter.					

Barriers/Interventions

Table 3-109 displays the barriers and interventions as documented by the health plan for the *Behavioral Health Coordination* and *Plan All-Cause Readmissions* PIPs. Barriers and interventions for the *Screening for Depression and Follow-Up Plan* PIP will be documented when the PIP progresses to including QI activities and interventions.

Table 3-109—Interventions Implemented/Planned for ‘Ohana QI PIPs

Barriers	Interventions
Behavioral Health Coordination	
1. Minimal data sharing and lack of standardization of data exchange requirements. 2. Lack of ongoing communication between partnering agencies. 3. Identifying gaps in data and workflow among health plans and CCS.	1. The Memorandums of Understanding (MOU) regarding data sharing was re-drafted and in review with DOH agencies.* 2. Having a workgroup with partnering agencies that meets at least on a quarterly basis.* MCOs and CCS have a workgroup that meets as needed or scheduled for every three weeks on the calendar. 3. Develop a workflow for ongoing communication between health plan and partnering agencies.*
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. 3. Members readmitting due to Congestive Heart Failure (CHF). 4. Members readmitting due to social challenges and lack of community services.	1. Multidisciplinary rounds within health plan to discuss high utilizers. 2. Contact with all members post-discharge via transition of care process. 3. Added CHF on Disease Management Program, and member outreach will be conducted post discharge. 4. Developed focused discharge planning process.
Screening for Depression and Follow-Up Plan	

* The documented interventions are required by MQD.

Strengths

- For all three PIPs, ‘Ohana QI received an overall *High Confidence* level rating for overall confidence in adherence to acceptable methodology for all phases of the PIP for Steps 1 through 8.
- For the *Behavioral Health Coordination* PIP, ‘Ohana QI received a *High Confidence* validation rating for overall confidence that the PIP achieved significant improvement for Step 9. The health plan documented statistically significant improvement over the baseline in both performance indicator rates.

Areas for Improvement

- For the *Plan All-Cause Readmissions* PIP, during Remeasurement 2, the health plan did not achieve any improvement over the baseline.

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 *Screening for Depression and Follow-Up Plan* PIP:
  - The health plan must ensure that the interventions are implemented in a timely manner to impact outcomes during the remeasurement period.
- 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 the use of quality improvement science-based tools, such as process mapping with FMEA, for causal/barrier analysis. The health plan must include a copy of the quality improvement tools used with the annual PIP submission.
- The health plan must evaluate each intervention listed in the barriers/interventions table for effectiveness.
- The health plan should collect the intervention effectiveness data more frequently (e.g., monthly, quarterly), unlike the annual performance indicator data. This would help the health plan understand intervention effectiveness and make any update to the interventions in a timely manner to impact remeasurement outcomes.
- Intervention effectiveness data must guide next steps for each individual intervention.

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 3-110 presents the 2024 scores for 'Ohana QI compared to the 2023 NCQA adult Medicaid national averages, the corresponding 2022 scores, and the QI Program (i.e., combination of the five QI health plans).[74, 75] Additionally, the overall member experience ratings (i.e., star ratings) resulting from the comparison of 'Ohana QI's 2024 scores to NCQA's 2023 Quality Compass Benchmark and Compare Quality Data are displayed below.[76]

Table 3-110—Adult Medicaid CAHPS Results for 'Ohana QI

Measure	2022 Scores	2024 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	60.19%	62.33%	★★★
Rating of All Health Care	53.57%	57.92%	★★★
Rating of Personal Doctor	71.49%	69.16%	★★★
Rating of Specialist Seen Most Often	71.90%	71.53%	★★★★
Composite Measures			
Getting Needed Care	80.41%	80.80%	★★
Getting Care Quickly	77.54%	79.35%	★★
How Well Doctors Communicate	91.74%	91.96%	★★
Customer Service	83.61%	89.50%	★★
Individual Item Measure			
Coordination of Care	88.50%	86.11%	★★★
Medical Assistance With Smoking and Tobacco Use Cessation Measure Items			
Advising Smokers and Tobacco Users to Quit	75.76%	67.21%	★
Discussing Cessation Medications	59.76%	55.37%	★★★★
Discussing Cessation Strategies	59.39%	53.66%	★★★★

A cell highlighted in green represents the score is statistically significantly higher than the 2023 NCQA adult Medicaid national average.
A cell highlighted in red represents the score is statistically significantly lower than the 2023 NCQA adult Medicaid national average.
▲ *Indicates the 2024 score is statistically significantly higher than the 2022 score.*
▲ *Indicates the 2024 score is statistically significantly lower than the 2022 score.*
↑ *Indicates the QI health plan's 2024 score is statistically significantly higher than the QI Program.*
↓ *Indicates the QI health plan's 2024 score is statistically significantly lower than the QI Program.*
Star Ratings based on percentiles:
★★★★★ *90th or Above* ★★★★ *75th-89th* ★★★ *50th-74th* ★★ *25th-49th* ★ *Below 25th*

[74] The adult population was last surveyed in 2022; therefore, the 2024 adult CAHPS scores are compared to the corresponding 2022 scores.

[75] National Committee for Quality Assurance. *HEDIS® Measurement Year 2023*, *Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2023.

[76] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2023.* Washington, DC: NCQA, September 2023.

Strengths

- For ‘Ohana QI’s adult Medicaid population, the following measures met or exceeded the 75th percentile:
  - *Rating of Specialist Seen Most Often*
  - *Discussing Cessation Medications*
  - *Discussing Cessation Strategies*
- Of the nine MQD member satisfaction Quality Strategy target measures—*Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Coordination of Care*—‘Ohana QI’s member experience rating for *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, and *Coordination of Care* exceeded the RY 2024 target.

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 3-111 provides a summary of the key drivers identified for ‘Ohana QI.

Table 3-111—’Ohana QI Key Drivers of Member Experience Analysis

Survey Item	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	✓	✓	—
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	—	—	✓
Q24. Health plan’s customer service gave the information or help needed	✓	—	NA

NA *Indicates that this question was not evaluated for this measure.*
— *Indicates the survey item is not strongly correlated with the measure or that the item did not perform poorly (i.e., not a key driver).*

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

- Respondents reported not always receiving care as soon as they needed when care was needed right away.
- Respondents reported not receiving an appointment for a checkup or routine care as soon as they needed.

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

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

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

- Respondents reported that their 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 provide the information or help they needed.

Recommendations

HSAG recommends that ‘Ohana QI explore what may be driving lower experience scores and develop initiatives designed to improve quality and access to care, including a focus on improving adult members’ overall experiences with their health plan, their doctor’s ability to communicate, customer service, getting needed care in a timely manner, and discussion of cessation strategies and medications to quit smoking/using tobacco.

Home and Community-Based CAHPS Survey

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

Findings

Table 3-112 presents the 2024 top-box scores for 'Ohana QI compared to the Hawaii HCBS Program (i.e., combination of the five QI health plans) scores, AHRQ's 2024 CAHPS Database benchmarks, and the corresponding 2023 scores.[77,78,79]

Table 3-112—HCBS Survey Results for 'Ohana QI

Measure	2023 Scores	2024 Scores
Global Ratings		
Rating of Personal Assistance and Behavioral Health Staff	83.16%+	75.00%+
Rating of Homemaker	80.00%+	76.92%+
Rating of Case Manager	68.97%+	66.67%+
Composite Measures		
Reliable and Helpful Staff	77.98%+	73.72%+
Staff Listen and Communicate Well	79.74%+	81.29%+
Helpful Case Manager	87.63%+	78.72%+
Choosing the Services that Matter to You	77.06%+	69.37%+
Transportation to Medical Appointments	67.32%+	63.70%+
Personal Safety and Respect	88.98%	93.43%+
Planning Your Time and Activities	52.10%+	49.96%+
Recommendation Measures		
Recommend Personal Assistance/Behavioral Health Staff	82.61%+	74.47%+
Recommend Homemaker	50.00%+	58.33%+
Recommend Case Manager	70.24%+	65.00%+
Unmet Need and Physical Safety Measures		
No Unmet Need in Dressing/Bathing	NA	NA
No Unmet Need in Meal Preparation/Eating	NA	NA
No Unmet Need in Medication Administration	NA	NA
No Unmet Need in Toileting	98.00%+	95.45%+
No Unmet Need with Household Tasks	NA	NA

[77] For this report, only the composite measure scores are displayed. For more detailed results of the items within the composite measure, please see the 2024 Hawaii HCBS CAHPS Survey full report.

[78] Agency for Healthcare Research and Quality. *The CAHPS® Home and Community-Based Services (HCBS) Survey Database 2024 Chartbook*. January 2024. Available at: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/cahps-database/2024-hcbs-chartbook.pdf. Accessed on: Jan 15, 2025.

[79] The 2024 HCBS CAHPS Database benchmarks represent survey data collected from January 1 to December 31, 2022. Caution should be exercised when comparing the 2024 HCBS CAHPS Database benchmarks to the Hawaii HCBS Program 2024 results, which represent survey data collected from July 23, 2024, to September 15, 2024.

Measure	2023 Scores	2024 Scores
Not Hit or Hurt by Staff	100.00%+	100.00%+
A cell highlighted in green represents the score is statistically significantly higher than the 2024 CAHPS Database benchmark. A cell highlighted in red represents the score is statistically significantly lower than the 2024 CAHPS Database benchmark. ▲ Indicates the 2024 score is statistically significantly higher than the 2023 score. ▼ Indicates the 2024 score is statistically significantly lower than the 2023 score. ↑ Indicates the QI health plan's score is statistically significantly higher than the Hawaii HCBS Program. ↓ Indicates the QI health plan's score is statistically significantly lower than the Hawaii HCBS Program. + Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results. Results based on fewer than 11 respondents were suppressed and noted as "NA".		

Strengths

- None of 'Ohana QI's 2024 scores were statistically significantly higher than the 2023 scores, the Hawaii HCBS Program, or AHRQ's 2024 CAHPS Database benchmark for any measure; therefore, no substantial strengths were identified.

Areas for Improvement

- For 'Ohana QI, the following measures scored statistically significantly lower than AHRQ's 2024 CAHPS Database benchmark:
  - *Reliable and Helpful Staff*
  - *Staff Listen and Communicate Well*
  - *Choosing the Services that Matter to You*
  - *Transportation to Medical Appointments*
  - *Planning Your Time and Activities*

Recommendations

HSAG recommends that 'Ohana QI explore what may be driving lower experience scores and develop initiatives designed to improve quality and access to care, including a focus on improving adult members' overall experiences with the reliability of staff, staff's ability to listen and communicate, ability to choose services that matter to the individual, receiving transportation to medical appointments, and ability to plan their time and activities.

Encounter Data Validation

HSAG evaluated the extent to which the encounter data in MQD's database were complete, accurate, and submitted by 'Ohana QI in a timely manner through a comparative analysis between MQD's electronic encounter data and the actuarial files submitted by 'Ohana QI to MQD's contracted actuary, Milliman.

Findings

Table 3-113 illustrates the percentage of records present in the Milliman-submitted files that were not found in the MQD-submitted files (record omission or underreporting to MQD) and the percentage of records present in the MQD-submitted files but not present in the Milliman-submitted files (record surplus or underreporting to Milliman). Lower rates indicate better performance for both record omission and record surplus.

Table 3-113—Record Omission and Surplus by Encounter Type

Encounter Type	Record Omission (Underreporting to MQD)	Record Surplus (Underreporting to Milliman)
Institutional	22.3%	17.3%
Professional	45.5%	33.3%
Pharmacy	0.1%	<0.1%

Note: Lower rates indicate better performance.
Red text indicates rates higher than 5.0 percent.

Element-level discrepancy was limited to those records present in both data sources with values present in both data sources. Records with values missing from both data sources were not included in the denominator. The numerator was the number of records with different non-missing values for a given data element. Lower data element discrepancy rates indicate that the values populated for a data element in the MQD-submitted encounter data were more accurate. As such, for the discrepancy indicator, lower rates indicate better performance. Table 3-114 to Table 3-116 present the data element discrepancy rates for each encounter type.

Table 3-114—Element Discrepancy by Key Data Element for Institutional Encounters

Key Data Element	Discrepancy Rate
Member, Date of Service, and Provider	
Member ID	0.0%
Member Date of Birth	2.1%
Detail First Date of Service	40.4%
Detail Last Date of Service	51.8%
Billing Provider NPI	0.0%
Billing Provider Type	100%
Servicing Provider NPI	2.3%
Servicing Provider ID	6.4%
Payment Information	
Allowed Amount	43.2%
Billed Amount	0.1%
COB Amount	22.6%
Coinsurance Amount	15.5%

Key Data Element	Discrepancy Rate
Copay Amount	0.3%
Deductible Amount	0.7%
MCO Paid Amount	6.7%
Value Code Amount	3.0%
Diagnosis Codes, Procedure Codes, and Drug Information	
Admission Diagnosis Code	0.0%
Primary Diagnosis Code	0.0%
All Secondary Diagnosis Codes	0.0%
All Surgical Procedure Codes	84.2%
Procedure Code	0.1%
Procedure Code Modifiers	4.6%
Units of Service	0.2%
NDC	<0.1%
Other Data Elements	
Admission Date	1.2%
Admission Source	0.0%
Admission Type	0.0%
DRG Code	72.5%
Discharge Date	0.0%
Discharge Status	0.0%
Encounter Flag	0.0%
MCO Paid Date	16.7%
Occurrence Span Codes	0.0%
POA Code	0.0%
All Secondary POA Codes	3.6%
Revenue Code	<0.1%
TOB Code	9.2%
Value Codes	2.7%

— indicates that the denominator was zero.
Red text indicates rates higher than 5.0 percent.

Table 3-115—Element Discrepancy by Key Data Element for Professional Encounters

Key Data Element	Discrepancy Rate
Member, Date of Service, and Provider	
Member ID	0.1%
Member Date of Birth	1.8%
Detail First Date of Service	0.3%
Detail Last Date of Service	0.3%
Billing Provider NPI	1.3%

Key Data Element	Discrepancy Rate
Billing Provider Type	100%
Servicing Provider NPI	1.3%
Servicing Provider ID	10.5%
Payment Information	
Allowed Amount	25.2%
Billed Amount	3.0%
COB Amount	8.9%
Coinsurance Amount	5.0%
Copay Amount	0.4%
Deductible Amount	0.4%
MCO Paid Amount	3.4%
Patient Paid Amount	0.2%
Diagnosis Codes, Procedure Codes, and Drug Information	
Primary Diagnosis Code	5.4%
All Secondary Diagnosis Codes	33.5%
Procedure Code	2.2%
Procedure Code Modifiers	13.7%
Units of Service	2.4%
NDC	9.3%
Other Data Elements	
Admission Date	—
Discharge Date	—
Encounter Flag	0.1%
POS Code	0.1%
MCO Paid Date	1.6%

— indicates that the denominator was zero.
Red text indicates rates higher than 5.0 percent.

Table 3-116—Element Discrepancy by Key Data Element for Pharmacy Encounters

Key Data Element	Discrepancy Rate
Member and Date of Service	
Member ID	<0.1%
Date of Service	0.0%
Payment Information	
Billed Amount	5.7%
COB Amount	0.4%
Coinsurance Amount	0.0%
Copay Amount	0.0%
Deductible Amount	0.0%

Key Data Element	Discrepancy Rate
Dispensing Fee	95.5%
Ingredient Cost	0.0%
MCO Paid Amount	0.0%
Patient Paid Amount	0.0%
Drug Information	
NDC	0.0%
Dispensing Quantity	<0.1%
Days' Supply	0.0%
New or Refill Flag	100%
Number of Refills	88.8%
Other Data Elements	
MCO Paid Date	<0.1%

— indicates that the denominator was zero.
Red text indicates rates higher than 5.0 percent.

Strengths

- The record omission and surplus rates for pharmacy encounters were below 5.0 percent. This indicates that encounters in both the MQD-submitted and the Milliman-submitted data could largely be identified in both data sources.
- All but 12 institutional encounter data elements, all but eight professional encounter data elements, and all but four pharmacy encounter data elements had a discrepancy rate less than 5.0 percent. This indicates that records which could be matched between the MQD-submitted and the Milliman-submitted data largely contained the same values.

Areas for Improvement

- The record omission and record surplus rates for institutional and professional encounters were high. Professional encounters had the highest record omission and record surplus rates at 45.5 percent and 33.3 percent, respectively. Institutional encounters had a record omission rate of 22.3 percent and a record surplus rate of 17.3 percent.
- Although matched records largely contained similar values between the MQD-submitted and the Milliman-submitted data, ‘Ohana QI should ensure the following data elements have accurate values:
  - Institutional encounters: Detail First Date of Service, Detail Last Date of Service, Billing Provider Type, Servicing Provider ID, Allowed Amount, COB Amount, Coinsurance Amount, MCO Paid Amount, All Surgical Procedure Codes, DRG Code, MCO Paid Date, and TOB Code.
  - Professional encounters: Billing Provider Type, Servicing Provider ID, Allowed Amount, COB Amount, Primary Diagnosis Code, All Secondary Diagnosis Codes, Procedure Code Modifiers, and NDC.

  - Pharmacy encounters: Billed Amount, Dispensing Fee, New or Refill Flag, and Number of Refills.

Recommendations

- ‘Ohana QI should review and work on the action items noted in the data discrepancy report.
- ‘Ohana QI should utilize the three-year encounter file that MQD will provide monthly to ensure the data it submits to HPMMIS are processed and submitted correctly. ‘Ohana QI should review any discrepancies within the file with MQD to reconcile any differences.
- ‘Ohana QI should continue to work with MQD and Milliman to ensure data submitted to HPMMIS in CY 2025 accurately reflect data needed for the CY 2026 rate setting activities.

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

As a result of the 2022 and 2023 compliance reviews, ‘Ohana QI had 16 corrective action items to address during 2023 and 2024. ‘Ohana QI took the necessary steps to plan interventions; update policies, procedures, and member and provider information; and make operational changes to address the deficiencies found. As a result of its CAP interventions, ‘Ohana QI was found to be fully compliant with all standards during 2024.

The results of the NAV activities revealed that ‘Ohana QI had well-defined processes and procedures in place to ensure efficient and accurate collection of member and provider data to support network adequacy calculation and reporting. ‘Ohana QI demonstrated efforts to identify gaps in provider networks throughout its service areas and identify ways to improve the accessibility and timeliness of care for members.

Overall, more than half (62.50 percent) of ‘Ohana QI’s performance measures fell below the 50th percentile across all domains, with half (51.56 percent) of the measure rates falling below the 25th percentile. While some measures showed improvement from MY 2023, ‘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

Chronic Conditions domains. Additionally, ‘Ohana QI should continue to evaluate the impact of the changes in its approach to managing provider specialty information. Sixteen MQD Quality Strategy targets were met or exceeded in MY 2023.

‘Ohana QI’s CAHPS results illustrate opportunities for improvement in members’ satisfaction. While none of the measures scored statistically significantly lower in 2024 than in 2022 and none of the measures scored statistically significantly lower than the 2023 NCQA adult Medicaid national averages, the following five measures were below the 50th percentiles: *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Advising Smokers and Tobacco Users to Quit*. 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 six of the nine measures MQD selected for monitoring within its Quality Strategy met or exceeded the RY 2024 target, ‘Ohana QI should focus improvement efforts on the *Advising Smokers and Tobacco Users to Quit* measure, which fell below the 25th percentile.

‘Ohana QI’s HCBS CAHPS Survey results illustrate opportunities for improvement in members’ experience. While none of the measures scored statistically significantly lower than the 2023 scores or the Hawaii HCBS Program, the following measures scored statistically significantly lower than AHRQ’s 2024 CAHPS Database benchmark: *Reliable and Helpful Staff*, *Listen and Communicate Well*, *Choosing the Services that Matter to You*, *Transportation to Medical Appointments*, and *Planning Your Time and Activities*, indicating a need for ‘Ohana QI to implement strategies to ensure members have access to high-quality care.

Although pharmacy encounters were relatively complete at the record level, the EDV activities revealed that ‘Ohana QI should improve its encounter data completeness for institutional and professional encounters, since either the record omission or the record surplus rate for each encounter type was above 5.0 percent (i.e., relatively poor performance). In addition, although matched records largely contained similar values between the MQD-submitted and the Milliman-submitted data, ‘Ohana QI had at least one data element for each encounter type that it should work on to improve its accuracy. Submitting accurate and complete encounter data assists MQD in monitoring issues concerning quality of care and access to care, as well as setting up proper capitation rates starting in CY 2026 with CY 2025 data.

‘Ohana QI progressed to the Outcomes stage of the two PIPs initiated in CY 2022 and the Design stage for the new PIP initiated in CY 2024. 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 *High Confidence* validation rating in both overall confidence in adherence to acceptable methodology for all phases of the PIP and overall confidence that that the PIP achieved significant improvement. During Remeasurement 2, the health plan documented statistically significant improvement over the baseline in both performance indicator rates. The health plan had been sharing data with ‘Ohana CCS; however, the data sharing with the DOH Behavioral Health Services Administration divisions had not yet started.

For the *Plan All-Cause Readmissions* PIP, ’Ohana QI received an overall *High Confidence* validation rating for overall confidence in adherence to acceptable methodology for all phases of the PIP and a *No*

Confidence validation rating for overall confidence that the PIP achieved significant improvement. 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. During Remeasurement 2, the health plan did not achieve any improvement over the baseline.

For the *Screening for Depression and Follow-Up Plan* PIP, ‘Ohana QI received a *High Confidence* rating for adherence to acceptable methodology for the PIP design. The health plan designed a scientifically sound project that was supported by using key research principles.

UnitedHealthcare Community Plan QUEST Integration (UHC CP QI) Results

Compliance Monitoring Review

The 2024 compliance monitoring review activity included follow-up reviews of the health plans' required corrective actions implemented to address deficiencies noted during the 2022 and 2023 reviews.

Findings

Table 3-117 presents the scores from HSAG's 2022 and 2023 compliance reviews, the number of CAPs required, the number of CAPs closed, and the results of the 2024 follow-up reviews of UHC CP QI.

Table 3-117—Standards, Compliance Scores, and CAPs—UHC CP QI

Standard Name	Standard Review Year	Compliance Review Score	# of CAPs Required	# of CAPs Closed	2024 Final Follow-Up Review Score
Assurances of Adequate Capacity and Services	2022	100%	0	NA	**100%**
Availability of Services	2022	100%	0	NA	**100%**
Confidentiality	2022	100%	0	NA	**100%**
Coordination and Continuity of Care	2022	100%	0	NA	**100%**
Coverage and Authorization of Services	2022	100%	0	NA	**100%**
Credentialing	2023	100%	0	NA	**100%**
Enrollee Information	2022	95%	2	2	**100%**
Enrollee Rights and Protections	2022	94%	1	1	**100%**
Enrollment and Disenrollment	2023	100%	0	NA	**100%**
Grievance and Appeal System	2022	98%	1	1	**100%**
Health Information Systems	2023	100%	0	NA	**100%**
Provider Selection	2023	100%	0	NA	**100%**
Practice Guidelines	2023	100%	0	NA	**100%**
Quality Assessment and Performance Improvement	2023	100%	0	NA	**100%**
Subcontractual Relationships and Delegation	2023	100%	0	NA	**100%**
Totals			**4**	**4**	**100%**

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

Strengths

The 2022 compliance review revealed that UHC CP QI had deficiencies in three of the eight standards reviewed. During 2023, UHC CP QI completed four corrective action items to bring them into full

compliance. To address the Enrollee Information, Enrollee Rights and Protections, and Grievance and Appeal System standard deficiencies, UHC CP QI updated its policies and procedures to ensure member materials were consistent, notifications of changes were given in a timely manner, and that advance directive and appeal procedures included all required information. Additionally, the member handbook was updated to include emergency and poststabilization services.

UHC CP QI performed well during the 2023 compliance review, with no corrective action items to be completed in 2024.

Areas for Improvement

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

Recommendations

HSAG recommends that UHC CP QI review the revised Medicaid managed care rules released in 2024 and implement operational changes, as applicable, to ensure continued compliance.

Validation of Performance Measures—NCQA HEDIS Compliance Audits

NCQA HEDIS Compliance Audit Findings

HSAG's review team assessed UHC CP QI's IS capabilities and its ability to process data for reporting accurate performance measure rates. UHC CP QI was found to be fully compliant with all HEDIS IS standards, as well as IS standard L for assessing case management data for LTSS measures. This demonstrated that UHC CP QI had effective IS processes and control procedures for reporting the required performance measure rates. UHC CP QI presented 20 supplemental data sources for consideration to use for supplementing its MY 2023 performance measure rates. HSAG determined nine data sources to be nonstandard supplemental data, and the remaining 11 were considered standard supplemental data. UHC CP QI withdrew one of the nonstandard data sources from reporting. HSAG reviewed the remaining 19 data sources, and no concerns were identified. All 19 supplemental data sources were approved for HEDIS MY 2023 reporting.

UHC CP QI was required to undergo convenience sample validation for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile—Total* and the *Immunization for Adolescents—Combination 1* indicators, as they were new to the scope of the audit for MY 2023, as well as all medical record exclusions. All cases successfully passed the validation process. The final statistical MRRV was conducted for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile—Total* and *Counseling for Nutrition—Total, Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%),* and *Immunizations for Adolescents—Combination 2* measure indicators, as well as all medical record exclusions. All selected cases passed the final MRRV without any critical errors.

All measures under the scope of the audit were determined to be *Reportable*. UHC CP QI was determined to be fully compliant with all IS standards; therefore, HSAG 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 3-118.

Table 3-118—UHC CP QI's Results for QI Measures Under Access and Risk-Adjusted Utilization

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	—	47.57%	—	★
45–64 Years	—	70.31%	—	★
65 Years and Older	—	90.84%	—	★★★★
Total	—	69.40%	—	★★
Ambulatory Care				
Emergency Department Visits	510.64	512.98	0.46%	★★★
Outpatient Visits	4,884.68	4,945.09	1.24%	★★★★
Asthma in Younger Adults Admission Rate*				
*Asthma in Younger Adults Admission Rate**	—	3.12	—	NC
Heart Failure Admission Rate*				
18–64 Years	48.16	52.86	9.74%	NC
65 Years and Older	117.89	123.13	4.44%	NC
Total (18 Years and Older)	69.70	76.08	9.15%	NC
Plan All-Cause Readmissions				
*Index Total Stays—Observed Readmissions—Total**	11.35%	10.35%	-8.83%	NC
Expected Readmissions—Total	11.06%	11.13%	0.63%	NC
*Index Total Stays—O/E Ratio—Total**	1.0256	0.9297	-9.35%	NC

** A lower rate indicates better performance.*
NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.
— Indicates that the health 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 2023 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*

The *Ambulatory Care* indicator rates met or exceeded the 50th percentile, with the *Outpatient Visits* indicator ranking at or above the 75th percentile. The *Adults' Access to Preventive/Ambulatory Health Services—65 years and Older* indicator met or exceeded the 75th percentile. All other measure indicators in this domain did not meet or exceed the 50th percentile or did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented.

UHC CP QI did not meet the MQD's established Quality Strategy targets for this domain.

Children's Preventive Health Performance Measure Results

UHC CP QI's Children's Preventive Health performance measure results are shown in Table 3-119.

Table 3-119—UHC CP QI's Results for QI Measures Under Children's Preventive Health

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Child and Adolescent Well-Care Visits				
Child and Adolescent Well-Care Visits	38.61%	41.80%	8.25%	★
Childhood Immunization Status				
Combination 3	49.88%	48.91%	-1.95%	★
Combination 7	45.01%	42.09%	-6.49%	★
Combination 10	30.90%	29.44%	-4.72%	★★
DTaP	53.77%	52.80%	-1.81%	★
Hepatitis A	68.61%	66.18%	-3.55%	★
Hepatitis B	75.67%	72.51%	-4.18%	★
HiB	73.72%	70.07%	-4.95%	★
Influenza	44.04%	40.15%	-8.84%	★★
IPV	75.43%	70.56%	-6.45%	★
MMR	70.07%	67.40%	-3.82%	★
Pneumococcal Conjugate	55.47%	52.55%	-5.26%	★
Rotavirus	62.53%	55.47%	-11.28%	★
VZV	70.07%	66.67%	-4.86%	★
Immunizations for Adolescents				
Combination 1 (Meningococcal, Tdap)	—	51.82%	—	★
Combination 2 (Meningococcal, Tdap, HPV)	—	28.47%	—	★
Meningococcal Serogroups A, C, W, Y	—	54.74%	—	★
Tdap	—	54.74%	—	★
HPV	—	30.90%	—	★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents				
BMI Percentile Documentation—3–11 Years	—	90.07%	—	★★★★

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
BMI Percentile Documentation—-12–17 Years	—	91.47%	—	★★★★★
BMI Percentile Documentation—Total	—	90.51%	—	★★★★★
Counseling for Nutrition—3–11 Years	—	62.77%	—	★★
Counseling for Nutrition—12–17 Years	—	55.81%	—	★
Counseling for Nutrition—Total	—	60.58%	—	★
Counseling for Physical Activity-3–11 Years	—	59.93%	—	★★
Counseling for Physical Activity—12–17 Years	—	61.24%	—	★★
Counseling for Physical Activity—Total	—	60.34%	—	★★
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	56.67%	53.94%	-4.80%	★★
Well-Child Visits for Age 15 Months to 30 Months of Life—Two or More Well-Child Visits	53.62%	54.01%	0.74%	★

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by MQD.
— Indicates that the health 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 2023 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

The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile Documentation* indicators all ranked at or above the 75th percentile, and two ranked at or above the 90th percentile. All other measure indicators in this domain did not meet or exceed the 50th percentile or did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented.

UHC CP QI met MQD's established Quality Strategy targets for *Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents—BMI Percentile Documentation—Total.* All other MQD Quality Strategy targets were not met for this domain.

Women's Health Performance Measure Results

UHC CP QI's Women's Health performance measure results are shown in Table 3-120.

Table 3-120—UHC CP QI's Results for QI Measures Under Women's Health

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Cervical Cancer Screening				
Cervical Cancer Screening	45.26%	48.42%	6.99%	★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	73.24%	74.21%	1.33%	★
Postpartum Care	79.08%	76.89%	-2.77%	★★
Prenatal and Postpartum Care: Under 21 Years of Age (Child Core)				
Timeliness of Prenatal Care: Under 21 Years of Age	—	44.12%	—	NC
Postpartum Care: Under 21 Years of Age	—	67.65%	—	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 health 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 2023 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

The indicator rates that could be compared to benchmarks in this domain did not meet or exceed the 50th percentile. The *Prenatal and Postpartum Care: Under 21 Years of Age (Child Core)* indicators in this domain did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented.

UHC CP QI did not meet the MQD's established Quality Strategy targets for this domain.

Care for Chronic Conditions Performance Measure Results

UHC CP QI's Care for Chronic Conditions performance measure results are shown in Table 3-121.

Table 3-121—UHC CP QI's Results for QI Measures Under Care for Chronic Conditions

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Asthma Medication Ratio				
5–11 Years	—	NA	—	NC
12–18 Years	—	NA	—	NC
19–50 Years	—	52.71%	—	★
51-64 Years	—	57.89%	—	★★
Total (5–64 Years)	—	54.46%	—	★

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Total Child Core Set (5–18 Years)	—	40.91%	—	NC
Total Adult Core Set (19–64 Years)	—	55.52%	—	NC
Blood Pressure Control for Patients With Diabetes				
Blood Pressure Control for Patients With Diabetes	68.61%	69.59%	1.42%	★★★
Concurrent Use of Opioids and Benzodiazepines*				
18–64 Years	12.05%	13.99%	16.05%	NC
65 Years and Older	16.50%	13.59%	-17.63%	NC
Total (18 Years and Older)	14.09%	13.80%	-2.10%	NC
Controlling High Blood Pressure				
18–64 Years	61.76%	60.87%	-1.45%	NC
65–85 Years	81.33%	71.06%	-12.62%	NC
Total	73.24%	67.64%	-7.64%	★★★★
Eye Exam for Patients With Diabetes				
Eye Exam for Patients With Diabetes	60.34%	63.99%	6.05%	★★★★★
Hemoglobin A1c Control for Patients With Diabetes				
HbA1c Control (<8.0%)—18–64 Years	—	59.01%	—	NC
HbA1c Control (<8.0%)—65–75 Years	—	74.07%	—	NC
HbA1c Control (<8.0%)—Total	63.26%	65.94%	4.23%	★★★★★
*HbA1c Poor Control (>9.0%)—18–64 Years**	—	29.73%	—	NC
*HbA1c Poor Control (>9.0%)—65–75 Years**	—	15.87%	—	NC
HbA1c Poor Control (>9.0%)——Total	27.25%	23.36%	-14.29%	★★★★★

** A lower rate indicates better performance.*
Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by MQD.
NA indicates that the health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
NC indicates that 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 health 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 2023 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*

Blood Pressure Control for Patients With Diabetes and *Controlling High Blood Pressure—Total* met or exceeded the 50th percentile. *Eye Exam for Patients With Diabetes, Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)—Total* and *HbA1c Poor Control (>9.0%)—Total* met

the 90th percentile. All other measure indicators in this domain did not meet the 50th percentile or did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented.

UHC CP QI met the MQD-established Quality Strategy target for *Blood Pressure Control for Patients With Diabetes, Controlling High Blood Pressure—Total, Eye Exam for Patients With Diabetes, Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)—Total,* and *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)—Total.* All other MQD Quality Strategy targets were not met for this domain.

Behavioral Health Performance Measure Results

UHC CP QI's Behavioral Health performance measure results are shown in Table 3-122.

Table 3-122—UHC CP QI's Results for QI Measures Under Behavioral Health

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	67.43%	76.51%	13.47%	★★★★★
Antidepressant Medication Management				
Effective Acute Phase Treatment—18–64 Years	—	65.64%	—	NC
Effective Acute Phase Treatment—65 Years and Older	—	81.11%	—	NC
Effective Acute Phase Treatment—Total	67.88%	71.15%	4.82%	★★★★
Effective Continuation Phase Treatment—18–64 Years	—	47.55%	—	NC
Effective Continuation Phase Treatment—65 Years and Older	—	66.11%	—	NC
Effective Continuation Phase Treatment—Total	50.78%	54.15%	6.64%	★★★★
Follow-Up After Emergency Department Visit for Mental Illness				
7-Day Follow-Up—6–17 Years	—	NA	—	NC
7-Day Follow-Up—18–64 Years	26.60%	35.41%	33.14%	★★★
7-Day Follow-Up—65 Years and Older	—	30.95%	—	★★
7-Day Follow-Up—Total	26.89%	35.10%	30.50%	★★
30-Day Follow-Up—6–17 Years	—	NA	—	NC
30-Day Follow-Up—18–64 Years	44.15%	53.77%	21.79%	★★★
30-Day Follow-Up—65 Years and Older	—	40.48%	—	★★
30-Day Follow-Up—Total	44.50%	52.37%	17.68%	★★
Follow-Up After Emergency Department Visit for Substance Use				
7-Day Follow-Up—13–17 Years	—	NA	—	NC

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
7-Day Follow-Up—18 Years and Older	26.25%	27.66%	5.38%	★★★
7-Day Follow-Up—Total	26.19%	27.70%	5.77%	★★★
7-Day Follow-Up—18–64 Years (Adult Core)	—	28.06%	—	NC
7-Day Follow-Up—65 Years and Older (Adult Core)	—	NA	—	NC
30-Day Follow-Up—13–17 Years	—	NA	—	NC
30-Day Follow-Up—18 Years and Older	37.71%	41.04%	8.84%	★★★
30-Day Follow-Up—Total	37.62%	40.99%	8.96%	★★★
30-Day Follow-Up—18–64 Years (Adult Core)	—	41.49%	—	NC
30-Day Follow-Up—65 Years and Older (Adult Core)	—	NA	—	NC
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase—Total	—	NA	—	NC
Continuation and Maintenance Phase—Total	—	NA	—	NC
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation—Total—13–17 Years	—	NA	—	NC
Initiation—Total—18–64 Years	—	37.18%	—	★
Initiation—Total—65 Years and Older	—	36.25%	—	★★
Initiation—Total	36.51%	37.12%	1.68%	★
Engagement—Total—13–17 Years	—	NA	—	NC
Engagement—Total—18–64 Years	—	8.60%	—	★
Engagement—Total—65 Years and Older	—	5.18%	—	★★
Engagement—Total	7.07%	7.99%	13.00%	★
Screening for Depression and Follow-Up Plan				
12–17 Years	16.99%	20.28%	19.31%	NC
18–64 Years	13.13%	14.04%	6.95%	NC
65 Years and Older	36.97%	35.45%	-4.12%	NC
Total (12 Years and Older)	22.34%	23.06%	3.22%	NC
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
1–11 Years	—	NA	—	NC
12–17 Years	—	NA	—	NC
Total	—	NA	—	NC
Use of Pharmacotherapy for Opioid Use Disorder				
Rate 1: Total	50.15%	50.93%	1.54%	NC
Rate 2: Buprenorphine	22.94%	24.38%	6.31%	NC

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Rate 3: Oral Naltrexone	0.31%	1.54%	404.63%	NC
Rate 4: Long-Acting, Injectable Naltrexone	0.31%	0.00%	-100.00%	NC
Rate 5: Methadone	28.44%	26.85%	-5.59%	NC

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by MQD.
NA indicates that the health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
NC indicates that 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 health 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 2023 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*

All indicator rates that could be compared to a benchmark for the *Antidepressant Medication Management* and *Follow-Up After Emergency Department Visit for Substance Use* measures ranked at or above the 50th percentile. Two of six indicators for *Follow-Up After Emergency Department Visit for Mental Illness* measure ranked at or above the 50th percentile. Additionally, *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* ranked at or above the 90th percentile. All other measure indicators in this domain either did not meet the 50th percentile or did not have national benchmarks to compare for MY 2023.

UHC CP QI met the MQD established Quality Strategy Target for *Adherence to Antipsychotic Medications for Individuals With Schizophrenia; Antidepressant Medication Management—Effective Acute Phase Treatment—Total* and *Effective Continuation Phase Treatment—Total; Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total; Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total; Screening for Depression and Follow-Up Plan—Total (12 Years and Older);* and *Use of Pharmacotherapy for Opioid Use Disorder—Rate 3* and *Rate 5.* All other MQD Quality Strategy targets were not met for this domain.

Long-Term Services and Supports Performance Measure Results

UHC CP QI's Long-Term Services and Supports performance measure results are shown in Table 3-123.

Table 3-123—UHC CP QI's Results for QI Measures Under Long-Term Services and Supports

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
LTSS Comprehensive Assessment and Update				
Assessment of Core Elements Documented	11.46%	8.33%	-27.27%	NC
Assessment of Supplemental Elements Documented	11.46%	8.33%	-27.27%	NC
LTSS Comprehensive Care Plan and Update				
Care Plan With Core Elements Documented	13.54%	10.42%	-23.08%	NC
Care Plan With Supplemental Elements Documented	13.54%	10.42%	-23.08%	NC
LTSS Minimizing Institutional Length of Stay				
Observed Rate	27.68%	32.60%	17.79%	NC
Risk-Adjusted Rate	33.44%	37.29%	11.50%	NC
O/E Ratio	0.8276	0.8743	5.64%	NC

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

The measures in this domain did not have applicable benchmarks; therefore, no comparison to national benchmarks is presented.

UHC CP QI met the MQD-established Quality Strategy target for *LTSS Comprehensive Care Plan and Update—Care Plan With Core Elements* and *Care Plan With Supplemental Elements,* and *LTSS Minimizing Institutional Length of Stay—Observed Rate.* All other MQD Quality Strategy targets were not met for this domain.

Strengths

Based on HSAG's analyses of UHC CP QI's 66 indicator rates comparable to benchmarks, 20 rates (30.30 percent) ranked at or above the 50th percentile, with six of these rates (9.09 percent) ranking at or above the 75th percentile and six rates (9.09 percent) ranking at or above the 90th percentile. Additionally, UHC CP QI met 19 MQD Quality Strategy targets for MY 2023.

Areas for Improvement

Conversely, 46 of UHC CP QI's 66 indicator rates comparable to benchmarks (69.70 percent) fell below the 50th percentile, with 29 of these rates (43.94 percent) falling below the 25th percentile, suggesting considerable opportunities for improvement across all domains.

Recommendations

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:

- Within the Children's Preventive Health domain, the following recommendations were identified:
  - Regarding the *Child and Adolescent Well-Care Visits* measure, HSAG recommends that UHC CP QI incentivize providers, members, and parents to complete visits, encourage teen-centered care through privacy and confidentiality, promote well-visits on social media or other outreach, and develop partnerships with community stakeholders.[80]
  - Regarding the *Childhood Immunization Status* measure, HSAG recommends that UHC CP QI provide education to providers and members about the importance of vaccination for disease prevention and encourage vaccination at every opportunity, including mild illness visits.
  - Regarding the *Well-Child Visits in the First 30 Months of Life* measure, HSAG recommends that UHC CP QI identify performance improvement efforts to improve well-child visits, drawing from other states' performance improvement initiatives. For instance, California and Virginia have focused on delays in newborn enrollment data, and Missouri and Texas focused on beneficiary barriers and implemented interventions such as utilizing patient portals and phone outreach. HSAG recommends that UHC CP QI identify other barriers to care and conduct a focus group on identifying abilities to address barriers.[81]
- Within the Women's Health domain, the following recommendations were identified:
  - Regarding the *Cervical Cancer Screening* measure, HSAG recommends that UHC CP QI consider utilizing one-on-one interactions with a healthcare professional, such as CHWs, which have been shown to improve cervical cancer screening.[82] Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness. In addition, HSAG recommends that UHC CP QI provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is lack of knowledge.
  - Regarding the *Prenatal and Postpartum Care* measure, HSAG recommends that UHC CP QI consider whether there are disparities/SDOH within UHC CP QI's population that contribute to lower access to care. Upon identification of a root cause, HSAG recommends that UHC CP QI implement appropriate interventions to reduce barriers to care. Strategies could include providing expanded access appointments outside of business hours to accommodate work schedules or childcare needs. Many appointments can be made via telehealth; therefore, ensuring members have access to these options could potentially increase performance in this measure.

[80] Centers for Medicare & Medicaid Services. Paving the Road to Good Health Strategies for Increasing Medicaid Adolescent Well-Care Visits. Available at: https://www.medicaid.gov/medicaid/benefits/downloads/paving-the-road-to-good-health.pdf. Accessed on: Jan 6, 2025.

[81] Centers for Medicare & Medicaid Services. Well-Child Care. Available at: https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/well-child-care/index.html. Accessed on: Jan 6, 2025.

[82] Popalis ML, Ramirez SI, Leach KM, et al. Improving cervical cancer screening rates: a scoping review of resources and interventions. *Cancer Causes Control*. 2022 Nov;33(11):1325–1333.

Validation of Network Adequacy

HSAG evaluated and assessed the data methods that UHC CP QI used to calculate results generated for each network adequacy indicator in the scope of the 2024 NAV activities. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that UHC CP QI used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator.

Findings

Based on the results of the ISCA combined with the virtual audit and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the health plan's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each health plan according to Table 3-124.

Table 3-124—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*
10.0% to 49.9%	*Low Confidence*
Less than 10% and/or any *Not Met* element has significant bias on the results	*No Confidence*

No indicators were designated as *Low Confidence* or *No Confidence* for UHC CP QI.

Analysis and Conclusions

HSAG determined that UHC CP QI was not compliant with network adequacy requirements for the Access and Availability Standard. MQD required at least 80 percent of the members for Behavioral Health, PCP Adult Sick Visits, and PCP Visits indicators to be provided an appointment within the designated time frame. MQD required at least 60 percent of the members for Urgent Care and PCP Pediatric Sick Visits and Specialist Visits to be provided an appointment within the designated time frame. Compliance was determined based on the health plan meeting the State's Access and Availability indicators. All indicators were calculated by MQD. Results are presented by provider type in Table 3-125.

Table 3-125—UHC CP QI Network Adequacy Access and Availability Compliance

Provider Type	Indicator	Compliance
Urgent Care and PCP Pediatric Sick Visits	Appointments within twenty-four (24) hours	*Not Met*

Provider Type	Indicator	Compliance
Visits with Specialists or Non-Emergency Hospital Stays**	Appointments within four (4) weeks or of sufficient timeliness to meet medical necessity	*Not Met*
Behavioral Health (routine visits for adults and children)	Appointment within twenty-one (21) days	*Not Met*
PCP Adult Sick Visits	Appointment within seventy-two (72) hours	*Not Met*
PCP Visits (routine visits for adults and children)	Appointments within twenty-one (21) days	*Not Met*

** MQD confirmed that in CY 2024, Visits with Specialists only included OB/GYN.

HSAG determined that UHC CP QI was compliant with a subset of network adequacy requirements for the Provider Ratios indicators. Compliance was determined based on the health plan meeting the State's Provider Ratio indicators. All indicators were calculated by MQD. Results are presented by provider type in Table 3-126.

Table 3-126—UHC CP QI Network Adequacy Provider Ratios Compliance

Provider Type	Ratio	Results	Compliance
Hospitals on Oahu	5	37	*Met*
Hospital on Kauai	1	14	*Met*
Hospital on Lanai	1	2	*Met*
Hospital on Maui	1	2	*Met*
Hospital on Molokai	1	2	*Met*
Hospitals on Hawaii (one in East Hawaii and one in West Hawaii)	2	25	*Met*
Other Behavioral Health Providers to include Psychologists, Licensed Mental Health Counselors, Licensed Clinical Social Workers, and APRNs—Behavioral Health for members with an SMI or SPMI diagnosis	1:100	1:32	*Met*
Behavioral Health Psychiatrist for members with an SMI or SPMI diagnosis. In geographic areas with a demonstrated shortage of qualified physicians, a psychiatric APRN-Rx may assume the role of psychiatrist.	1:150	1:152	*Not Met*
PCPs	1:300	1:22	*Met*

HSAG determined that UHC CP QI was compliant with a subset of network adequacy requirements for the Mandatory Provider Types indicators. Compliance was determined based on the health plan meeting the State's Mandatory Provider Type indicators, which includes one servicing provider within each

provider type. All indicators were calculated by MQD. Results are presented by provider type in Table 3-127, and noncompliant results are presented in Table 3-128.

Table 3-127—UHC CP QI Network Adequacy Mandatory Provider Types Compliance

Provider Type	Compliance
Home Health Agencies and Hospices	*Met*
LTSS Providers	*Met*
DME	*Met*
Case Management Agencies	*Met*
Laboratories which have either a CLIA 1988 certificate or a waiver of a certificate of registration	*Met*
Optometrists	*Met*
Physical and Occupational Therapists, Audiologists, and Speech-Language Pathologists	*Met*
Providers of lodging and meals associated with obtaining necessary medical care	*Met*
Sign language interpreters and interpreters for languages other than English	*Met*
Physician Specialists, including but not limited to Cardiologists, Endocrinologists, General Surgeons, Geriatricians, Hematologists, Infectious Disease Specialists, Nephrologists, Neurologists, OB/GYNs, Oncologists, Ophthalmologists, Orthopedists, Otolaryngologists, Pediatric Specialists, Plastic and Reconstructive Surgeons, Pulmonologists, Radiologists, and Urologists	*Met*
Behavioral Health Providers: Licensed Therapists, Counselors, and CSACs	*Met*
Non-Emergency Transportation Providers (both ground and air)	*Met*

Table 3-128—UHC CP QI Network Adequacy Mandatory Provider Types Noncompliance

Provider Type	Compliance
Peer Support Specialists	*Not Met*
Emergency Transportation Providers (both ground and air)	*Not Met**
Licensed dietitians	*Not Met*
Community health workers	*Not Met*

* Did not meet for emergency ground transportation

During the NAV review period, HSAG determined that the Access and Availability provider types in Table 3-129 were not required by MQD, resulting in an *Unable to Validate* designation for each associated provider type.

Table 3-129—UHC CP QI Network Adequacy Mandatory Provider Types *Unable to Validate* Indicators

Provider Type
State-Licensed Special Treatment Facilities for the provision of substance abuse therapy/treatment
PAs
CPs

HSAG determined that UHC CP QI was compliant with a subset of network adequacy requirements for the Time and Distance indicators. MQD required at least 85 percent of members to have access to the providers within the associated time or distance parameters. Compliance was determined based on the health plan meeting the State's Time and Distance indicators for both Urban and Rural classifications. All indicators were calculated by MQD. Results are presented by provider type and urbanicity in Table 3-130 and noncompliant results are presented in Table 3-131.

Table 3-130—UHC CP QI Network Adequacy Time and Distance ≥85% Compliance by Urbanicity

Provider Type	Urbanicity	Compliance
PCPs (Adult and Pediatric)	Urban	*Met*
	Rural	*Met*
Specialists (Adult and Pediatric)	Urban	*Met*
	Rural	*Met***
OB/GYN	Urban	*Met*
	Rural	*Met*
Adult Day Care/Adult Day Health	Urban	*Met*
Hospitals	Urban	*Met*
	Rural	*Met*
Behavioral Health Provider (Adult and Pediatric)	Urban	*Met*
	Rural	*Met*
Long-term Services and Supports (LTSS) Providers	Urban	*Met*
	Rural	*Met***
24-Hour Pharmacy	Urban	*Met*
Pharmacies	Urban	*Met*
	Rural	*Met*

** *Met* for a subset of provider types.

Table 3-131—UHC CP QI Network Adequacy Time and Distance < 85% Noncompliance by Urbanicity

Provider Type	Urbanicity	Compliance
Adult Day Care/Adult Day Health	Rural	*Not Met*
LTSS Providers (Assisted Living Facilities/E-ARCH)	Rural	*Not Met*

Provider Type	Urbanicity	Compliance
LTSS Providers (CCMA)	Rural	*Not Met*
LTSS Providers (PERS Providers)	Rural	*Not Met*
LTSS Providers (Home Health Agencies)	Rural	*Not Met*
Otolaryngologists	Rural	*Not Met*

During the NAV review period, HSAG determined that the Access and Availability indicators in Table 3-132 were not required by MQD, resulting in an *Unable to Validate* designation for each associated indicator.

Table 3-132—UHC CP QI Network Adequacy Time and Distance *Unable to Validate* Indicators

Provider Type	Urbanicity	Indicator
Emergency Services Facilities	Urban	Within 30 minute driving time
	Rural	Within 60 minute driving time

Strengths

HSAG identified the following strengths related to NAV for UHC CP QI:

- UHC CP QI efficiently maintained the accuracy and completeness of provider information through its monthly directory audit process. An automated process was in place that pulled provider database records for a statistically valid sample size of providers. UHC CP QI conducted outreach to providers, and data collected were compared to the on-file records to confirm accuracy, ensure completeness, and identify errors.
- UHC CP QI maintained detailed process documentation for creation of the network adequacy report, ensuring business continuity of the network adequacy reporting process.

Areas for Improvement

No specific opportunities were identified related to the data collection and management processes that UHC CP QI had in place to inform network adequacy standard and indicator calculations.

Recommendations

While HSAG had no recommendations related to UHC CP QI's processes for producing the network adequacy results, HSAG recommends that UHC CP QI continue to monitor and address any gaps in its provider network.

Validation of Performance Improvement Projects

In CY 2024, UHC CP QI continued the two PIPs initiated in 2022. The selected PIP topics were *Behavioral Health Coordination* and *Plan All-Cause Readmissions*. For the CY 2024 submission, the health plan progressed to the Design, Implementation, and Outcomes stages of the PIPs and submitted Steps 1 through 8 in the PIP Submission Form. The PIPs were assessed for improvement in outcomes in Step 9.

In CY 2024, UHC CP QI also submitted a new PIP: *Screening for Depression and Follow-Up Plan*. For this PIP, UHC CP QI progressed to the Design stage of the PIP and submitted Steps 1 through 6 in the PIP submission form.

Table 3-133 displays the topics, progression status, and measurement periods reported for the PIPs.

Table 3-133—CY 2024 UHC CP QI PIP Topics and Status

PIP Topic	PIP Progression Status	Baseline Measurement Period	Measurement Period Reported in CY 2023
Behavioral Health Coordination	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	07/01/2021 to 09/30/2021	07/01/2022 to 09/30/2022 (Remeasurement 1)
Plan All-Cause Readmissions	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	CY 2021	CY 2022 (Remeasurement 1)
Screening for Depression and Follow-Up Plan	PIP Design Stage (Steps 1 through 6)	01/01/2024 to 12/31/2024	Not Applicable

The focus of the nonclinical *Behavioral Health Coordination* PIP is to integrate care between the DOH Behavioral Health Services Administration divisions, ‘Ohana 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 SMI and SPMI, developmental disabilities, and other chronic issues. The methodology for this PIP was defined by 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.

The focus of the clinical *Screening for Depression and Follow-Up Plan* PIP is to increase depression screening and documentation of a follow-up plan for members 12 years of age or older who screened positive for depression.

Findings

Table 3-134 illustrates the validation results for the two PIPs submitted by UHC CP QI for CY 2023 validation.

Table 3-134—CY 2023 PIP Validation Results for UHC CP QI

PIP Topic	Validation Rating 1			Validation Rating 2		
	Overall Confidence in Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Behavioral Health Coordination	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Plan All-Cause Readmissions	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
Screening for Depression Screening and Follow-Up Plan	100%	100%	*High Confidence*	*Not Assessed*[4]		

[1] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) 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] **Confidence Level**— Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.
4 **Not Assessed**—HSAG did not assess Step 9, as the QI health plans only reported the Design stage.

The *Behavioral Health Coordination* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *High Confidence* level rating that the PIP achieved significant improvement.

The *Plan All-Cause Readmissions* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *Moderate Confidence* level rating that the PIP achieved significant improvement.

The *Screening for Depression and Follow-Up Plan* PIP was validated through the first six steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for

adhering to acceptable PIP methodology. UHC CP QI had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

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 MQD. UHC CP QI documented the PIP design accurately and as discussed during the workgroup meetings. UHC CP QI's data collection process was methodologically sound; however, the data collection processes to capture the combined reviews and data sharing with the DOH Behavioral Health Services Administration divisions were not defined. At the time of the PIP submission, the health plan was awaiting approval of the DSA by the DOH Behavioral Health Services Administration divisions. The DSA was approved and executed in December 2024 and is effective as of January 1, 2025.

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 MQD, and the health plan-specific 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.

Screening for Depression and Follow-Up Plan

UHC CP QI met 100 percent of the requirements in the Design stage, Steps 1 through 6. The selected PIP topic was required by MQD. 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 CMS Child Core Set *CDF-CH* measure and CMS Adult Core Set *CDF-AD* measure. UHC CP QI's data collection process was also found to be methodologically sound.

Implementation (Steps 7-8)

Behavioral Health Coordination

UHC CP QI accurately reported and analyzed the Remeasurement 2 rates for the two performance indicators. UHC CP QI conducted appropriate quality improvement processes to identify barriers, and it deployed logical interventions linked to the identified barriers. UHC CP QI also drafted and shared the DSA with the DOH Behavioral Health Services Administration divisions. At the time of the PIP submission, the health plan was awaiting approval of the DSA by the DOH Behavioral Health Services

Administration divisions. The DSA was approved and executed in December 2024 and is effective as of January 1, 2025.

The health plan also implemented a new documentation process for combined reviews and completed a training on the new process for its clinical and behavioral health teams.

Plan All-Cause Readmissions

UHC CP QI accurately reported and analyzed Remeasurement 2 rates. UHC CP QI conducted appropriate quality improvement processes. As part of the Readmissions Collaborative workgroup, the health plan identified barriers, and deployed logical interventions linked to the identified barriers. UHC CP QI included an evaluation of effectiveness for each intervention and appropriate next steps for the interventions.

Screening for Depression and Follow-Up Plan

UHC CP QI has not progressed to reporting and analyzing data or conducting QI activities.

Outcomes (Step 9)

Behavioral Health Coordination

The health plan achieved statistically significant improvement in the Remeasurement 2 rates for both performance indicators over the baseline.

Plan All-Cause Readmissions

The health plan achieved statistically nonsignificant improvement in the Remeasurement 2 performance indicator over the baseline.

Screening for Depression and Follow-Up Plan

The health plan has not progressed to reporting remeasurement outcomes. HSAG will assess and validate the first remeasurement period in the 2026 validation cycle.

Analysis of Results

Table 3-135 displays the data that the health plan reported for the *Behavioral Health Coordination* PIP.

Table 3-135—Outcomes for the *Behavioral Health Coordination* PIP

Performance Indicator	Baseline (07/01/2021–09/30/2021)		Remeasurement 1 (07/01/2022–09/30/2022)		Remeasurement 2 (07/01/2023–09/30/2023)		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%	N: 90 D: 236	38.1%*	N: 63 D: 192	32.8%*	*Yes*
2. Percent of shared members whose data are actively shared at a regular frequency with partner agencies.	N: 849 D: 2,634	32.2%	N: 854 D: 2,768	30.9%	N: 1,092 D: 2,982	36.7%*	*Not Assessed*

*Rate demonstrates statistically significant improvement over the baseline rate.
N–Numerator D–Denominator
HSAG rounded percentages to the first decimal place.

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, and for Remeasurement 1, the Performance Indicator 1 rate increased to 38.1 percent, which represents a statistically significant improvement over the baseline. For Remeasurement 2, the rate was 32.8 percent, which represents a statistically significant increase of 12.2 percentage points over the baseline. The health plan sustained improvement during Remeasurement 2.

The baseline rate for the percentage of shared members whose data were actively shared with the partner agencies during the measurement period was 32.2 percent, and for Remeasurement 1, the Performance Indicator 2 rate decreased to 30.9 percent. For Remeasurement 2, the rate was 36.7 percent, which represents a statistically significant increase of 4.5 percentage points over the baseline. The health plan was not assessed for sustained improvement because it had not achieved statistically significant improvement during Remeasurement 1.

Table 3-136 displays the data that the health plan reported for the *Plan All-Cause Readmissions* PIP.

Table 3-136—Outcomes for the *Plan All-Cause Readmissions* PIP

Performance Indicator	Baseline (01/01/2021–12/31/2021)		Remeasurement 1 (01/01/2022–12/31/2022)		Remeasurement 2(01/01/2023–12/31/2023)		Sustained Improvement
For members 18–64 years of age, the number of acute inpatient and observation stay discharges during the	N: 133	11.7%	N: 128	11.4%	N: 116	10.4%	*Not Assessed*

Performance Indicator	Baseline (01/01/2021–12/31/2021)		Remeasurement 1 (01/01/2022–12/31/2022)		Remeasurement 2(01/01/2023–12/31/2023)		Sustained Improvement
measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	D: 1,134		D: 1,128		D: 1,121		

N–Numerator D–Denominator
HSAG rounded percentages to the first decimal place.

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, and for Remeasurement 1, the rate decreased to 11.4 percent. For Remeasurement 2, the rate was 10.4 percent, which represents a statistically nonsignificant decrease (a decrease in the readmission rate is favorable) of 1.3 percentage points from the baseline.

Table 3-137 will display the data for the *Screening for Depression and Follow-Up Plan* PIP once the health plan reports performance indicator results.

Table 3-137—Performance Indicator Results for the *Screening for Depression and Follow-Up Plan* PIP

Performance Indicator	Baseline (01/01/2023–12/31/2023)		Remeasurement 1 (01/01/2024–12/31/2024)		Sustained Improvement
1. Percentage of members ages 12 to 17 screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter.					
2. Percentage of members aged 18 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and, if positive, a follow-up plan is documented on the date of the eligible encounter.					

Barriers/Interventions

Table 3-138 displays the barriers and interventions as documented by the health plan for the *Behavioral Health Coordination* and *Plan All-Cause Readmissions* PIPs. Barriers and interventions for the *Screening for Depression and Follow-Up Plan* PIP will be documented when the PIP progresses to including QI activities and interventions.

Table 3-138—Interventions Implemented/Planned for UHC CP QI PIPs

Barriers	Interventions
Behavioral Health Coordination	
1. Uncertainty regarding current data exchange processes; unclear internal and external workflows across entities. 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.	1. Assess current data exchange and workflow processes between the different partnering agencies. 2. Explore system capabilities for reporting outcomes. 3. Identify data fields/format/mechanisms/ reports for data sharing. 4. Create training regarding combined reviews and trigger events for all clinical/behavioral health staff. 5. Draft DSA on workflow processes for care coordination and data sharing components. (Completed) 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 DSA 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 primary care provider (PCP). 5. Social determinants of health (SDOH) challenges (transportation, housing, etc.).	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. (Discontinued) 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.

Barriers	Interventions
6. Lack of resources or inadequate or limited (untimely) access to services/support post-discharge. 7. Members with an underlying, untreated behavioral health 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 SDOH needs to ensure adequate placement, services and supports, and care coordination post-discharge. 6. This intervention is associated with the member attribution intervention. With the appropriate provider assigned, members can receive timely access to care and care coordination between UHCCP and providers. The intervention also focuses on early identification of services and supports needed and development of contingency plans. 7. Create a process with specific parameters for when to assess or screen for underlying, untreated behavioral health 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.
Screening for Depression and Follow-Up Plan	

* The documented interventions are required by MQD.

Strengths

- For all three PIPs, UHC CP QI received an overall *High Confidence* validation rating for overall confidence in adherence to acceptable methodology for all phases of the PIP for Steps 1 through 8.
- For the *Behavioral Health Coordination* PIP, the health plan achieved statistically significant improvement over the baseline during the Remeasurement 2 period for both performance indicator rates.
- For the *Plan All-Cause Readmissions* PIP, the health plan demonstrated a statistically nonsignificant improvement in performance with a decrease in the observed readmission rate in Remeasurement 2.

Areas for Improvement

- For the *Plan All-Cause Readmissions* PIP, the health plan has an opportunity for improvement in achievement of statistically significant improvement in the performance indicator rate.

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 *Screening for Depression and Follow-Up Plan* PIP:
  - The health plan must ensure that the interventions are implemented in a timely manner to impact outcomes during the remeasurement period.
- The health plan must 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. Also, the health plan must provide a copy of the quality improvement tool(s) used to complete its causal/barrier analysis.
- The health plan should consider the use of quality improvement science-based tools, such as process mapping with FMEA, for causal/barrier analysis.
- The health plan must evaluate each intervention listed in the barriers/interventions table for effectiveness.
- The health plan should collect the intervention effectiveness data more frequently (e.g., monthly or quarterly), unlike the annual performance indicator data. This would help the health plan understand intervention effectiveness and make any updates to the interventions in a timely manner to impact remeasurement outcomes.
- Intervention effectiveness data must guide next steps for each individual intervention.
- For the *Behavioral Health Coordination* PIP, HSAG recommends that the health plan document performance indicator rates to at least one decimal place for each measurement period.

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 3-139 presents the 2024 scores for UHC CP QI compared to the 2023 NCQA adult Medicaid national averages, the corresponding 2022 scores, and QI Program (i.e., combination of the five QI

health plans).[83,84] Additionally, the overall member experience ratings (i.e., star ratings) resulting from the comparison of UHC CP QI's 2024 scores to NCQA's 2023 Quality Compass Benchmark and Compare Quality Data are displayed below.[85]

Table 3-139—Adult Medicaid CAHPS Results for UHC CP QI

Measure	2022 Scores	2024 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	68.10%	60.92%	★★
Rating of All Health Care	68.10%	66.00%	★★★★★
Rating of Personal Doctor	63.01%	65.12%	★★
Rating of Specialist Seen Most Often	70.00%+	67.80%+	★★★
Composite Measures			
Getting Needed Care	77.82%+	77.37%+	★
Getting Care Quickly	74.47%+	76.90%+	★★
How Well Doctors Communicate	88.09%	95.85% ▲	★★★★★
Customer Service	83.59%+	86.54%+	★
Individual Item Measure			
Coordination of Care	81.16%+	92.06%+	★★★★★
Medical Assistance With Smoking and Tobacco Use Cessation Measure Items			
Advising Smokers and Tobacco Users to Quit	81.48%	71.23%+	★★
Discussing Cessation Medications	54.07%	48.65%+	★★
Discussing Cessation Strategies	45.19%	43.84%+	★★

A cell highlighted in green represents the score is statistically significantly higher than the 2023 NCQA adult Medicaid national average.
A cell highlighted in red represents the score is statistically significantly lower than the 2023 NCQA adult Medicaid national average.
▲ *Indicates the 2024 score is statistically significantly higher than the 2022 score.*
▼ *Indicates the 2024 score is statistically significantly lower than the 2022 score.*
↑ *Indicates the QI health plan's 2024 score is statistically significantly higher than the QI Program.*
↓ *Indicates the QI health plan's 2024 score is statistically significantly lower than the QI Program.*
+ *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*

[83] The adult population was last surveyed in 2022; therefore, the 2024 adult CAHPS scores are compared to the corresponding 2022 scores.
[84] National Committee for Quality Assurance. *HEDIS® Measurement Year 2023*, *Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2023.
[85] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2023.* Washington, DC: NCQA, September 2023.

Strengths

- For UHC CP QI's adult Medicaid population, the following three measures scored statistically significantly higher than the 2023 NCQA adult Medicaid national averages:
  - *Rating of All Health Care*
  - *How Well Doctors Communicate*
  - *Coordination of Care*
- In addition, the *How Well Doctors Communicate* measure scored statistically significantly higher in 2024 than in 2022.
- Also, the following three measures met or exceeded the 90th percentiles:
  - *Rating of All Health Care*
  - *How Well Doctors Communicate*
  - *Coordination of Care*
- Of the nine MQD member satisfaction Quality Strategy target measures—*Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Coordination of Care*—UHC CP QI's member experience rating for *Rating of All Health Care*, *How Well Doctors Communicate*, *Customer Service*, and *Coordination of Care* exceeded the RY 2024 target.

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 3-140 provides a summary of the key drivers identified for UHC CP QI.

Table 3-140—UHC CP QI Key Drivers of Member Experience Analysis

Survey Item	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	✓	✓	NA
Q24. Health plan's customer service gave the information or help needed	✓	—	NA

Survey Item	Key Drivers		
	Rating of Health Plan	*Rating of All Health Care*	*Rating of Personal Doctor*
Q27. Ease of filling out forms from health plan	✓	—	NA

NA *Indicates that this question was not evaluated for this measure.*
— *Indicates the survey item is not strongly correlated with the measure or that the item did not perform poorly (i.e., not a key driver).*

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

- Respondents reported not always receiving care as soon as they needed when care was needed right away.

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

- Respondents reported their health plan’s customer service did not provide the information or help they needed.
- Respondents reported that it was not always easy to fill out forms from their health plan

Recommendations

HSAG recommends that UHC CP QI explore what may be driving lower experience scores and develop initiatives designed to improve quality and access to care, including a focus on improving adult members’ overall experiences with their health plan, their personal doctor, customer service, getting needed care in a timely manner, and discussion of cessation strategies and medications to quit smoking/using tobacco.

Home and Community-Based CAHPS Survey

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

Findings

Table 3-141 presents the 2024 top-box scores for UHC CP QI compared to the Hawaii HCBS Program (i.e., combination of the five QI health plans) scores, AHRQ's 2024 CAHPS Database benchmarks, and the corresponding 2023 scores.[86,87,88]

Table 3-141—HCBS Survey Results for UHC CP QI

Measure	2023 Scores	2024 Scores
Global Ratings		
Rating of Personal Assistance and Behavioral Health Staff	78.23%	81.25%
Rating of Homemaker	79.31%+	82.76%+
Rating of Case Manager	72.73%	71.21%
Composite Measures		
Reliable and Helpful Staff	77.79%+	81.00%+
Staff Listen and Communicate Well	77.87%+	82.90%+
Helpful Case Manager Composite	88.11%+	89.24%+
Choosing the Services that Matter to You	68.84%	70.15%
Transportation to Medical Appointments	70.61%	68.21%
Personal Safety and Respect	89.63%	90.33%
Planning Your Time and Activities	54.75%	55.27%
Recommendation Measures		
Recommend Personal Assistance/Behavioral Health Staff	73.95%	76.53%+
Recommend Homemaker	70.37%+	82.61%+
Recommend Case Manager	70.67%	70.73%
Unmet Need and Physical Safety Measures		
No Unmet Need in Dressing/Bathing	33.33%+	NA
No Unmet Need in Meal Preparation/Eating	NA	NA
No Unmet Need in Medication Administration	NA	NA
No Unmet Need in Toileting	98.00%+	96.00%+
No Unmet Need with Household Tasks	NA	NA

[86] For this report, only the composite measure scores are displayed. For more detailed results of the items within the composite measure, please see the 2024 Hawaii HCBS CAHPS Survey full report.

[87] Agency for Healthcare Research and Quality. *The CAHPS® Home and Community-Based Services (HCBS) Survey Database 2024 Chartbook*. January 2024. Available at: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/cahps-database/2024-hcbs-chartbook.pdf. Accessed on: Jan 15, 2025.

[88] The 2024 HCBS CAHPS Database benchmarks represent survey data collected from January 1 to December 31, 2022. Caution should be exercised when comparing the 2024 HCBS CAHPS Database benchmarks to the Hawaii HCBS Program 2024 results, which represent survey data collected from July 23, 2024, to September 15, 2024.

Measure	2023 Scores	2024 Scores
Not Hit or Hurt by Staff	100.00%	100.00%

A cell highlighted in green represents the score is statistically significantly higher than the 2024 CAHPS Database benchmark.
A cell highlighted in red represents the score is statistically significantly lower than the 2024 CAHPS Database benchmark.
▲ *Indicates the 2024 score is statistically significantly higher than the 2023 score.*
▼ *Indicates the 2024 score is statistically significantly lower than the 2023 score.*
↑ *Indicates the QI health plan's score is statistically significantly higher than the Hawaii HCBS Program.*
↓ *Indicates the QI health plan's score is statistically significantly lower than the Hawaii HCBS Program.*
\+ *Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.*
Results based on fewer than 11 respondents were suppressed and noted as "NA".

Strengths

- None of UHC CP QI's 2024 scores were not statistically significantly higher than the 2023 scores, the Hawaii HCBS Program, or AHRQ's 2024 CAHPS Database benchmark for any measure; therefore, no substantial strengths were identified.

Areas for Improvement

- For UHC CP QI, the following measures scored statistically significantly lower than AHRQ's 2024 CAHPS Database benchmark:
  - *Staff Listen and Communicate Well*
  - *Choosing the Services that Matter to You*
  - *Transportation to Medical Appointments*
  - *Personal Safety and Respect*

Recommendations

HSAG recommends that 'UHC CP QI explore what may be driving lower experience scores and develop initiatives designed to improve quality and access to care, including a focus on improving adult members' overall experiences with staff's ability to listen and communicate, ability to choose services that matter to the individual, receiving transportation to medical appointments, and their personal safety and respect.

Encounter Data Validation

HSAG evaluated the extent to which the encounter data in MQD's database were complete, accurate, and submitted by UHC CP QI in a timely manner through a comparative analysis between MQD's electronic encounter data and the actuarial files submitted by UHC CP QI to MQD's contracted actuary, Milliman.

Findings

Table 3-142 illustrates the percentage of records present in the Milliman-submitted files that were not found in the MQD-submitted files (record omission or underreporting to MQD) and the percentage of records present in the MQD-submitted files but not present in the Milliman-submitted files (record surplus or underreporting to Milliman). Lower rates indicate better performance for both record omission and record surplus.

Table 3-142—Record Omission and Surplus by Encounter Type

Encounter Type	Record Omission (Underreporting to MQD)	Record Surplus (Underreporting to Milliman)
Institutional	60.6%	74.8%
Professional	57.1%	65.0%
Pharmacy	11.1%	10.7%

Note: Lower rates indicate better performance.
Red text indicates rates higher than 5.0 percent.

Element-level discrepancy was limited to those records present in both data sources with values present in both data sources. Records with values missing from both data sources were not included in the denominator. The numerator was the number of records with different non-missing values for a given data element. Lower data element discrepancy rates indicate that the values populated for a data element in the MQD-submitted encounter data were more accurate. As such, for the discrepancy indicator, lower rates indicate better performance. Table 3-143 to Table 3-145 present the data element discrepancy rates for each encounter type.

Table 3-143—Element Discrepancy by Key Data Element for Institutional Encounters

Key Data Element	Discrepancy Rate
Member, Date of Service, and Provider	
Member ID	<0.1%
Member Date of Birth	<0.1%
Detail First Date of Service	24.2%
Detail Last Date of Service	0.0%
Billing Provider NPI	16.8%
Billing Provider Type	100%
Servicing Provider NPI	31.7%
Servicing Provider ID	65.6%
Payment Information	
Allowed Amount	2.5%
Billed Amount	37.4%
COB Amount	4.7%
Coinsurance Amount	10.8%

Key Data Element	Discrepancy Rate
Copay Amount	0.0%
Deductible Amount	0.5%
MCO Paid Amount	0.5%
Value Code Amount	<0.1%
Diagnosis Codes, Procedure Codes, and Drug Information	
Admission Diagnosis Code	44.3%
Primary Diagnosis Code	0.0%
All Secondary Diagnosis Codes	9.8%
All Surgical Procedure Codes	6.6%
Procedure Code	0.0%
Procedure Code Modifiers	—
Units of Service	28.2%
NDC	0.1%
Other Data Elements	
Admission Date	0.0%
Admission Source	—
Admission Type	—
DRG Code	3.7%
Discharge Date	29.2%
Discharge Status	0.0%
Encounter Flag	0.0%
MCO Paid Date	0.0%
Occurrence Span Codes	86.7%
POA Code	0.0%
All Secondary POA Codes	9.9%
Revenue Code	0.0%
TOB Code	4.9%
Value Codes	0.0%

— indicates that the denominator was zero.
Red text indicates rates higher than 5.0 percent.

Table 3-144—Element Discrepancy by Key Data Element for Professional Encounters

Key Data Element	Discrepancy Rate
Member, Date of Service, and Provider	
Member ID	<0.1%
Member Date of Birth	<0.1%
Detail First Date of Service	14.4%
Detail Last Date of Service	0.1%
Billing Provider NPI	55.7%

Key Data Element	Discrepancy Rate
Billing Provider Type	100%
Servicing Provider NPI	1.5%
Servicing Provider ID	24.1%
Payment Information	
Allowed Amount	0.5%
Billed Amount	0.6%
COB Amount	0.1%
Coinsurance Amount	22.3%
Copay Amount	0.6%
Deductible Amount	1.1%
MCO Paid Amount	0.7%
Patient Paid Amount	<0.1%
Diagnosis Codes, Procedure Codes, and Drug Information	
Primary Diagnosis Code	4.9%
All Secondary Diagnosis Codes	26.1%
Procedure Code	0.7%
Procedure Code Modifiers	0.1%
Units of Service	11.0%
NDC	0.8%
Other Data Elements	
Admission Date	67.0%
Discharge Date	18.8%
Encounter Flag	<0.1%
POS Code	0.1%
MCO Paid Date	<0.1%

— indicates that the denominator was zero.
Red text indicates rates higher than 5.0 percent.

Table 3-145—Element Discrepancy by Key Data Element for Pharmacy Encounters

Key Data Element	Discrepancy Rate
Member and Date of Service	
Member ID	<0.1%
Date of Service	0.0%
Payment Information	
Billed Amount	94.2%
COB Amount	0.0%
Coinsurance Amount	0.0%
Copay Amount	0.0%
Deductible Amount	0.0%

Key Data Element	Discrepancy Rate
Dispensing Fee	93.1%
Ingredient Cost	<0.1%
MCO Paid Amount	<0.1%
Patient Paid Amount	0.0%
Drug Information	
NDC	0.0%
Dispensing Quantity	0.4%
Days' Supply	<0.1%
New or Refill Flag	50.7%
Number of Refills	89.4%
Other Data Elements	
MCO Paid Date	0.2%

— indicates that the denominator was zero.
Red text indicates rates higher than 5.0 percent.

Strengths

- All but 14 institutional encounter data elements, all but nine professional encounter data elements, and all but four pharmacy encounter data elements had a discrepancy rate less than 5.0 percent. This indicates that records which could be matched between the MQD-submitted and the Milliman-submitted data largely contained the same values.

Areas for Improvement

- The record omission and record surplus rates for all encounter types were high. Institutional and professional encounters had the highest record omission rates at 60.6 percent and 57.1 percent, respectively, while pharmacy encounters had a record omission rate of 11.1 percent. Additionally, institutional encounters and professional encounters had the highest record surplus rates at 74.8 percent and 65.0 percent, respectively, while pharmacy encounters had a record surplus rate of 10.7 percent.
- Although matched records largely contained similar values between the MQD-submitted and the Milliman-submitted data, UHC CP QI should ensure the following data elements have accurate values:
  - Institutional encounters: Detail First Date of Service, Billing Provider NPI, Billing Provider Type, Servicing Provider NPI, Servicing Provider ID, Billed Amount, Coinsurance Amount, Admission Diagnosis Code, All Secondary Diagnosis Codes, All Surgical Procedure Codes, Units of Service, Discharge Date, Occurrence Span Codes, and All Secondary POA Codes.
  - Professional encounters: Detail First Date of Service, Billing Provider NPI, Billing Provider Type, Servicing Provider ID, Coinsurance Amount, All Secondary Diagnosis Codes, Units of Service, Admission Date, and Discharge Date.

– Pharmacy encounters: Billed Amount, Dispensing Fee, New or Refill Flag, and Number of Refills.

Recommendations

- UHC CP QI should review and work on the action items noted in the data discrepancy report.
- UHC CP QI should utilize the three-year encounter file that MQD will provide monthly to ensure the data it submits to HPMMIS are processed and submitted correctly. UHC CP QI should review any discrepancies within the file with MQD to reconcile any differences.
- UHC CP QI should continue to work with MQD and Milliman to ensure data submitted to HPMMIS in CY 2025 accurately reflect data needed for the CY 2026 rate setting activities.

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

As a result of the 2022 compliance review, UHC CP QI had four corrective action items to address, which were successfully completed in 2023. UHC CP QI was found to be 100 percent compliant with all standards during the 2023 compliance review and did not have any corrective action items in 2024.

The results of the NAV activities revealed that UHC CP QI had well-defined processes and procedures in place to ensure efficient and accurate collection of member and provider data to support network adequacy calculation and reporting. UHC CP QI demonstrated efforts to identify gaps in provider networks throughout its service areas and identify ways to improve the accessibility and timeliness of care for members.

Over two-thirds (69.7 percent) of UHC CP QI's measure rates fell below the 50th percentile, with almost half (43.93 percent) of the measure rates falling below the 25th percentile. While some measures showed improvement from MY 2022, UHC CP QI's performance demonstrated the need to improve process and outcome measures across most domains. UHC CP QI should address performance in the Children's Preventive Health and Women's Health domains. Overall, 19 MQD Quality Strategy targets were met in MY 2023.

UHC CP QI's CAHPS results illustrate opportunities for improvement in members' satisfaction. While none of the measures scored statistically significantly lower in 2024 than in 2022 and none of the measures scored statistically significantly lower than the 2023 NCQA adult Medicaid national averages, the following eight measures were below the 50th percentiles: *Rating of Health Plan*, *Rating of Personal Doctor*, *Getting Needed Care*, *Getting Care Quickly*, *Customer Service*, *Advising Smokers and Tobacco Users to Quit*, *Discussing Cessation Medications*, and *Discussing Cessation Strategies*. 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 four of the nine measures MQD selected for monitoring within its Quality Strategy met or exceeded the RY 2024 target, KFHP QI should focus improvement efforts on the *Getting Needed Care* and *Customer Service* measures, which fell below the 25th percentile.

UHC CP QI's HCBS CAHPS Survey results illustrate positive performance and opportunities for improvement in members' experience. While none of the measures scored statistically significantly lower than the 2023 scores or the Hawaii HCBS Program, the following measures scored statistically significantly lower than AHRQ's 2024 CAHPS Database benchmark: *Staff Listen and Communicate Well*, *Choosing the Services that Matter to You*, *Transportation to Medical Appointments*, and *Personal Safety and Respect*, indicating a need for UHC CP QI to implement strategies to ensure members have access to high-quality care.

The EDV activities revealed that UHC CP QI should improve its encounter data completeness for institutional, professional, and pharmacy encounters, since both the record omission and record surplus rates for each encounter type were above 5.0 percent (i.e., relatively poor performance). In addition, although matched records largely contained similar values between the MQD-submitted and the Milliman-submitted data, UHC CP QI had at least one data element for each encounter type that it should work on to improve its accuracy. Submitting accurate and complete encounter data assists MQD in monitoring issues concerning quality of care and access to care, as well as setting up proper capitation rates starting in CY 2026 with CY 2025 data.

UHC CP QI progressed to the Outcomes stage of the two PIPs initiated in CY 2022 and the Design stage for the new PIP initiated in CY 2024. 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 *High Confidence* validation rating for both overall confidence in adherence to acceptable methodology for all phases of the PIP and overall confidence that the PIP achieved significant improvement. The reported data were accurate, and the health plan achieved statistically significant improvement over the baseline during the Remeasurement 2 period for both performance indicators.

For the *Plan All-Cause Readmissions* PIP, UHC CP QI received an overall *High Confidence* validation rating for overall confidence in adherence to acceptable methodology for all phases of the PIP and a *Moderate Confidence* validation rating for overall confidence that the PIP achieved significant improvement. The documented PIP design and data were accurate. The health plan conducted appropriate QI processes to identify barriers, and it deployed interventions that were logically linked to

the identified barriers. The health plan demonstrated a statistically nonsignificant improvement in performance with a decrease in the observed readmission rate.

For the *Screening for Depression and Follow-Up Plan* PIP, UHC CP QI received a *High Confidence* level rating for adherence to acceptable methodology for the PIP design. The health plan designed a scientifically sound project that was supported by using key research principles.

‘Ohana Community Care Services (‘Ohana CCS) Results

Compliance Monitoring Review

The 2024 compliance monitoring review activity included follow-up reviews of the health plans' required corrective actions implemented to address deficiencies noted during the 2022 and 2023 reviews.

Findings

Table 3-146 presents the scores from HSAG's 2022 and 2023 compliance reviews, the number of CAPs required, the number of CAPs closed, and the results of the 2024 follow-up reviews of ‘Ohana CCS.

Table 3-146—Standards, Compliance Scores, and CAPs—‘Ohana CCS

Standard Name	Standard Review Year	Compliance Review Score	# of CAPs Required	# of CAPs Closed	2024 Final Follow-Up Review Score
Assurances of Adequate Capacity and Services	2022	100%	0	NA	**100%**
Availability of Services	2022	96%	1	1	**100%**
Confidentiality	2022	100%	0	NA	**100%**
Coordination and Continuity of Care	2022	100%	0	NA	**100%**
Coverage and Authorization of Services	2022	93%	4	4	**100%**
Credentialing	2023	99%	1	1	**100%**
Enrollee Information	2022	86%	4	4	**100%**
Enrollee Rights and Protections	2022	93%	1	1	**100%**
Enrollment and Disenrollment	2023	100%	0	NA	**100%**
Grievance and Appeal System	2022	100%	0	NA	**100%**
Health Information Systems	2023	100%	0	NA	**100%**
Provider Selection	2023	100%	0	NA	**100%**
Practice Guidelines	2023	100%	0	NA	**100%**
Quality Assessment and Performance Improvement	2023	100%	0	NA	**100%**
Subcontractual Relationships and Delegation	2023	100%	0	NA	**100%**
Totals			**11**	**11**	**100%**
NA = Not Applicable. Reevaluation was not necessary as the health plan achieved 100% for the standard.					

Strengths

The 2022 compliance review revealed that ‘Ohana CCS had deficiencies in four of the eight standards reviewed. During 2023 and 2024, ‘Ohana CCS completed 11 corrective action items to bring them into

full compliance. To address the Availability of Services standard deficiency, ‘Ohana CCS updated the provider manual to ensure timely access standards were accurate. To address the Coverage and Authorization of Services standard deficiencies, ‘Ohana CCS updated its policies, procedures, and templates to ensure that they accurately reflect State and federal Medicaid managed care regulations and ensure that authorizations were made within required time frames. To address deficiencies in the Enrollee Information and Enrollee Rights and Protections standards, ‘Ohana CCS updated its policies and procedures, member handbook, and provider directory to ensure accessibility standards were met and that they included all required information.

‘Ohana CCS performed well during the 2023 compliance review, with only one corrective action item to be completed in 2024. To address the Credentialing standard deficiency, HSAG conducted follow-up file reviews on a sample of organizational provider credentialing and recredentialing files. HSAG found that all files were fully compliant with the verification of licensing requirements, accreditation status, and exclusions.

Areas for Improvement

As a result of its CAP interventions, ‘Ohana CCS was found to be fully compliant with all standards and had no continuing corrective actions.

Recommendations

HSAG recommends that ‘Ohana CCS review the revised Medicaid managed care rules released in 2024 and implement operational changes, as applicable, to ensure continued compliance.

Validation of Performance Measures—NCQA HEDIS Compliance Audits

NCQA HEDIS Compliance Audit Findings

HSAG’s review team assessed ‘Ohana CCS’ IS capabilities and its ability to process data for reporting accurate performance measure rates. ‘Ohana CCS was fully compliant with all HEDIS IS standards. This demonstrated that ‘Ohana CCS had effective IS processes and control procedures in place for reporting the required performance measure rates. ‘Ohana CCS presented 18 supplemental data sources for consideration to use for supplementing its MY 2023 performance measure rates. HSAG determined 11 data sources to be nonstandard supplemental data, and the remaining seven were determined to be standard supplemental data. ‘Ohana CCS withdrew three of the 18 supplemental data sources, leaving eight standard data sources and seven nonstandard data sources. No concerns were identified, and the eight standard and seven nonstandard data sources were approved for HEDIS MY 2023 reporting.

‘Ohana CCS was only required to report administrative measures; therefore, MRRV did not apply to the scope of the audit. All measures under the scope of the audit were determined to be *Reportable*. Since ‘Ohana CCS was determined to be fully compliant with all IS standards, HSAG did not have any recommendations.

Access and Risk-Adjusted Utilization Performance Measure Results

Table 3-147—'Ohana CCS' Results for QI Measures Under Access and Risk-Adjusted Utilization

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Ambulatory Care				
Emergency Department Visits	596.36	528.14	-11.44%	★★★
Outpatient Visits	2,657.62	2,130.75	-19.82%	★

MY 2023 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*

'Ohana CCS' Access and Risk-Adjusted Utilization performance measure results are shown in Table 3-147. The *Ambulatory Care—Emergency Department Visits* rate ranked at or above the 50th percentile when compared to the national benchmark.

Behavioral Health Performance Measure Results

'Ohana CCS' Behavioral Health performance measure results are shown in Table 3-148.

Table 3-148—'Ohana CCS' Results for QI Measures Under Behavioral Health

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	67.28%	65.64%	-2.44%	★★★
Antidepressant Medication Management				
Effective Acute Phase Treatment—Total	58.87%	57.03%	-3.14%	★★
Effective Continuation Phase Treatment—Total	46.75%	36.95%	-20.97%	★
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	73.03%	65.86%	-9.82%	★★★★★
7-Day Follow-Up—65 Years and Older	60.61%	NA	—	NC
7-Day Follow-Up—Total	72.07%	65.13%	-9.63%	★★★★★
30-Day Follow-Up—6–17 Years	NA	NA	—	NC
30-Day Follow-Up—18–64 Years	90.08%	83.54%	-7.26%	★★★★★
30-Day Follow-Up—65 Years and Older	87.88%	NA	—	NC
30-Day Follow-Up—Total	89.91%	83.14%	-7.52%	★★★★★

Measure	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Relative Difference	MY 2023 Performance Level
Follow-Up After Emergency Department Visit for Substance Use				
7-Day Follow-Up—13–17 Years	NA	NA	—	NC
7-Day Follow-Up—18 Years and Older	42.46%	54.29%	27.86%	★★★★★
7-Day Follow-Up—Total	42.46%	54.29%	27.86%	★★★★★
30-Day Follow-Up—13–17 Years	NA	NA	—	NC
30-Day Follow-Up—18 Years and Older	68.16%	77.86%	14.23%	★★★★★
30-Day Follow-Up—Total	68.16%	77.86%	14.23%	★★★★★
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation—13–17 Years	NA	NA	—	NC
Initiation—18–64 Years	29.53%	32.10%	8.70%	★
Initiation—-65 Years and Older	35.82%	25.00%	-30.21%	★
Initiation—Total	30.38%	31.35%	3.17%	★
Engagement—13–17 Years	NA	NA	—	NC
Engagement—18–64 Years	6.28%	11.60%	84.79%	★★
Engagement—65 Years and Older	1.49%	12.50%	738.93%	★★★★★
Engagement—Total	5.63%	11.70%	107.67%	★★

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by 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 health 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 2023 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*

Nine of the measure rates ranked at or above the 90th percentile. Conversely, seven measure rates ranked below the 50th percentile.

'Ohana CCS met the MQD-established Quality Strategy target for *Follow-Up After Emergency Department for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total, Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total,* and *Initiation and Engagement of Substance Use Disorder Treatment—Engagement—Total.* All other MQD Quality Strategy targets were not met for this domain.

Strengths

Based on HSAG's analyses of the 19 'Ohana CCS measure rates with comparable benchmarks, 11 of these measure rates (57.89 percent) ranked at or above the 50th percentile. Nine of the 19 measure rates

(47.37 percent) met or exceeded the 90th percentile. ‘Ohana CCS met five MQD Quality Strategy targets for MY 2023.

Areas for Improvement

Seven measure rates (36.84 percent) fell below the 50th percentile, suggesting opportunities for improvement.

Recommendations

HSAG recommends that ‘Ohana CCS focus on improving performance related to the following measures:

- Within the Behavioral Health domain, the following recommendations were identified:
  - Regarding the *Antidepressant Medication Management* measure, HSAG recommends that ‘Ohana CCS consider clinical recommendations shown to improve adherence to antidepressants, such as assessing depressive symptoms at baseline and each follow-up, as well as providing psychoeducation to members and their families.[89]
  - Regarding the *Initiation and Engagement of Substance Use Disorder Treatment* measure, HSAG recommends that ‘Ohana CCS review patient data for any patterns present by ZIP Code and other demographics for case management prioritization. For instance, one study suggests that members who are male and have a schizophrenia spectrum disorder diagnosis are less likely to initiate treatment, while current drug dependence and recent arrest were associated with lowered odds of engaging in treatment. Current drug dependence is associated with factors that make scheduling and attending treatment appointments difficult, such as severe symptoms, chaotic living situations, and self-care and life functioning issues.[90]

Validation of Network Adequacy

HSAG evaluated and assessed the data methods that ‘Ohana CCS used to calculate results generated for each network adequacy indicator in the scope of the 2024 NAV activities. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG’s overall confidence that `Ohana CCS used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator.

[89] Solmi M, Miola A, Croatto G, et al. How can we improve antidepressant adherence in the management of depression? A targeted review and 10 clinical recommendations. *Brazilian Journal of Psychiatry*. 2021;43(2):189–202.

[90] Brown CH, Bennett ME, Li L, Bellack AS. Predictors of initiation and engagement in substance abuse treatment among individuals with co-occurring serious mental illness and substance use disorders. *Addictive Behaviors.* 2010;36(5):439-47.

Findings

Based on the results of the ISCA combined with the virtual audit and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the health plan's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each health plan according to Table 3-149.

Table 3-149—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*
10.0% to 49.9%	*Low Confidence*
Less than 10% and/or any *Not Met* element has significant bias on the results	*No Confidence*

No indicators were designated as *Low Confidence* or *No Confidence* for ‘Ohana CCS.

Analysis and Conclusions

HSAG determined that ‘Ohana CCS was not compliant with network adequacy requirements for the Access and Availability standard. MQD required at least 80 percent of members for the Behavioral Health indicators to be provided an appointment within the designated time frame. Compliance was determined based on the health plan meeting the State's Access and Availability indicators. All indicators were calculated by MQD. Results are presented by provider type in Table 3-150.

Table 3-150—‘Ohana CCS Network Adequacy Access and Availability Compliance

Provider Type	Compliance
Behavioral Health (Standard)	*Not Met*
Behavioral Health (Urgent)	*Not Met*

HSAG determined that ‘Ohana CCS was compliant with a subset of network adequacy requirements for the Mandatory Provider Types indicators. Compliance was determined based on the health plan meeting the State's Mandatory Provider Type indicators, which includes one servicing provider within each provider type. All indicators were calculated by MQD. Results are presented by provider type in Table 3-151, and noncompliant results are presented in Table 3-152.

Table 3-151—‘Ohana CCS Network Adequacy Mandatory Provider Types Compliance

Provider Type	Compliance
Behavioral Healthcare Specialist services as provided by Psychiatrists, Psychologists, Social Workers, CSACs, and Advanced Practice Nurses trained in psychology	*Met*
Case Management	*Met*
SUD Services	*Met*
Pharmacies	*Met*
Laboratory Services	*Met*
Representative Payee	*Met*

Table 3-152—‘Ohana CCS Network Adequacy Mandatory Provider Types Noncompliance

Provider Type	Compliance
Crisis Services: Mobile Crisis Response, Crisis Residential Services	*Not Met*
Day Treatment Programs	*Not Met*
Interpretation Services	*Not Met*
Mental Health Rehabilitation Services	*Not Met*
PSR/Clubhouse	*Not Met*
Supported Employment	*Not Met*

During the NAV review period, HSAG determined that the Access and Availability provider types in Table 3-153 were not required by MQD, resulting in an *Unable to Validate* designation for each associated indicator.

Table 3-153—‘Ohana CCS Network Adequacy Mandatory Provider Types *Unable to Validate* Indicators

Provider Type
Inpatient Behavioral Health Hospital Services
Outpatient Behavioral Health Hospital Services
CIS
Peer Specialist

HSAG determined that ‘Ohana CCS was compliant with a subset of network adequacy requirements for the Time and Distance indicators. MQD required at least 85 percent of members to have access to the providers within the associated time or distance parameters. Compliance was determined based on the health plan meeting the State’s Time and Distance indicators for both Urban and Rural classifications. All indicators were calculated by MQD. Results are presented by provider type and urbanicity in Table 3-154, and noncompliant results are presented in Table 3-155.

Table 3-154—'Ohana CCS Network Adequacy Time and Distance ≥85% Compliance by Urbanicity

Provider Type	Urbanicity	Compliance
Hospitals	Urban	*Met*
	Rural	*Met*
Mental Health Providers	Urban	*Met*
	Rural	*Met*
Pharmacies	Urban	*Met*
	Rural	*Met*

Table 3-155—'Ohana CCS Network Adequacy Time and Distance < 85% Noncompliance by Urbanicity

Provider Type	Urbanicity	Compliance
24-Hour Pharmacy	Rural	*Not Met*

During the NAV review period, HSAG determined that the Access and Availability indicators in Table 3-156 were not required by MQD, resulting in an *Unable to Validate* designation for each associated indicator.

Table 3-156—'Ohana CCS Network Adequacy Time and Distance *Unable to Validate* Indicators

Provider Type	Urbanicity	Indicator
Emergency Services Facilities	Urban	Within 30 minute driving time
	Rural	Within 60 minute driving time

Strengths

HSAG identified the following strengths related to NAV for 'Ohana CCS:

- 'Ohana CCS demonstrated the ability to maintain accurate and complete member data through the use of a data file matching process of the 834 file to identify existing members within the system, automated reports to identify missing and incomplete data, and systems capabilities to update demographic information collected through various member-level interactions more current than what is provided through the 834 file.
- 'Ohana CCS maintained detailed process documentation for creation of the network adequacy report by extracting robust data and cleaning processes to ensure business continuity of the network adequacy reporting process.

Areas for Improvement

No specific opportunities were identified related to the data collection and management processes 'Ohana CCS had in place to inform network adequacy standard and indicator calculations.

Recommendations

While HSAG had no recommendations related to 'Ohana CCS' processes for producing the network adequacy results, HSAG recommends that 'Ohana CCS continue to monitor and address any gaps in its provider network.

Validation of Performance Improvement Projects

In CY 2024, 'Ohana CCS continued two PIPs—*Behavioral Health Coordination* and *7-Day Follow-up After Emergency Department Visit for Mental Illness*. For the CY 2024 submission, the health plan progressed to the Outcomes stage of the PIPs and submitted Steps 1 through 8 in the PIP Submission Form. The PIPs were assessed for improvement in outcomes in Step 9.

Table 3-157 displays the topics, progression status, and measurement periods reported for the PIPs.

Table 3-157—CY 2024 'Ohana CCS PIP Topics and Status

PIP Topic	PIP Progression Status	Baseline Measurement Period	Measurement Period Reported in CY 2024
Behavioral Health Coordination	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	07/01/2021 to 09/30/2021	07/01/2023 to 09/30/2023 (Remeasurement 2)
7-Day Follow-up After Emergency Department Visit for Mental Illness	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	CY 2021	CY 2023 (Remeasurement 2)

The focus of the nonclinical *Behavioral Health Coordination* PIP is to integrate care between DOH Behavioral Health Services Administration divisions, 'Ohana 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 SMI and SPMI, developmental disabilities, and other chronic issues. The methodology for this PIP was defined by 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.

Findings

Table 3-158 illustrates the validation results for the two PIPs submitted by 'Ohana CCS for CY 2024 validation.

Table 3-158—CY 2024 PIP Validation Results for 'Ohana CCS

PIP Topic	Validation Rating 1			Validation Rating 2		
	Overall Confidence in Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Behavioral Health Coordination	100%	100%	*High Confidence*	100%	100%	*High Confidence*
7-Day Follow-up After Emergency Department Visit for Mental Illness	100%	100%	*High Confidence*	33%	100%	*No Confidence*

[1] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) 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] **Confidence Level**— Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

The *Behavioral Health Coordination* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *High Confidence* level rating that the PIP achieved significant improvement.

The *7-Day Follow-up After Emergency Department Visit for Mental Illness* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *No Confidence* level rating that the PIP achieved significant improvement.

Design (Steps 1-6)

Behavioral Health Coordination

'Ohana CCS met 100 percent of the evaluation elements in the Design stage, Steps 1 through 6. The selected PIP topic was required by MQD. 'Ohana CCS documented the PIP design accurately. 'Ohana CCS' data collection process appeared methodologically sound. The health plan has ongoing monthly meetings with DOH Behavioral Health Services Administration divisions on an as-needed basis; however, at the time of the PIP submission, the health plan was awaiting approval of its formal DSA with the DOH Behavioral Health Services Administration divisions. The DSA was finalized and executed in December 2024 and is effective as of January 1, 2025.

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 MQD, and the health 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.

Implementation (Steps 7-8)

Behavioral Health Coordination

'Ohana CCS accurately reported and analyzed the Remeasurement 2 rates 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. 'Ohana CCS also drafted the DSA with the DOH Behavioral Health Services Administration divisions.

7-Day Follow-up After Emergency Department Visit for Mental Illness

'Ohana CCS accurately reported and analyzed the Remeasurement 2 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. 'Ohana CCS included an evaluation of effectiveness for each intervention and appropriate next steps for the interventions.

Outcomes (Step 9)

Behavioral Health Coordination

During Remeasurement 2, the health plan sustained statistically significant improvement over the baseline in the Performance Indicator 1 rate and documented a rate of 100 percent for Performance Indicator 2.

7-Day Follow-up After Emergency Department Visit for Mental Illness

During Remeasurement 2, the health plan did not achieve any improvement and had a statistically nonsignificant decline in the Remeasurement 2 rate compared to the baseline.

Analysis of Results

Table 3-159 displays the data that the health plan reported for the *Behavioral Health Coordination* PIP.

Table 3-159—Outcomes for the *Behavioral Health Coordination* PIP

Performance Indicator	Baseline (07/01/2021–09/30/2021)		Remeasurement 1 (07/01/2022–09/30/2022)		Remeasurement 2 (07/01/2023–09/30/2023)		Sustained Improvement
1. Percent of shared members with eligible trigger events who received a combined review in the past three months.	N: 4	3.0%	N: 17	11.8%*	N: 82	25.2%*	*Yes*
	D: 132		D: 144		D: 326		
2. Percent of shared members whose data are actively shared at a regular frequency with partner agencies.	N: 4,558	100%	N: 4,764	100%	N: 5,560	100%	*Not Applicable*
	D: 4,558		D: 4,764		D: 5,560		

*Rate demonstrates statistically significant improvement over the baseline rate.
N–Numerator D–Denominator
HSAG rounded percentages to the first decimal place.

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 3.0 percent, and for Remeasurement 1, the Performance Indicator 1 rate increased to 11.8 percent. For Remeasurement 2, the rate was 25.2 percent, which represents a statistically significant increase of 22.2 percentage points over the baseline. The health plan sustained improvement during Remeasurement 2. Only formal reviews were included in the baseline data. Due to enhanced data-capturing capability to capture informal combined reviews during the remeasurement periods compared to the baseline, the improvement in Performance Indicator 1 rate should be interpreted with caution.

The rate for the percentage of shared members whose data were actively shared with the partner agencies during the baseline measurement period was 100 percent. The health plan documented that it sends enrollment files of all shared members to all health plans on a regular basis. The enrollment files include information useful for behavioral health coordination such as the community-based case management (CBCM) agency to which members are assigned and each member's acuity level. Additionally, the health plan documented that no data were being sent to DOH agencies unless meetings were held between CCS and the DOH agencies, and data regarding a member were exchanged at the time of the meeting from both parties. For Remeasurement 1 and Remeasurement 2, the Performance Indicator 2 rate remained at 100 percent, and the data-sharing process was the same as during the baseline.

Table 3-160 displays the data that the health plan reported for the *7-Day Follow-up After Emergency Department Visit for Mental Illness* PIP.

Table 3-160—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 (01/01/2022–12/31/2022)		Remeasurement 2 (01/01/2023–12/31/2023)		Sustained Improvement
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	69.9%	N: 307	72.1%	N: 282	65.1%	
	D: 452		D: 426		D: 433		

N–Numerator D–Denominator
HSAG rounded percentages to the first decimal place.

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, and for Remeasurement 1, the rate increased to 72.1 percent. During Remeasurement 2, the rate was 65.1 percent, which represents a statistically nonsignificant decline of 4.8 percentage points compared to the baseline rate.

Barriers/Interventions

Table 3-161 displays the barriers and interventions as documented by the health plan for both PIPs.

Table 3-161—Interventions Implemented/Planned for 'Ohana CCS PIPs

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. Drafted DSA with the DOH agencies. DSA is being reviewed by the DOH agencies.* 2. Having a workgroup with partnering agencies that meets at least on a quarterly basis.* 3. Developed a workflow for ongoing communication with the health plans.*
7-Day Follow-up After Emergency Department Visit for Mental Illness	
1. 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. 2. Members do not identify their case manager.	1. Educated ED facility at the Queens Medical Center that was 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 established rapport to work toward the common goal of ED utilization reduction. (Discontinued) 2. Queens ED facility provides ED census directly to the 'Ohana CCS team to identify all members who were at the ED the day prior (Medicaid and CCS members). The CCS

Barriers	Interventions
	team then informs the case management agencies to have them reach out to the members to encourage the members to complete the follow-up visits within seven days post ED visit for mental illness. This intervention is being expanded to Straub's ED facility.

* The documented interventions are required by MQD.

Strengths

- For both PIPs, 'Ohana CCS received an overall *High Confidence* validation rating for overall confidence to acceptable methodology for all phases of the PIP for Steps 1 through 8. The *Behavioral Health Coordination* PIP also achieved a *High Confidence* validation rating for overall confidence that the PIP achieved significant improvement.
- For the *Behavioral Health Coordination* PIP, during Remeasurement 2, the health plan sustained statistically significant improvement over the baseline in the Performance Indicator 1 rate and documented a rate of 100 percent for Performance Indicator 2 for the baseline and the remeasurement periods.

Areas for Improvement

For the *7-Day Follow-up After Emergency Department Visit for Mental Illness* PIP, the health plan did not achieve any improvement over the baseline.

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.
- The health plan should consider the use of quality improvement science-based tools, such as process mapping with FMEA, for causal/barrier analysis.
- The health plan must evaluate each intervention listed in the barriers/interventions table for effectiveness.
- The health plan should collect the intervention effectiveness data more frequently (e.g., monthly or quarterly), unlike the annual performance indicator data. This would help 'Ohana CCS understand intervention effectiveness and make any updates to the interventions in a timely manner to impact remeasurement outcomes.
- Intervention effectiveness data must guide next steps for each individual intervention.

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 follow-up on compliance monitoring review findings and NAV activities indicated that ‘Ohana CCS continued to improve its operational foundation to support the quality, accessibility, and timeliness of care and service delivery, performance on outcome and process measures showed some room for improvement.

As a result of the 2022 and 2023 compliance reviews, ‘Ohana CCS had 11 corrective action items to address during 2023 and 2024. ‘Ohana CCS took the necessary steps to plan interventions; update policies, procedures, and member and provider information; and make operational changes to address the deficiencies found. As a result of its CAP interventions, ‘Ohana CCS was found to be fully compliant with all standards during 2024.

The results of the NAV activities revealed that ‘Ohana CCS had well-defined processes and procedures in place to ensure efficient and accurate collection of member and provider data to support network adequacy calculation and reporting. ‘Ohana CCS demonstrated efforts to identify gaps in provider networks throughout its service areas and identify ways to improve the accessibility and timeliness of care for members.

Overall, more than half (57.89 percent) of ‘Ohana CCS’ measure rates ranked at or above the 50th percentile, with seven measure rates (36.84 percent) falling below the 50th percentile. ‘Ohana CCS should address performance in the Behavioral Health domain, specifically the *Antidepressant Medication Management* and *Initiation and Engagement of Substance Use Disorder Treatment* performance measures. Overall, five MQD Quality Strategy targets were met in MY 2023.

‘Ohana CCS progressed to the Outcomes stage of the two PIPs initiated in CY 2024. 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 *High Confidence* validation rating in both overall confidence in adherence to acceptable methodology for all phases of the PIP and overall confidence that the PIP achieved significant improvement. The health plan documented sustained statistically significant improvement over the baseline in the Performance Indicator 1 rate and documented a rate of 100 percent for Performance Indicator 2 for the baseline and the remeasurement periods.

For the *7-Day Follow-up After Emergency Department Visit for Mental Illness* PIP, ‘Ohana CCS received an overall *High Confidence* validation rating for overall confidence in adherence to acceptable methodology for all phases of the PIP and a *No Confidence* validation rating for overall confidence that the PIP achieved significant improvement. The health plan conducted appropriate quality improvement

processes to identify barriers, and it deployed interventions that were logically linked to the identified barriers. During Remeasurement 2, the health plan did not achieve any improvement over the baseline.

4. Comparative Analysis of Health Plan Performance

Introduction

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

Compliance Monitoring Review

Table 4-1 provides information that can be used to compare all Hawaii Medicaid managed care health plans' performance on implementing CAPs required to resolve deficiencies for each of the compliance standard areas reviewed in 2022 and 2023.

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

Standard Name	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI	'Ohana CCS	Total # CAPs per Standard
Assurances of Adequate Capacity and Services	NA	NA	3	NA	NA	NA	**3**
Availability of Services	NA	NA	2	1	NA	1	**4**
Confidentiality	NA	NA	NA	NA	NA	NA	**0**
Coordination and Continuity of Care	2	1	1	2	NA	NA	**6**
Coverage and Authorization of Services	4	1	NA	7	NA	4	**16**
Credentialing	2	1	NA	1	NA	1	**5**
Enrollee Information	4	4	2	4	2	4	**20**
Enrollee Rights and Protections	1	NA	1	1	1	1	**5**
Enrollment and Disenrollment	NA	NA	NA	NA	NA	NA	**0**
Grievance and Appeal System	2	5	1	NA	1	NA	**9**
Health Information Systems	NA	NA	NA	NA	NA	NA	**0**
Provider Selection	NA	NA	NA	NA	NA	NA	**0**
Practice Guidelines	NA	NA	NA	NA	NA	NA	**0**
Quality Assessment and Performance Improvement	NA	NA	NA	NA	NA	NA	**0**
Subcontractual Relationships and Delegation	NA	1	1	NA	NA	NA	**2**
Total # CAPs and Resolved CAPs by Health Plan:	**15/15**	**13/13**	**11/11**	**16/16**	**4/4**	**11/11**	**70/70**

Numerator = # of CAPs "closed" and found compliant during follow-up review.
Denominator = Total # of CAPs required for the standard following the 2022 or 2023 compliance review.
NA = Not Applicable. Reevaluation was not necessary as the health plan achieved 100 percent for the standard.

Across all six health plans, performance was strongest in the areas of Confidentiality, Enrollment and Disenrollment, Health Information Systems, Provider Selection, Practice Guidelines, and Quality Assessment and Performance Improvement during the 2022 and 2023 compliance reviews, with no corrective actions required.

The Enrollee Information standard had the most individual elements requiring CAPs (20), followed by the Coverage and Authorization of Services standard with 16 elements requiring CAPs, and Grievance and Appeal System with nine elements requiring CAPs. 'Ohana QI had the most individual elements requiring correction. UHC CP QI had the fewest standard areas and individual elements requiring CAPs.

As a result of the CAP interventions, all health plans were found to be fully compliant with all standards in 2024 and had no continuing corrective actions.

Validation of Performance Measures—HEDIS Compliance Audits

NCQA HEDIS Compliance Audits

Table 4-2 compares each QI health plan's compliance with NCQA's HEDIS IS standards reviewed during the MY 2023 NCQA HEDIS Compliance Audit.

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

IS Standard	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
IS A—Administrative Data	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*
IS M—Medical Record Review Processes	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*
IS C—Clinical and Care Delivery Data	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*
IS R—Data Management and Reporting	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*
IS L—Case Management Data	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*

HEDIS Performance Measure Results

This section of the report highlights the health plans' performance for the current MY by domain of care. Each table illustrates the health plans' MY 2023 measure rates and their performance relative to NCQA's 2023 Quality Compass national Medicaid HMO percentiles for HEDIS MY 2022, 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 4-3 displays the Access and Risk-Adjusted Utilization measure rates for each QI health plan.

Table 4-3—MY 2023 Comparison of Access and Risk-Adjusted Utilization Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	‘Ohana QI	UHC CP QI
Adults' Access to Preventive/Ambulatory Health Services					
20–44 Years	52.19% ★	63.48% ★	58.57% ★	48.95% ★	47.57% ★
45–64 Years	66.29% ★	76.15% ★★	73.25% ★	68.40% ★	70.31% ★
65 Years and Older	73.73% ★★	76.29% ★★	83.76% ★★★	80.72% ★★★	90.84% ★★★★
Total	58.72% ★	68.54% ★★	65.75% ★	60.70% ★	69.40% ★★
Ambulatory Care					
Emergency Department Visits	467.74 ★★★★	414.98 ★★★★	384.74 ★★★★★	560.91 ★★★	512.98 ★★★
Outpatient Visits	2,890.18 ★	3,296.57 ★★	3,059.61 ★	4,097.03 ★★★	4,945.09 ★★★★
Asthma in Younger Adults Admission Rate*					
*Asthma in Younger Adults Admission Rate**	2.95 —	2.53 —	2.75 —	2.71 —	3.12 —
Heart Failure Admission Rate*					
18–64 Years	41.39 —	27.92 —	29.19 —	72.61 —	52.86 —
65 Years and Older	117.25 —	73.79 —	116.61 —	196.03 —	123.13 —
Total (18 Years and Older)	48.63 —	31.40 —	37.26 —	91.17 —	76.08 —
Plan All-Cause Readmissions					
*Index Total Stays—Observed Readmissions—Total**	7.39% —	7.91% —	7.45% —	10.56% —	10.35% —

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Expected Readmissions—Total	9.87% —	9.68% —	9.69% —	11.89% —	11.13% —
*Index Total Stays—O/E Ratio—Total**	0.7485 —	0.8173 —	0.7690 —	0.8885 —	0.9297 —

Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by 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.
MY 2023 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*

Within the Access and Risk-Adjusted Utilization performance measure domain, four of five QI health plans (AlohaCare QI, HMSA QI, KFHP QI, and 'Ohana QI) met MQD's established target for *Plan All-Cause Readmissions—Index Total Stays—O/E Ratio—Total* rate. Two health plans (HMSA QI and KFHP QI) met MQD's established target for *Heart Failure Admission Rate—Total (18 Years and Older)*.

Adults' Access to Preventive/Ambulatory Health Services—65 Years and Older ranked at or above the 50th percentile for three plans. *Ambulatory Care—Emergency Department Visits* ranked at or above the 50th percentile for all five health plans, and *Ambulatory Care—Outpatient Visits* ranked at or above the 50th percentile for two health plans. All other measure indicators in this domain did not meet or exceed the 50th percentile or did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented.

Children's Preventive Health

Table 4-4 displays the Children's Preventive Health measure rates for each health plan compared to the national Medicaid percentiles.

Table 4-4—MY 2023 Comparison of Children's Preventive Health Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Child and Adolescent Well-Care Visits					
Child and Adolescent Well-Care Visits	42.51% ★	55.29% ★★★★	42.94% ★	36.67% ★	41.80% ★
Childhood Immunization Status					
Combination 3	44.04% ★	63.75% ★★	68.65% ★★★	36.72% ★	48.91% ★
Combination 7	37.71% ★	54.99% ★★	65.73% ★★★★★	29.25% ★	42.09% ★
Combination 10	25.06% ★★	35.04% ★★★	52.46% ★★★★★	19.70% ★	29.44% ★★

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
DTaP	52.55% ★	67.40% ★★	72.41% ★★★	46.87% ★	52.80% ★
Hepatitis A	67.15% ★	79.08% ★★	82.34% ★★★	66.57% ★	66.18% ★
Hepatitis B	63.75% ★	81.02% ★	86.83% ★★★	60.00% ★	72.51% ★
HiB	67.88% ★	82.00% ★★	82.13% ★★	62.69% ★	70.07% ★
Influenza	38.20% ★★	46.96% ★★★	60.40% ★★★★★	38.81% ★★	40.15% ★★
IPV	69.34% ★	81.51% ★	82.86% ★★	63.58% ★	70.56% ★
MMR	67.88% ★	80.78% ★★	83.80% ★★	67.46% ★	67.40% ★
Pneumococcal Conjugate	51.34% ★	68.61% ★★	69.59% ★★	47.46% ★	52.55% ★
Rotavirus	54.01% ★	66.91% ★★	77.95% ★★★★★	47.16% ★	55.47% ★
VZV	67.64% ★	80.54% ★	83.39% ★★	65.97% ★	66.67% ★
Immunizations for Adolescents					
Combination 1 (Meningococcal, Tdap)	59.85% ★	69.10% ★	73.48% ★★	50.15% ★	51.82% ★
Combination 2 (Meningococcal, Tdap, HPV)	32.12% ★★	40.88% ★★★	52.93% ★★★★★	23.72% ★	28.47% ★
Meningococcal Serogroups A, C, W, Y	61.80% ★	71.53% ★	74.25% ★	54.05% ★	54.74% ★
Tdap	61.56% ★	71.78% ★	75.47% ★	51.95% ★	54.74% ★
HPV	33.33% ★★	43.07% ★★★★	54.25% ★★★★★	25.23% ★	30.90% ★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children and Adolescents					
BMI Percentile Documentation—3–11 Years	83.92% ★★★	86.19% ★★★★	97.34% ★★★★★	84.62% ★★★	90.07% ★★★★
BMI Percentile Documentation—12–17 Years	77.56% ★★	90.91% ★★★★★	95.71% ★★★★★	78.40% ★★★	91.47% ★★★★★
BMI Percentile Documentation—Total	81.51% ★★★	88.01% ★★★★	96.77% ★★★★★	82.73% ★★★	90.51% ★★★★★
Counseling for Nutrition—3–11 Years	75.69% ★★★	79.52% ★★★★	97.72% ★★★★★	72.73% ★★★	62.77% ★★
Counseling for Nutrition—12–17 Years	73.08% ★★★	79.55% ★★★★	97.86% ★★★★★	67.20% ★★	55.81% ★

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Counseling for Nutrition—Total	74.70% ★★★	79.53% ★★★★	97.77% ★★★★★	71.05% ★★★	60.58% ★
Counseling for Physical Activity-3–11 Years	73.33% ★★★	77.14% ★★★★	97.72% ★★★★★	70.98% ★★★	59.93% ★★
Counseling for Physical Activity—12–17 Years	73.72% ★★★	78.03% ★★★★	97.86% ★★★★★	67.20% ★★	61.24% ★★
Counseling for Physical Activity—Total	73.48% ★★★	77.49% ★★★★	97.77% ★★★★★	69.83% ★★★	60.34% ★★
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	56.03% ★★	68.53% ★★★★★	72.10% ★★★★★	58.24% ★★	53.94% ★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	57.47% ★	73.72% ★★★★	80.11% ★★★★★	58.16% ★	54.01% ★

Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by MQD.
MY 2023 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*

Within the Children's Preventive Health performance measure domain, KFHP QI performed best among the health plans, with 21 measure rates ranking at or above the 50th percentile, 17 of which met or exceeded the 90th percentile. UHC CP QI demonstrated the lowest performance among the health plans, with 27 measure indicator rates that could be compared to benchmarks ranking below the 50th percentile, 19 of which were below the 25th percentile.

HMSA QI, KFHP QI, and UHC CP QI met MQD's established target for *Weight Assessment and Counseling for Nutrition/Physical Activity—BMI Percentile Documentation—Total*. HMSA QI and KFHP QI met MQD's established target for *Childhood Immunization Status—Combination 3* and *Combination 7* and for *Immunization for Adolescents—Combination 2.* Finally, HMSA QI and KFHP QI met MQD's established target for both *Well-Child Visits in the First 30 Months of Life* indicators.

Women's Health

Table 4-5 displays the Women's Health measure rates for each health plan compared to the national Medicaid percentiles.

Table 4-5—MY 2023 Comparison of Women's Health Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Cervical Cancer Screening					
Cervical Cancer Screening	47.69% ★	59.55% ★★★	61.12% ★★★	40.63% ★	48.42% ★
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	73.48% ★	82.79% ★★	90.63% ★★★★	66.99% ★	74.21% ★
Postpartum Care	76.64% ★★	78.14% ★★★	85.07% ★★★★★	69.28% ★	76.89% ★★
Prenatal and Postpartum Care: Under 21 Years of Age (Child Core)					
Timeliness of Prenatal Care: Under 21 Years of Age	63.91% —	63.31% —	77.59% —	NA	44.12% —
Postpartum Care: Under 21 Years of Age	65.41% —	60.79% —	75.86% —	NA	67.65% —

Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by MQD.
— Indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.
MY 2023 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*

Within the Women's Health performance measure domain, KFHP QI performed best among the health plans, with three measure rates ranking at or above the 50th percentile, one of which met or exceeded the 90th percentile. 'Ohana QI demonstrated the lowest performance among the health plans, with three measure indicator rates that could be compared to benchmarks ranking below the 50th percentile, all three of which were below the 25th percentile. The *Prenatal and Postpartum Care: Under 21 Years of Age (Child Core)* measure did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented.

Additionally, KFHP QI reached MQD's established targets in this domain for *Cervical Cancer Screening*, *Prenatal and Postpartum Care—Timeliness of Prenatal Care,* and *Postpartum Care*. HMSA QI also reached MQD's established target for *Cervical Cancer Screening.*

Care for Chronic Conditions

Table 4-6 displays the Care for Chronic Conditions measure rates for each health plan compared to the national Medicaid percentiles.

Table 4-6—MY 2023 Comparison of Care for Chronic Conditions Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Asthma Medication Ratio					
5–11 Years	75.00% ★★	55.28% ★	97.04% ★★★★★	NA	NA
12–18 Years	53.49% ★	50.86% ★	100.00% ★★★★★	NA	NA
19–50 Years	48.08% ★	42.04% ★	81.31% ★★★★★	50.77% ★	52.71% ★
51–64 Years	58.89% ★★	49.41% ★	90.91% ★★★★★	41.82% ★	57.89% ★★
Total (5–64 Years)	54.07% ★	46.97% ★	89.67% ★★★★★	44.36% ★	54.46% ★
Total Child Core Set (5–18 Years)	63.86% —	53.43% —	97.95% —	23.08% —	40.91% —
Total Adult Core Set (19–64 Years)	51.34% —	44.56% —	85.15% —	46.67% —	55.52% —
Blood Pressure Control for Patients With Diabetes					
Blood Pressure Control for Patients With Diabetes	54.74% ★	64.06% ★★★	76.32% ★★★★★	57.91% ★	69.59% ★★★
Concurrent Use of Opioids and Benzodiazepines*					
18–64 Years	10.84% —	13.65% —	6.45% —	16.51% —	13.99% —
65 Years and Older	7.58% —	9.29% —	7.92% —	21.30% —	13.59% —
Total (18 Years and Older)	10.35% —	13.32% —	6.77% —	17.66% —	13.80% —
Controlling High Blood Pressure					
18–64 Years	49.49% —	58.64% —	71.43% —	56.72% —	60.87% —
65–85 Years	49.14% —	62.96% —	78.13% —	56.64% —	71.06% —
Total	49.39% ★	59.51% ★★	73.68% ★★★★★	56.69% ★★	67.64% ★★★★
Eye Exam for Patients With Diabetes					
Eye Exam for Patients With Diabetes	54.74% ★★★	59.41% ★★★★	71.16% ★★★★★	57.18% ★★★	63.99% ★★★★★
Hemoglobin A1c Control for Patients With Diabetes					
HbA1c Control (<8.0%)—18–64 Years	40.80% —	53.58% —	55.21% —	54.41% —	59.01% —
HbA1c Control (<8.0%)—65–75 Years	56.47% —	66.67% —	70.07% —	59.76% —	74.07% —

Measure	AlohaCare QI	HMSA QI	KFHP QI	‘Ohana QI	UHC CP QI
HbA1c Control (<8.0%)—Total	44.04% ★	55.50% ★★★	58.02% ★★★★	55.47% ★★★	65.94% ★★★★★
*HbA1c Poor Control (>9.0%)—18–64 Years**	50.31% —	38.40% —	33.35% —	35.26% —	29.73% —
*HbA1c Poor Control (>9.0%)—65–75 Years**	36.47% —	25.00% —	20.62% —	34.15% —	15.87% —
*HbA1c Poor Control (>9.0%)—Total**	47.45% ★	36.43% ★★★	30.94% ★★★★	35.04% ★★★	23.36% ★★★★★

Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by MQD.
— Indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.
** A lower rate indicates better performance.*
MY 2023 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*

Within the Care for Chronic Conditions performance measure domain, KFHP QI performed the best among the health plans, with 10 measure rates ranking at or above the 75th percentile and eight of which met or exceeded the 90th percentile. AlohaCare QI demonstrated the lowest performance among the health plans, with nine measure indicator rates that could be compared to benchmarks ranking below the 50th percentile, seven of which were below the 25th percentile.

MQD’s Quality Strategy target was met for seven of the measures by KFHP QI and five of the measures by UHC CP QI. Four of the five health plans met or exceeded the MQD’s Quality Strategy target for the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)—Total* measure.

Behavioral Health

Table 4-7 displays the Behavioral Health measure rates for each health plan compared to the national Medicaid percentiles.

Table 4-7—MY 2023 Comparison of Behavioral Health Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	‘Ohana QI	UHC CP QI
Adherence to Antipsychotic Medications for Individuals With Schizophrenia					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	61.41% ★★★	59.03% ★★	68.29% ★★★★	74.47% ★★★★★	76.51% ★★★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment—18–64 Years	53.39% —	65.94% —	72.73% —	64.76% —	65.64% —

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Effective Acute Phase Treatment—65 Years and Older	75.00% —	67.92% —	83.87% —	88.57% —	81.11% —
Effective Acute Phase Treatment—Total	54.81% ★	66.00% ★★★	73.52% ★★★★	67.94% ★★★★	71.15% ★★★★
Effective Continuation Phase Treatment—18–64 Years	35.89% —	46.97% —	51.35% —	46.26% —	47.55% —
Effective Continuation Phase Treatment—65 Years and Older	56.25% —	50.94% —	48.39% —	65.71% —	66.11% —
Effective Continuation Phase Treatment—Total	37.22% ★	47.08% ★★★	51.14% ★★★★	48.85% ★★★★	54.15% ★★★★
Follow-Up After Emergency Department Visit for Mental Illness					
7-Day Follow-Up—6–17 Years	22.50% ★	34.00% ★	NA	NA	NA
7-Day Follow-Up—18–64 Years	30.95% ★★	25.37% ★	23.53% ★	37.50% ★★★	35.41% ★★★
7-Day Follow-Up—65 Years and Older	NA	NA	NA	NA	30.95% ★★
7-Day Follow-Up—Total	30.49% ★	26.21% ★	29.89% ★	37.76% ★★	35.10% ★★
30-Day Follow-Up—6–17 Years	40.00% ★	46.67% ★	NA	NA	NA
30-Day Follow-Up—18–64 Years	45.83% ★★	42.78% ★★	46.32% ★★	55.88% ★★★	53.77% ★★★
30-Day Follow-Up—65 Years and Older	NA	NA	NA	NA	40.48% ★★
30-Day Follow-Up—Total	45.74% ★	42.67% ★	49.43% ★★	56.12% ★★★	52.37% ★★
Follow-Up After Emergency Department Visit for Substance Use					
7-Day Follow-Up—13–17 Years	NA	21.05% ★★★	NA	NA	NA
7-Day Follow-Up—18 Years and Older	27.10% ★★★	26.87% ★★★	20.49% ★★	29.67% ★★★	27.66% ★★★
7-Day Follow-Up—Total	26.98% ★★★	26.64% ★★★	20.00% ★★	29.08% ★★★	27.70% ★★★
7-Day Follow-Up—18–64 Years (Adult Core)	27.22% —	27.37% —	20.50% —	28.82% —	28.06% —
7-Day Follow-Up—65 Years and Older (Adult Core)	NA	14.81% —	NA	NA	NA
30-Day Follow-Up—13–17 Years	NA	38.60% ★★★	NA	NA	NA
30-Day Follow-Up—18 Years and Older	39.69% ★★★	42.36% ★★★	39.02% ★★★	46.33% ★★★★	41.04% ★★★

Measure	AlohaCare QI	HMSA QI	KFHP QI	‘Ohana QI	UHC CP QI
30-Day Follow-Up—Total	39.29% ★★★	42.21% ★★★	38.14% ★★★	45.42% ★★★★	40.99% ★★★
30-Day Follow-Up—18–64 Years (Adult Core)	39.56% —	42.89% —	39.50% —	45.49% —	41.49% —
30-Day Follow-Up—65 Years and Older (Adult Core)	NA	29.63% —	NA	NA	NA
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase—Total	49.18% ★★★★	47.18% ★★★	66.67% ★★★★★	NA	NA
Continuation and Maintenance Phase—Total	47.37% ★	59.15% ★★★	NA	NA	NA
Initiation and Engagement of Substance Use Disorder Treatment					
Initiation—Total—13–17 Years	31.08% ★	41.97% ★★	40.43% ★★	NA	NA
Initiation—Total—18–64 Years	41.02% ★★	33.73% ★	28.21% ★	34.13% ★	37.18% ★
Initiation—Total—65 Years and Older	45.26% ★★★	30.82% ★	46.15% ★★★	40.22% ★★	36.25% ★★
Initiation—Total	40.95% ★★	33.96% ★	29.92% ★	34.33% ★	37.12% ★
Engagement—Total—13–17 Years	5.41% ★	23.36% ★★★★★	21.28% ★★★★★	NA	NA
Engagement—Total—18–64 Years	9.13% ★	11.24% ★★	6.75% ★	8.59% ★	8.60% ★
Engagement—Total—65 Years and Older	5.84% ★★★	3.93% ★★	1.54% ★	11.96% ★★★★★	5.18% ★★
Engagement—Total	8.80% ★	11.39% ★★	7.09% ★	8.80% ★	7.99% ★
Screening for Depression and Follow-Up Plan					
12–17 Years	41.51% —	47.16% —	1.56% —	17.82% —	20.28% —
18–64 Years	29.09% —	25.29% —	6.08% —	11.57% —	14.04% —
65 Years and Older	28.92% —	24.23% —	8.60% —	24.06% —	35.45% —
Total (12 Years and Older)	31.77% —	29.79% —	5.47% —	14.71% —	23.06% —
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics					
1–11 Years	NA	NA	NA	NA	NA
12–17 Years	NA	43.33% ★	NA	NA	NA
Total	NA	45.71% ★	NA	NA	NA

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Use of Pharmacotherapy for Opioid Use Disorder					
Rate 1: Total	55.15% —	57.90% —	57.38% —	59.18% —	50.93% —
Rate 2: Buprenorphine	33.58% —	38.13% —	45.90% —	21.72% —	24.38% —
Rate 3: Oral Naltrexone	0.98% —	1.41% —	0.00% —	0.75% —	1.54% —
Rate 4: Long-Acting, Injectable Naltrexone	0.25% —	0.27% —	0.00% —	0.00% —	0.00% —
Rate 5: Methadone	22.06% —	19.91% —	14.75% —	38.95% —	26.85% —

Cells highlighted yellow indicate the health plan met or exceeded the target threshold established by 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.
MY 2023 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*

Within the Behavioral Health performance measure domain, both HMSA QI and 'Ohana QI performed the best among the health plans, with 11 measure rates ranking at or above the 50th percentile. 'Ohana QI additionally had four measure rates that met or exceeded the 75th percentile and two that met or exceeded the 90th percentile. AlohaCare QI demonstrated the lowest performance among the health plans, with 15 measure indicator rates that could be compared to benchmarks ranking below the 50th percentile, 11 of which were below the 25th percentile.

Within the Behavioral Health domain, nine measure indicator rates had established Quality Strategy targets. All five QI health plans reached the established MQD targets for the *Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* indicator rates. For *Antidepressant Medication Management—Effective Acute Phase Treatment—Total* and *Effective Continuation Phase Treatment—Total,* four of the five health plans (HMSA QI, KFHP QI, 'Ohana QI, UHC CP QI) met the established MQD target and performed at or above the 50th percentile, three of which performed at or above the 75th percentile (KFHP QI, 'Ohana QI, UHC CP QI).

Long-Term Services and Supports

Table 4-8 displays the long-term services and supports measure rates for each health plan.

Table 4-8—MY 2023 Comparison of LTSS Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
LTSS Comprehensive Assessment and Update					
Assessment of Core Elements Documented	47.92% —	26.04% —	44.79% —	50.00% —	8.33% —
Assessment of Supplemental Elements Documented	47.92% —	18.75% —	42.71% —	47.92% —	8.33% —
LTSS Comprehensive Care Plan and Update					
Care Plan With Core Elements Documented	66.67% —	2.08% —	35.42% —	50.00% —	10.42% —
Care Plan With Supplemental Elements Documented	66.67% —	2.08% —	35.42% —	42.71% —	10.42% —
LTSS Minimizing Institutional Length of Stay					
Observed Rate	4.66% —	NA	28.51% —	1.40% —	32.60% —
Risk-Adjusted Rate	31.36% —	NA	35.92% —	37.87% —	37.29% —
Observed/Expected (O/E) Ratio	0.1486 —	NA	0.7937 —	0.0371 —	0.8743 —

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

For *LTSS Comprehensive Assessment and Update—Assessment of Core Elements Documented* and *Assessment of Supplemental Elements Documented,* four of the five health plans (AlohaCare QI, HMSA QI, KFHP QI, and 'Ohana QI) met the established MQD target. For *LTSS Comprehensive Care Plan and Update—Care Plan With Core Elements Documented* and *Care Plan With Supplemental Elements Documented,* four of the five health plans (AlohaCare QI, KFHP QI, 'Ohana QI, UHC CP QI) met the established MQD target. For *LTSS Minimizing Institutional Length of Stay—Observed Rate,* two of the five health plans (KFHP QI and UHC CP QI) met the established MQD target.

Summary of MQD Quality Strategy Targets

Table 4-9 summarizes health plan performance relative to MQD's Quality Strategy targets. Highlighted cells indicate whether health plan performance for a given measure rate met or exceeded the target threshold established by MQD.

Table 4-9—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					
Adults' Access to Preventive/Ambulatory Health Services—Total	Not Met	Not Met	Not Met	Not Met	Not Met
*Heart Failure Admission Rate—Total**	Not Met	Met	Met	Not Met	Not Met
*Plan All-Cause Readmissions—Index Total Stays—O/E Ratio—Total**	Met	Met	Met	Met	Not Met
Children's Preventive Health					
Child and Adolescent Well-Care Visits	Not Met	Met	Not Met	Not Met	Not Met
Childhood Immunization Status—Combination 3	Not Met	Met	Met	Not Met	Not Met
Childhood Immunization Status—Combination 7	Not Met	Met	Met	Not Met	Not Met
Childhood Immunization Status—Combination 10	Not Met	Not Met	Met	Not Met	Not Met
Immunizations for Adolescents—Combination 1 (Meningococcal, Tdap)	Not Met	Not Met	Met	Not Met	Not Met
Immunizations for Adolescents—Combination 2 (Meningococcal, Tdap, HPV)	Not Met	Met	Met	Not Met	Not Met
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total	Not Met	Met	Met	Not Met	Met
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	Not Met	Not Met	Met	Not Met	Not Met
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	Not Met	Not Met	Met	Not Met	Not Met
Well-Child Visits in the First 30 Months of Life—Well-Child Visits	Not Met	Met	Met	Not Met	Not Met

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
in the First 15 Months of Life—Six or More Well-Child Visits					
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	Not Met	Met	Met	Not Met	Not Met
Women's Health					
Cervical Cancer Screening	Not Met	Met	Met	Not Met	Not Met
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Not Met	Not Met	Met	Not Met	Not Met
Prenatal and Postpartum Care—Postpartum Care	Not Met	Not Met	Met	Not Met	Not Met
Care for Chronic Conditions					
Asthma Medication Ratio—Total	Not Met	Not Met	Met	Not Met	Not Met
Blood Pressure Control for Patients With Diabetes	Not Met	Met	Met	Not Met	Met
*Concurrent Use of Opioids and Benzodiazepines—Total**	Met	Not Met	Met	Not Met	Not Met
Controlling High Blood Pressure—Total	Not Met	Not Met	Met	Not Met	Met
Eye Exam for Patients With Diabetes	Not Met	Not Met	Met	Not Met	Met
Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)—Total	Not Met	Met	Met	Met	Met
Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)—Total	Not Met	Not Met	Met	Met	Met
Behavioral Health					
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	Not Met	Not Met	Not Met	Met	Met
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	Not Met	Met	Met	Met	Met
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	Not Met	Met	Met	Met	Met

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total	Not Met	Not Met	Not Met	Met	Met
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total	Not Met	Not Met	Not Met	Met	Met
Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total	Met	Met	Met	Met	Met
Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total	Met	Met	Met	Met	Met
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase—Total	Met	Not Met	Met	Not Met	Not Met
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase—Total	Not Met	Not Met	Not Met	Not Met	Not Met
Initiation and Engagement of Substance Use Disorder Treatment—Initiation—Total	Met	Not Met	Not Met	Not Met	Not Met
Initiation and Engagement of Substance Use Disorder Treatment—Engagement—Total	Not Met	Not Met	Not Met	Not Met	Not Met
Screening for Depression and Follow-Up Plan—Total—12 Years and Older	Met	Met	Not Met	Not Met	Met
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	Not Met	Not Met	Not Met	Not Met	Not Met
Use of Pharmacotherapy for Opioid Use Disorder—Rate 1: Total	Met	Met	Met	Met	Not Met
Use of Pharmacotherapy for Opioid Use Disorder—Rate 2: Buprenorphine	Met	Met	Met	Not Met	Not Met
Use of Pharmacotherapy for Opioid Use Disorder—Rate 3: Oral Naltrexone	Not Met	Met	Not Met	Not Met	Met

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Use of Pharmacotherapy for Opioid Use Disorder—Rate 4: Long-Acting, Injectable Naltrexone	Not Met	Not Met	Not Met	Not Met	Not Met
Use of Pharmacotherapy for Opioid Use Disorder—Rate 5: Methadone	Met	Not Met	Not Met	Met	Met
Long-Term Services and Supports (LTSS)					
LTSS Comprehensive Assessment and Update—Assessment of Core Elements Documented	Met	Met	Met	Met	Not Met
LTSS Comprehensive Assessment and Update—Assessment of Supplemental Elements Documented	Met	Met	Met	Met	Not Met
LTSS Comprehensive Care Plan and Update—Care Plan With Core Elements Documented	Met	Not Met	Met	Met	Met
LTSS Comprehensive Care Plan and Update—Care Plan With Supplemental Elements Documented	Met	Not Met	Met	Met	Met
LTSS Minimizing Institutional Length of Stay—Observed Rate	Not Met	Not Met	Met	Not Met	Met
LTSS Minimizing Institutional Length of Stay—Risk-Adjusted Rate	Not Met	Not Met	Not Met	Not Met	Not Met
Percent MQD Targets Met	**27.08%**	**45.83%**	**72.92%**	**33.33%**	**39.58%**
Total MQD Targets Met	**14**	**22**	**35**	**16**	**19**

Validation of Network Adequacy

HSAG assessed the QI health plans' results across all standards and determined that the indicators in Table 4-10 were not included in the MQD-required reporting templates, resulting in an *Unable to Validate* designation for each associated indicator.

Table 4-10—QI Health Plans—Network Adequacy Standards Unable to Validate

Standard	Provider Type	Indicator
Time and Distance	Emergency Services Facilities—Urban	Within 30-minute driving time

Standard	Provider Type	Indicator
	Emergency Services Facilities—Rural	Within 60-minute driving time
Mandatory Provider Types	CPs in Network	At least 1 provider
	PAs in Network	At least 1 provider
	State licensed Special Treatment Facilities for the provision of substance abuse therapy/treatment	At least 1 provider

HSAG assessed the QI health plans' standards and indicators and determined that all QI health plans did not meet MQD's requirements for the following indicators presented in Table 4-11.

Table 4-11—QI MCOs—Network Adequacy Standards Noncompliance

Standard	Provider Type	Indicator
Access and Availability	Urgent Care and PCP Pediatric	Sick visit appointments within 24 hours
	Specialist or non-emergency hospital	Appointments within four (4) weeks or of sufficient timeliness to meet medical necessity
Mandatory Provider Types	Community Health Workers	At least 1 provider

HSAG assessed the QI health plans' standards and indicators and determined that all QI health plans met MQD's requirements for the following indicators presented in Table 4-12.

Table 4-12—QI MCOs—Network Adequacy Standards Compliance

Standard	Provider Type	Indicator
Provider Ratios	Hospitals on Oahu	5
	Hospitals on Maui	1
Mandatory Provider Types	Home Health Agencies and Hospices	At least 1 provider
	DME	At least 1 provider
	Case management agencies	At least 1 provider
	Laboratories which have either a CLIA 1988 certificate or a waiver of a certificate of registration	At least 1 provider
	Optometrists	At least 1 provider

Standard	Provider Type	Indicator
	Physician Specialists, including but not limited to Cardiologists, Endocrinologists, General Surgeons, Geriatricians, Hematologists, Infectious Disease Specialists, Nephrologists, Neurologists, OB/GYNs, Oncologists, Ophthalmologists, Orthopedists, Otolaryngologists, Pediatric Specialists, Plastic and Reconstructive Surgeons, Pulmonologists, Radiologists, and Urologists	At least 1 provider
	Behavioral Health Providers: Licensed Therapists, Counselors, and CSACs	At least 1 provider
Time and Distance	Adult Day Care/Adult Health—Urban	Within 30-minute driving time
	Behavioral Health Provider—Urban	Within 30-minute driving time
	Behavioral Health Provider—Rural	Within 60-minute driving time
	Hospital—Urban	Within 30-minute driving time
	Hospital—Rural	Within 60-minute driving time
	OB/GYN—Urban	Within 30-minute driving time
	OB/GYN—Rural	Within 60-minute driving time
	PCP—Urban	Within 30-minute driving time
	PCP—Rural	Within 60-minute driving time
	Pharmacy—Rural	Within 60-minute driving time

HSAG assessed 'Ohana CCS' results across all standards and determined that the indicators in Table 4-13 were not included in the MQD-required reporting templates, resulting in an *Unable to Validate* designation for each associated indicator.

Table 4-13—CCS—Network Adequacy Standards Unable to Validate

Standard	Provider Type	Indicator
Time and Distance	Emergency Services Facilities—Urban	Within 30-minute driving time

Standard	Provider Type	Indicator
	Emergency Services Facilities—Rural	Within 60-minute driving time
Mandatory Provider Types	CIS in Network	At least 1 provider
	Inpatient Behavioral Health Hospital Services in Network	At least 1 provider
	Outpatient Behavioral Health Hospital Services in Network	At least 1 provider
	Peer Specialist in Network	At least 1 provider

Validation of Performance Improvement Projects

Table 4-14 summarizes HSAG's key validation findings for the three PIPs conducted by the QI health plans.

Table 4-14—PIP Validation Findings for the QI Health Plans

Health Plan Name	Validation Rating 1: Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Validation Rating 2: Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Behavioral Health Coordination						
AlohaCare QI	100%	100%	*High Confidence*	100%	100%	*High Confidence*
HMSA QI	100%	100%	*High Confidence*	33%	100%	*Moderate Confidence*
KFHP QI	100%	100%	*High Confidence*	33%	100%	*No Confidence*
'Ohana QI	100%	100%	*High Confidence*	100%	100%	*High Confidence*

Health Plan Name	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
UHC CP QI	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Plan All-Cause Readmissions						
AlohaCare QI	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
HMSA QI	100%	100%	*High Confidence*	33%	100%	*No Confidence*
KFHP QI	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
‘Ohana QI	100%	100%	*High Confidence*	33%	100%	*No Confidence*
UHC CP QI	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
Screening for Depression and Follow-Up Plan						
AlohaCare QI	100%	100%	*High Confidence*	*Not Assessed*[4]		
HMSA QI	100%	100%	*High Confidence*	*Not Assessed*[4]		
KFHP QI	100%	100%	*High Confidence*	*Not Assessed*[4]		
‘Ohana QI	100%	100%	*High Confidence*	*Not Assessed*[4]		

Health Plan Name	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
UHC CP QI	100%	100%	*High Confidence*	*Not Assessed*[4]		

[1] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) 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] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.
[4] **Not Assessed**—HSAG did not assess Step 9, as the QI plans only reported the Design stage.

Table 4-15 summarizes HSAG's key validation findings for the two PIPs conducted by 'Ohana CCS.

Table 4-15—PIP Validation Findings for 'Ohana CCS

PIP Topic	Validation Rating 1			Validation Rating 2		
	Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Behavioral Health Coordination	100%	100%	*High Confidence*	100%	100%	*High Confidence*
7-Day Follow-up After Emergency Department Visit for Mental Illness	100%	100%	*High Confidence*	33%	100%	*No Confidence*

[1] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) 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] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

CY 2024 was the third validation year for the ongoing PIPs and the first validation year for the new PIP. All the PIP topics were required by MQD and address 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 objectives included in MQD's Quality Strategy. In addition to the PIPs, MQD 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.

The health plans drafted and shared DSAs with the DOH Behavioral Health Services Administration divisions. The DSAs were approved and executed in December 2024 and are effective as of January 1, 2025. Moving forward, HSAG recommends that MQD continue to engage with the health plans and DOH Behavioral Health divisions to ensure that progress is made toward data sharing and an integrated care approach. The PIPs are submitted to the EQRO for annual validation; however, MQD may require the health plans to provide an update on the status of their interventions quarterly. Any system barriers to implementing interventions should be addressed in a timely manner. The health plans should also continue to report to 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, the *7-Day Follow-up After Emergency Department Visit for Mental Illness* PIP, and the *Screening for Depression and Follow-Up Plan* PIP, the health plans may be encouraged to seek member input regarding barriers to accessing care and expand the successful interventions to realize a statistically significant improvement in the performance indicator rate.

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

Statewide Comparisons—QI Health Plans

Table 4-16 presents the 2023 adult population scores for each QI health plan and the QI Program (i.e., combination of the five QI health plans).[91] Additionally, results comparing the QI health plans to the overall QI Program are displayed below.

[91] The QI Program 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.

Table 4-16—Comparison of 2024 QUEST Integration Adult CAHPS Results

	AlohaCare QI	HMSA QI	KFHP QI	‘Ohana QI	UHC CP QI	QI Program
Global Ratings						
Rating of Health Plan	63.60%	63.67%	67.37%	62.33%	60.92%	63.92%
Rating of All Health Care	53.08%	57.40%	56.73%	57.92%	66.00%	57.72%
Rating of Personal Doctor	68.52%	64.93%	62.95%	69.16%	65.12%	66.02%
Rating of Specialist Seen Most Often	64.10%+	65.38%	65.32%	71.53%	67.80%+	67.13%
Composite Measures						
Getting Needed Care	80.29%	77.80%	78.71%	80.80%	77.37%+	79.28%
Getting Care Quickly	75.63%+	76.75%	75.59%	79.35%	76.90%+	76.87%
How Well Doctors Communicate	90.82%	92.02%	89.41%	91.96%	95.85%	91.77%
Customer Service	88.13%+	86.16%+	88.07%	89.50%	86.54%+	87.90%
Individual Item Measure						
Coordination of Care	87.32%+	89.69%+	80.41%+	86.11%	92.06%+	86.70%
Medical Assistance With Smoking and Tobacco Use Cessation Measure Items						
Advising Smokers and Tobacco Users to Quit	69.11%	68.82%+	70.30%	67.21%	71.23%+	69.14%
Discussing Cessation Medications	50.41%	48.91%+	51.49%	55.37%	48.65%+	51.28%
Discussing Cessation Strategies	47.97%	45.16%+	53.47%	53.66%	43.84%+	49.32%

Cells highlighted in green represent scores that are statistically significantly higher than the 2023 NCQA adult Medicaid national averages.
Cells highlighted in red represent scores that are statistically significantly lower than the 2023 NCQA adult Medicaid national averages.
↑ *Indicates the QI health plan’s 2024 score is statistically significantly higher than the QI Program.*
↓ *Indicates the QI health plan’s 2024 score is statistically significantly lower than the QI Program.*
\+ *Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.*

Comparison of the 2024 QI Program and QI health plans’ scores to the 2023 NCQA adult Medicaid national averages revealed the following summary results:

- The QI Program scored statistically significantly higher than the national average on one measure, *Rating of Health Plan*.
- The QI Program scored statistically significantly lower than the national average on one measure, *Getting Care Quickly*.
- AlohaCare QI, HMSA QI, and ‘Ohana QI did not score statistically significantly higher or lower than the national averages for any measure.
- KFHP QI scored statistically significantly higher than the national average on one measure, *Rating of Health Plan*.

- UHC CP QI scored statistically significantly higher than the national averages on three measures: *Rating of All Health Care*, *How Well Doctors Communicate*, and *Coordination of Care*.

Comparison of the QI health plans' scores to the QI Program 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 for any measure.

National Average Comparisons—Statewide Child Medicaid

Table 4-17 presents the 2024 top-box scores for the general child and CCC statewide populations.

Table 4-17—Comparison of 2024 Child Statewide CAHPS Results

	General Child Statewide	CCC Statewide
Global Ratings		
Rating of Health Plan	73.45%	65.45%
Rating of All Health Care	76.51%	66.39%
Rating of Personal Doctor	80.18%	72.41%
Rating of Specialist Seen Most Often	76.19%+	68.75%+
Composite Measures		
Getting Needed Care	80.76%+	85.59%+
Getting Care Quickly	79.32%	79.67%+
How Well Doctors Communicate	95.81%	94.03%
Customer Service	81.25%+	84.21%+
Individual Item Measure		
Coordination of Care	80.77%+	85.71%+
CCC Composite and Item Measures		
Access to Specialized Services	NA	72.71%+
FCC: Personal Doctor Who Knows Child	NA	91.22%+
Coordination of Care for Children with Chronic Conditions	NA	83.58%+
FCC: Getting Needed Information	NA	86.07%
Access to Prescription Medicines	NA	90.83%

Cells highlighted in green represent scores that are statistically significantly higher than the 2023 NCQA child Medicaid and CCC Medicaid national averages.
Cells highlighted in red represent scores that are statistically significantly lower than the 2023 NCQA child Medicaid and CCC Medicaid national averages.
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
NA *Indicates that this measure is not applicable for the population.*

Comparison of the general child statewide population's 2024 scores to the 2023 NCQA general child Medicaid national averages revealed the following summary results:

- The general child statewide population scored statistically significantly higher than the national average on one measure, *Rating of All Health Care*.
- The general child statewide population did not score statistically significantly lower than the national averages for any measure.

Comparison of the CCC statewide population's 2024 scores to the 2023 NCQA CCC Medicaid national averages revealed the following summary results:

- The CCC statewide population did not score statistically significantly higher than the national averages for any measure.
- The CCC statewide population scored statistically significantly lower than the national average on one measure, *Getting Care Quickly*.

National Average Comparisons—CHIP

Table 4-18 presents the 2023 top-box scores for the general and CCC Hawaii CHIP populations.

Table 4-18—Comparison of 2024 Hawaii CHIP CAHPS Results

	General Hawaii CHIP	CCC Hawaii CHIP
Global Ratings		
Rating of Health Plan	74.60%	71.35%
Rating of All Health Care	70.59%	67.57%
Rating of Personal Doctor	78.13%	80.65%
Rating of Specialist Seen Most Often	72.34%+	59.09%+
Composite Measures		
Getting Needed Care	78.05%	83.17%
Getting Care Quickly	80.75%	89.30%+
How Well Doctors Communicate	95.75%	96.63%
Customer Service	88.06%+	86.27%+
Individual Item Measure		
Coordination of Care	85.92%+	90.12%+
CCC Composite and Item Measures		
Access to Specialized Services	NA	83.06%+
FCC: Personal Doctor Who Knows Child	NA	91.94%

	General Hawaii CHIP	CCC Hawaii CHIP
Coordination of Care for Children with Chronic Conditions	NA	79.90%+
FCC: Getting Needed Information	NA	89.80%
Access to Prescription Medicines	NA	94.17%

Cells highlighted in green represent scores that are statistically significantly higher than the 2023 NCQA child Medicaid and CCC Medicaid national averages.
Cells highlighted in red represent scores that are statistically significantly lower than the 2023 NCQA child Medicaid and CCC Medicaid national averages.
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
NA *Indicates that this measure is not applicable for the population.*

Comparison of the general Hawaii CHIP population's 2024 scores to the 2023 NCQA child Medicaid national averages revealed the following summary results:

- The general CHIP population scored statistically significantly higher than the national average on one measure, *How Well Doctors Communicate*.
- The general CHIP population did not score statistically significantly lower than the national averages for any measure.

Comparison of the CCC Hawaii CHIP population's 2024 scores to the 2023 NCQA CCC Medicaid national averages revealed the following summary results:

- The CCC Hawaii CHIP population scored statistically significantly higher than the national averages on three measures: *How Well Doctors Communicate*, *Access to Specialized Services*, and *Access to Prescription Medicines*.
- The CCC Hawaii CHIP population scored statistically significantly lower than the national average on one measure, *Rating of Specialist Seen Most Often*.

NCQA Comparisons—QI Health Plans

Table 4-19 presents the QI Program's adult population scores and each participating QI health plan's member experience ratings and 2024 scores for the four global ratings, four composite measures, one individual item measure, and medical assistance with smoking and tobacco use cessation measure items.

Table 4-19—Adult Medicaid CAHPS National Comparisons

	QI Program	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Global Ratings						
Rating of Health Plan	★★★ **63.92%**	★★★ 63.60%	★★★ 63.67%	★★★★ 67.37%	★★★ 62.33%	★★ 60.92%

	QI Program	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Rating of All Health Care	★★★ **57.72%**	★★ 53.08%	★★★ 57.40%	★★★ 56.73%	★★★ 57.92%	★★★★★ 66.00%
Rating of Personal Doctor	★★ **66.02%**	★★★ 68.52%	★★ 64.93%	★ 62.95%	★★★ 69.16%	★★ 65.12%
Rating of Specialist Seen Most Often	★★★ **67.13%**	★★ 64.10%+	★★ 65.38%	★★ 65.32%	★★★★ 71.53%	★★★ 67.80%+
Composite Measures						
Getting Needed Care	★★ **79.28%**	★★ 80.29%	★ 77.80%	★★ 78.71%	★★ 80.80%	★ 77.37%+
Getting Care Quickly	★★ **76.87%**	★ 75.63%+	★★ 76.75%	★ 75.59%	★★ 79.35%	★★ 76.90%+
How Well Doctors Communicate	★★ **91.77%**	★ 90.82%	★★ 92.02%	★ 89.41%	★★ 91.96%	★★★★★ 95.85%
Customer Service	★ **87.90%**	★★ 88.13%+	★ 86.16%+	★ 88.07%	★★ 89.50%	★ 86.54%+
Individual Item Measure						
Coordination of Care	★★★ **86.70%**	★★★★ 87.32%+	★★★★★ 89.69%+	★ 80.41%+	★★★ 86.11%	★★★★★ 92.06%+
Medical Assistance With Smoking and Tobacco Use Cessation Measure Items						
Advising Smokers and Tobacco Users to Quit	★★ **69.14%**	★★ 69.11%	★★ 68.82%+	★★ 70.30%	★ 67.21%	★★ 71.23%+
Discussing Cessation Medications	★★★ **51.28%**	★★★ 50.41%	★★ 48.91%+	★★★ 51.49%	★★★★ 55.37%	★★ 48.65%+
Discussing Cessation Strategies	★★★ **49.32%**	★★★ 47.97%	★★ 45.16%+	★★★★ 53.47%	★★★★ 53.66%	★★ 43.84%+

Star Assignments Based on Percentiles:
★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th
+ *Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.*

Comparison of the 2024 QI Program's scores to the 2023 NCQA adult Medicaid Quality Compass data revealed the following:

- The QI Program did not score at or above the 90th percentiles for any measure.
- The QI Program scored below the 25th percentile on one measure, *Customer Service*.

One of the goals MQD identified for the Hawaii Medicaid program is to improve member experience with health plan services. MQD selected the following nine 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*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care, Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Coordination of Care*.

- AlohaCare QI's member experience ratings exceeded the RY 2024 target for *Rating of Health Plan*, *Rating of Personal Doctor*, and *Coordination of Care*.
- HMSA QI's member experience ratings exceeded the RY 2024 target for *Rating of Health Plan* and *Coordination of Care*.
- KFHP QI's member experience ratings exceeded the RY 2024 target for *Rating of Health Plan* and *Customer Service*.
- 'Ohana QI's member experience ratings exceeded the RY 2024 target for *Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, *Getting Needed Care, Getting Care Quickly*, *Customer Service*, and *Coordination of Care*.
- UHC CP QI's member experience ratings exceeded the RY 2024 target for *Rating of All Health Care*, *How Well Doctors Communicate*, *Customer Service*, and *Coordination of Care*.

NCQA Comparisons—Statewide Child Medicaid

Table 4-20 presents the general child statewide population's member experience ratings and 2024 top-box scores for the four global ratings, four composite measures, and one individual item measure.

Table 4-20—General Child Statewide CAHPS National Comparisons

Measure	Score	Star Rating
Global Ratings		
Rating of Health Plan	73.45%	★★★
Rating of All Health Care	76.51%	★★★★★
Rating of Personal Doctor	80.18%	★★★★
Rating of Specialist Seen Most Often	76.19%+	★★★★
Composite Measures		
Getting Needed Care	80.76%+	★★
Getting Care Quickly	79.32%	★
How Well Doctors Communicate	95.81%	★★★★
Customer Service	81.25%+	★

Measure	Score	Star Rating
Individual Item Measure		
Coordination of Care	80.77%+	★
Star Ratings based on percentiles: ★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–4th ★★ 25th–49th ★ Below 25th + *Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.*		

Comparison of the general child statewide population's scores to the NCQA's 2023 Quality Compass Benchmark and Compare Quality Data revealed the following:

- The general child statewide population scored at or above the 90th percentile on one measure, *Rating of All Health Care*.
- The general child statewide population scored below the 25th percentiles on three measures: *Getting Care Quickly*, *Customer Service*, and *Coordination of Care*.

Table 4-21 presents the CCC statewide population's member experience ratings and 2024 top-box scores for the four global ratings, four composite measures, one individual item measure, and five CCC composite and item measures measure.

Table 4-21—CCC Statewide CAHPS National Comparisons

Measure	Score	Star Rating
Global Ratings		
Rating of Health Plan	65.45%	★
Rating of All Health Care	66.39%	★★
Rating of Personal Doctor	72.41%	★
Rating of Specialist Seen Most Often	68.75%+	★★
Composite Measures		
Getting Needed Care	85.59%+	★★★
Getting Care Quickly	79.67%+	★
How Well Doctors Communicate	94.03%	★★★
Customer Service	84.21%+	★
Individual Item Measure		
Coordination of Care	85.71%+	★★★
CCC Composite and Item Measures		
Access to Specialized Services	72.71%+	★★★
FCC: Personal Doctor Who Knows Child	91.22%+	★★★

Measure	Score	Star Rating
Coordination of Care for Children with Chronic Conditions	83.58%+	★★★★★
FCC: Getting Needed Information	86.07%	★
Access to Prescription Medicines	90.83%	★★★
Star Ratings based on percentiles: ★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th + *Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.*		

Comparison of the CCC statewide population's scores to the NCQA's 2023 Quality Compass Benchmark and Compare Quality Data revealed the following:

- The CCC statewide population scored at or above the 90th percentile on one measure, *Coordination of Care for Children with Chronic Conditions*.
- The CCC statewide population scored below the 25th percentiles on five measures: *Rating of Health Plan*, *Rating of Personal Doctor*, *Getting Care Quickly*, *Customer Service*, and *FCC: Getting Needed Information*.

NCQA Comparisons—Hawaii CHIP

Table 4-22 presents the general Hawaii CHIP population's member experience ratings and 2024 top-box scores for the four global ratings, four composite measures, and one individual item measure.[92]

Table 4-22—General Hawaii CHIP CAHPS National Comparisons

Measure	Score	Star Rating
Global Ratings		
Rating of Health Plan	74.60%	★★★
Rating of All Health Care	70.59%	★★★
Rating of Personal Doctor	78.13%	★★★
Rating of Specialist Seen Most Often	72.34%+	★★★
Composite Measures		
Getting Needed Care	78.05%	★
Getting Care Quickly	80.75%	★
How Well Doctors Communicate	95.75%	★★★★

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

Measure	Score	Star Rating
Customer Service	88.06%+	★★★
Individual Item Measure		
Coordination of Care	85.92%+	★★★
Star Ratings based on percentiles: ★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th + *Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.*		

Comparison of the general Hawaii CHIP population's scores to the NCQA's 2023 Quality Compass Benchmark and Compare Quality Data revealed the following:

- The general Hawaii CHIP population did not score at or above the 90th percentiles for any measure.
- The general Hawaii CHIP population scored below the 25th percentiles on two measures: *Getting Needed Care* and *Getting Care Quickly*.

Table 4-23 presents the CCC Hawaii CHIP populations' member experience ratings and 2024 top-box scores for the four global ratings, four composite measures, one individual item measure, and five CCC composite and item measures.[93]

Table 4-23—CCC Hawaii CHIP CAHPS National Comparisons

Measure	Score	Star Rating
Global Ratings		
Rating of Health Plan	71.35%	★★★★
Rating of All Health Care	67.57%	★★★
Rating of Personal Doctor	80.65%	★★★★
Rating of Specialist Seen Most Often	59.09%+	★
Composite Measures		
Getting Needed Care	83.17%	★★
Getting Care Quickly	89.30%+	★★
How Well Doctors Communicate	96.63%	★★★★
Customer Service	86.27%+	★★
Individual Item Measure		

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

Measure	Score	Star Rating
Coordination of Care	90.12%+	★★★★★
CCC Composite and Item Measures		
Access to Specialized Services	83.06%+	★★★★★
FCC: Personal Doctor Who Knows Child	91.94%	★★★
Coordination of Care for Children with Chronic	79.90%+	★★★★
FCC: Getting Needed Information	89.80%	★★
Access to Prescription Medicines	94.17%	★★★★★
Star Ratings based on percentiles: ★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th + *Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.*		

Comparison of the CCC Hawaii CHIP population's scores to the NCQA's 2023 Quality Compass Benchmark and Compare Quality Data revealed the following:

- The CCC Hawaii CHIP population scored at or above the 90th percentiles on three measures: *Coordination of Care*, *Access to Specialized Services*, and *Access to Prescription Medicines*.
- The CCC Hawaii CHIP population scored below the 25th percentile on one measure, *Rating of Specialist Seen Most Often*.

Home and Community-Based Services CAHPS Survey

Table 4-24 presents a summary of the statistically significant differences in performance that exist between the QI health plans' 2024 top-box scores.[94,95,96] Higher scores indicate that members reported more positive healthcare experiences.

[94] For more detailed results on the plan comparisons analysis, please see the 2024 Hawaii HCBS CAHPS Survey full report.

[95] Agency for Healthcare Research and Quality. The CAHPS Databases. *The CAHPS® Home and Community-Based Services (HCBS) Survey Database 2024 Chartbook*. Available at: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/cahps-database/2024-hcbs-chartbook.pdf. Accessed on: Jan 15, 2025.

[96] The 2024 HCBS CAHPS Database benchmarks represent survey data collected from January 1 to December 31, 2022. Caution should be exercised when comparing the 2024 HCBS CAHPS Database benchmarks to the Hawaii HCBS Program 2024 results, which represent survey data collected from July 23, 2024, to September 15, 2024.

Table 4-24—Comparison of 2024 Hawaii HCBS CAHPS Results

Measure	HI HCBS Program	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Global Ratings						
Rating of Personal Assistance and Behavioral Health Staff	77.67%	83.72%+	55.56%+	78.26%+	75.00%+	81.25%
Rating of Homemaker	75.75%+	60.00%+	NA	NA	76.92%+	82.76%+
Rating of Case Manager	70.45%	62.69%+	80.00%+	77.42%+	66.67%+	71.21%
Composite Measures						
Reliable and Helpful Staff	78.84%	82.47%+	72.14%+	77.99%+	73.72%+	81.00%+
Staff Listen and Communicate Well	83.14%	86.66%+	82.70%+	81.76%+	81.29%+	82.90%+
Helpful Case Manager	86.63%	86.93%+	NA	86.19%+	78.72%+	89.24%+
Choosing the Services that Matter to You	70.63%	73.83%+	64.29%+	77.29%+	69.37%+	70.15%
Transportation to Medical Appointments	68.60%	70.51%+	75.63%+	68.12%+	63.70%+	68.21%
Personal Safety and Respect	91.11%	89.92%+	93.06%+	90.81%+	93.43%+	90.33%
Planning Your Time and Activities	54.27%	53.71%+	56.07%+	56.19%+	49.96%+	55.27%
Recommendation Measures						
Recommend Personal Assistance/Behavioral Health Staff	74.25%	75.61%+	72.22% +	60.87%+	74.47%+	76.53%+
Recommend Homemaker	75.88%+	71.43%+	NA	NA	58.33%+	82.61%+
Recommend Case Manager	71.65%	65.08%+	93.75%+ ↑	75.86%+	65.00%+	70.73%
Unmet Need and Physical Safety Measures						
No Unmet Need in Dressing/Bathing	35.02%+	NA	NA	NA	NA	NA
No Unmet Need in Meal Preparation/Eating	25.49%+	NA	NA	NA	NA	NA
No Unmet Need in Medication Administration	NA	NA	NA	NA	NA	NA
No Unmet Need in Toileting	95.65%	90.00%+	NA	100.00%+	95.45%+	96.00%+
No Unmet Need with Household Tasks	39.92%+	NA	NA	NA	NA	NA
Not Hit or Hurt by Staff	100.00%	100.00%+	100.00%+	100.00%+	100.00%+	100.00%

Measure	HI HCBS Program	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
A cell highlighted in green represents the score is statistically significantly higher than the 2024 CAHPS Database benchmark. *A cell highlighted in red represents the score is statistically significantly lower than the 2024 CAHPS Database benchmark.* ↑ *Indicates the QI health plan's score is statistically significantly higher than the Hawaii HCBS Program.* ↓ *Indicates the QI health plan's score is statistically significantly lower than the Hawaii HCBS Program.* *Results based on fewer than 11 respondents were suppressed and noted as "NA".* *+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.*						

Comparison of the 2024 Hawaii HCBS Program and QI health plans' scores to AHRQ's 2024 CAHPS Database benchmark revealed the following summary results:

- The Hawaii HCBS Program scored statistically significantly lower than AHRQ's 2024 CAHPS Database benchmarks on nine measures: *Rating of Case Manager, Reliable and Helpful Staff, Staff Listen and Communicate Well, Helpful Case Manager, Choosing the Services that Matter to You, Transportation to Medical Appointments, Personal Safety and Respect, Planning Your Time and Activities,* and *Recommend Personal Assistance/Behavioral Health Staff*.
- HMSA QI scored statistically significantly higher than AHRQ's 2024 CAHPS Database benchmark on one measure, *Recommend Case Manager*.
- KFHP QI scored statistically significantly higher than AHRQ's 2024 CAHPS Database benchmark on one measure, *No Unmet Need in Toileting*.
- AlohaCare QI scored statistically significantly lower than AHRQ's 2024 CAHPS Database benchmark on one measure, *Rating of Case Manager*.
- HMSA QI scored statistically significantly lower than AHRQ's 2024 CAHPS Database benchmark on one measure, *Rating of Personal Assistance and Behavioral Health Staff*.
- KFHP QI scored statistically significantly lower than AHRQ's 2024 CAHPS Database benchmark on one measure, *Recommend Personal Assistance/Behavioral Health Staff*.
- 'Ohana QI scored statistically significantly lower than AHRQ's 2024 CAHPS Database benchmark on five measures: *Reliable and Helpful Staff, Planning Your Time and Activities, Staff Listen and Communicate Well*, *Choosing the Services that Matter to You*, and *Transportation to Medical Appointments* .
- UHC CP QI scored statistically significantly lower than AHRQ's 2024 CAHPS Database benchmark on four measures, *Personal Safety and Respect. Staff Listen and Communicate Well*, *Choosing the Services that Matter to You*, and *Transportation to Medical Appointments*.

Comparison of the QI health plans' 2024 scores to the Hawaii HCBS Program revealed the following summary results:

- HMSA QI scored statistically significantly higher than the Hawaii HCBS Program on one measure, *Recommend Case Manager*.
- AlohaCare QI, KFHP QI, 'Ohana QI, and UHC CP QI did not score statistically significantly higher or lower than the Hawaii HCBS Program for any measure.

Encounter Data Validation

The MQD contracted with HSAG to perform an EDV study as part of CMS' Protocol 5.[97] The EDV study focused on three activities:

1. Comparative analysis—evaluation of MQD's electronic encounter data completeness and accuracy through a comparative analysis between MQD's electronic encounter data and the actuarial files submitted by the QI health plans to MQD's contracted actuary, Milliman.
2. Technical assistance with the QI health plans regarding the findings from the comparative analysis so that the health plans can identity the root cause(s) of any issues and take appropriate actions to improve MQD's encounter data quality.
3. Best practice recommendations to MQD regarding encounter data submission companion guides and requirements.

Comparative Analysis Findings

HSAG assessed summary metrics designed to evaluate discrepancies between two data sources—i.e., primary (data QI health plans submitted to Milliman for rate setting purposes) and secondary (data QI health plans submitted to MQD's HPMMIS) through record omission and record surplus.

Table 4-25 illustrates the percentage of records present in the Milliman-submitted files that were not found in the MQD-submitted files (record omission) and the percentage of records present in the MQD-submitted files but not present in the Milliman-submitted files (record surplus). Lower rates indicate better performance for both record omission and record surplus. HSAG considered rates of 5.0 percent to be sufficiently low for no concerns. Most of the QI health plans had a rate higher than 5.0 percent (i.e., relatively poor record-level data completeness as indicated by red font text) for one or both measures for all three encounter types (i.e., institutional, professional, and pharmacy). Specifically, while HMSA QI met the less than 5.0 percent criteria for record omission for institutional and professional encounters, only 'Ohana QI had a pharmacy record omission rate less than 5.0 percent; all other QI health plans had higher record omission rates. For record surplus rates, all QI health plans except AlohaCare QI had higher rates for institutional encounters; however, AlohaCare QI and KFHP QI met the criteria for professional record surplus rates and HMSA QI and 'Ohana QI met the less than 5.0 percent criteria for pharmacy encounters.

[97] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *CMS External Quality Review (EQR) Protocols*, February 2023 Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: July 1, 2024.

Table 4-25—Record Omission and Surplus Rates by QI Health Plan and Encounter Type

MCO	Institutional Encounters		Professional Encounters		Pharmacy Encounters	
	Omission (Under-reporting to MQD)	Surplus (Under-reporting to Milliman)	Omission (Under-reporting to MQD)	Surplus (Under-reporting to Milliman)	Omission (Under-reporting to MQD)	Surplus (Under-reporting to Milliman)
AlohaCare QI	87.5%	0.6%	7.6%	2.6%	9.1%	9.1%
HMSA QI	3.9%	29.5%	2.5%	12.3%	11.9%	0.4%
KFHP QI	45.7%	10.0%	22.8%	4.2%	6.4%	8.9%
‘Ohana QI	22.3%	17.3%	45.5%	33.3%	0.1%	<0.1%
UHC CP QI	60.6%	74.8%	57.1%	65.0%	11.1%	10.7%

Red text indicates rates higher than 5.0 percent.

Table 4-26 shows the data elements assessed for the element-level discrepancy rate for institutional encounters across all QI health plans. Element-level discrepancy was limited to those records present in both data sources with values present in both data sources. Records with values missing from both data sources were not included in the denominator. The numerator was the number of records with different non-missing values for a given data element. Lower data element discrepancy rates indicate that the values populated for a data element in the MQD-submitted encounter data were more accurate. As such, for the discrepancy indicator, lower rates indicate better performance. For the 38 institutional data elements, the number of data elements with discrepancy rates higher than 5.0 percent ranged from nine data elements (AlohaCare QI, relatively better performance) to 14 data elements (UHC CP QI, relatively worse performance).

Table 4-26—Data Element Discrepancy by QI Health Plan for Institutional Encounters

Key Data Element	AlohaCare QI	HMSA QI	KFHP QI	‘Ohana QI	UHC CP QI
Member, Date of Service, and Provider					
Member ID	0.0%	<0.1%	<0.1%	0.0%	<0.1%
Member Date of Birth	0.0%	2.5%	3.1%	2.1%	<0.1%
Detail First Date of Service	0.6%	2.2%	0.8%	40.4%	24.2%
Detail Last Date of Service	0.6%	2.2%	0.8%	51.8%	0.0%
Billing Provider NPI	0.0%	1.0%	0.0%	0.0%	16.8%
Billing Provider Type	15.9%	3.7%	0.0%	100%	100%
Servicing Provider NPI	0.1%	1.0%	99.9%	2.3%	31.7%
Servicing Provider ID	0.5%	12.3%	88.6%	6.4%	65.6%

Key Data Element	AlohaCare QI	HMSA QI	KFHP QI	‘Ohana QI	UHC CP QI
Payment Information					
Allowed Amount	19.2%	35.3%	16.3%	43.2%	2.5%
Billed Amount	0.4%	47.7%	8.0%	0.1%	37.4%
COB Amount	6.7%	10.5%	20.3%	22.6%	4.7%
Coinsurance Amount	0.0%	0.0%	<0.1%	15.5%	10.8%
Copay Amount	0.0%	0.0%	0.2%	0.3%	0.0%
Deductible Amount	0.0%	0.0%	0.0%	0.7%	0.5%
MCO Paid Amount	<0.1%	<0.1%	1.5%	6.7%	0.5%
Value Code Amount	0.1%	<0.1%	3.4%	3.0%	<0.1%
Diagnosis Codes, Procedure Codes, and Drug Information					
Admission Diagnosis Code	0.0%	0.0%	0.0%	0.0%	44.3%
Primary Diagnosis Code	0.0%	<0.1%	0.0%	0.0%	0.0%
All Secondary Diagnosis Codes	10.6%	90.1%	1.2%	0.0%	9.8%
All Surgical Procedure Codes	0.0%	65.7%	8.1%	84.2%	6.6%
Procedure Code	3.4%	3.5%	0.9%	0.1%	0.0%
Procedure Code Modifiers	1.0%	4.5%	1.5%	4.6%	—
Units of Service	0.3%	9.6%	0.4%	0.2%	28.2%
NDC	5.2%	1.0%	1.3%	<0.1%	0.1%
Other Data Elements					
Admission Date	0.0%	0.0%	0.0%	1.2%	0.0%
Admission Source	<0.1%	<0.1%	2.0%	0.0%	—
Admission Type	0.5%	0.1%	<0.1%	0.0%	—
DRG Code	0.0%	—	3.9%	72.5%	3.7%
Discharge Date	—	27.9%	0.5%	0.0%	29.2%
Discharge Status	98.0%	21.2%	0.0%	0.0%	0.0%
Encounter Flag	0.0%	<0.1%	79.0%	0.0%	0.0%
MCO Paid Date	0.0%	0.0%	<0.1%	16.7%	0.0%
Occurrence Span Codes	92.4%	1.5%	—	0.0%	86.7%

Key Data Element	AlohaCare QI	HMSA QI	KFHP QI	‘Ohana QI	UHC CP QI
POA Code	—	—	0.0%	0.0%	0.0%
All Secondary POA Codes	100%	90.2%	5.6%	3.6%	9.9%
Revenue Code	0.2%	1.9%	0.5%	<0.1%	0.0%
TOB Code	9.4%	100%	12.6%	9.2%	4.9%
Value Codes	0.0%	0.0%	6.3%	2.7%	0.0%
— indicates that the denominator was zero. Red text indicates rates higher than 5.0 percent.					

Table 4-27 shows the data elements assessed for the element-level discrepancy rate for professional encounters across all QI health plans. Element-level discrepancy was limited to those records present in both data sources with values present in both data sources. Records with values missing from both data sources were not included in the denominator. The numerator was the number of records with different non-missing values for a given data element. Lower data element discrepancy rates indicate that the values populated for a data element in the MQD-submitted encounter data were more accurate. As such, for the discrepancy indicator, lower rates indicate better performance. For the 27 professional data elements, the number of data elements with discrepancy rates higher than 5.0 percent ranged from five data elements (AlohaCare QI, relatively better performance) to 10 data elements (KFHP QI, relatively worse performance).

Table 4-27—Data Element Discrepancy by QI Health Plan for Professional Encounters

Key Data Element	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Member, Date of Service, and Provider					
Member ID	<0.1%	<0.1%	<0.1%	0.1%	<0.1%
Member Date of Birth	<0.1%	1.8%	3.3%	1.8%	<0.1%
Detail First Date of Service	0.6%	<0.1%	0.5%	0.3%	14.4%
Detail Last Date of Service	0.6%	<0.1%	0.5%	0.3%	0.1%
Billing Provider NPI	<0.1%	1.4%	0.0%	1.3%	55.7%
Billing Provider Type	70.5%	67.0%	89.7%	100%	100%
Servicing Provider NPI	<0.1%	0.3%	<0.1%	1.3%	1.5%
Servicing Provider ID	2.0%	3.0%	11.6%	10.5%	24.1%
Payment Information					
Allowed Amount	17.1%	28.9%	80.8%	25.2%	0.5%
Billed Amount	4.5%	0.6%	17.4%	3.0%	0.6%
COB Amount	0.4%	3.9%	18.8%	8.9%	0.1%

Key Data Element	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Coinsurance Amount	0.0%	0.0%	<0.1%	5.0%	22.3%
Copay Amount	0.0%	0.0%	0.1%	0.4%	0.6%
Deductible Amount	0.0%	0.0%	0.0%	0.4%	1.1%
MCO Paid Amount	4.0%	5.5%	9.5%	3.4%	0.7%
Patient Paid Amount	<0.1%	<0.1%	0.1%	0.2%	<0.1%
Diagnosis Codes, Procedure Codes, and Drug Information					
Primary Diagnosis Code	5.9%	5.6%	1.8%	5.4%	4.9%
All Secondary Diagnosis Codes	33.2%	31.6%	28.1%	33.5%	26.1%
Procedure Code	5.0%	0.8%	8.9%	2.2%	0.7%
Procedure Code Modifiers	0.7%	0.1%	1.7%	13.7%	0.1%
Units of Service	0.7%	0.5%	2.5%	2.4%	11.0%
NDC	1.6%	0.7%	3.7%	9.3%	0.8%
Other Data Elements					
Admission Date	77.1%	74.6%	68.8%	—	67.0%
Discharge Date	—	—	87.4%	—	18.8%
Encounter Flag	0.0%	19.1%	0.0%	0.1%	<0.1%
POS Code	0.1%	0.2%	0.3%	0.1%	0.1%
MCO Paid Date	<0.1%	<0.1%	0.6%	1.6%	<0.1%

— indicates that the denominator was zero.
Red text indicates rates higher than 5.0 percent.

Table 4-28 shows the data elements assessed for the element-level discrepancy rate for pharmacy encounters across all QI health plans. Element-level discrepancy was limited to those records present in both data sources with values present in both data sources. Records with values missing from both data sources were not included in the denominator. The numerator was the number of records with different non-missing values for a given data element. Lower data element discrepancy rates indicate that the values populated for a data element in the MQD-submitted encounter data were more accurate. As such, for the discrepancy indicator, lower rates indicate better performance. For the 17 pharmacy data elements, the number of data elements with discrepancy rates higher than 5.0 percent ranged from one data element (AlohaCare QI, relatively better performance) to five data elements (KFHP QI, relatively worse performance).

Table 4-28—Data Element Discrepancy by QI Health Plan for Pharmacy Encounters

Key Data Element	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Member and Date of Service					
Member ID	<0.1%	0.0%	0.1%	<0.1%	<0.1%
Date of Service	0.0%	0.0%	0.0%	0.0%	0.0%
Payment Information					
Billed Amount	0.0%	98.4%	13.9%	5.7%	94.2%
COB Amount	0.0%	3.9%	0.3%	0.4%	0.0%
Coinsurance Amount	0.0%	0.0%	0.0%	0.0%	0.0%
Copay Amount	0.0%	0.0%	0.0%	0.0%	0.0%
Deductible Amount	0.0%	0.0%	0.0%	0.0%	0.0%
Dispensing Fee	94.5%	0.0%	79.2%	95.5%	93.1%
Ingredient Cost	0.0%	99.8%	<0.1%	0.0%	<0.1%
MCO Paid Amount	0.0%	<0.1%	13.8%	0.0%	<0.1%
Patient Paid Amount	0.0%	0.0%	0.0%	0.0%	0.0%
Drug Information					
NDC	0.0%	<0.1%	<0.1%	0.0%	0.0%
Dispensing Quantity	0.0%	3.1%	98.6%	<0.1%	0.4%
Days' Supply	0.0%	0.0%	<0.1%	0.0%	<0.1%
New or Refill Flag	0.0%	—	<0.1%	100%	50.7%
Number of Refills	0.0%	87.9%	100%	88.8%	89.4%
Other Data Elements					
MCO Paid Date	<0.1%	100%	<0.1%	<0.1%	0.2%

— indicates that the denominator was zero.
Red text indicates rates higher than 5.0 percent.

5. Assessment of Follow-Up on Prior Year Recommendations

Introduction

This section of the report presents an assessment of how effectively the health plans addressed the improvement recommendations made by HSAG in the prior year (2023) as a result of the EQR activity findings for compliance monitoring, HEDIS, PIPs, and CAHPS. The CCS program members were not separately sampled for the survey activities as they were included in the QI health plans' sampling; therefore, there are no separate CAHPS 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 2022 and 2023 compliance reviews were carried over to 2024. The specific compliance review findings and recommendations were reported in the respective EQR Report of Results. As appropriate, HSAG conducted technical assistance for the health plans and conducted the follow-up assessments of compliance. All health plans successfully addressed the findings and recommendations from the 2022 and 2023 compliance reviews. The specific results of the 2024 re-evaluation of CAPs are found in Section 3 of this report.

Performance Improvement Projects

HSAG provides recommendations on the initial PIP submission to address any deficiencies noted in the PIP processes or documentation. The health plans have an opportunity to address the recommendations in the resubmission or the next annual PIP submission. HSAG is also available to provide technical assistance to the health plans as the PIP progresses and the health plans work toward implementing the recommended improvements.

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.

2023 HEDIS Performance Measure Recommendations

Based on HSAG's analyses of AlohaCare QI's 30 measure rates comparable to benchmarks, two measure rates (6.7 percent) ranked at or above the 50th percentile, with one of these rates (3.3 percent) ranking at or above the 90th percentile. The *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* measure rate ranked at or above the 50th percentile, indicating that children and adolescent members are receiving the recommended well-child visits.

Conversely, 28 of AlohaCare QI's measure rates comparable to benchmarks (93.3 percent) fell below the 50th percentile, with 24 rates (80.0 percent) falling below the 25th percentile, suggesting considerable opportunities for improvement across most domains of care. Additionally, AlohaCare QI met seven MQD Quality Strategy targets for HEDIS MY 2022. 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—3–11 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—Well-Child Visits for Ages 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*
- Care for Chronic Conditions
  - *Controlling High Blood Pressure—Total*
- Behavioral Health
  - *Follow-Up After Hospitalization for Mental Illness*—all *7-Day Follow-Up* and *30-Day Follow-Up* rates

Improvement Activities Implemented

- Children's Preventive Health
  - *Child and Adolescent Well-Care Visits (WCV)—3–11 Years, 18–21 Years,* and *Total*
  - *Childhood Immunization Status (CIS)—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 (W30)—Well-Child Visits for Ages 15 Months to 30 Months—Two or More Well-Child Visits*
    1. Reviewed and updated the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program to match the revised Bright Futures periodicity schedule, informed practitioners of changes.
    2. Included WCV, W30 and CIS measures (focus on Combo 3 while promoting Combo 10) in the P4P financial incentive program for practitioners.
    3. Omnichannel (text/Interactive voice response (IVR)/digital/mailing) message campaign: To remind parent/guardian/member about member being due for their well-child/well-care visit, immunizations and information regarding Wellness rewards they could redeem.
    4. Text messaging/(IVR) monthly campaign via mPulse to remind parent/guardian/member of need for well-child/well-care visit and/or immunizations.
    5. Send quarterly birthday card reminders.
    6. Stratified population by risk categories; assigned to appropriate health services staff based on assignment of risk category for appropriate level of contact.
    7. Bidirectional data sharing between 14 community health centers (CHCs) and AlohaCare.
    8. Reminder Calls: Outreach calls are used to remind parent/guardian about members due for their well-care visit. Also, during the call, parent/guardian are helped with scheduling member's well-care appointment and coordinating transportation to visit if needed—(Conducted by Gaps In Care (GIC) Coordinator for specific target population).
    9. Additional targeted outreach to members in targeted areas where health disparities were found.
    10. Island Member Appreciation events: Reminders of the importance of completing well-child/well-care visits and rewards redemption as well as assistance with rewards redemption if visit is completed.
    11. Provided Wellness rewards posters and flyers to providers to post and distribute to patients at the provider offices.
- Women's Health
  - *Cervical Cancer Screening (CCS)*
    1. Provided members educational materials online, via text, IVR, and mail.
    - Bidirectional data sharing between 14 CHCs and AlohaCare.
    - Care team checks for member-supplied information about cervical cancer screening while conduction Health and Functional Assessment (HFA), coordinates referral to provider when care gap is identified.

- IVR/text campaigns (monthly) to remind eligible members of recommendation for routine cervical cancer screening.

– *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

1. Provided members educational materials online, via text, IVR.
2. High Risk Pregnant Members will be contacted by the AlohaCare High Risk Maternal Child Health Program Manager (HRMCH) to schedule an initial HFA, an initial Health Action Plan (HAP), and schedules an Interdisciplinary Care Team (ICT) meeting with the member and her obstetrical (OB) provider. Services:
   - Assistance with scheduling OB medical appointments.
   - Coordination of ground transportation, flights and lodging to attend OB appointments and hospitalizations.
   - Coordination of obtaining prenatal and postpartum medical supplies (breast pumps, blood pressure machines, diapers, safe sleep cribs, and infant formula).
   - Education, support and community resources through Healthy Mothers/Healthy Babies Coalition of Hawaii during the pregnancy and postpartum period.
   - Identification of barriers such as psychosocial concerns, educational and discharge planning needs.
   - AlohaCare coordinates with providers on interventions to support the member receiving timely prenatal and postpartum care.
3. Offered members wellness rewards financial incentives for completion of services.
4. P4P financial incentive program for practitioners for members with controlled blood pressure readings.
5. Healthy Mothers/Healthy Babies is contracted to perform outreach to all pregnant members to educate and assist with access to prenatal services.

- Care for Chronic Conditions

– *Controlling High Blood Pressure—Total*

1. A series of hypertension mPulse-focused monthly text campaigns, which includes educational information, appointment reminders, and tips for self-management, and links to resources.
2. Telephonic outreach by the Health Services care teams addressing gaps in care through education.
3. Telephonic outreach by AlohaCare Pharmacy targeting members to close specific medication gaps and provide education on medication adherence/prescription refills.
4. Telephonic clinical education by the Disease Management Nurse or Health Coordination Clinician addressing members with hypertension above the normal ranges.
5. Offer enrollment into AlohaCare's Remote Hypertension Monitoring Program (Digital Medicine by Ochsner Health) with Ochsner Health, which provides blood pressure cuffs, coaching education and assistance to improve accountability, medication adherence, and provide self-management tips and tools.

6. Informing members about the Controlling High Blood Pressure rewards program via the AlohaCare website, text messaging, IVR, mailings.
7. Provide information from American Heart Association (AHA) regarding hypertension education.
8. Completion of the HFA to identify members who need additional support for management of hypertension.
9. P4P financial incentive program for practitioners when assigned members have controlled blood pressure readings.

- Behavioral Health
  – *Follow-Up After Hospitalization for Mental Illness*—all *7-Day Follow-Up* and *30-Day Follow-Up*
    1. Rapid Admit Impact Rounds occur daily where both medical and behavioral health admissions are discussed with the multidisciplinary team members. This activity allows activation of appropriate resources to interact and prepare for discharge with the member and care team while hospitalized, if appropriate.
    2. AlohaCare QI partnered with CHC providers belonging to the Accountable Healthcare Alliance of Rural Organizations (AHARO), a virtual accountable care organization, to notify them when their patients are admitted to hospitals with a mental health disorder. This activity is an effort to reduce the time of follow-up within 15 days of discharge.
    3. AlohaCare QI hired a dedicated and designated inpatient coordinator to engage with members at the bedside at Queens Medical Center. Other AlohaCare QI resources engage with members in other hospitals as needed and as possible based on their condition and discharge needs. Special emphasis is given to those who have been difficult to engage or unable to engage prior their current admission.
    4. AlohaCare QI partnered with CHC providers belonging to AHARO, a virtual accountable care organization, to notify a designated contact when their patients are discharged from hospitals with a mental health disorder. This activity is an effort to prepare or calendar a post discharge follow-up within 15 days of discharge.
    5. This past year, AlohaCare QI added two full time Certified Peer Support Specialists (PSS) to its multidisciplinary team. These individuals have been instrumental in assisting the team and members, sharing their experiences and encouraging engagement in programs and services.
    6. Engagement Coordinators, Community Health Workers (CHWs), PSS' and Community Integrated Service (CIS) Coordinators are available to assist Lead Case Managers in locating members in the community, providing education and support services for the homeless, addictive disorders and mentally ill membership to ensure services and supports are available for every member's needs.

HSAG Assessment

HSAG has determined that AlohaCare QI has addressed the prior year recommendations.

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

2023 Recommendations

HSAG performed an analysis of key drivers of member experience for the following three global ratings: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*. AlohaCare QI should consider determining whether potential quality improvement activities could improve member experience on each of the key drivers identified. Table 5-1 provides a summary of the key drivers identified for AlohaCare QI.

Table 5-1—AlohaCare QI Key Drivers of Member Experience Analysis

Key Drivers	*Rating of Health Plan*	*Rating of All Health Care*	*Rating of Personal Doctor*
Q9. Ease of getting the care, tests, or treatment the child needed	✓	✓	
Q17. Child's personal doctor spent enough time with the child			✓
Q20. Child's personal doctor seemed informed and up-to-date about care the child received from other doctors or health providers	✓	✓	✓
Q23. Child received appointment with a specialist as soon as needed	✓		**N/A**
Q30. 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 and timeliness 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 child's plan.
- Respondents reported that it was not always easy to fill out forms from their child's health 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 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 their child's personal doctor did not always spend enough time with their child.

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 child's plan.
- Respondents reported that it was not always easy to fill out forms from their child's health plan.
  1. AlohaCare QI added CAHPS to the list of discussion topics to the Provider Servicing Plan for Provider Relations Field Staff.
  2. Articles regarding CAHPS questions and tips were published in the provider newsletter and the AlohaCare QI website for providers and members.
- Respondents reported not always receiving an appointment with a specialist as soon as they needed.
  1. Promote use of AlohaCare QI's contracted Nurse Advice Line as a way for members to obtain medical advice during off-hours or when they cannot reach their provider.
  2. Promote use of telehealth urgent care. Several contracted urgent cares have a telehealth option. AlohaCare QI also contracts with Amwell, a digital platform that offers telehealth urgent care. AlohaCare QI is exploring ways to promote this service as a way for members to access care for their sick visits.
  3. Focus on expanding specialist network and access by:
     - Launched e-consult program with ConferMED. This program enables PCPs to consult with a specialist electronically.
     - Enhanced internal workflows to assist members and providers in accessing specialists. Includes educating staff on how to find specialists offering telehealth.
     - Continued a Specialty Program which offers a bonus to specific Specialists providing services to members.
     - Launch of Gold Carding Program which removes administrative burden of submitting prior authorizations for specific specialists. This will help retain specialists and improve access to care.
     - Initial stages of exploring the feasibility of opening a specialty clinic.
- 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 their child's personal doctor did not always spend enough time with their child.
  1. AlohaCare QI added CAHPS to the list of discussion topics to the Provider Servicing Plan for Provider Relations Field Staff.
  2. Articles regarding CAHPS questions and tips were published in AlohaCare's provider newsletter and the AlohaCare QI website for providers and members.

HSAG Assessment

HSAG has determined that AlohaCare QI has addressed the prior year recommendations.

Home and Community-Based Services CAHPS Survey

2023 Recommendations

For AlohaCare QI, the mean score for the following measure was statistically significantly lower than the HI HCBS Program mean score:

- *Recommend Personal Assistance/Behavioral Health Staff*

In addition, the mean scores for the following nine measures were lower than the HI HCBS Program mean scores:

- *Rating of Personal Assistance and Behavioral Health Staff*
- *Reliable and Helpful Staff*
- *Staff Listen and Communicate Well*
- *Choosing the Services that Matter to You*
- *Transportation to Medical Appointments*
- *Personal Safety and Respect*
- *Planning Your Time and Activities*
- *Recommend Case Manager*
- *No Unmet Need in Toileting*

Improvement Activities Implemented

- *Recommend Personal Assistance/Behavioral Health Staff*
- *Rating of Personal Assistance and Behavioral Health Staff*
- *Reliable and Helpful Staff*
    1. Member's choice of agency or the self-direction option for members who choose Personal Assistance or Respite services.
    2. Development of a Personal Assistance tool.
    3. Ensure services are provided by quality, credentialed and licensed providers.
    4. Back-up plan when regularly scheduled providers are unavailable including paid and unpaid providers.
- *Staff Listen and Communicate Well*
    1. AlohaCare QI added CAHPS to the list of discussion topics to the Provider Servicing Plan for Provider Relations Field Staff. Articles regarding CAHPS questions and tips were published in the provider newsletter and the AlohaCare QI website for providers and members.
    2. Monitor member complaints and grievances; look for trends when members state practitioners do not spend enough time with them or listen to what they have to say.

3. Educate practitioners on CAHPS survey, share results along with key drivers and recommendations for improvement.

- *Choosing the Services that Matter to You*
  1. Member's choice of agency or the self-direction option for members who choose Personal Assistance or Respite services.
  2. Services are provided in home and in community-based settings and compliant with applicable standards in accordance with the QUEST Integration contract.
- *Transportation to Medical Appointments*
  1. AlohaCare QI added CAHPS to the list of discussion topics to the Provider Servicing Plan for Provider Relations Field Staff.
  2. Articles regarding CAHPS questions and tips were published in the provider newsletter and the AlohaCare QI website for providers and members.
  3. Member-facing staff educate members on transportation benefits.
  4. Member-facing staff assist members with scheduling medical appointments.
  5. Members provided education on availability of telehealth, when appropriate.
  6. Monitor members' complaints and grievances as they relate to transportation.
- *Personal Safety and Respect*
  1. Written recommendation by an appropriately trained and certified rehabilitation professional (e.g., Physical therapist or Occupational therapist) who has performed an onsite evaluation in the member's primary community residence.
  2. All protected health information (PHI) is safeguarded.
- *Planning Your Time and Activities*
  1. AlohaCare QI added CAHPS to the list of discussion topics to the Provider Servicing Plan for Provider Relations Field Staff.
  2. Articles regarding CAHPS questions and tips were published in the provider newsletter and the AlohaCare QI website for providers and members.
  3. Health Services team to review and authorize personal assistance devices, when appropriate
  4. Member-facing staff encourage members to participate in social activities, when able
- *Recommend Case Manager*
  1. AlohaCare QI will provide members with services that are appropriate to their medical needs.
  2. The Health Coordinator conducts a face-to-face assessment to determine if the member is appropriate for At-Risk services or will need institutional level of care (LOC).
  3. Assessments will be done within 15 days of identification that members need health coordination based on results of the HFA.
- *No Unmet Need in Toileting*
  1. Health Services team to quickly process requests for durable medical equipment (DME)-toileting related items, i.e. briefs, commode chair, cane, walker, etc.

HSAG Assessment

HSAG has determined that AlohaCare QI has addressed the prior year recommendations.

Provider Survey

2023 Recommendations

For AlohaCare QI, the top-box scores for the following two measures were lower in 2023 than in 2021, although no measure's top-box score was statistically significantly lower:

- *Timeliness of Claims Payments*
- *Access to Substance Abuse Treatment*

In addition, the top-box scores for the following three measures were statistically significantly lower than the QI Program aggregate:

- *Adequacy of Specialists*
- *Availability of Mental Health Providers*
- *Access to Substance Abuse Treatment*

Improvement Activities Implemented

- *Timeliness of Claims Payments*
    1. Increased monitoring activities at the provider type level to identify problem categories.
    2. Leveraged automation to process common claim pends.
    3. Developing preprocesses for complex pends to leverage reporting tools and automation.
- *Access to Substance Abuse Treatment*
- *Adequacy of Specialists*
- *Availability of Mental Health Providers*
    1. Executed contract and launched workflow with Community Empowerment Resources to provide substance use treatment to members.
    2. Promote use of telehealth to access mental health providers. AlohaCare QI contracts with Amwell, a digital platform that offers telehealth visits with a psychiatrist or therapist. AlohaCare QI has educated its staff on how to connect members to this service.
    3. Promote Hawai'i Cares. Staff are reeducated on how and when to connect members to Hawai'i Cares to access Mental Health Providers.
    4. Promote use of AlohaCare QI's contracted Nurse Advice Line as a way for members to obtain medical advice during off-hours or when they cannot reach their provider.
    5. Focus on expanding specialist network and access by:

- – Launched e-consult program with ConferMED. This program enables PCPs to consult with a specialist electronically.
- – Enhanced internal workflows to assist members and providers in accessing specialists. Includes educating staff on how to find specialists offering telehealth.
- – Continued a Specialty Program which offers a bonus to specific specialists providing services to members.
- – Launch of Gold Carding Program, which removes administrative burden of submitting prior authorizations for specific specialists. This will help retain specialists and improve access to care.
- – Initial stages of exploring the feasibility of opening a specialty clinic.

HSAG Assessment

HSAG has determined that AlohaCare QI has addressed the prior year recommendations.

HMSA QUEST Integration (HMSA QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

Since HMSA QI did not attempt to abstract case management records or data for the three LTSS measures, it was not compliant with IS standard 8.0 for assessing case management data. HSAG recommends that HMSA QI prepare for the case management record review activities concurrently with its MRRV activities for MY 2023 reporting, as both activities are conducted on the same timeline.

Improvement Activities Implemented

HMSA QI has successfully submitted data for the three LTSS measures in MY2023. HMSA QI will be submitting data for the required LTSS measures in MY2024.

2023 HEDIS Performance Measure Recommendations

Based on HSAG's analyses of HMSA QI's 30 measure rates comparable to benchmarks, 13 measure rates (43.3 percent) ranked at or above the 50th percentile, with three of these rates (10.0 percent) ranking at or above the 75th percentile and one rate (3.3 percent) ranking at or above the 90th percentile, indicating 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 18–64 years of age who were hospitalized for a mental health illness. Additionally, HMSA QI met 11 MQD Quality Strategy targets for HEDIS MY 2022.

Conversely, 17 of HMSA QI's measure rates (56.7 percent) comparable to benchmarks fell below the 50th percentile, with seven rates (23.3 percent) falling below the 25th percentile, suggesting

considerable opportunities for improvement across timely receipt of childhood immunizations, along with timely prenatal and postpartum 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—Hepatitis B*, *IPV*, *MMR*, *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*
- Women's Health
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*

Improvement Activities Implemented

HMSA QI continues to partner with a vendor to provide incentives to members when they complete healthcare activities. Eligible healthcare activities include well-child visits with immunizations and prenatal and postpartum care visits. HMSA QI developed a maternal health webpage for members, including resources and content to support members throughout their maternal health journey. The online content includes information on the importance of prenatal and postpartum visits. The webpage is available at https://hmsa.com/maternalhealth.

HMSA QI continues its two primary care provider 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. These quality payment programs continue to include measures for childhood immunizations which encompass Hepatitis B and all vaccines grouped in Combos 3 and 7 and well-child visits in the first 30 months of life. Additionally, the FQHC Pay-for-Quality program includes measures for the timeliness of prenatal and postpartum care visits.

On a monthly basis, HMSA QI sends members age-specific mailers that remind them to complete their well-child exams and immunizations. These reminders include applicable vaccinations aligned to the Bright Futures screening and periodicity schedule. In 2024, HMSA QI refreshed the mailers with updated developmental milestones and immunization schedule inserts. HMSA QI also added a 2-months old mailer to the 6- and 12-months old sequence of mailings, to remind members sooner and further reinforce and support member education on well-child visits and immunizations.

HSAG Assessment

HSAG has determined that HMSA QI has addressed the prior year recommendations. HMSA QI should continue to explore other innovative ideas to encourage members to obtain preventative care services.

CAHPS—Child Survey

2023 Recommendations

HSAG performed an analysis of key drivers of member experience for the following three global ratings: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*. HMSA QI should consider determining whether potential quality improvement activities could improve member experience on each of the key drivers identified. Table 5-2 provides a summary of the key drivers identified for HMSA QI.

Table 5-2—HMSA QI Key Drivers of Member Experience Analysis

Key Drivers	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor
Q4. Child received care as soon as needed when care was needed right away	✓	✓	
Q9. Ease of getting the care, tests, or treatment the child needed	✓	✓	
Q20. Child's personal doctor seemed informed and up-to-date about care the child received from other doctors or health providers	✓	✓	

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

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

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.

Improvement Activities Implemented

The Payment Transformation program (described above) also includes incentives for provider organizations to improve CAHPS performance in areas including Getting Needed Care, which includes a question on ease of getting care, tests, and treatment; Getting Appointments and Care Quickly, which

includes a question on getting care when needed right away; and Care Coordination, which includes a question on how well-informed personal doctors seem about care received from specialists.

HSAG Assessment

HSAG has determined that HMSA QI has addressed the prior year recommendations. In addition to payment transformation, HMSA QI should continue to explore other opportunities to improve member satisfaction.

Home and Community-Based Services CAHPS Survey

2023 Recommendations

For HMSA QI, the mean scores for the following three measures were statistically significantly lower than the HI HCBS Program mean scores:

- *Transportation to Medical Appointments*
- *Planning Your Time and Activities*
- *Recommend Case Manager*

In addition, the mean scores for the following five measures were lower than the HI HCBS Program mean scores:

- *Rating of Personal Assistance and Behavioral Health Staff*
- *Rating of Case Manager*
- *Choosing the Services that Matter to You*
- *Personal Safety and Respect*
- *Recommend Personal Assistance/Behavioral Health Staff*

Improvement Activities Implemented

In 2023, HMSA QI began piloting a new case management model that includes pairing Health Coordinators with Care Coordinators and Community Health Workers to assist with member outreach and engagement. In addition, HMSA QI has Health Coordinator Assistants pre-populating member packets for all newly identified HCBS members. These new processes are attempts to reduce some of the administrative burden on the Health Coordinators, particularly those managing members receiving LTSS, and to increase member engagement and satisfaction.

HMSA QI will continue to expand its incorporation of Care Coordinators and Community Health Workers into the member's care team with the goal of increasing member engagement and satisfaction. HMSA QI is also expanding the Community Integration Services (CIS) program to assist members with pre-tenancy and tenancy services to help members attain and maintain safe and affordable housing.

HSAG Assessment

HSAG has determined that HMSA QI has addressed the prior year recommendations.

Provider Survey

2023 Recommendations

For HMSA QI, the 2023 top-box score for the following measure was statistically significantly lower than the QI Program aggregate:

- *Access to Substance Abuse Treatment*

In addition, the top-box score for the following measure was lower in 2023 than in 2021, although the measure's top-box score was not statistically significantly lower:

- *Timeliness of Claims Payments*

Improvement Activities Implemented

Access to Substance Abuse Treatment: HMSA QI works on expanding participating providers and facilities who specialize in substance abuse treatment which can aide in access to substance abuse treatment. HMSA QI is willing to contract with providers who are credentialed to treat substance abuse and facilities that are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) and/or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and are clinically supervised by a medical doctor (MD). Facilities that dispense methadone and/or treating Medicare members must have the Substance Abuse and Mental Health Services Administration (SAMHSA) certification as an Opioid Treatment Program as a requirement to be a participating provider. For the calendar year of 2024, HMSA has established 76 new contracts with providers who specialize in behavioral health or substance abuse treatment.

Currently, HMSA QI's behavioral health vendor, Carelon Behavioral Health, offers case management services for members who consent to receive services. This program can assist members with access to substance abuse treatment. The case manager assists members in finding resources and scheduling appointments for both behavioral health and substance use treatment. This assistance from case managers can help members navigate through the healthcare system and reduce barriers that may exist with accessing certain treatment or programs. HMSA QI understands that behavioral health is just as important as physical health, therefore the behavioral health case management program will continue under HMSA QI internally effective January 1, 2025, and continue to offer the same case management services for members. This will allow us to manage members with a holistic approach and allow one case manager to address all the needs of the member.

Starting January 1, 2025, HMSA QI will be partnering with Magellan Hawai'i as its new behavioral health vendor. Magellan is a clinical-first organization with over 50 years of experience collaborating

with health plans across the country and in Hawai'i. This extensive background underscores their commitment to delivering high-quality, evidence based behavioral health services. The new partnership with Magellan Hawai'i will introduce innovative tools and proven strategies, aimed at enhancing care delivery and outcomes. These include comprehensive analytic reporting provided to healthcare providers, extensive outreach programs to assist members with care transitions, and targeted initiatives to improve HEDIS measures. In addition, Magellan will assist with building provider relationships in the community thus potentially expanding HMSA QI's provider network which will create more access for members including substance abuse treatment.

Timeliness of Claims Payment: Through refinement of processes, workflows, and training/auditing of staff, for the past two quarters of 2023, the percent of claims for specific providers- Hospital Inpatient, Hospital Outpatient, FQHC/rural health clinic (RHC), Nursing Home, community care foster family home (CCFFH), Hospice, Home Health Agency, and all other provider types exceeded benchmark of 90% processed at 30 days after claims receipt. HMSA QI continues to monitor and identify opportunities to maintain performance.

HSAG Assessment

HSAG has determined that HMSA QI has addressed the prior year recommendations.

Kaiser Foundation Health Plan QUEST Integration (KFHP QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

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.

2023 HEDIS Performance Measure Recommendations

Based on HSAG's analyses of KFHP QI's 30 measure rates comparable to benchmarks, 20 measure rates (66.7 percent) ranked at or above the 50th percentile, with six rates (20.0 percent) meeting or exceeding the 75th percentile and seven rates (23.3 percent) meeting or exceeding the 90th percentile, indicating strong performance across all domains. Additionally, KFHP QI met 13 MQD Quality Strategy targets for HEDIS MY 2022.

Conversely, 10 of KFHP QI's measure rates comparable to benchmarks (33.3 percent) fell below the 50th percentile, five of which (16.7 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, 12–17 Years, 18–21 Years,* and *Total*
  - *Childhood Immunization Status—HiB*

Improvement Activities Implemented

KFHP QI is continuing its processes and has implemented PDSA's (Plan-do-study-act) for appointment reminders via live phone calls for pediatric visits. Initially, KFHP QI tried reminder calls 1-2 days before the appointment but found that parents didn't have enough time to reschedule if needed, so KFHP QI is adjusting the calls to 5-7 days before the appointment.

KFHP QI is working on reminders for children who are overdue or due soon for vaccines and booking them for well-child exams.

HSAG Assessment

HSAG has determined that KFHP QI has addressed the prior year recommendations. KFHP QI should also continue to explore other innovative ideas to increase child preventative care visits.

CAHPS—Child Survey

2023 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
Q20. Child's personal doctor seemed informed and up-to-date about care the child received from other doctors or health providers	✓		✓
Q30. 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 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 fill out forms from their child's health 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 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.

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.

Improvement Activities Implemented

Review the Well-Child questionnaire by 12/31/2024 to identify ways to make the form and mobile app response more user-friendly for parents prior to doctor's visits.

Physicians and providers will undergo refresher training on how best to communicate their review of the medical record and awareness of care provided by specialists/other providers. The next cycle of this training will be launched before 6/30/25.

HSAG Assessment

While KFHP QI has documented planned interventions to address the 2023 recommendations, no interventions were implemented during 2024. HSAG has determined that KFHP QI has minimally addressed the prior year recommendations.

Home and Community-Based Services CAHPS Survey

2023 Recommendations

None of the mean scores were lower/statistically significantly lower than the HI HCBS Program; therefore, no substantial weaknesses were identified.

Improvement Activities Implemented

Not applicable.

HSAG Assessment

Not applicable.

Provider Survey

2023 Recommendations

For KFHP QI, the top-box scores for the following seven measures were lower in 2023 than in 2021, although no measure's top-box score was statistically significantly lower:

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

Improvement Activities Implemented

1. Complete enhanced provider training deck by 1/31/2025.
2. Providers currently receive information on all the topics above. Enhance training of provider services staff to emphasize these topics with new contracted providers, including Health Plan and HPMG providers by 3/31/2025. For existing providers by 12/31/2025.
3. Review and expand provider manual to emphasize information regarding the topics above (target submission of provider manual to MQD by 6/30/2025).
4. Review additional provider tools / resources for posting on the Community Provider Portal websites.

HSAG Assessment

While KFHP QI has documented planned interventions to address the 2023 recommendations, no interventions were implemented during 2024. HSAG has determined that KFHP QI has minimally addressed the prior year recommendations.

‘Ohana Health Plan QUEST Integration (‘Ohana QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

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.

2023 HEDIS Performance Measure Recommendations

Based on HSAG's analyses of 'Ohana QI's 28 measure rates comparable to benchmarks, one measure rate (3.6 percent) ranked at or above the 75th percentile. Additionally, 'Ohana QI met four MQD Quality Strategy targets for HEDIS MY 2022.

Conversely, 27 measure rates comparable to benchmarks (96.4 percent) ranked below the 50th percentile, with 21 measure rates (75.0 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—3–11 Years, 12–17 Years, 18–21 Years,* and *Total*
  - *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 in the First 15 Months of Life—Six or More Well-Child Visits* and *Well-Child Visits for 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* and *Postpartum Care*
- Chronic Conditions
  - *Controlling High Blood Pressure—Total*
- Behavioral Health
  - *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—18–64 Years, 7-Day Follow-Up—Total, 30-Day Follow-Up—18–64 Years,* and *30-Day Follow-Up—Total*

Improvement Activities Implemented

Children's Preventive Health

Child and Adolescent Well-Care Visits—3–11 Years, 12–17 Years, 18–21 Years, and *Total*

- Medicaid Partnership for Quality (P4Q) Provider Incentive Program:

- ‘Ohana QI understands that the provider-member relationship is a key component in ensuring superior healthcare and the satisfaction of members. ‘Ohana QI recognizes these important partnerships and developed the P4Q program to reward PCPs for submitting documentation for HEDIS measures (International Classification of Diseases (ICD) 10, Current Procedural Terminology (CPT), CPT II, National Drug Code (NDC)). To help maximize gap closures, ‘Ohana QI pays $0.01 for certain CPT II codes to allow billing without receiving a non-payable code denial. Using CPT II codes for certain preventive care services and test results makes it easier for providers to share data with the health plan quickly and efficiently.
  - Additional bonus incentives are given to providers, pediatricians, and FQHCs.
- Member Incentive Program
  - Members are able to earn My Health Pays rewards when they complete healthy activities such as yearly wellness exams, annual screenings, tests, and other ways to protect their health. Members receive their My Health Pays™ Visa® Prepaid Card after they earn their first reward from ‘Ohana QI. My Health Pays reward dollars are added to member’s rewards card after the claim is processed for each activity that is completed. My Health Pays rewards can be used to help pay for utilities, transportation, telecommunications, childcare services, education, rent, and everyday items from Walmart.
- EPSDT Periodicity Letters
  - Members receive a letter indicating that they are due for a EPSDT visit.
- Electronic Medical Record Integration
  - ‘Ohana QI made large gains to increase electronic medical record (EMR) access and implemented several key EMR integrations. As a result, the health plan hopes that ‘Ohana has reduced provider burden and made it significantly easier to do business with us. In addition, by increasing the ability to retrieve charts, ‘Ohana QI hopes that its HEDIS scores become closer to a true representation of the care members receive and ‘Ohana QI is better able to identify areas of true clinical need, rather than gaps in data.
  - Implementation of Epic Payor Platform for Queen’s Clinically Integrated Physician Network (QCIPN) who owns a large portion of ‘Ohana QI’s membership (approximately 9%). In addition, ‘Ohana QI was able to add multiple FQHC’s through integration with Athena and Healow platforms. ‘Ohana QI’s outfacing provider representatives consistently reach out to their assigned providers in hope of obtaining the highest level of access.
- Well-Child Visit targeted call campaign:
  - ‘Ohana QI completed a call campaign that conducted active outreach to all families/parents with children that had a well-child visit gap. During these calls, staff provided education regarding the importance of routine care appointments and how to get access to appropriate practitioners. Staff also assisted families that needed help scheduling appointments and provided resources on establishing a PCP and finding specialists.

Childhood Immunization Status—Combination 3, Combination 7, Combination 10, DTaP, Hepatitis A, Hepatitis B, HiB, IPV, MMR, Pneumococcal Conjugate, Rotavirus, and *VZV*

- Fluvention® is a multi-layered seasonal campaign designed to promote vaccinations as the key to flu prevention. The program for all members who are eligible for a flu vaccine, with a specific focus on

members who are pregnant, between six (6) months and five (5) years old, 65 years or older, and/or have a chronic condition(s), as these members have a higher risk of developing flu-related complications. This initiative strives to increase influenza vaccination rates through a collection of targeted services and activities:

- Member Outreach and Marketing: In collaboration with Marketing, the Fluvention team helps create member-facing materials to educate on the importance of receiving a flu shot through the following methods
  - IVR/on-hold messaging
  - Proactive Outreach Manager (POM)/Auto-dialer outbound phone calls
  - Texts and/or e-mails
  - Flu-specific messaging on the health plan website and social media platforms
- Provider Facing Materials: In collaboration with Marketing, the Fluvention team helps create provider-facing materials including:
  - Email template for provider facing teams to utilize
  - Web article and newsletter content to equip providers with key talking points on flu vaccination
  - Leave behind flyer
- Care Management: Care Managers interact directly with members to reinforce the importance of the flu vaccine and are alerted to members who have not yet had an annual flu vaccine. Member educational materials, described above, are also provided to members following outreach. Care Managers are provided with talking points that encourage them to talk to pregnant members about the importance of flu vaccinations and how to address specific concerns pregnant and/or breastfeeding moms may have about vaccinations.

- Hawaii Immunization registry and health information exchanges

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 and *Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits*

- EPSDT Periodicity Letters
  - Members receive a letter indicating that they are due for a EPSDT visit.
- ‘Ohana QI initiated the Hallmark campaign. The objective of ‘Ohana QI’s Hallmark campaign was to support member satisfaction/retention and address quality care gaps by engaging with members in a new, more personalized way through co-branded Hallmark cards. Traditional outreach methods have yielded low engagement rates—letters/postcards are often unopened and outbound call campaigns have low reach rates. In addition, ‘Ohana QI members are often wary of corporate call campaigns from Centene/Wellcare due to the out of state phone number shown on caller ID and corporate branding on mailers may have led to confusion on ‘Ohana Health Plan’s brand identity. To address these barriers, selected cohorts of Medicaid and Medicare members were mailed a Hallmark card that expressed ‘Ohana QI’s appreciation for their membership along with a targeted insert - Medicaid topics included Child and Adolescent Well-Care Visits and a CAHPS survey reminder. A

total of 13,000 cards were sent out with mail drops staged in three waves throughout the year, timed to align with recommended care gap closure timeframes.

- Medicaid Partnership for Quality (P4Q) Provider Incentive Program:
  - ‘Ohana QI understands that the provider-member relationship is a key component in ensuring superior healthcare and the satisfaction of members. ‘Ohana QI recognizes these important partnerships and developed the P4Q program to reward PCPs for submitting documentation for HEDIS measures (ICD10, CPT, CPT II, NDC). To help maximize gap closures, ‘Ohana QI pays $0.01 for certain CPT II codes to allow billing without receiving a non-payable code denial. Using CPT II codes for certain preventive care services and test results makes it easier for providers to share data with the health plan quickly and efficiently.
  - Additional bonus incentives are given to providers, pediatricians, and FQHCs.
- Member Incentive Program:
  - Members are able to earn My Health Pays rewards when they complete healthy activities such as yearly wellness exams, annual screenings, tests, and other ways to protect their health. Members receive their My Health Pays™ Visa® Prepaid Card after they earn their first reward from ‘Ohana QI. My Health Pays reward dollars are added to member’s rewards card after the claim is processed for each activity that is completed. My Health Pays rewards can be used to help pay for utilities, transportation, telecommunications, childcare services, education, rent, and everyday items from Walmart.
- Partnership with Mana ‘Ohana
  - The program, Mana ‘Ohana, is a community based, midwifery-led model of care that offers Hawaii residents with a holistic perinatal care experience. The program includes clinical and social services deployed when, where, and how services are needed. This program offers ‘Ohana QI’s members exclusive access to a broad-based program designed to screen, triage, and support women and their newborns throughout the perinatal period by providing culturally anchored and responsive outreach and services that meet members where they are. The goal of the program is to reduce costs and to increase quality of care for ‘Ohana QI members. The program aims to do this by decreasing rates of cesarean section/other birth complications, decreasing neonatal intensive care unit (NICU) infants, and increasing HEDIS quality scores (prenatal, postpartum and well child visits within the first 15 months).
  - Healthy Mothers Healthy Babies (HMHB) manages the maternal & child health program for ‘Ohana QI. HMHB outreaches to members within 10 business days of receipt of the electronic data file from ‘Ohana QI. HMHB prioritizes members who are later along in their pregnancy, or who for some other clinical reason take precedence (such as high-risk members). Up to three (3) outbound telephone calls are made, in the day and evening, to maximize the response rate. During engagement, HMHB staff conducts triage and assesses the need for the following:
    - Appropriate Behavioral and/or Clinical services
    - Facilitate engagement for prenatal and/or postpartum care visits
    - Identification of other needs and provide SDOH services
  - HMHB engages with members with SDOH programs and on-going case management throughout pregnancy, birth, and postpartum periods. Additional follow-ups with well-child visits are

conducted. HMHB mails outreach material and member educational module to each member within 14 days of the receipt of contact information.
  - HMHB prepares annual reports describing program outcomes. The program evaluation instrument will minimally include member experience with the program, information about referrals to care and/or social programs in and outside of HMHB, additional patterns and data around engagement to be mutually defined by the Parties. Reports will be shared with ‘Ohana QI’s Director of Quality and distributed across ‘Ohana QI. HMHB presents to ‘Ohana QI’s executive committee, or other teams on request at mutually agreed upon times.
  - HMHB engages with members to increase the rates of the following measures:
    - Timeliness of Prenatal and Postpartum Care
      - Increase the number of pregnant members that receive a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.
      - Increase the number of members that had a postpartum visit on or between 7 and 84 days after delivery.
    - Well-Child Visits in the First 15 Months of Life
      - Increase the number of child members that receive at least 6 wellness visits within the first 15 months of life.

Women’s Health

Cervical Cancer Screening (CCS)

- Medicaid Partnership for Quality (P4Q) Provider Incentive Program:
  - ‘Ohana QI understands that the provider-member relationship is a key component in ensuring superior healthcare and the satisfaction of members. ‘Ohana QI recognizes these important partnerships and developed the P4Q program to reward PCPs for submitting documentation for HEDIS measures (ICD10, CPT, CPT II, NDC). To help maximize gap closures, ‘Ohana QI pays $0.01 for certain CPT II codes to allow billing without receiving a non-payable code denial. Using CPT II codes for certain preventive care services and test results makes it easier for providers to share data with the health plan quickly and efficiently.
- Targeted CCS call campaign :
  - ‘Ohana QI completed a call campaign that conducted active outreach to all members with a CCS care gap. During these calls, staff provided education regarding the importance of CCS and how to get access to appropriate practitioners. Staff also assisted members that needed help scheduling an appointment.

Prenatal and Postpartum Care—Timeliness of Prenatal Care and *Postpartum Care*

- Partnership with Mana ‘Ohana
  - The program, Mana ‘Ohana, is a community based, midwifery-led model of care that offers Hawaii Residents with a holistic perinatal care experience. The program includes clinical and

social services deployed when, where, and how services are needed. This program offers ‘Ohana QI’s members exclusive access to a broad-based program designed to screen, triage, and support women and their newborns throughout the perinatal period by providing culturally anchored and responsive outreach and services that meet members where they are. The goal of the program is to reduce costs and to increase quality of care for ‘Ohana QI members. The program aims to do this by decreasing rates of cesarean section/other birth complications, decreasing NICU infants, and increasing HEDIS quality scores (prenatal, postpartum and well child visits within the first 15 months).

  - Healthy Mothers Healthy Babies (HMHB) manages the maternal & child health program for ‘Ohana QI. HMHB outreaches to members within 10 business days of receipt of the electronic data file from ‘Ohana QI. HMHB prioritizes members who are later along in their pregnancy, or who for some other clinical reason take precedence (such as high-risk members). Up to three (3) outbound telephone calls are made, in the day and evening, to maximize the response rate. During engagement, HMHB staff conducts triage and assesses the need for the following:
    - Appropriate Behavioral and/or Clinical services
    - Facilitate engagement for prenatal and/or postpartum care visits
    - Identification of other needs and provide SDOH services
  - HMHB engages with members with SDOH programs and on-going case management throughout pregnancy, birth, and postpartum periods. Additional follow-ups with well-child visits are conducted. HMHB mails outreach material and member educational module to each member within 14 days of the receipt of contact information.
  - HMHB prepares annual reports describing program outcomes. The program evaluation instrument will minimally include member experience with the program, information about referrals to care and/or social programs in and outside of HMHB, additional patterns and data around engagement to be mutually defined by the Parties. Reports will be shared with ‘Ohana’s Director of Quality and distributed across ‘Ohana QI. HMHB presents to ‘Ohana QI’s executive committee, or other teams on request at mutually agreed upon times.
  - HMHB engages with members to increase the rates of the following measures:
    - Timeliness of Prenatal and Postpartum Care
      - Increase the number of pregnant members that receive a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.
      - Increase the number of members that had a postpartum visit on or between 7 and 84 days after delivery.
    - Well-Child Visits in the First 15 Months of Life
      - Increase the number of child members that receive at least 6 wellness visits within the first 15 months of life.
- EPSDT Letter and Brochure: Mothers are sent a letter to congratulate them on their new baby and informing them of ‘Ohana QI's EPSDT Program
- Provider Education using HEDIS Adult Pocket Guides: Provider educational material on HEDIS-related women's health measures.

- ‘Ohana Health Plan Baby Shower - Campaign to invite pregnant mothers to celebrate healthy pregnancy, provide resources and education for prenatal, postnatal, and childcare.

Chronic Conditions

Controlling High Blood Pressure—Total

- The Supportive Care Program identifies members with high-cost care and high utilization with a chronic limiting condition, providing in home services by contracting hospice agency for symptom and condition management to improve quality of life.
- Medicaid Partnership for Quality (P4Q) Provider Incentive Program:
  - ‘Ohana QI understands that the provider-member relationship is a key component in ensuring superior healthcare and the satisfaction of members. ‘Ohana QI recognizes these important partnerships and developed the P4Q program to reward PCPs for submitting documentation for Healthcare Effectiveness HEDIS measures (ICD10, CPT, CPT II, NDC). To help maximize gap closures, ‘Ohana QI pays $0.01 for certain CPT II codes to allow billing without receiving a non-payable code denial. Using CPT II codes for certain preventive care services and test results makes it easier for providers to share data with the health plan quickly and efficiently.

Behavioral Health (BH)

Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—18–64 Years, 7-Day Follow-Up—Total, 30-Day Follow-Up—18–64 Years, and *30-Day Follow-Up—Total*

- Medicaid Behavioral Health Bonus Provider Incentive Program:
  - Behavioral health (BH) practitioners are provided incentives for submitting claim/encounter containing the requisite diagnosis and/or procedure codes to receive the bonus payment for eligible members for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* measure.
  - Resourced and assigned internal Qualified Mental Health Practitioners (QMHPs) and CHW to track and complete follow-up with members who discharge from these facilities and maintains relationship with BH unit in respective facilities (Queens, Castle, Maui Memorial, and Hilo Medical). The Quality Improvement Department facilitates the intervention on all members who discharge statewide and tracks/monitors members who are needing follow-ups and communicate daily with ‘Ohana QI’s QMHPs and CHW, as well as service coordination and utilization management as needed.

HSAG Assessment

HSAG has determined that ‘Ohana QI has addressed the prior year recommendations.

CAHPS—Child Survey

2023 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*
Q9. Ease of getting the care, tests, or treatment the child needed	✓	✓	
Q17. Child's personal doctor spent enough time with the child	✓		✓
Q20. Child's personal doctor seemed informed and up-to-date about care the child received from other doctors or health providers	✓	✓	✓
Q23. Child received appointment with a specialist as soon as 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 that it was not always easy to get the care, tests, or treatment they thought their child needed through their plan.
- Respondents reported not always receiving an appointment with a specialist as soon as their child 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 child's personal doctor did not always spend enough time with their child.
- Respondents reported their child's personal doctor did not always seem informed and up-to-date about the care their child received from other doctors or health providers.

Improvement Activities Implemented

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

Provider Focused Activities:

- Companywide education has been deployed emphasizing CAHPS including topics around behavioral economics. 'Ohana QI has launched several initiatives within its provider community to streamline processes and procedures which might delay or cause members to not receive care. For instance, 'Ohana QI rescinded over 50 prior authorization criteria across a variety of services and is in the process of creating "gold card" relationships with key providers. 'Ohana QI piloted innovative ideas for connecting with members and providing relevant information in a meaningful way. Examples include:
  - Partnership with Hallmark to send cards to members which include a short insert around a specific health topic or benefit (including what to ask your PCP and how to utilize the member reward incentive program).
  - Partnership with a local provider group to develop and deploy educational videos featuring real providers and staff. Topics included "how to maximize your visit" to help ensure members experience at the PCP office the best it can be.
  - Advancing value-based contracting with key strategic providers which aligns goals around HEDIS and CAHPS outcomes.
  - Increased investment in provider relations teams to help identify and address barriers to members receiving the care that they need.

Member Focused Activities:

- 'Ohana QI continued the Hallmark campaign to support member satisfaction/retention and address quality care gaps by engaging with members in a new, more personalized way through co-branded Hallmark cards. Traditional outreach methods have yielded low engagement rates – letters/postcards are often unopened and outbound call campaigns have low reach rates. In addition, 'Ohana QI members are often wary of corporate call campaigns from Centene/Wellcare due to the out of state phone number shown on caller ID and corporate branding on mailers may have led to confusion on 'Ohana QI's brand identity. To address these barriers, selected cohorts of Medicaid and Medicare members were mailed a Hallmark card that expressed 'Ohana QI's appreciation for their membership along with a targeted insert - Medicaid topics included Child and Adolescent Well-Care Visit and a CAHPS survey reminder. Medicare topics included Controlling Blood Pressure, HbA1c control, Annual Wellness Visit, and preventive screenings.
- Parents may not always understand how to establish a PCP for their child or know when to schedule an appointment for their child's routine care. Parents may also lack knowledge on available resources for scheduling specialist appointments. 'Ohana QI addressed this barrier by providing active outreach to all families/parents with children that had a well-child visit gap. During these calls, staff provided education regarding the importance of routine care appointments and how to get access to appropriate practitioners. Staff also assisted families that needed help scheduling appointments and provided resources on establishing a PCP and finding specialists.

Access to Care:

- The Contracting and Network Development team focused on enhancing recruiting strategies to target specialists, including BH prescribing practitioners. The Networking department provided provider education to BH providers on the resources that ‘Ohana has available to help with recruiting strategies. ‘Ohana QI also continues to educate members on utilizing telemedicine and virtual visits.
- An opportunity was also identified to partner with Hazel Health, a telehealth provider, to improve children’s immediate access to BH healthcare needs in times when there are limited BH practitioners available.

HSAG Assessment

HSAG has determined that ‘Ohana QI has addressed the prior year recommendations.

Home and Community-Based Services CAHPS Survey

2023 Recommendations

For ‘Ohana QI, the mean scores for the following five measures were lower than the HI HCBS Program mean scores, although no measure’s mean score was statistically significantly lower:

- *Rating of Case Manager*
- *Transportation to Medical Appointments*
- *Personal Safety and Respect*
- *Planning Your Time and Activities*
- *Recommend Homemaker*

Improvement Activities Implemented

- Health Coordinators are provided with continuous training on up-to-date processes and procedures including member benefits, to provide education to their members regarding services that are available.
- Streamlined Community Health Worker partnership with Case Manager/Health Coordinator to provide a better member experience.
- Improved email communication with Intelliride:
  - The vendor created one email address that includes all the agents who work on ‘Ohana QI travel requests. This provides transparency for all requests to all agents and the supervisor. The ‘Ohana QI Utilization Management Supervisor meets regularly with the Intelliride Supervisor to address any concerns and escalations and the two contacts are in touch with each other as situations occur.
- Vivia Pilot Program

- Unique home care solution: shifting from a time-based model to a task-based model, allowing caregivers to care for up to 10x more members.
    - Vivia's caregiving staff are full-time employees with guaranteed hours.
    - Vivia furnishes transportation for its employees via company car, to serve a geographic neighborhood of At-Risk and LTSS members.
    - Payment transformation pilot of "Per Visit" reimbursement.
    - Member requires PA1 or PA2 services that are short in duration and/or intermittent and can be provided with a visit that is less than 2 hours per day.
    - There has been a statewide staffing shortage at home care agencies and as a result, staffing Personal Assistance (PA) 1 and PA2 services for members has been difficult during/since the pandemic. Vivia has been able to start services fairly quickly and has staffed some members who have been without agency services for over 1 year. This will hopefully improve overall member satisfaction with HCBS.
- The Member Advisory Committee is a group of members, parents, guardians, member advocacy groups, and health plan staff as appropriate, that reviews and reports on a variety of quality and service issues. The health plan understands that the ability to effectively engage stakeholders, including members/family members/caregivers, advocates, and community organizations in the quality program is a crucial component of collaborative efforts to enhance a patient-centered service delivery system, to optimize clinical outcomes, and to positively affect program operations.

HSAG Assessment

HSAG has determined that 'Ohana QI has addressed the prior year recommendations.

Provider Survey

2023 Recommendations

For 'Ohana QI, the top-box scores for all nine 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*
- *Helpfulness of Health Coordinators*
- *Adequacy of Specialists*
- *Availability of Mental Health Providers*

- *Access to Substance Abuse Treatment*

Improvement Activities Implemented

The Provider Satisfaction Survey allows ‘Ohana QI to gather valuable feedback to identify areas of highest priority to address concerns which can lead to better patient care and outcomes. To drive provider satisfaction survey awareness, ‘Ohana QI has created general and targeted educational flyers. Both general and targeted flyers are sent to convey critical nature of provider feedback to improvement initiatives. Call campaigns are conducted to follow up with providers to learn of the barriers that they are experiencing. The Provider Satisfaction Survey is to be added to the Provider Meeting Agenda to explain how ‘Ohana QI uses feedback to make changes in the administration of ‘Ohana QI’s business at both the corporate and local levels.

In 2023 and into 2024 the Hawaii Medicaid program compensation changed structurally overall. Additional All Patient Refined Diagnosis Related Groups (APR-DRG) billing guidance was given to refine and standardize the change to APR-DRG inpatient reimbursement that had happened the previous year, and professional fees were raised to a Medicare for Medicaid fee structure.

In conjunction with that, ‘Ohana QI reduced the number of professional and allied and ancillary provider claims hitting payment integrity edits in 2024. ‘Ohana QI also started a project this year for members of its senior leadership team to reach out to and engage a certain amount of provider practices to “talk story” with them about their experiences with ‘Ohana QI. In support of a better provider experience, ‘Ohana QI also increased the number of staff in the provider relations department to 10 employees. ‘Ohana QI is now able to be more proactive in holding additional Joint Operating Committees (JOCs) with many key providers and flagging potential claims processing issues or potential errors to research, outreach, and root cause issues. The vast majority of auto-adjudicated claims pass through the core processing system in less than 10 days and most payments should be in hand 2-3 weeks (electronic funds transfer (EFT) and paper) post submission for these claims. At the 30 day benchmark, ‘Ohana QI is consistently processing over 99 percent of claims in 30 days.

‘Ohana QI also implemented an authorization waiver for all specialists (to include mental health and substance abuse providers as well) performing services in place of service 11 so long as they are accepting new patient referrals. ‘Ohana QI’s hope is that this will ease the administrative burden on specialist practices, encourage them to take new patients, and allow them to schedule appointments timelier if they are not waiting on an authorization from the health plan. ‘Ohana QI will monitor back-end utilization to ensure there is no abuse of the program, but ‘Ohana QI hopes it will be well received by both the primary care and specialist community. ‘Ohana QI continues to add additional providers to the gold card list as they indicate a willingness to open panel and/or ‘Ohana QI allows any newly participating specialists to be gold carded so long as they remain open panel/accepting new members.

‘Ohana QI is currently working on a partnership with Hazel Health & The Hawaii State Department of Health to expand equitable access to care and enhance student mental wellness for youth. Hazel Health targets school aged youth who need immediate community support and comprehensive care that

includes behavioral health conditions. With this partnership, ‘Ohana QI expects to see an increase in accessibility for behavioral health services.

In regard to substance abuse, ‘Ohana QI’s family peer specialists conduct outreach to targeted members to do assertive outreach, refer to partnering treatment providers and care coordination, and enroll in the Opioid Use Disorder program. ‘Ohana QI’s partnership with Hawaii Health and Harm Reduction Center addresses opioid use disorder within the Medicaid population. ‘Ohana QI also utilizes the American Specialty Health program as a value-added benefit to help members to find alternative treatment and coaching for optimal pain relief with or without opioids.

On the pharmacy side, ‘Ohana QI migrated from CVS Caremark to Express Scripts, Inc (ESI) as its pharmacy benefits manager (PBM) in 2024. With this change, ‘Ohana QI also had many internal organizational changes that were beneficial to improving pharmacy customer service for both providers and members, including an upgrade in pharmacy help desk services through the call center.

‘Ohana QI offers one of the most robust formularies currently in the State. Additional provider, pharmacy, care agency, and staff education were implemented in 2024. The goal is to foster better understanding of the formulary (what is covered), explain benefits, navigate provider resources (website, posted preferred drug list [PDL]), and reduce any point-of-sale (POS) issues.

In 2024, ‘Ohana QI has continued to tailor its formulary as well as its non-formulary offerings to provide better understanding for providers and members.

- ‘Ohana QI enhanced its pharmacy prescription offering to up to 100-day supply for select maintenance medication for both Medicaid plans (QI and Community Care Services).
- ‘Ohana QI updated its ‘Ohana QI website to make it more user friendly.
- ‘Ohana QI moved to a new formulary platform to better manage its formulary. This enhancement provides a user-friendly search and display tool functions for members and providers.
- Aligned drug criteria for prior authorization (PA) requests to reduce the administrative burden and confusion for providers.
- Monthly formulary updates are posted on the website.
- Updated drug criteria are posted on the website.
- Removed Step-Therapy (ST) requirements to improve medication access.
- Cleaned up transition fill process for better access.

‘Ohana QI also continued to drive direct pharmacy partnerships that provide better access to medication, improved quality outcomes, and foster a community care team model including enhanced long-acting injectable (LAI) access for houseless or hard to contact members through 5-Minute Pharmacy partnerships.

With the launch of the FIDE-SNP plan, a fully integrated benefit offering for dual-eligible members, this offering has helped to streamline pharmacy benefits and reduce confusion with COB and POS access issues for dual-eligible members.

‘Ohana QI also restructured the health coordination department to align with the new fully integrated dual-eligible special needs plan (FIDE-SNP) product in March of 2024. This ensures that dual-eligible members are being serviced by a specialized group of health coordinators skilled at coordinating care between the two benefit plans. To enhance rapport between members and providers, case managers were designated as the primary health plan contact, supported by non-member-facing staff. Previously, cases were assigned to a team, and members often got confused by being contacted by different team members.

In July 2024, ‘Ohana QI further restructured the health coordination department by decreasing caseloads from 200 to 65 to further enhance member and provider rapport and to improve performance metrics.

The health coordination team also participates in the JOCs with provider groups to discuss their needs and the needs of their patients. During these meetings, providers receive an introduction to health coordination and related programs, information on how to send referrals, and panel-specific reports. Providers are also invited to participate in Interdisciplinary Team (IDT) meetings for health-coordinated members, including those who qualify for CCS and FIDE, when appropriate.

HSAG Assessment

HSAG has determined that ‘Ohana QI has addressed the prior year recommendations.

UnitedHealthcare Community Plan QUEST Integration (UHC CP QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

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.

2023 HEDIS Performance Measure Recommendations

Based on HSAG’s analyses of UHC CP QI’s 28 measure rates comparable to benchmarks, seven measure rates (25.0 percent) ranked at or above the 50th percentile, with three of these rates (10.7 percent) ranking at or above the 75th percentile and one rate (3.6 percent) ranking at or above the 90th percentile, indicating positive performance in several areas, including follow-up visits for members hospitalized for mental illness and care for members with diabetes and high blood pressure. Additionally, UHC CP QI met nine MQD Quality Strategy targets for HEDIS MY 2022.

Conversely, 21 of UHC CP QI’s 28 measure rates comparable to benchmarks (75.0 percent) fell below the 50th percentile, with 18 of these rates (64.3 percent) falling below the 25th percentile, suggesting

considerable opportunities for improvement across all domains. HSAG recommends that UHC CP QI focus on improving performance related to the following measures with rates that fell below the 25th percentile for the QI population:

- 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*

Improvement Activities Implemented

- **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*

UHC CP QI operates an EPSDT program for children and adolescents up to the age of 21. The EPSDT program promotes EPSDT services (including immunizations) that align with updated Bright Futures screening and periodicity schedule. EPSDT outreach and education activities include reminder mailers for members who are due or overdue for screening, welcome mailers for new members, pregnancy mailers for pregnant women within 21 days after confirmation of their pregnancy, and delivery mailers for new mothers within 14 days of delivery. UHC CP QI also collaborates with providers and various State agencies such as the Department of Health on promotional and educational programs to encourage screenings and immunizations.

UHC CP QI also partners with the Early Intervention Program (EIP) to provides early intervention services and supports to eligible EPSDT members until their third birthday. All EIP members are offered Health Coordination upon enrollment and again prior to transition at the age of three if the family declined prior Health Coordination. As part of the EIP program, the EIP case manager and UHC CP QI Health Coordinators collaborate on complex care to support the member and family with EPSDT services as well as transition out of the program at three years old.

UHC CP QI has a Member Rewards program to encourage members with an open care gap to complete a well-child visit or to take all their recommended childhood and adolescent immunizations. UHC CP QI's Member Rewards program offers eligible members a gift card as a reward for addressing an

outstanding care or services. Member Rewards measures include Childhood Immunization Status (CIS – Combo 10), Immunizations for Adolescents (IMA – Combo 2), Well-Child Visits in the First 30 Months of Life (W30), and Child and Adolescent Well-child Visits (WCV).

UHC CP QI has provider incentive programs for qualifying physician practices for performance tied to addressing patient care opportunities for certain HEDIS® measures. The Community Plan PCP incentive program (CP-PCPi) offers select providers with additional incentives for helping members become more engaged in their preventive healthcare. UHC CP QI also has a Community Plan Health Equity Program incentive (CP-HEPi) that is designed to reduce healthcare disparities. The focus of the CP-HEPi program is to address health inequities with various measures including well child visits.

UHC CP QI participates in a child immunization program that sends a postcard reminder for missed dosed vaccines targeting parents or guardians of children at ages six months, eight months, and 16 months. The program is ongoing and runs year-round.

UHC CP QI has a Live Agent Program where live agents makes outbound calls to members and assist with scheduling appointments. The live agent makes three attempts to connect with the member to schedule an appointment. The program targets members who were identified as noncompliant for childhood immunizations and well child visits. The program is ongoing and runs year-round.

UHC CP QI also launched a new campaign targeting members with an open gap for well-child visits (WCV). As part of the live calling program, they also schedule the medical appointments directly with the provider or clinic if needed. The program launched in August 2024 and is ongoing through year-end.

- **Women's Health**
  - *Cervical Cancer Screening*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

UHC CP QI has a maternity support program, Hāpai Mālama (also called Healthy First Steps), for pregnant and postpartum women to promote a healthy pregnancy and improve birth outcomes. The program promotes early and ongoing prenatal care, with a focus on decreasing NICU admissions and reducing the incidence of premature and low birth weight babies and postpartum care. The program provides ongoing support, education, monthly calls, appointment assistance and reminders, assistance with breast feeding and ordering a breast pump prior to delivery, as well as a rewards program for attending prenatal, postpartum, and EPSDT/well child visits. Hāpai Mālama supports members with a healthy pregnancy, and those who are at high risk or rising risk.

UHC CP QI uses WellHop, a virtual platform that connects women of similar gestational ages to prenatal and post-natal support in a virtual group setting. The platform is available for all pregnant women and new mothers who gave birth in the last 15 months. The group sessions are for UHC CP QI members to gain knowledge and social support related to pregnancy, birth, returning to work, stress reduction, and infant care.

UHC CP QI deployed a women's health email campaign in late October 2024. The email campaign encouraged women to complete their yearly wellness exam and preventive screenings for both breast cancer and cervical cancer. The email targeted thousands of women between ages 21 to 64 years for cervical cancer screening and women between ages 50 to 74 years for breast cancer screening.

UHCP CP QI's Summer 2024 edition of the member newsletter (HealthTalk) featured an article, "Know your risk and take action" highlighting risk factors for breast cancer and cervical cancer and encouraging members to complete a screening and/or to get vaccinated against human papillomavirus (HPV).

UHC CP QI has a Member Rewards program to encourage members with an open care gap to complete a cervical cancer screening and postpartum care. UHC CP QI's Member Rewards program offers eligible members a gift card as a reward for closing a care gap. Member Rewards measures include Cervical Cancer Screening and Postpartum Care (PPC). Members complete an attestation online or by mail to receive their reward. The program launched in summer 2024 and runs through year-end.

UHC CP QI launched Babyscripts in December 2023. Babyscripts is a mobile app based maternity engagement, education, and rewards platform for pregnant members, offering rewards when enrolling and completing prenatal and postpartum visits. Rewards offered are a Walmart Healthy Living e-Gift card for Hawaii for enrollment, prenatal visit, and postpartum visit.

UHC CP QI has provider incentive programs for qualifying physician practices for performance tied to addressing patient care opportunities for certain HEDIS® measures. The Community Plan PCP incentive program (CP-PCPi) offers select providers with additional incentives for helping members become more engaged in their preventive healthcare. UHC CP QI also has a Community Plan Health Equity Program incentive (CP-HEPi) that is designed to reduce healthcare disparities. The focus of the CP-HEPi program is to address health inequities with various measures including timeliness of prenatal care and postpartum care.

HSAG Assessment

HSAG has determined that UHC CP QI has addressed the prior year recommendations.

CAHPS—Child Survey

2023 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
Q17. Child's personal doctor spent enough time with the child	✓	✓	✓
Q20. Child's personal doctor seemed informed and up-to-date about care the child received from other doctors or health providers			✓
Q23. Child received appointment with a specialist as soon as needed		✓	**N/A**
Q30. 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 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 fill out forms from their child's health plan.
- Respondents reported not always receiving an appointment with a specialist as soon as their child needed.

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 child's personal doctor did not always spend enough time with their child.
- Respondents reported their child's personal doctor did not always seem informed and up-to-date about the care their child received from other doctors or health providers.

Improvement Activities Implemented

- **Access and timeliness:**

UHC CP QI continues to promote its UHC Doctor Chat platform for telehealth/virtual visits. UHC Doctor Chat is a chat-first platform supported by live video for members to connect with a doctor from their computer or mobile device for non-emergent care. UHC Doctor Chat is available to all UHC CP QI members via website or mobile app. As part of its promotion efforts, UHC CP QI featured the app in the Summer 2024 and Fall 2024 editions of the member newsletter (HealthTalk). Additionally, UHC CP QI promoted the platform by email blast to more than 2,000 network providers in July 2024.

UHC CP QI also offers NurseLine services which is available 24 hours a day, seven days a week to all UHC CP QI members. Members can call NurseLine to ask if they need to go to the urgent care center, the emergency room, or to schedule an appointment with their PCP. UHC CP QI nurses can also help educate members about staying healthy.

- **Quality of care:**

UHC CP QI has a Care Model program to improve care coordination and elevate member outcomes. Care Model provides a care management/coordination team for members with chronic complex condition to help increase member engagement, offer resources to fill gaps in care, and develop personalized health goals using evidence-based clinical guidelines. Care Model provides many benefits including an extended care team, which consists of the PCP, pharmacist, medical and behavioral director, and peer specialist. The program also has tools for helping members engage with care providers, such as appointment reminders and help with transportation.

UHC CP QI encourages members to take charge of their care to make the most of their provider visits. UHC CP QI published in its Spring 2024 edition of the member newsletter (HealthTalk) a "Take Charge" article with recommendations for members to take action before going to their medical appointments. The tips included telling their provider about other providers they are seeing, including behavioral health providers, and to bring copies of any test results or treatment plans from other providers as well.

UHC CP QI's provider portal includes resources for coordination of care for both medical and behavioral health providers, such as a Confidential Exchange of Information Form and a Coordinating Care flyer with guidelines for effective communication and tools like the Coordination of Care Checklist. The provider portal also links to external resources such as the AHRQ Academy for Integrated Behavioral Health and Primary Care and SAMHSA [Substance Abuse and Mental Health Services Administration] on Care Coordination.

HSAG Assessment

HSAG has determined that UHC CP QI has addressed the prior year recommendations.

Home and Community-Based Services CAHPS Survey

2023 Recommendations

For UHC CP QI, the mean score for one measure was lower than the HI HCBS Program mean score, although the measure's mean score was not statistically significantly lower:

- *Choosing the Services that Matter to You*

Improvement Activities Implemented

UHC CP QI has actively and diligently participated in Person-Centered Organization (PCO) training in the past year, with robust attendance from Health Coordination. UHC CP QI incorporated PCO tools and skills such as "Important to/Important For" in its existing processes and promotes the tools as part of staff training to help improve with member engagement overall. PCO tools and concepts are also

introduced to new hires as part of new hire orientation. UHC CP QI is working to expand PCO training across its organization.

UHC CP QI's Health Coordinators continue to use the State's "One Page Description – My Profile" tool for all LTSS members. UHC CP QI Health Coordinators complete the tool to help customize member Health Action Plans to each member's unique needs, preferences, and goals.

UHC CP QI uses a care management platform, CommunityCare, to document all case management activities and store HCBS documents such as the Health Action Plan. The CommunityCare platform grants access to various UHC CP QI interdisciplinary teams including Behavioral Health Field Care Advocates as part of UHC CP QI's Care Model program. All UHC CP QI interdisciplinary teams are able to review member Health Action Plans to identify member goals and interventions. UHC CP QI also conducts interdisciplinary case conferences to optimize member experience and outcomes.

UHC CP QI's Health Coordinators continue to complete a comprehensive review of member Health Action Plans every 90 days with the member and their representative(s). This activity is completed with the member to ensure that the Health Action Plan continues to support member needs and align with their preferences.

HSAG Assessment

HSAG has determined that UHC CP QI has addressed the prior year recommendations.

Provider Survey

2023 Recommendations

For UHC CP QI, the 2023 top-box scores for the following four measures were statistically significantly lower than the QI Program aggregate:

- *Adequate Access to Non-Formulary Drugs*
- *Helpfulness of Health Coordinators*
- *Adequacy of Specialists*
- *Access to Substance Abuse Treatment*

Improvement Activities Implemented

- **Adequate Access to Non-Formulary Drugs:**

UHC CP QI continues to maintain a Preferred Drug List (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. 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 Physician 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 continues to offer providers the CoverMyMeds tool, which enables prescribers to submit pharmacy prior authorization requests online more quickly. 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 electronic prior authorization (ePA).

UHC CP QI continues to promote its Electronic Prior Authorization (ePA) option to prescribers. 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 prior authorization determinations, which gives members access to their medications more quickly.

UHC CP QI has a 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. The work group activities are ongoing.

UHC CP QI is currently reviewing certain medication requirements to identify criteria to be potentially eliminated or streamlined. The process is ongoing and occurs year-round. UHC CP QI continues to assess for opportunities to further streamline pharmacy guidelines and requirements.

UHC CP QI is also working on a process enhancement to list alternative covered medications before the provider submits an ePA request for a non-preferred medication. Some electronic health record interfaces could be linked to UHC CP QI's ePA site so a provider would not have to exit the program they are in to see which alternative products are covered.

- **Helpfulness of Health Coordinators:**

UHC CP QI promotes its Health Coordination program at provider town halls. At the town halls, UHC CP QI explains the role of a Health Coordinator and how providers can request or refer members to Health Coordination. UHC CP QI is also developing collateral to help educate providers about Health Coordination roles and responsibilities.

UHC CP QI completed staff training and education for its Health Coordinators. The training included a review of Health Coordination policies and procedures with emphasis on "providing Health Coordination *to support the PCP and other providers in the network* in providing appropriate care to members" (emphasis added).

- **Adequacy of Specialists**

UHC CP QI has ongoing efforts to identify and contract with providers who are new to the market, particularly specialists that fill a network need or who practice in a rural area and/or on the neighbor

islands. UHC CP QI also has in its network Oahu-based medical groups who maintain office locations on the neighbor islands. UHC CP QI works with these Oahu-based providers to maintain access. As part of its network strategy, UHC CP QI also revisits with providers who previously declined contracting in the past. UHC CP QI also executes single case agreements with non-contracted providers to enable members to receive care timely. This is completed on a case-by-case basis.

UHC CP QI is also building its telehealth network by incentivizing Oahu-based providers to provide care and services to members on the neighbor islands via telehealth or virtual visits. UHC CP QI offers per diems to Oahu-based providers who travel to the neighbor islands to provide care. UHC CP QI is also exploring contracting opportunities with telehealth specialists on the mainland. This effort is ongoing.

- **Access to Substance Abuse Treatment**

UHC CP QI deploys its integrated Optum BH (OBH) team to assist with referrals to substance abuse treatment facilities specific to a member's unique substance abuse needs. The OBH team also assesses member need for substance abuse treatment for all inpatient discharges. The OBH team collaborates with Health Coordination, Utilization Management, and external case management teams (e.g., CCS) to identify members who need substance abuse treatment and connect them with the appropriate facility or resource. UHC CP QI's OBH team has also reached out to community provider such as FQHCs to explore collaborative opportunities to increase access to care for substance abuse treatment.

UHC CP QI is developing tools and resources for PCPs to help support their members who need mental health services. The tools will help PCPs identify behavioral health providers in the area who are accepting new patients, as well as providers who can conduct appointments via telehealth. It will also connect the PCP with the OBH team and link to other resources such as medical transportation. This project is in progress.

HSAG Assessment

HSAG has determined that UHC CP QI has addressed the prior year recommendations.

‘Ohana Community Care Services (‘Ohana CCS)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

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.

2023 HEDIS Performance Measure Recommendations

Based on HSAG’s analyses of the 17 ‘Ohana CCS measure rates with comparable benchmarks, 13 of these measure rates (76.5 percent) ranked at or above the 50th percentile. One measure rate (5.9 percent) ranked at or above the 75th percentile but below the 90th percentile, and six of the 17 measure rates (35.3 percent) met or exceeded the 90th percentile, indicating positive performance related to follow-up after a discharge for mental illness. ‘Ohana CCS met nine MQD Quality Strategy targets for HEDIS MY 2022.

Conversely, four measure rates (23.5 percent) fell below the 50th percentile, suggesting opportunities for improvement. HSAG recommends that ‘Ohana CCS focus on improving performance related to the following measures for the CCS population:

- Behavioral Health
  - *Antidepressant Medication Management—Effective Acute Phase Treatment*
  - *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*

Improvement Activities Implemented

In 2022, ‘Ohana CCS’ parent organization Centene Corporation implemented several process changes which had major impacts on HEDIS reporting. Among these changes were how provider specialty is derived, a critical component of the *Follow-Up After Hospitalization for Mental Illness* measure. ‘Ohana CCS has worked through those data issues for *Follow-Up After Hospitalization for Mental Illness* and projects performance above the 95th percentile for MY 2023. The following interventions have been implemented to improve *Follow-Up After Hospitalization for Mental Illness* rates:

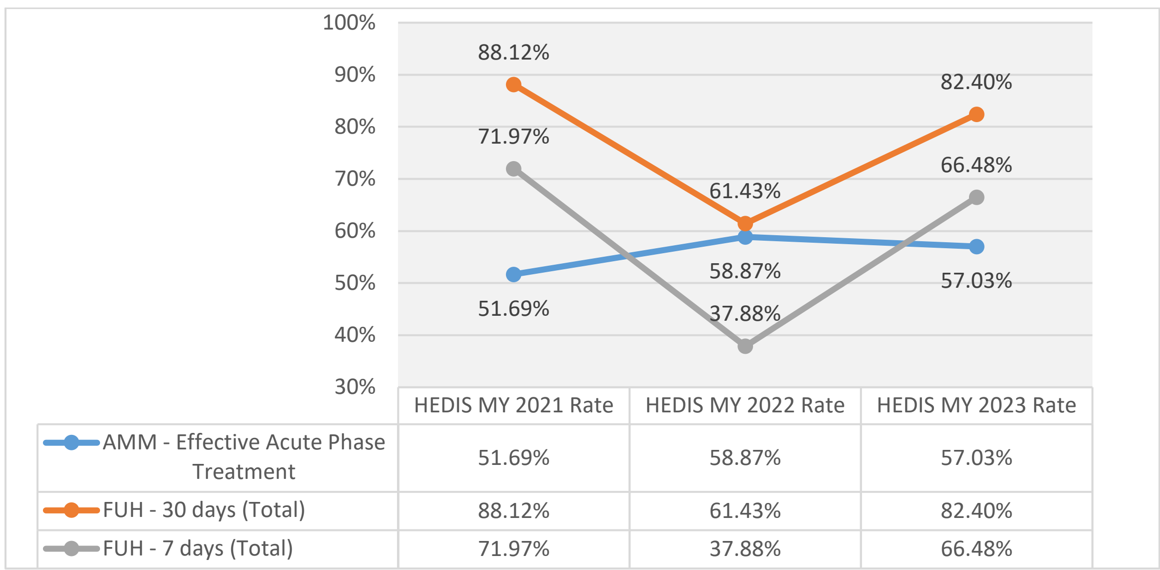
- It has been identified that members who transition coverage from Medicaid to CCS during their hospital stays are not getting their follow up within seven days. To address this barrier, ‘Ohana CCS collaborates with the other QI health plan’s FUH team to ensure a smooth transition and to support with timely follow up visits.

- Members are not always aware or do not understand the importance of post-hospital follow-up care. Articles are published in the member newsletters to guide members on what to do post hospital discharge including the importance of reaching out to case manager for support and resources.

With regard to *Antidepressant Medication Management*, ‘Ohana CCS recognizes the area of opportunity and has been working diligently on adding additional layers and quality interventions including:

- Leveraging ‘Ohana CCS case management team to provide additional education, coaching, and guidance to managing depression.
- Partnering with 5 Minute Pharmacy by providing non-adherent member lists for targeted interventions including tailored messaging, refill concierge, and communication to prescribers.
- Pharmacy allows providers to prescribe 100-day supply of medications (previously providers could prescribe up to 90-day supply).
- Article published in the provider newsletter to address the importance of medication adherence to their members.

While 2023 demonstrated a slight decline, ‘Ohana CCS continues to develop and implement additional interventions to bring this measure to the high-performing level of the majority of CCS HEDIS measures.



	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate
AMM - Effective Acute Phase Treatment	51.69%	58.87%	57.03%
FUH - 30 days (Total)	88.12%	61.43%	82.40%
FUH - 7 days (Total)	71.97%	37.88%	66.48%

HSAG Assessment

HSAG has determined that ‘Ohana CCS has addressed the prior year recommendations.

Appendix A. Methodologies for Conducting EQR Activities

Introduction

In CY 2024, HSAG, as the EQRO for MQD, conducted the following EQR activities for the QI health plans and CCS program in accordance with applicable CMS protocols:

- Follow-up reevaluation of compliance following implementation of 2022 and 2023 CAPs
- Validation of performance measures (i.e., NCQA HEDIS Compliance Audits)
- Validation of network adequacy
- Validation of PIPs
- A survey of adult Medicaid members using the CAHPS survey
- A survey of a statewide sample of child and CHIP members using the child Medicaid CAHPS survey
- A survey of members receiving HCBS using the HCBS CAHPS survey
- Validation of encounter data

Table A-1 provides a timeline for conducting each of the EQR activities.

Table A-1—Timeline for EQR Activities

Activity	EQR Activity Start Date	EQR Activity End Date
Compliance Review	2/9/2024	12/23/2024
PMV	11/17/2023	7/15/2024
NAV	5/31/2024	1/15/2025
PIPs	1/17/2024	1/24/2025
CAHPS	10/18/2023	10/8/2024
HCBS CAHPS	4/4/2024	2/25/2025
EDV	8/3/2023	2/28/2025

For each EQR activity conducted in 2024, 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-2 delineates the compliance review activities as well as the standards reviewed during the current three-year compliance review cycle (2022 through 2024).

Table A-2—Three-Year Compliance Review Schedule

<table>
<tr><th></th><th>Year One (2022)</th><th>Year Two (2023)</th><th>Year Three (2024)</th></tr>
<tr><th>Standard</th><th colspan="2">Review of Standards</th><th>CAP Review</th></tr>
<tr><td>Availability of Services</td><td>✓</td><td></td><td rowspan="15">Review of Standards/Elements that received a Partially Met or Not Met score during the 2022 and 2023 reviews.</td></tr>
<tr><td>Assurances of Adequate Capacity and Services</td><td>✓</td><td></td></tr>
<tr><td>Coordination and Continuity of Care</td><td>✓</td><td></td></tr>
<tr><td>Confidentiality</td><td>✓</td><td></td></tr>
<tr><td>Coverage and Authorization of Services</td><td>✓</td><td></td></tr>
<tr><td>Enrollee Information</td><td>✓</td><td></td></tr>
<tr><td>Enrollee Rights and Protections</td><td>✓</td><td></td></tr>
<tr><td>Grievance and Appeal System</td><td>✓</td><td></td></tr>
<tr><td>Provider Selection</td><td></td><td>✓</td></tr>
<tr><td>Subcontractual Relationships and Delegation</td><td></td><td>✓</td></tr>
<tr><td>Credentialing</td><td></td><td>✓</td></tr>
<tr><td>Quality Assessment and Performance Improvement</td><td></td><td>✓</td></tr>
<tr><td>Health Information Systems</td><td></td><td>✓</td></tr>
<tr><td>Practice Guidelines</td><td></td><td>✓</td></tr>
<tr><td>Enrollment and Disenrollment</td><td></td><td>✓</td></tr>
</table>

HSAG divided the federal regulations into 16 standards consisting of related regulations and contract requirements. Table A-3 describes the standards and associated regulations and requirements reviewed for each standard.

Table A-3—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

Standard Title	Regulations Included
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 42 USC §1396 Title V of ARRA 2009, §5006
Credentialing	438.214 NCQA Credentialing and Recredentialing Standards and Guidelines
Enrollee Information	438.10
Enrollee Rights and Protections	422.128 438.100 438.110
Enrollment and Disenrollment	438.3 438.56
Health Information Systems	438.242 431.60 431.70 438.10
Grievance and Appeal System	438.228 438.400 438.402 438.406 438.408 438.410 438.414 438.416 438.420 438.424
Practice Guidelines	438.236
Provider Selection	438.12

Standard Title	Regulations Included
	438.102 438.214 438.608 438.610 42 CFR Part 455, Subpart B & E
Quality Assessment and Performance Improvement	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 conducted a follow-up review of compliance with federal and State requirements for standard areas for which the QI health plans and CCS had implemented required corrective actions based on findings of deficiency from the 2022 and 2023 compliance reviews. Once each health plan's final compliance review report was produced, the health plan prepared and submitted a CAP for MQD's and HSAG's review and approval. Once the CAP was approved, the health plan implemented the planned corrective actions and submitted documented evidence that the activities were completed and that the plan was now in compliance. MQD and HSAG performed a desk review of the documentation and issued a final report of findings once the plan was determined to meet the requirement(s) and was in full compliance.

Technical Methods of Data Collection and Analysis

Prior to beginning the compliance monitoring follow-up reviews, HSAG developed a data collection tool to use in the review of each health plan reflecting the areas for required corrective actions. The CAP tool contained the applicable federal and/or State regulation and the action the health plan was required to take to become fully compliant.

HSAG conducted the follow-up compliance monitoring 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*, February 2023.[98]

[98] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *CMS External Quality Review (EQR) Protocols*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: July 1, 2024.

Description of Data Obtained

The health plans used the CAP tool to describe their proposed corrective action, provide the expected date of completion, and list the documents provided to demonstrate implementation of the corrective actions. HSAG assessed the health plans' compliance with federal and State requirements from a wide range of written documents provided by the health plans, including committee meeting agendas and minutes, policies and procedures, monitoring reports, and delegation subcontracts and agreements.

Additionally, HSAG evaluated implementation of corrective actions for care coordination and credentialing by conducting follow-up file reviews in 2024. Table A-4 lists the file review data sources HSAG used and the period to which the data applied.

Table A-4—Description of File Review Data Sources

Data Obtained	Period to Which the Data Applied
Care coordination files	July 1, 2023–December 31, 2023
Organizational provider credentialing and recredentialing files	September 1, 2023–December 31, 2023

Upon the successful completion of all CAP items, HSAG provided the health plan and MQD with the completed CAP evaluation tool. The plan-specific results are summarized in Section 3 of this report.

How Conclusions Were Drawn

HSAG reviewed all documents submitted by the health plans and the results of the follow-up file reviews to evaluate the degree to which corrective actions were implemented. HSAG reviewed the CAP implementation and evaluated whether:

- The corrective actions taken by the health plan were communicated and training was provided to involved providers, health plan staff members, and delegated entities.
- The corrective actions and associated performance results are being monitored and tracked over time.
- The corrective actions appear to be effective and were implemented according to the established time frames.
- Revisions to corrective actions were made if problems were identified.
- Corrective actions resulted in demonstrated improvements in the targeted performance area.

To draw conclusions about the quality of, timeliness of, and access to care and services provided by the Medicaid health plans, HSAG assigned each of the standards reviewed for implementation of corrective actions in 2024 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-5 depicts assignment of the standards to the domains of care.

Table A-5—Assignment of Compliance Standards to the Quality, Timeliness, and Access Domains

Compliance Review Standard	Quality	Timeliness	Access
Assurances of Adequate Capacity and Services		✓	✓
Availability of Services		✓	✓
Coordination and Continuity of Care	✓	✓	✓
Coverage and Authorization of Services	✓	✓	✓
Credentialing	✓		
Enrollee Information	✓		
Enrollee Rights and Protections	✓	✓	✓
Grievance and Appeal System	✓	✓	✓
Subcontractual Relationships and Delegation	✓		

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 2023 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			
Adults' Access to Preventive/Ambulatory Health Services		✓	Admin
*Ambulatory Care**		✓	Admin
*Asthma in Younger Adults Admission Rate**	✓		Admin
*Heart Failure Admission Rate**	✓		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^
Immunizations for Adolescents	✓		Hybrid
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	✓		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			
Asthma Medication Ratio	✓		Admin
Blood Pressure Control for Patients With Diabetes	✓		Hybrid
*Concurrent Use of Opioids and Benzodiazepines**	✓		Admin
Controlling High Blood Pressure	✓		Hybrid
Eye Exam for Patients With Diabetes	✓		Hybrid
*Hemoglobin A1c Control for Patients With Diabetes**	✓		Hybrid^
Behavioral Health			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		✓	Admin
Antidepressant Medication Management			
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication		✓	Admin
Follow-Up After Emergency Department Visit for Substance Use	✓	✓	Admin
Follow-Up After Emergency Department Visit for Mental Illness	✓	✓	Admin
Follow-Up After Hospitalization for Mental Illness	✓	✓	Admin
Follow-Up Care for Children Prescribed ADHD Medication	✓		Admin
Initiation and Engagement of Substance Use Disorder Treatment	✓	✓	Admin
Screening for Depression and Follow-Up Plan	✓		Admin
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	✓		Admin
Use of Pharmacotherapy for Opioid Use Disorder	✓		Admin

Performance Measure	QI	CCS	Methodology
Long-Term Services and Supports (LTSS)			
LTSS Comprehensive Assessment and Update	✓		CMR[1]
LTSS Comprehensive Care Plan and Update	✓		CMR[1]
LTSS Minimizing Institutional Length of Stay	✓		Admin

* A lower rate indicates better performance.

[1] This measure was reported using the case management review (CMR) methodology.

^ KFHP QI received approval from 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 2023, Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures*. The measurement period reviewed for the health plans was MY 2023 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.
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 measures reported using electronic clinical data systems (ECDS) when the denominator is fewer than 30.
*NB***	*No Benefit.* The health plan did not offer the health benefit required by the measure (e.g., mental health, chemical dependency).
NR	*Not Reported.* The health plan chose not to report the measure.
NQ	*Not Required.* The health plan was not required to report the measure.
BR	*Biased Rate.* The calculated rate was materially biased.
UN	*Un-Audited.* The health plan chose to report a measure that is not required to be audited. This result 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 2023, Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures.*
- Source code, computer programming, and query language used by the health plans to calculate the selected non-HEDIS 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 2023 NCQA Quality Compass national Medicaid HMO percentiles for HEDIS MY 2022 and to the previous year's rates, where applicable. Measure rates reported by the health plans, but not audited by HSAG in MY 2023, are not presented within this report. Additionally, certain measures do not have applicable benchmarks. For these reasons, the HEDIS MY 2023 rate, relative difference, and MY 2023 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 MQD's Quality Strategy target for HEDIS MY 2023. 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: *Concurrent Use of Opioids and Benzodiazepines—Total, Heart Failure Admission Rate—Total,* and *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Total.*

Table A-8—MQD QI Quality Strategy Measures and Targets

Measure	MQD Quality Strategy Target
Access and Risk-Adjusted Utilization	
Adults' Access to Preventive/Ambulatory Health Services	74.32%
*Asthma in Younger Adults Admission Rate**	2.48
Heart Failure Admission Rate—Total	43.82
Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Total	0.8969
Children's Preventive Care	
Child and Adolescent Well-Care Visits	47.88%
Childhood Immunization Status—Combination 3	58.15%
Childhood Immunization Status—Combination 7	50.06%
Childhood Immunization Status—Combination 10	39.87%
Immunizations for Adolescents—Combination 1	69.58%

Measure	MQD Quality Strategy Target
Immunizations for Adolescents—Combination 2	40.12%
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life	66.28%
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 30 Months of Life	71.38%
Weight Assessment and Counseling for Nutrition/Physical Activity—Counseling for Nutrition	80.96%
Weight Assessment and Counseling for Nutrition/Physical Activity—Counseling for Physical Activity	78.51%
Weight Assessment and Counseling for Nutrition/Physical Activity—BMI Percentile Documentation	84.13%
Women's Health	
Cervical Cancer Screening—Total	58.04%
Prenatal and Postpartum Care—Timeliness of Prenatal Care	87.13%
Prenatal and Postpartum Care—Postpartum Care	80.66%
Care for Chronic Conditions	
Asthma Medication Ratio	64.96%
Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8%)	52.96%
Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9%)	35.62%
Eye Exam for Patients With Diabetes	62.75%
Blood Pressure Control for Patients With Diabetes	60.82%
Concurrent Use of Opioids and Benzodiazepines—Total	12.72%
Controlling High Blood Pressure—Total	60.09%
Behavioral Health	
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	72.06%
Antidepressant Medication Management—Effective Acute Phase Treatment	62.74%
Antidepressant Medication Management—Effective Continuation Phase Treatment	45.42%
Diabetes Screening for People w/ Schizophrenia or Bipolar Dx using Antipsychotics	71.53%
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	41.61%
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	62.89%
Follow-Up After Emergency Department Visit for Mental Illness— 7-Day Follow-Up—Total	33.42%

Measure	MQD Quality Strategy Target
Follow-Up After Emergency Department Visit for Mental Illness— 30-Day Follow-Up—Total	50.15%
Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence—7-Day Follow-Up—Total	18.41%
Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence—30-Day Follow-Up—Total	26.22%
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total	38.56%
Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total	11.53%
Screening for Depression and Follow-Up Plan	20.17%
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	64.00%
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	48.00%
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	64.08%
Use of Pharmacotherapy for Opioid Use Disorder—Total (Rate 1)	52.44%
Use of Pharmacotherapy for Opioid Use Disorder—Buprenorphine (Rate 2)	32.46%
Use of Pharmacotherapy for Opioid Use Disorder—Oral Naltrexone (Rate 3)	1.02%
Use of Pharmacotherapy for Opioid Use Disorder—Long-Acting, Injectable Naltrexone (Rate 4)	0.27%
Use of Pharmacotherapy for Opioid Use Disorder—Methadone (Rate 5)	21.01%
Long-Term Services and Supports (LTSS)	
LTSS Comprehensive Assessment and Update—Assessment of Core Elements	19.48%
LTSS Comprehensive Assessment and Update—Assessment of Supplemental Elements	17.88%
LTSS Comprehensive Care Plan and Update— Assessment of Core Elements	10.32%
LTSS Comprehensive Care Plan and Update— Assessment of Supplemental Elements	10.32%
LTSS Minimizing Institutional Length of Stay—Observed Rate	17.70%
LTSS Minimizing Institutional Length of Stay—Risk-adjusted Rate	55.94%

Table A-9—MQD CCS Quality Strategy Measures and Targets

Measure	MQD Quality Strategy Target
Access and Risk-Adjusted Utilization	
Adults' Access to Preventive/Ambulatory Health Services (Total) (per 1,000 Member Months)	74.32%
Behavioral Health	
Adherence to Antipsychotic Medications for Individuals with Schizophrenia—Total	72.06%
Antidepressant Medication Management—Effective Acute Phase Treatment	62.74%
Antidepressant Medication Management—Effective Continuation Phase Treatment	45.42%
Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence—7-Day Follow-Up—Total	18.41%
Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence—30-Day Follow-Up—Total	26.22%
Follow-Up After Emergency Department for Mental Illness—7-Day Follow-Up—Total	33.42%
Follow-Up After Emergency Department for Mental Illness—30-Day Follow-Up—Total	50.15%
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	41.61%
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	62.89%
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total	38.56%
Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total	11.53%

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			
Adults' Access to Preventive/Ambulatory Health Services			✓
Ambulatory Care—Emergency Department Visits—Total			✓

Performance Measure	Quality	Timeliness	Access
Ambulatory Care—Outpatient Visits—Total			✓
Asthma in Younger Adults Admission Rate	✓		
PQI 08: Heart Failure Admission Rate	✓		
Plan All-Cause Readmissions	✓		
Children's Preventive Health			
Child and Adolescent Well-Care Visits	✓		✓
Childhood Immunization Status	✓		✓
Immunization for Adolescents	✓		✓
Weight Assessment and Counseling for Nutrition and Physical Activity for Child	✓		
Well-Child Visits in the First 30 Months of Life	✓		✓
Women's Health			
Cervical Cancer Screening	✓		
Prenatal and Postpartum Care	✓	✓	✓
Care for Chronic Conditions			
Asthma Medication Ratio	✓		
Hemoglobin A1c Control for Patients With Diabetes	✓		
Eye Exam for Patients With Diabetes	✓		
Blood Pressure Control for Patients With Diabetes	✓		
Concurrent Use of Opioids and Benzodiazepines	✓		
Controlling High Blood Pressure	✓	✓	
Behavioral Health			
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	✓		✓
Antidepressant Medication Management	✓		
Follow-Up After ED Visit for Alcohol and Other Drug 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 Assessment and Update	✓	✓	
LTSS Comprehensive Care Plan and Update	✓	✓	
LTSS Minimizing Institutional Length of Stay	✓		

NA indicates that the measure is not appropriate to classify into a performance domain (i.e., quality, timeliness, access).

Validation of Network Adequacy

Objectives

Title 42 CFR §438.350(a) requires states that contract with MCOs, PIHPs, or PAHPs have a qualified EQRO perform an EQR that includes validation of network adequacy to ensure provider networks are sufficient to provide timely and accessible care to Medicaid and CHIP beneficiaries across the continuum of services. This report will sometimes collectively refer to these MCOs and PIHP as "health plans." If states elect to conduct NAV for each health plan, the EQRO will validate the indicators produced by MQD as if they were calculated by the health plan, and validate the health plans' systems and processes, as well as source data provided to the state, to inform network adequacy analysis activities.

The objectives of the validation of network adequacy are to:

- Assess the accuracy of MQD-defined network adequacy indicators reported by MQD and the health plans.
- Evaluate the collection of provider data, reliability and validity of network adequacy data, methods used to assess network adequacy, and systems and processes used.
- Determine an indicator-level validation rating, which refers to the overall confidence that an acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators, as set forth by MQD.

Technical Methods of Data Collection and Analysis

HSAG collected network adequacy data from MQD and the health plans via a secure file transfer protocol (SFTP) site and via virtual NAV audits. HSAG used the collected data to conduct the validation of network adequacy in accordance with the Centers for Medicare & Medicaid Services (CMS) EQR *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 4).[99]

HSAG conducted a virtual review with MQD and the health plans. HSAG collected information using several methods, including interviews, system demonstrations, review of source data output files, primary source verification (PSV), observation of data processing, and review of final network adequacy indicator-level reports. The virtual review activities performed for each included the following:

- Opening meeting

[99] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: January 13, 2025.

- Review of the Information Systems Capabilities Assessment Tool (ISCAT) and supporting documentation
- Evaluation of underlying systems and processes
- Overview of data collection, integration, methods, and control procedures
- Network adequacy source data PSV and results
- Closing conference

HSAG conducted interviews with MQD and key health plan staff members who were involved with the calculation and reporting of network adequacy indicators.

HSAG evaluated and assessed the systems, processes, and methods MQD used to calculate results generated for each network adequacy indicator in the scope of the 2024 NAV activities, on behalf of the health plans. Plan-specific network adequacy results for standards and indicators calculated by MQD along with the plan-specific validation rating determinations are determined at the plan-level and are inclusive of activities conducted by MQD.

Description of Data Obtained

HSAG prepared a document request packet that was submitted to MQD and each health plan outlining the activities conducted during the validation process. The document request packet included a request for documentation to support HSAG's ability to assess MQD and each health plan's information systems and processes, network adequacy indicator methodology, and accuracy of network adequacy reporting at the indicator level. Documents requested included an ISCAT, a timetable for completion, and instructions for submission. HSAG worked with MQD and the health plans to identify all data sources informing calculation and reporting at the network adequacy indicator level. HSAG obtained the following data and documentation from MQD and each health plan to conduct the NAV audits:

- Information systems data from the ISCAT
- Network adequacy logic for calculation of network adequacy indicators
- Network adequacy data files
- Network adequacy monitoring data
- Supporting documentation, including policies and procedures, data dictionaries, system flow diagrams, system log files, and data collection process descriptions

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of care provided by the health plans, HSAG assigned each of the standards reviewed for NAV activities to one or more of three domains of care. This assignment to domains of care is depicted in Table A-11.

Table A-11—Assignment of NAV Audit Activities to the Quality, Timeliness, and Access Domains

NAV Standard	Quality	Timeliness	Access
Time and Distance—CCS	✓	✓	✓
Access and Availability—CCS	✓	✓	✓
Mandatory Provider Types—CCS	✓	✓	✓
Time and Distance—QI	✓	✓	✓
Access and Availability—QI	✓	✓	✓
Mandatory Provider Types—QI	✓	✓	✓
Provider-to Enrollee Ratios—QI	✓	✓	✓

HSAG calculated each network adequacy indicator's validation score by identifying the number of *Met* and *Not Met* elements recorded in the HSAG CMS EQR Protocol 4 Worksheet 4.6, noted in Table A-13.

Table A-12—Validation Score Calculation

Worksheet 4.6 Summary
A. Total number of *Met* elements
B. Total number of *Not Met* elements
Score = A / (A + B) x 100
Number of *Not Met* elements determined to have significant bias on the results.

The overall validation rating refers to HSAG's overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. CMS EQR Protocol 4 defines validation rating designations at the indicator level, which are defined in Table A-13 and assigned by HSAG once HSAG has calculated the validation score for each indicator.

Table A-13—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	High confidence
50.0% to 89.9%	Moderate confidence
10.0% to 49.9%	Low confidence
Less than 10% and/or any *Not Met* element has significant bias on the results	No confidence

Significant bias was determined based on the magnitude of errors detected and not solely based on the number of elements *Met* or *Not Met*. HSAG determined that a *Not Met* element had significant bias on the results by:

- Requesting that the health plan provide a root cause analysis of the finding.
- Working with the health plan to quantify the estimated impact of an error, omission, or other finding on the indicator calculation.
- Reviewing the root cause, proposed corrective action, timeline for corrections, and estimated impact, within HSAG's NAV Oversight Review Committee, to determine the degree of bias.
- Finalizing a bias determination within HSAG's NAV Oversight Review Committee based on the following threshold:
  - The impact biased the reported network adequacy indicator result by more than 5 percentage points, the impact resulted in a change in network adequacy compliance (i.e., the indicator result changed from compliant to noncompliant or changed from noncompliant to compliant), or the impact was unable to be quantified and therefore was determined to have the potential for significant bias.

By assessing each health plan's performance and NAV reporting process, HSAG identified areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement. Table A-14 provides a list of network adequacy standards and indicators HSAG validated.

Table A-14—QI Provider Ratios

Provider Ratios	
Provider Type (Adult and Pediatric)	**Provider Ratio**
Primary Care Physicians (PCPs)	1:300
Behavioral Health—Psychiatrist	*1:150 Members with a serious mental illness (SMI) or severe and persistent mental illness (SPMI) diagnosis.
Other Behavioral Health Providers to include Psychologists, Licensed Mental Health Counselors, Licensed Clinical Social Workers, and Advanced Practice Registered Nurses (APRNs)—Behavioral Health	1:100 Members with a SMI or SPMI diagnosis
Hospitals	A minimum of five [5] on Oahu, one [1] on Maui, one [1] on Kauai, two [2] on Hawaii (one [1] in East Hawaii and one [1] in West Hawaii), one (1) on Lanai, and one (1) on Molokai

Table A-15 lists the network adequacy indicators for QI Time and Distance that HSAG validated.

Table A-15—QI Time and Distance

Time and Distance		
Provider/Facility Type (Adult and Pediatric)	**Urban; Honolulu Metropolitan Statistical Area (MSA)**	**Rural**
PCPs (Adult and Pediatric)	Thirty (30) minute driving time	Sixty (60) minute driving time
Specialists (Adult and Pediatric)	Thirty (30) minute driving time	Sixty (60) minute driving time
Obstetricians/Gynecologists (OB/GYNs)	Thirty (30) minute driving time	Sixty (60) minute driving time
Adult Day Care/Adult Day Health	Thirty (30) minute driving time	Sixty (60) minute driving time
Hospitals	Thirty (30) minute driving time	Sixty (60) minute driving time
Behavioral Health Provider (Adult and Pediatric)	Thirty (30) minute driving time	Sixty (60) minute driving time
Emergency Services Facilities	Thirty (30) minute driving time	Sixty (60) minute driving time
Long-Term Services and Supports (LTSS) Providers	Thirty (30) minute driving time	Sixty (60) minute driving time
24-Hour Pharmacy	Sixty (60) minute driving time	NA
Pharmacies	Fifteen (15) minute driving time	Sixty (60) minute driving time

Table A-16 lists the network adequacy indicators for QI Availability of Services that HSAG validated.

Table A-16—QI Availability of Services

Availability of Services	
Health Service	**Wait Time**
Urgent Care and PCP Pediatric Sick Visits*	Appointments within twenty-four (24) hours
PCP Adult Sick Visits	Appointments within seventy-two (72) hours
Behavioral Health (routine visits for adults and children)	Appointments within twenty-one (21) days
PCP Visits (routine visits for adults and children)	Appointments within twenty-one (21) days
Visits with Specialists or Non-Emergency Hospital Stays**	Appointments within four (4) weeks or of sufficient timeliness to meet medical necessity

*MQD confirmed that in CY 2024, Urgent Care visits were not evaluated and were not assessed by HSAG in year one CMS Protocol 4 NAV audit.

**MQD confirmed that in CY 2024, Visits with Specialists only included OB/GYN.

Table A-17 lists the network adequacy indicators for QI Minimum Required Provider Types that HSAG validated.

Table A-17—QI Minimum Required Provider Types

Required in Network but No Ratio or Time/Distance Requirement
Home Health Agencies and Hospices
LTSS Providers: Adult Day Care Facilities, Adult Day Health Facilities, Assisted Living Facilities, Community Care Foster Family Home (CCFFH), Community Care Management Agency (CCMA), Expanded Adult Residential Care Homes (E-ARCHs), Home-Delivered Meal Providers, Non-Medical Transportation Providers, Nursing Facilities (NFs), Personal Care Assistance Providers, Personal Emergency Response System (PERS) Providers, Private Duty Nursing (PDN), Respite Care Providers, and Specialized Medical Equipment and Supply Providers
Durable Medical Equipment (DME)
Case Management Agencies
Peer Support Specialists certified by the Adult Mental Health Division (AMHD) as a part of their Hawaii certified peer specialist program or a program that meets the criteria established by AMHD
State-Licensed Special Treatment Facilities for the provision of substance abuse therapy/treatment
Laboratories which have either a Clinical Laboratory Improvement Amendments (CLIA) 1988 certificate or a waiver of a certificate of registration
Optometrists
Physical and Occupational Therapists, Audiologists, and Speech-Language Pathologists
Licensed Dietitians
Physician Assistants (PAs)
Community Health Workers
Providers of lodging and meals associated with obtaining necessary medical care
Sign language interpreters and interpreters for languages other than English
Community Paramedics (CPs)
Physician Specialists, including but not limited to Cardiologists, Endocrinologists, General Surgeons, Geriatricians, Hematologists, Infectious Disease Specialists, Nephrologists, Neurologists, OB/GYNs, Oncologists, Ophthalmologists, Orthopedists, Otolaryngologists, Pediatric Specialists, Plastic and Reconstructive Surgeons, Pulmonologists, Radiologists, and Urologists
Behavioral Health Providers: Licensed Therapists, Counselors, and Certified Substance Abuse Counselors (CSACs)
Emergency Transportation Providers (both ground and air)
Non-Emergency Transportation Providers (both ground and air)

Table A-18 lists the network adequacy indicators for CCS Time and Distance that HSAG validated.

Table A-18—Community Care Service (CCS) Time and Distance

Time and Distance Standards		
Provider/Facility Type (Adult and Pediatric)	**Urban; Honolulu Metropolitan Statistical Area (MSA)**	**Rural**
Emergency Services Facilities	Thirty (30) minute driving time	Sixty (60) minute driving time
Mental Health Providers	Thirty (30) minute driving time	Sixty (60) minute driving time
Hospitals	Thirty (30) minute driving time	Sixty (60) minute driving time
24-Hour Pharmacy	Sixty (60) minute driving time	NA
Pharmacies	Fifteen (15) minute driving time	Sixty (60) minute driving time

Table A-19 lists the network adequacy indicators for CCS Availability of Services that HSAG validated.

Table A-19—CCS Availability of Services

Availability of Services	
Health Service	**Wait Time**
Behavioral Health Provider Visits (Urgent)	Appointments within seventy-two (72) hours
Behavioral Health Provider Visits (Standard)	Appointments within twenty-one (21) days

Table A-20 lists the network adequacy indicators for CCS Minimum Required Provider Types that HSAG validated.

Table A-20—CCS Minimum Required Provider Types

Required in Network but No Ratio or Time/Distance Requirement
Behavioral Healthcare Specialist services as provided by Psychiatrists, Psychologists, Social Workers, Certified Substance Abuse Counselors (CSACs), and Advanced Practice Nurses trained in psychology
Case Management
Inpatient Behavioral Health Hospital Services
Outpatient Behavioral Health Hospital Services
Mental Health Rehabilitation Services
Substance use disorder (SUD) Services
Day Treatment Programs
Psychosocial Rehabilitation (PSR)/Clubhouse
Pharmacies
Laboratory Services
Crisis Services: Mobile Crisis Response, Crisis Residential Services
Interpretation Services
Community Integration Services (CIS)

Required in Network but No Ratio or Time/Distance Requirement
Representative Payee
Supported Employment
Peer Specialist

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:

- Measuring performance using objective quality indicators.
- Implementing system interventions to achieve improvement in quality.
- Evaluating effectiveness of the interventions.
- Planning and initiating of activities for increasing or sustaining improvement.

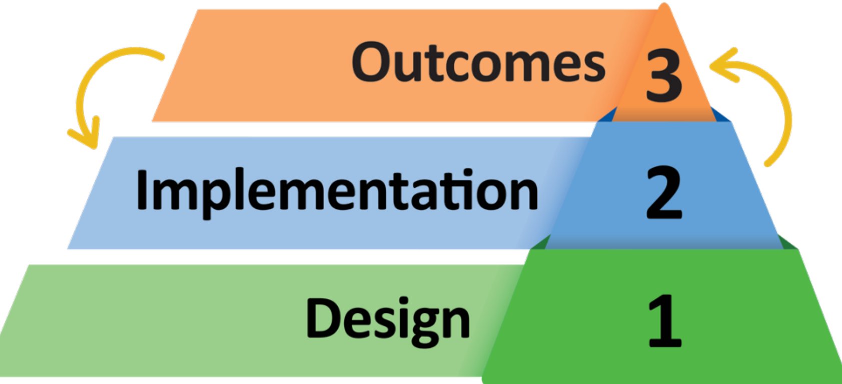
Technical Methods of Data Collection and Analysis

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*, February 2023.[100]

Figure A-1 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.

[100] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *CMS External Quality Review (EQR) Protocols*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 8, 2024.

Figure A-1—Stages of the PIP Process



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 EQR Protocol 1. With 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 EQR Protocol 1 steps:

Table A-21—CMS EQR 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*.

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 2024, the QI health plans submitted three PIPs and the CCS health plan submitted two PIPs and provided detailed information about the PIP design (Steps 1–6), provided baseline and Remeasurement 1 data (Step 7), and documented improvement strategies (Step 8) in the PIP Submission Forms.

The PIP topics that were validated in 2024 are included in Table A-22.

Table A-22—PIP Topics in 2024

Health Plan	PIP Topic
All QI health plans	• *Behavioral Health Coordination* • *Plan All-Cause Readmissions* • *Screening for Depression and Follow-Up Plan*
‘Ohana CCS	• *Behavioral Health Coordination* • *7-Day Follow-Up After Emergency Department Visit for Mental Illness*

How Conclusions Were Drawn

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation ratings summarizing overall PIP performance. One validation rating reflects HSAG's confidence that the health plan adhered to acceptable methodology for all phases of design and data collection, and conducted accurate data analysis and interpretation of PIP results. This validation rating is based on the scores for applicable evaluation elements in Steps 1 through 8 of HSAG's PIP Validation Tool.

HSAG only assigns the second validation rating for PIPs that have progressed to the Outcomes stage (Step 9), which reflects HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. The second validation rating is based on scores from Step 9 in the PIP Validation Tool. For each applicable validation rating, HSAG reports the percentage of applicable evaluation elements that received a *Met* validation score and the corresponding confidence level: *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*. The confidence level definitions for each validation rating are as follows:

1. Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Steps 1 Through 8)
    - *High Confidence*: High confidence in reported PIP results. The health plan received a *Met* score for all critical evaluation elements and a *Met* score for 90 percent to 100 percent of all evaluation elements across all steps.
    - *Moderate Confidence*: Moderate confidence in reported PIP results. The health plan received a *Met* score for all critical evaluation elements and a *Met* score for 80 percent to 89 percent of all evaluation elements across all steps.
    - *Low Confidence*: Low confidence in reported PIP results. Across all steps, the health plan received a *Met* score for 65 percent to 79 percent of all evaluation elements or a *Partially Met* score for one or more critical evaluation elements.
    - *No Confidence*: No confidence in reported PIP results. Across all steps, the health plan received a *Met* score for less than 65 percent of all evaluation elements or a *Not Met* score for one or more critical evaluation elements.
2. Overall Confidence That the PIP Achieved Significant Improvement (Step 9)
    - *High Confidence*: All performance indicators demonstrated statistically significant improvement over the baseline.
    - *Moderate Confidence*: One of the three scenarios below occurred:
        - All performance indicators demonstrated improvement over the baseline, and some but not all performance indicators demonstrated statistically significant improvement over the baseline.
        - All performance indicators demonstrated improvement over the baseline, and none of the performance indicators demonstrated statistically significant improvement over the baseline.
        - Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
    - *Low Confidence:* The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator or some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated statistically significant improvement over the baseline.
    - *No Confidence:* The remeasurement methodology was not the same as the baseline methodology for all performance indicators or none of the performance indicators demonstrated improvement over the baseline.

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-23.

Table A-23—Assignment of PIPs to the Quality, Timeliness, and Access Domains

Performance Improvement Project	Quality	Timeliness	Access
Behavioral Health Coordination	✓	✓	✓
Plan-All Cause Readmissions	✓	✓	✓
7-Day Follow-Up After Emergency Department Visit for Mental Illness	✓	✓	✓
Screening for Depression and Follow-Up Plan	✓	✓	✓

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Objectives

The primary objective of the adult Medicaid CAHPS survey was to obtain information effectively and efficiently 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 statewide child Medicaid CAHPS survey was to obtain information effectively and efficiently on the levels of experience with the parents/caretakers of the statewide child Medicaid population to provide to MQD and to meet the State's obligation for CAHPS measure reporting to CMS. Results were provided to MQD in a statewide aggregate report.

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

Technical Methods of Data Collection and Analysis

Data collection for the CAHPS 5.1 Adult Medicaid Health Plan Survey with the HEDIS supplemental item set to adult Medicaid members of the QI health plans. Adult Medicaid members included as eligible for the survey were 18 years of age or older as of December 31, 2023. Data Collection for the Statewide Child Medicaid CAHPS survey and the Hawaii CHIP CAHPS survey was accomplished through administration of the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set (with the CCC measurement set) to a statewide sample of child Medicaid members and a statewide sample of Hawaii CHIP members. Statewide child Medicaid and Hawaii CHIP members included as eligible for the survey were 17 years of age or younger as of December 31, 2023. All adult members and parents/caretakers of sampled statewide child Medicaid and Hawaii CHIP members completed the surveys from February to May 2024.

The survey administration protocol employed was a mixed mode methodology, which allowed for three methods by which sampled adult members and parents/caretakers of child members could complete the survey: (1) mail, (2) Internet, or (3) telephone. A cover letter was mailed to all sampled adult members

and parents/caretakers of child members that provided two options by which they could complete the survey: (1) complete the paper-based survey and return it using the pre-addressed, postage-paid return envelope, or (2) complete the web-based survey via a URL or quick response (QR) code and designated username. All sampled adult members and parents/caretakers of child members received an English version of the survey with the option to request to complete the survey in one of four alternate, non-English languages (i.e., Chinese, Ilocano, Korean, and Vietnamese). Non-respondents received a reminder postcard, followed by a second survey mailing and a second reminder postcard. Computer Assisted Telephone Interviewing (CATI) was conducted for sampled members who had not completed a survey or who had requested to complete the survey in one of the four alternate, non-English languages. A series of up to three CATI calls was made to each non-respondent at different times of the day, on different days of the week, and in different weeks. It is important to note the CAHPS 5.1H Adult Medicaid Health Plan Survey is only made available by NCQA in English, Spanish, and Chinese. Although NCQA added a standard Chinese translation for the adult Medicaid CAHPS Survey in 2020, the Chinese survey can only be used during the mail phase. Therefore, HSAG submitted a request for a survey protocol enhancement and received NCQA's approval to allow members the option to complete the CAHPS Survey in the designated alternate languages during CATI.[101]

The adult CAHPS survey included a set of standardized items (39 questions), and the child CAHPS survey included a set of standardized items (76 questions) that assessed members' and parents'/caretakers' of child members perspectives on their/their child's care. Data from survey respondents were aggregated into a database for analysis. An analysis of the CAHPS survey results was conducted using NCQA HEDIS Specifications for Survey Measures.[102] NCQA requires a minimum of 100 respondents 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 respondents for a measure was not achieved, the result of the measure was denoted with a cross (+).

The survey questions were categorized into 12 measures of experience for the adult CAHPS survey and 14 measures of experience for the child CAHPS survey. These measures included four global ratings, four composite scores, one individual item measure, three medical assistance with smoking and tobacco use cessation measure items (adult population only), and five CCC composites/items (CCC population only). The global measures (also referred to as global ratings) reflect overall member 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 looks at coordination of care. The medical assistance with smoking and tobacco use cessation measure items assess the percentage of smokers or tobacco users who were advised to quit, were recommended cessation medications, and were provided cessation methods or strategies. The CCC composite and item measures are sets of questions

[101] National Committee for Quality Assurance. *HEDIS® Measurement Year 2023*, *Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2023.

[102] Ibid.

and individual questions that look at different aspects of care and health care needs for the CCC population (e.g., *Access to Prescription Medicines* or *Coordination of Care for Children with Chronic Conditions*).

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, one individual item measure, and five CCC composites/items, the percentage of respondents who chose a positive response was calculated. CAHPS composite and individual item measure questions' response choices were: "Never," "Sometimes," "Usually," and "Always." CAHPS CCC composites/items questions' response choices were: "Never," "Sometimes," "Usually," and "Always" or: "Yes," and "No." A positive or top-box response for the composite measures and individual item measure was defined as a response of "Usually" or "Always." A positive or top-box response for the CCC composites/items was defined as a response of "Usually" or "Always" or "Yes." 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).

Three overall scores that assess different facets of providing medical assistance with smoking and tobacco use cessation were calculated for the adult population only. Responses of "Sometimes," "Usually," and "Always" were used to determine if the member qualified for inclusion in the numerator. The scores presented follow NCQA's methodology of calculating a rolling average using the current and prior years' results; however, HSAG did not administer the adult Medicaid CAHPS survey in 2023 or 2021, so those results are not available. Please exercise caution when reviewing the trend analysis results for the medical assistance with smoking and tobacco use cessation measure items, as the 2024 results contain members who responded to the survey and indicated they were current smokers or tobacco users in 2024 or 2022, and the 2022 results contain members who responded to the survey and indicated they were current smokers or tobacco users in 2022 or 2020.

For each CAHPS measure, the resulting scores were compared to NCQA's 2023 Quality Compass Benchmark and Compare Quality Data.[103] 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-24.

Table A-24—Star Rating Percentile Distributions

Stars	Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or between the 75th and 89th percentiles

[103] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2023*. Washington, DC: NCQA, September 2023.

Stars	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 the general Hawaii CHIP results.[104,105,106] The adult Medicaid 2024 scores were compared to their corresponding 2022 scores, and the general Hawaii CHIP 2024 scores were compared to their corresponding 2023 scores to determine whether there were statistically significant differences.[107] A *t* test was performed to determine whether adult Medicaid results in 2024 were statistically significantly different from results in 2022 and whether general Hawaii CHIP results in 2024 were statistically significantly different from results in 2023. A difference was considered statistically significant if the two-sided *p* value of the *t* test was less than 0.05. The two-sided *p* value of the *t* test is the probability of observing a test statistic as extreme as or more extreme than the one actually observed by chance. Scores that were statistically significantly higher in 2024 than in 2023 and 2022 are noted with upward triangles (▲). Scores that were statistically significantly lower in 2024 than in 2023 and 2022 are noted with downward triangles (▼). Scores in 2024 that were not statistically significantly different from scores in 2023 and 2022 are not noted with triangles.

Also, HSAG performed plan comparisons of the adult Medicaid results. The QI health plans' 2024 scores were compared to the QI Program to determine if there were any statistically significant differences. Statistically significant differences between the QI health plan scores and the QI Program are noted with arrows (↑ or ↓). QI health plan scores that were not statistically significantly different than the QI Program aggregate are not noted with arrows. Also, HSAG compared each of the adult Medicaid QI health plan's and the QI Program's 2024 scores to the 2023 NCQA adult Medicaid national averages, the general child statewide population's and the general Hawaii CHIP population's 2024 scores to the 2023 NCQA child Medicaid national averages, and the CCC child statewide population's and the CCC Hawaii CHIP population's 2024 scores to the 2023 NCQA CCC Medicaid national

[104] HSAG recalculated the 2022 and 2023 top-box scores to report scores out to two decimal places. Therefore, the 2022 and 2023 results in this report will not match previous reports.

[105] Since this is the first-year parents/caretakers of Hawaii CHIP members in the State of Hawaii were administered the CAHPS Survey with the CCC measurement set, trend results are unavailable for the CCC population.

[106] Since this is the first-year parents/caretakers of a statewide population of child members were administered the CAHPS Survey for the State of Hawaii, trend results are unavailable for the CCC population.

[107] The adult Medicaid population was last surveyed in 2022; therefore, the 2024 adult Medicaid CAHPS scores are compared to the corresponding 2022 scores.

averages.[108] Scores that were statistically significantly higher than the 2023 NCQA national averages are represented by green highlighted cells. Scores that were statistically significantly lower than the 2023 NCQA national averages are represented by red highlighted cells. These comparisons are performed for each of the measures.

Also, HSAG performed a key drivers of member experience analysis of the adult Medicaid, the general child statewide, and the general Hawaii 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 QI health plan/program is performing on the survey item (i.e., question).
- How ***important*** that item is to respondents' overall experience.

Description of Data Obtained

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 (including any oversample) minus ineligible members. Ineligible members of the sample met one or more of the following criteria: were deceased, were invalid (they did not meet the eligible population criteria), mentally or physically incapacitated (adult population only), or had a language barrier (the survey was made available in English, Chinese, Ilocano, Korean, and Vietnamese). This information was recorded by the survey vendor and provided to HSAG in the data received.

Following the administration of the child and adult CAHPS surveys, HSAG provided MQD with plan-specific reports and a statewide aggregate report of the adult Medicaid results, as well as a statewide aggregate report of the statewide Child Medicaid survey and Hawaii CHIP survey results. Plan-specific results of the adult CAHPS survey are summarized in Section 3 and statewide child Medicaid and Hawaii 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, as well as statewide child Medicaid and Hawaii CHIP, are provided in Section 4 of this report.

[108] NCQA's Quality Compass benchmarks for the general child Medicaid population and CCC Medicaid population were used for comparative purposes, since NCQA does not publish separate benchmarking data for CHIP; therefore, caution should be exercised when interpreting these results.

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to services provided by the QI health plans, HSAG assigned each of the measures and the corresponding survey items (i.e., questions) to one or more of these three domains. This assignment to domains is depicted in Table A-25.

Table A-25—Assignment of CAHPS Measures to the Quality, Timeliness, and Access Domains

CAHPS Topic	Quality	Timeliness	Access
Global Ratings			
Rating of Health Plan	✓		
Rating of All Health Care	✓		
Rating of Personal Doctor	✓		
Rating of Specialist Seen Most Often	✓		
Composite Measures			
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
How Well Doctors Communicate	✓		
Customer Service	✓		
Individual Item Measure			
Coordination of Care	✓		
CCC Composite and Item Measures			
Access to Specialized Services	✓		✓
FCC: Personal Doctor Who Knows Child	✓		
Coordination of Care for Children with Chronic Conditions	✓		
FCC: Getting Needed Information	✓		
Access to Prescription Medicines	✓		✓
Medical Assistance With Smoking and Tobacco Use Cessation Measure Items			
Advising Smokers and Tobacco Users to Quit	✓		
Discussing Cessation Medications	✓		
Discussing Cessation Strategies	✓		

Home and Community-Based CAHPS Survey

Objectives

The primary objective of the HCBS CAHPS survey is to gather direct feedback from Medicaid members receiving HCBS services about their experiences and the quality of the LTSS they receive. The survey

provides state Medicaid agencies with standard individual experience metrics for HCBS programs that are applicable to all populations served by these programs, including elderly and people with one or more disabilities (including physical disabilities, cognitive disabilities, intellectual impairments, or disabilities due to mental illness). Results were provided at both plan-specific and statewide aggregate levels.

Technical Methods of Data Collection and Analysis

The technical method of data collection was through administration of the HCBS CAHPS Survey without the Supplemental Employment module. The method of data collection for the surveys was via CATI. Members could complete the survey over the telephone in either English or in one of four non-English languages predominant in the State of Hawaii: Chinese, Ilocano, Korean, or Vietnamese. Prior to survey administration, a pre-notification letter was sent out to members alerting them to expect a telephone call to complete the survey, and assured members that the survey was sponsored by MQD. For the HCBS CAHPS Survey, adult members included as eligible for the survey: (1) were 18 years of age or older as of April 30, 2024, (2) were continuously enrolled in the HI HCBS Program and the same QUEST Integration (QI) health plan during the three-month measurement period (February 1, 2024, to April 30, 2024) with no gaps in enrollment, and (3) must have had received at least one qualifying HCBS service, including self-directed services during the three-month measurement period.[109] The survey was administered to eligible adult members enrolled in one of the five QI health plans from July to September 2024. While HSAG attempted to obtain responses to the survey directly from members, proxy respondents (including legal guardians, family members, and friends) were allowed if the member was unable to participate in the survey and offered a specific individual to respond to the survey questions on his or her behalf. If a paid caregiver responded to the survey on behalf of the members, these completed surveys were excluded from the analysis.

The survey questions were categorized into various measures of member experience. The survey included 96 core questions that yielded 19 measures. These measures included three global ratings, seven composite measures, three recommendation measures, five unmet need measures, and one physical safety measure. The global ratings reflect overall member experience with the personal assistance and behavioral health staff, homemaker, and case manager. The composite measures are sets of questions grouped together to address different aspects of care (e.g., *Helpful Case Manager* or *Personal Safety and Respect*). The recommendation measures evaluate whether a member would recommend their personal assistance and behavioral health staff, homemaker, or case manager to family and friends. The unmet need measures assess whether certain needs are not being met due to lack of staff. The physical safety measure evaluates whether any staff hit or hurt the member.

For each CAHPS measure, the resulting top-box scores were compared to AHRQ's 2024 CAHPS Database benchmark to see if the QI health plans' and HI HCBS Program's top-box scores were

[109] For more detailed information on the eligible population, please see the 2024 Hawaii HCBS CAHPS Survey full report.

statistically significantly higher or lower.[110, 111, 112] A score was considered statistically significantly different from the CAHPS database benchmark if the ninety-five percent confidence interval of the score did not enclose the CAHPS database benchmark.

HSAG calculated top-box scores for each measure in accordance with Centers for Medicare & Medicaid Services (CMS)' *Technical Assistance Guide for Analyzing Data from the HCBS CAHPS Survey*.[113] Top-box scores represent the percentage of eligible respondents who answered with the most positive response. Some survey questions in the HCBS CAHPS survey allowed respondents to complete an alternative question with alternative response options. Top-box responses were defined as follows:

- "9" or "10" for the standard global rating response or "Excellent" for the alternative response option.
- "Always," "Yes," or "All" for the standard composite rating response, or "Mostly yes" for the alternative response option.
- "Definitely yes" for standard recommendation rating response.
- "Yes" for Question 27 in the *No Unmet Need in Toileting* measure.

HSAG reverse coded certain HCBS CAHPS Survey items to ensure that the most positive responses of each question were given the highest values according to the topic and wording. For reverse coded response options, the top-box responses were defined as follows:

- "No" for the standard physical safety rating response, standard unmet need measures response, Question 65 and Question 68 in the *Personal Safety and Respect* composite measure, and Question 79 in the *Planning Your Time and Activities* composite measure.
- "Never" or "Mostly no" for Question 29 and Question 42 in the *Staff Listen and Communicate Well* composite measure.

Additionally, HSAG performed a trend analysis of the HCBS results. A *t* test to determine whether results in 2024 were statistically significantly different from results in 2023.[114] A difference was

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[110] HSAG recalculated the 2023 mean scores to top-box scores for HCBS CAHPS Database benchmark comparability. Therefore, the 2023 results in this report will not match previous reports.

[111] Agency for Healthcare Research and Quality. The CAHPS Databases. *The CAHPS® Home and Community-Based Services (HCBS) Survey Database 2024 Chartbook*. Available at: https://www.ahrq.gov/sites/default/files/wysiwyg/cahps/cahps-database/2024-hcbs-chartbook.pdf. Accessed on: Jan 15, 2025.

[112] HCBS CAHPS Database benchmarks were not available for 2024 at the time this report was prepared; therefore, 2022 data were used for this comparative analysis; therefore, caution should be exercised when comparing the 2022 HCBS CAHPS Database benchmarks to the 2024 results.

[113] Centers for Medicare & Medicaid Services. CAHPS Home and Community-Based Services Survey. *Technical Assistance Guide for Analyzing Data from the HCBS CAHPS Survey*. July 2021. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/hcbscahps-appk-data-analysis-guide.pdf. Accessed on: Jan 14, 2025.

[114] HSAG recalculated the 2023 mean scores to top-box scores for HCBS CAHPS Database benchmark comparability; therefore, the 2023 results in this report will not match previous reports.

considered statistically significant if the two-sided *p* value of the *t* test was less than 0.05. The two-sided *p* value of the *t* test is the probability of observing a test statistic as extreme as or more extreme than the one actually observed by chance. Statistically significant results are noted with directional triangles. Scores that were statistically significantly higher in 2024 than in 2023 are noted with upward triangles (▲). Scores that were statistically significantly lower in 2024 than in 2023 are noted with downward triangles (▼). Scores in 2024 that were not statistically significantly different from scores in 2023 are not noted with triangles.

Also, HSAG performed plan comparisons of the HCBS results. HSAG compared the QI health plans' results to the HI HCBS Program to determine if there were statistically significant differences. Statistically significant differences between the health plan scores and the HI HCBS Program are noted with arrows. Health plan scores that were statistically significantly higher than the HI HCBS Program are noted with upward arrows (↑). Health plan scores that were statistically significantly lower than the HI HCBS Program are noted with downward arrows (↓). Health plan scores that were not statistically significantly different than the HI HCBS Program are not noted with arrows.[115] For purposes of reporting members' experience with care results, CMS requires a minimum of 11 respondents per measure (i.e., a minimum cell size of 11). If a cell size was less than 11, the measure's results were suppressed. Suppressed results are noted in the figures as "NA." Scores with fewer than 100 respondents are denoted with a cross (+). Caution should be used when evaluating scores derived from fewer than 100 respondents.

Description of Data Obtained

The HCBS 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 one eligible question was answered, excluding the six interviewer questions used to determine eligibility.[116] 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 and did not have a proxy. Ineligible members were identified during the survey process. This information was recorded by the survey vendor and provided to HSAG in the data received.

[115] A global *F* test was calculated first, which determined whether the difference between health plans was significant. If the *F* test demonstrated health plan-level differences, then a *t* test was performed for each health plan. The *t* test determined whether each health plan's rate was significantly different from the aggregate rate. This analytic approach follows AHRQ's recommended methodology for identifying statistically significant plan-level performance differences.

[116] Centers for Medicare & Medicaid Services. CAHPS Home and Community-Based Services Survey. *Technical Assistance Guide for Analyzing Data from the HCBS CAHPS Survey*. July 2021. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/hcbscahps-appk-data-analysis-guide.pdf. Accessed on: Jan 15, 2025.

Following the administration of the HCBS CAHPS survey, HSAG provided MQD with a statewide aggregate report of the HCBS survey results, including statewide aggregate results and plan-level results.

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to care and 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-26.

Table A-26—Assignment of HCBS CAHPS Measures to the Quality, Timeliness, and Access Domains

CAHPS Topic	Quality	Timeliness	Access
Global Ratings			
Rating of Personal Assistance and Behavioral Health Staff	✓		
Rating of Homemaker	✓		
Rating of Case Manager	✓		
Composite Measures			
Reliable and Helpful Staff	✓	✓	
Staff Listen and Communicate Well	✓		
Helpful Case Manager	✓		
Choosing the Services that Matter to You	✓		✓
Transportation to Medical Appointments	✓	✓	✓
Personal Safety and Respect	✓		
Planning Your Time and Activities			✓
Recommendation Measures			
Recommend Personal Assistance/Behavioral Health Staff	✓		
Recommend Homemaker	✓		
Recommend Case Manager	✓		
Unmet Need Measures			
No Unmet Need in Dressing/Bathing	✓		✓
No Unmet Need in Meal Preparation/Eating	✓		✓
No Unmet Need in Medication Administration	✓	✓	✓
No Unmet Need in Toileting	✓		✓
No Unmet Need with Household Tasks	✓		✓
Physical Safety Measure			
Not Hit or Hurt by Staff	✓		

Encounter Data Validation

During CY 2023, MQD contracted with HSAG to conduct an EDV study. In alignment with the CMS EQR *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023 (CMS EQR Protocol 5).[117] HSAG conducted the following three evaluation activities for the EDV activity:

- Comparative analysis—evaluation of MQD's electronic encounter data completeness and accuracy through a comparative analysis between MQD's electronic encounter data and the actuarial files submitted by the QI health plans to MQD's contracted actuary, Milliman.
- Technical assistance with the QI health plans regarding the findings from the comparative analysis so that the QI health plans can identity the root cause(s) and take appropriate actions to improve MQD's encounter data quality.
- Best practice recommendations to MQD regarding encounter data submission companion guides and requirements.

Objectives

The goal of the comparative analysis is to evaluate the extent to which the encounter data in MQD's database are complete, accurate, and submitted by the QI health plans in a timely manner. This activity corresponds to Activity 3: Analyze Electronic Encounter Data in the CMS EQR Protocol 5. In addition, as a follow-up to the comparative analysis activity, HSAG provided technical assistance to assist the QI health plans in addressing and resolving noteworthy encounter data issues from the comparative analysis. Lastly, HSAG reviewed the encounter submission companion guides and the encounter data requirements put forth by MQD and then made recommendations to MQD on needed updates, as applicable. This activity corresponds to Activity 1: Review State Requirements in the CMS EQR Protocol 5.

Technical Methods of Data Collection and Analysis

HSAG developed a data requirements document requesting encounter data from both MQD and Milliman. After receiving data files from both data sources, HSAG conducted a preliminary file review to ensure that the submitted data were adequate to conduct the evaluation. Based on the preliminary file review results, HSAG generated a report that highlighted the major findings requiring any resubmissions.

[117] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5: Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: August 4, 2023.

Once HSAG received and processed the final set of data from MQD and Milliman, HSAG conducted a series of comparative analyses, which were divided into two analytic sections. First, HSAG assessed record-level data completeness using the following metrics for each encounter data type:

- **Record Omission**: The number and percentage of records present in Milliman's data, but not in MQD's encounter data. This is also described as an underreporting to MQD.
- **Record Surplus**: The number and percentage of records present in MQD's encounter data, but not in Milliman's data. This is also described as an underreporting to Milliman.

Second, based on the number of records present in both data sources, HSAG evaluated the element-level completeness based on the following metrics for each key data element listed in Table A-27:

- **Element Omission**: The number and percentage of records with values present in Milliman's data, but not in MQD's encounter data. This is also described as an underreporting to MQD.
- **Element Surplus**: The number and percentage of records with values present in MQD's encounter data, but not in Milliman's data. This is also described as an underreporting to Milliman.
- **Element Missing Values**: The number and percentage of records with values missing from both MQD's encounter data and Milliman's data.

Table A-27—List of Data Elements Included in the Comparative Analysis

Data Elements	Professional	Institutional	Pharmacy
Member ID and Date of Birth	✓	✓	✓
Detail First Date of Service	✓	✓	✓
Detail Last Date of Service	✓	✓	
Billing Provider NPI	✓	✓	
Billing Provider Type	✓	✓	
Servicing Provider NPI and ID	✓	✓	
Occurrence Span Codes		✓	
Value Codes and Value Codes Amount		✓	
Primary Diagnosis Code	✓	✓	
All Secondary Diagnosis Codes	✓	✓	
All Surgical Procedure Codes		✓	
Procedure Code	✓	✓	
Procedure Code Modifiers	✓	✓	
Units of Service	✓	✓	
Revenue Code		✓	
DRG Code		✓	
TOB Code		✓	

Data Elements	Professional	Institutional	Pharmacy
Admission Date and Discharge Date	✓	✓	
Admission Source, Admission Type, Admission Diagnosis Code, Primary POA Code, All Secondary POA Codes, and Discharge Status		✓	
POS Code	✓		
NDC	✓	✓	✓
Dispensing Quantity			✓
Days' Supply			✓
Billed, COB Amount, Copay, Coinsurance, Deductible , and MCO Paid Amount	✓	✓	✓
Allowed Amount	✓	✓	
Patient Paid Amount*	✓		✓
Dispensing Fee			✓
Ingredient Cost			✓
New or Refill Flag and Number of Refills			✓
MCO Paid Date	✓	✓	✓
Encounter Flag	✓	✓	

* Patient Paid Amount not available for institutional encounters during the study period.

Element-level discrepancy was limited to those records with values present in both MQD's encounter data and Milliman's data. For each key data element, HSAG determined the number and percentage of records with the same values in both MQD's encounter data and Milliman's data (i.e., **element discrepancy**).

Finally, for the records present in both data sources, HSAG evaluated the number and percentage of records with different values for at least one key data element relevant to each encounter data type (i.e., **overall element discrepancy**).

Description of Data Obtained

HSAG used data from both MQD and Milliman with dates of service in CY 2022 to evaluate the accuracy and completeness of the encounter data. To ensure that the extracted data from both sources represented the same universe of encounters, the data targeted final paid professional, institutional, and pharmacy encounters with MCO paid dates on or before March 31, 2023, and submitted to MQD by April 30, 2023. Additionally, HSAG limited MQD's data to records with an adjudication status of 11 (i.e., pended), 31 (i.e., approved and accepted), or 41 (i.e., accepted by MQD, and denied and paid by the QI health plans) as these represent claim lines in their final status.

Once HSAG received data files from both data sources, the analytic team conducted a preliminary file review to ensure that the submitted data were adequate to conduct the evaluation. The preliminary file review included the following basic checks:

- Data extraction—Extracted based on the data requirements document.
- Percentage present—Required data fields were present in the file and had values in those fields.
- Percentage of valid values—The values were the expected values (e.g., valid ICD-10 codes in the diagnosis fields).
- Evaluation of matching claim numbers—The percentage of claim numbers matched between the two data sources.

Based on the preliminary file review results, HSAG generated a report that highlighted major findings requiring any resubmissions.

How Conclusions Were Drawn

Since MQD has not yet established standards in the QI health plan contract for results from the comparative analysis, HSAG selected results needing the QI health plans' attention based on its experience. Table A-28 displays the criteria HSAG used to determine rates needing the QI health plans' review and investigation.

Table A-28—Criteria Used to Determine Rates Needing the QI Health Plans' Review

Measure	Criteria
Record Omission (i.e., underreporting to MQD) and Record Surplus (i.e., underreporting to Milliman)	> 5.0%
Element Omission (i.e., underreporting to MQD) and Element Surplus (i.e., underreporting to Milliman)	> 5.0%
Element Discrepancy	> 5.0%

Based on these criteria, HSAG provided technical assistance through the following steps:

- First, HSAG drafted health plan-specific encounter data discrepancy reports,[118] which included a description of key issues for the QI health plans to review and investigate, and then reviewed them with MQD and Milliman for feedback.
- Upon MQD's review and approval, HSAG distributed the data discrepancy reports to the QI health plans, along with data samples to assist the health plans with their internal investigations. In addition, HSAG and MQD conducted collaborative technical assistance sessions with each QI health

[118] Before drafting the encounter data discrepancy reports, HSAG submitted a template to MQD for review and approval to help ensure that the data discrepancy reports follow MQD's general process for action plans.

plan to review and discuss the data issues identified in the study, whereby root causes of discrepancies were determined.

- Based on the health plans' internal investigations, the QI health plans provided written responses to the data discrepancy reports noting the potential root cause(s) and action plans, if applicable.
- HSAG, Milliman, and MQD then reviewed the written responses and followed up with the QI health plans for any further clarification.
- Lastly, HSAG distributed the final data discrepancy reports to the QI health plans, Milliman, and MQD to document the action items agreed upon by health plans, Milliman, and MQD.

For the best practice recommendations to MQD, HSAG reviewed the following existing documents provided by MQD and then made recommendations to MQD on needed updates, as applicable, to the encounter submission companion guides and the encounter data requirements documents.

Table A-29—Documents Reviewed

#	Documentation Reviewed
1	Contract requirements regarding the encounter data submissions from the QI health plans
2	Encounter data submission companion guides for all types of encounters (e.g., professional, institutional, and pharmacy)
3	Memos and meeting notes related to the encounter data submission requirements
4	Systematic changes from MQD since January 2022
5	Upcoming changes from MQD and the QI health plans

In addition, HSAG compiled recommendations based on the QI health plans' action items in the final data discrepancy reports. HSAG reviewed the recommendations with MQD before finalizing them.

Goal 1—Advance primary care, prevention, and health promotion								
Objective 1—Enhance timely and comprehensive pediatric care Objective 2—Reduce unintended pregnancies and improve pregnancy-related care Objective 3—Increase utilization of adult preventive screenings in the primary care setting Objective 4—Expand adult primary care preventive services								
PM Code	**Performance Measure Name**	**Measure Steward**	**Objective**				**RY 2024 Target**	**RY 2024 Result**
			1	**2**	**3**	**4**		
AAP	Adults' Access to Preventive/Ambulatory Health Services: Total	NCQA		✓	✓	✓	72.89%	65.98%
ADD	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	NCQA	✓				47.07%	50.73%
ADD	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	NCQA	✓				62.85%	57.89%
AMR	Asthma Medication Ratio	NCQA	✓		✓	✓	63.71%	58.76%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing	NCQA	✓				41.92%	53.18%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing	NCQA	✓				23.10%	30.43%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing	NCQA	✓				22.11%	29.43%
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA	✓				62.77%	46.73%
BCS	Breast Cancer Screening: Breast Cancer Screening	NCQA			✓		54.26%	50.47%
BPD	Blood Pressure Control for Patients With Diabetes	NCQA				✓	59.65%	64.13%
CBP	Controlling High Blood Pressure (<140/90)	NCQA			✓	✓	58.94%	60.44%
CCP-AD; CCP-CH	Contraceptive Care—Postpartum Women: Long-Acting Reversible Method of Contraception (LARC)—3 Days	OPA	✓	✓			2.98%	4.79%
CCP-AD; CCP-CH	Contraceptive Care—Postpartum Women: Long-Acting Reversible Method of Contraception (LARC)—90 Days	OPA	✓	✓			NT	19.64%

PM Code	Performance Measure Name	Measure Steward	Objective				RY 2024 Target	RY 2024 Result
Goal 1—Advance primary care, prevention, and health promotion								
Objective 1—Enhance timely and comprehensive pediatric care Objective 2—Reduce unintended pregnancies and improve pregnancy-related care Objective 3—Increase utilization of adult preventive screenings in the primary care setting Objective 4—Expand adult primary care preventive services								
			1	2	3	4		
CCP-AD; CCP-CH	Contraceptive Care—Postpartum Women: Most or Moderately Effective Contraception—3 Days	OPA	✓	✓			9.23%	11.03%
CCP-AD; CCP-CH	Contraceptive Care—Postpartum Women: Most or Moderately Effective Contraception—90 Days	OPA	✓	✓			NT	45.20%
CCS	Cervical Cancer Screening: Cervical Cancer Screening	NCQA			✓		56.93%	55.23%
CCW-AD; CCW-CH	Contraceptive Care—All Women Ages 21 to 44: Most Effective or Moderately Effective Method of Contraception	OPA	✓	✓			5.01%	4.03%
CCW-AD; CCW-CH	Contraceptive Care—All Women Ages 21 to 44: Long-Acting Reversible Method of Contraception (LARC)	OPA	✓	✓			23.14%	19.40%
CDF-CH; CDF-AD	Screening for Depression and Follow-Up Plan: Negative Screen for Depression During an Outpatient Visit Using A Standardized Tool	CMS	✓		✓		19.78%	31.64%
CHL	Chlamydia Screening in Women: Total	NCQA	✓		✓		50.16%	51.36%
CIS	Childhood Immunization Status: Combination 3	NCQA	✓				57.03%	58.38%
CIS	Childhood Immunization Status: Combination 7	NCQA	✓				49.09%	51.01%
CIS	Childhood Immunization Status: Combination 10	NCQA	✓				39.11%	34.27%
COL	Colorectal Cancer Screening	NCQA			✓		47.53%	38.23%
DEV-CH	Developmental Screening in the First Three Years of Life	OHSU	✓				24.62%	24.81%
EED	Eye Exam for Patients With Diabetes	NCQA			✓	✓	61.55%	60.41%

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

Objective 1—Enhance timely and comprehensive pediatric care
Objective 2—Reduce unintended pregnancies and improve pregnancy-related care
Objective 3—Increase utilization of adult preventive screenings in the primary care setting
Objective 4—Expand adult primary care preventive services

PM Code	Performance Measure Name	Measure Steward	Objective				RY 2024 Target	RY 2024 Result
			1	2	3	4		
Falls1	Falls: Screening for Future Fall Risk: Part 1: Screening	NCQA			✓		48.56%	—
Falls2	Falls: Screening for Future Fall Risk: Part 2: Risk Assessment	NCQA			✓		75.00%	—
Falls3	Falls: Screening for Future Fall Risk: Part 3: Plan of Care	NCQA			✓		58.50%	—
HBD	Hemoglobin A1c Control for Patients With Diabetes: HbA1c Control (<8%)	NCQA				✓	51.94%	55.54%
HBD	Hemoglobin A1c Control for Patients With Diabetes: HbA1c Poor Control (>9%)▼	NCQA				✓	37.84%	35.43%
HVL-AD	HIV Viral Load Suppression: HIV Viral Load Suppression	HRSA			✓	✓	3.74%	23.45%
IMA	Immunizations for Adolescents: Combination 1 (Meningococcal, Tdap)	NCQA	✓				68.24%	65.98%
IMA	Immunizations for Adolescents: Combination 2 (Meningococcal, Tdap, HPV)	NCQA	✓				39.35%	39.05%
PPC	Prenatal and Postpartum Care: Timeliness of Prenatal Care	NCQA		✓			85.46%	80.27%
PPC	Prenatal and Postpartum Care: Postpartum Care	NCQA		✓			79.11%	77.99%
SSD	Diabetes Screening for People w/Schizophrenia or Bipolar Dx using Antipsychotics	NCQA			✓		70.16%	72.56%
W30	Well-Child Visits in the First 30 Months of Life: 15 Months	NCQA	✓				65.00%	64.97%
W30	Well-Child Visits in the First 30 Months of Life: 30 Months	NCQA	✓				70.00%	69.13%
WCC	Weight Assessment and Counseling for Nutrition/Physical Activity: BMI Percentile Documentation	NCQA	✓				82.51%	87.72%
WCC	Weight Assessment and Counseling for Nutrition/Physical Activity: Counseling for Nutrition	NCQA	✓				79.41%	79.29%
WCC	Weight Assessment and Counseling for Nutrition/Physical Activity: Counseling for Physical Activity	NCQA	✓				77.00%	77.74%
WCV	Child and Adolescent Well-Care Visits	NCQA	✓				46.96%	49.61%
CAHPS 5.1H	Composite Measure: Getting Needed Care: Composite Measure: Getting Needed Care (CHIP)	AHRQ	✓				79.69%	78.05%

Goal 1—Advance primary care, prevention, and health promotion								
Objective 1—Enhance timely and comprehensive pediatric care Objective 2—Reduce unintended pregnancies and improve pregnancy-related care Objective 3—Increase utilization of adult preventive screenings in the primary care setting Objective 4—Expand adult primary care preventive services								
PM Code	**Performance Measure Name**	**Measure Steward**	**Objective**				**RY 2024 Target**	**RY 2024 Result**
			1	**2**	**3**	**4**		
CAHPS 5.1H	Composite Measure: Getting Needed Care: Composite Measure: Getting Needed Care (Child)	AHRQ	✓				77.37%	80.76%
CAHPS 5.1H	Composite Measure: Getting Care Quickly: Composite Measure: Getting Care Quickly (CHIP)	AHRQ	✓				79.29%	80.75%
CAHPS 5.1H	Composite Measure: Getting Care Quickly: Child	AHRQ	✓				80.50%	79.32%
CAHPS 5.1H	Composite Measure: How Well Doctors Communicate: CHIP	AHRQ	✓				96.56%	95.75%
CAHPS 5.1H	Composite Measure: How Well Doctors Communicate: Child	AHRQ	✓				94.33%	95.81%
CAHPS 5.1H	Composite Measure: Customer Service: CHIP	AHRQ	✓				89.99%	88.06%
CAHPS 5.1H	Composite Measure: Customer Service: Child	AHRQ	✓				87.77%	81.25%
CAHPS 5.1H	Individual Measures: Coordination of Care: CHIP	AHRQ	✓				87.87%	85.92%
CAHPS 5.1H	Individual Measures: Coordination of Care: Child	AHRQ	✓				86.25%	80.77%
CAHPS 5.1H	Global Rating Measure: Rating of Health Plan: CHIP	AHRQ	✓				76.15%	74.60%
CAHPS 5.1H	Global Rating Measure: Rating of Health Plan: Global Rating Measure: Rating of Health Plan (Adults)	AHRQ	✓		✓	✓	62.83%	63.92%
CAHPS 5.1H	Global Rating Measure: Rating of All Health Care: Global Rating Measure: Rating of All Health Care (CHIP)	AHRQ	✓				66.16%	70.59%

Goal 1—Advance primary care, prevention, and health promotion								
Objective 1—Enhance timely and comprehensive pediatric care Objective 2—Reduce unintended pregnancies and improve pregnancy-related care Objective 3—Increase utilization of adult preventive screenings in the primary care setting Objective 4—Expand adult primary care preventive services								
PM Code	**Performance Measure Name**	**Measure Steward**	**Objective**				**RY 2024 Target**	**RY 2024 Result**
			1	**2**	**3**	**4**		
CAHPS 5.1H	Global Rating Measure: Rating of All Health Care: Global Rating Measure: Rating of All Health Care (Adults)	AHRQ			✓	✓	59.57%	57.72%
CAHPS 5.1H	Global Rating Measure: Rating of All Health Care: Global Rating Measure: Rating of All Health Care (Child)	AHRQ	✓				69.49%	76.51%
CAHPS 5.1H	Global Rating Measure: Rating of Personal Doctor: Global Rating Measure: Rating of Personal Doctor (CHIP)	AHRQ	✓				78.48%	78.13%
CAHPS 5.1H	Global Rating Measure: Rating of Personal Doctor: Global Rating Measure: Rating of Personal Doctor (Adults)	AHRQ			✓		66.40%	66.02%
CAHPS 5.1H	Global Rating Measure: Rating of Personal Doctor: Global Rating Measure: Rating of Personal Doctor (Child)	AHRQ	✓				79.29%	80.18%

Goal 2—Integrate behavioral health with physical health across the continuum of care						
Objective 5—Promote behavioral health integration and build behavioral health capacity Objective 6—Support specialized behavioral health services for serious intellectual/developmental disorders, mental illness, and substance use disorders (SUD)						
PM Code	**Performance Measure Name**	**Measure Steward**	**Objective**		**RY 2024 Target**	**RY 2024 Result**
			5	**6**		
ADD	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	NCQA	✓	✓	47.07%	50.73%
ADD	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	NCQA	✓	✓	62.85%	57.89%
AMM	Antidepressant Medication Management: Effective Acute Phase Treatment	NCQA	✓	✓	61.54%	66.26%
AMM	Antidepressant Medication Management: Effective Continuation Phase Treatment	NCQA	✓	✓	44.54%	47.36%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing	NCQA	✓	✓	41.92%	53.18%

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

Objective 5—Promote behavioral health integration and build behavioral health capacity
Objective 6—Support specialized behavioral health services for serious intellectual/developmental disorders, mental illness, and substance use disorders (SUD)

PM Code	Performance Measure Name	Measure Steward	Objective		RY 2024 Target	RY 2024 Result
			5	6		
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing	NCQA	✓	✓	23.10%	30.43%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing	NCQA	✓	✓	22.11%	29.43%
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA	✓	✓	62.77%	46.73%
CDF-CH; CDF-AD	Screening for Depression and Follow-Up Plan: Negative Screen for Depression During an Outpatient Visit Using A Standardized Tool	CMS	✓		19.78%	31.64%
COB-AD	Concurrent Use of Opioids and Benzodiazepines ▼	PQA		✓	12.99%	13.02%
DMH	Diagnosed Mental Health Disorders	NCQA	✓	✓	NT	17.94%
FUA	Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence: 30-Day Follow-Up (Total)	NCQA	✓	✓	25.71%	41.48%
FUA	Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence: 7-Day Follow-Up (Total)	NCQA	✓	✓	18.05%	26.64%
FUH	Follow-Up After Hospitalization for Mental Illness: 30-Day Follow-Up	NCQA	✓	✓	61.68%	60.00%
FUH	Follow-Up After Hospitalization for Mental Illness: 7-Day Follow-Up	NCQA	✓	✓	40.81%	45.97%
FUM	Follow-Up After Emergency Department Visit for Mental Illness: 30-Day Follow-Up (Total)	NCQA	✓	✓	49.18%	46.87%
FUM	Follow-Up After Emergency Department Visit for Mental Illness: 7-Day Follow-Up (Total)	NCQA	✓	✓	32.77%	30.02%
HPCMI-AD	Diabetes Care for People with SMI: HbA1c Poor Control (>9.0%): Diabetes Care for People with SMI: HbA1c Poor Control (>9.0%) ▼	NCQA	✓	✓	49.20%	42.78%
IET	Initiation and Engagement of AOD Abuse or Dependence Treatment: Initiation of AOD Treatment (Total)	NCQA	✓	✓	37.82%	35.41%

Goal 2—Integrate behavioral health with physical health across the continuum of care						
Objective 5—Promote behavioral health integration and build behavioral health capacity Objective 6—Support specialized behavioral health services for serious intellectual/developmental disorders, mental illness, and substance use disorders (SUD)						
PM Code	**Performance Measure Name**	**Measure Steward**	**Objective**		**RY 2024 Target**	**RY 2024 Result**
			5	**6**		
IET	Initiation and Engagement of AOD Abuse or Dependence Treatment: Engagement of AOD Treatment (Total)	NCQA	✓	✓	11.31%	9.81%
OHD-AD	Use of Opioids at High Dosage in Persons Without Cancer: Use of Opioids at High Dosage in Persons Without Cancer▼	PQA	✓	✓	10.41%	6.81%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Total (Rate 1)	CMS		✓	51.43%	56.71%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Buprenorphine (Rate 2)	CMS		✓	31.83%	34.39%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Oral Naltrexone (Rate 3)	CMS		✓	1.00%	1.23%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Long-Acting, Injectable Naltrexone (Rate 4)	CMS		✓	0.27%	0.19%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Methadone (Rate 5)	CMS		✓	20.60%	22.81%
SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	NCQA	✓	✓	70.68%	69.20%
SSD	Diabetes Screening for People w/ Schizophrenia or Bipolar Dx using Antipsychotics	NCQA		✓	70.16%	72.56%

Goal 3—Improve outcomes for high-need, high-cost individuals								
Objective 7—Provide appropriate care coordination for populations with special health care needs Objective 8—Provide team-based care for beneficiaries with high-needs high-cost conditions Objective 9—Advance care at the end of life Objective 10—Provide supportive housing to homeless beneficiaries with complex health needs								
PM Code	**Performance Measure Name**	**Measure Steward**	**Objective**				**RY 2024 Target**	**RY 2024 Result**
			7	**8**	**9**	**10**		
ACP	Advance Care Planning: Medicaid ABD—40-64 Years	NCQA			✓		NT	16.91%
ACP	Advance Care Planning: Medicaid ABD—65+ Years	NCQA			✓		0.35%	50.07%
ACP	Advance Care Planning: Medicaid non-ABD—40-64 Years	NCQA			✓		5.82%	5.02%
ACP	Advance Care Planning: Medicaid non-ABD—65+ Years	NCQA			✓		1.46%	35.29%
ACP	Advance Care Planning: LTSS—18+ Years	NCQA			✓		7.05%	43.70%

PM Code	Performance Measure Name	Measure Steward	Objective				RY 2024 Target	RY 2024 Result
Goal 3—Improve outcomes for high-need, high-cost individuals								
Objective 7—Provide appropriate care coordination for populations with special health care needs Objective 8—Provide team-based care for beneficiaries with high-needs high-cost conditions Objective 9—Advance care at the end of life Objective 10—Provide supportive housing to homeless beneficiaries with complex health needs								
			7	8	9	10		
ADD	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	NCQA	✓	✓			47.07%	50.73%
ADD	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	NCQA	✓	✓			62.85%	57.89%
AMM	Antidepressant Medication Management: Effective Acute Phase Treatment	NCQA		✓			61.54%	66.26%
AMM	Antidepressant Medication Management: Effective Continuation Phase Treatment	NCQA		✓			44.54%	47.36%
AMR	Asthma Medication Ratio	NCQA	✓				63.71%	58.76%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing	NCQA	✓				41.92%	53.18%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing	NCQA	✓				23.10%	30.43%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing	NCQA	✓				22.11%	29.43%
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA	✓				62.77%	46.73%
BPD	Blood Pressure Control for Patients With Diabetes	NCQA	✓	✓			59.65%	64.13%
COB-AD	Concurrent Use of Opioids and Benzodiazepines▼	PQA	✓	✓			12.99%	13.02%
EED	Eye Exam for Patients With Diabetes	NCQA	✓	✓			61.55%	60.41%
FUA	Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence: 30-Day Follow-Up (Total)	NCQA	✓	✓			25.71%	41.48%
FUA	Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence: 7-Day Follow-Up (Total)	NCQA	✓	✓			18.05%	26.64%
FUH	Follow-Up After Hospitalization for Mental Illness: 30-Day Follow-Up	NCQA	✓	✓			61.68%	60.00%
FUH	Follow-Up After Hospitalization for Mental Illness: 7-Day Follow-Up	NCQA	✓	✓			40.81%	45.97%

Goal 3—Improve outcomes for high-need, high-cost individuals								
Objective 7—Provide appropriate care coordination for populations with special health care needs Objective 8—Provide team-based care for beneficiaries with high-needs high-cost conditions Objective 9—Advance care at the end of life Objective 10—Provide supportive housing to homeless beneficiaries with complex health needs								
PM Code	**Performance Measure Name**	**Measure Steward**	**Objective**				**RY 2024 Target**	**RY 2024 Result**
			7	**8**	**9**	**10**		
FUM	Follow-Up After Emergency Department Visit for Mental Illness: 30-Day Follow-Up (Total)	NCQA	✓	✓			49.18%	46.87%
FUM	Follow-Up After Emergency Department Visit for Mental Illness: 7-Day Follow-Up (Total)	NCQA	✓	✓			32.77%	30.02%
HBD	Hemoglobin A1c Control for Patients With Diabetes: HbA1c Control (<8%)	NCQA	✓	✓			51.94%	55.54%
HBD	Hemoglobin A1c Control for Patients With Diabetes: HbA1c Poor Control (>9%)▼	NCQA	✓	✓			37.84%	35.43%
HPCMI-AD	Diabetes Care for People with SMI: HbA1c Poor Control (>9.0%)▼	NCQA	✓	✓			49.20%	42.78%
IET	Initiation and Engagement of AOD Abuse or Dependence Treatment: Initiation of AOD Treatment (Total)	NCQA	✓	✓			37.82%	35.41%
IET	Initiation and Engagement of AOD Abuse or Dependence Treatment: Engagement of AOD Treatment (Total)	NCQA	✓	✓			11.31%	9.81%
SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	NCQA	✓	✓			70.68%	69.20%
SSD	Diabetes Screening for People w/ Schizophrenia or Bipolar Dx using Antipsychotics	NCQA	✓	✓			70.16%	72.56%
PQI01	PQI 01: Diabetes Short-Term Complications Admission Rate▼	AHRQ	✓	✓			8.26	9.45
PQI03	PQI 03: Diabetes Long-Term Complications Admission Rate▼	AHRQ	✓	✓			15.24	17.31
PQI05	PQI 05: COPD or Asthma in Older Adults Admission Rate▼	AHRQ	✓	✓			18.49	23.21
PQI07	PQI 07: Hypertension Admission Rate▼	AHRQ	✓	✓			3.32	4.07
PQI08	PQI 08: Heart Failure Admission Rate▼	AHRQ	✓	✓			44.74	46.08
PQI14	PQI 14: Uncontrolled Diabetes Admission Rate▼	AHRQ	✓	✓			1.97	1.98
PQI15	PQI 15: Asthma in Younger Adults Admission Rate▼	AHRQ	✓	✓			2.53	2.70
PQI16	PQI 16: Lower-Extremity Amputation among Patients with Diabetes Admission Rate▼	AHRQ	✓	✓			4.42	5.47

PM Code	Performance Measure Name	Measure Steward	Objective				RY 2024 Target	RY 2024 Result
			7	8	9	10		
Goal 3—Improve outcomes for high-need, high-cost individuals								
Objective 7—Provide appropriate care coordination for populations with special health care needs Objective 8—Provide team-based care for beneficiaries with high-needs high-cost conditions Objective 9—Advance care at the end of life Objective 10—Provide supportive housing to homeless beneficiaries with complex health needs								
PQI92	PQI 92: Chronic Conditions Composite6	AHRQ	✓	✓			86.64	98.51
LTSS-CPU	LTSS Comprehensive Care Plan and Update: Assessment of Core Elements	CMS	✓				10.12%	20.58%
LTSS-CPU	LTSS Comprehensive Care Plan and Update: Assessment of Supplemental Elements	CMS	✓				10.12%	19.93%
LTSS-PCP	LTSS Shared Care Plan with Primary Care Practitioner	CMS	✓	✓			18.77%	15.43%
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment after Inpatient Discharge	CMS	✓				10.84%	7.49%
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment and Care Plan after Inpatient Discharge	CMS	✓				1.34%	3.57%
CAHPS 5.1H	Composite Measure: How Well Doctors Communicate: CHIP	AHRQ	✓	✓			96.56%	95.75%
CAHPS 5.1H	Composite Measure: How Well Doctors Communicate: Adults	AHRQ	✓	✓			92.41%	91.77%
CAHPS 5.1H	Composite Measure: How Well Doctors Communicate: Composite Measure: Child	AHRQ	✓	✓			94.33%	95.81%
CAHPS 5.1H	Individual Measures: Coordination of Care: CHIP	AHRQ	✓	✓			87.87%	85.92%
CAHPS 5.1H	Individual Measures: Coordination of Care: Adults	AHRQ	✓	✓			83.33%	86.70%
CAHPS 5.1H	Individual Measures: Coordination of Care: Child	AHRQ	✓	✓			86.25%	80.77%

Goal 4—Support community initiatives to improve population health					
Objective 11—Assess and address social determinants of health needs					
PM Code	Performance Measure Name	Measure Steward	Objective 11	RY 2024 Target	RY 2024 Result
LTSS-CAU	LTSS Comprehensive Assessment and Update: Assessment of Core Elements	CMS	✓	19.10%	22.81%
LTSS-CAU	LTSS Comprehensive Assessment and Update: Assessment of Supplemental Elements	CMS	✓	17.53%	21.26%
LTSS-CPU	LTSS Comprehensive Care Plan and Update: Assessment of Core Elements	CMS	✓	10.12%	20.58%
LTSS-CPU	LTSS Comprehensive Care Plan and Update: Assessment of Supplemental Elements	CMS	✓	10.12%	19.93%
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment after Inpatient Discharge	CMS	✓	10.84%	7.49%
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment and Care Plan after Inpatient Discharge	CMS	✓	1.34%	3.57%

Goal 5—Enhance care in LTSS settings						
Objective 12—Enhance community integration/reintegration of LTSS beneficiaries Objective 13—Enhance nursing facility and Home and Community Based Services (HCBS); prevent or delay progression to nursing facility level of care						
PM Code	Performance Measure Name	Measure Steward	Objective		RY 2024 Target	RY 2024 Result
			12	13		
LTSS-AIF	LTSS Admission to an Institution from the Community: Short Term Stay	CMS	✓	✓	35.48	75.58
LTSS-AIF	LTSS Admission to an Institution from the Community: Medium-Term Stay	CMS	✓	✓	7.42	10.47
LTSS-AIF	LTSS Admission to an Institution from the Community: Long-Term Stay	CMS	✓	✓	3.93	8.19
LTSS-CAU	LTSS Comprehensive Assessment and Update: Assessment of Core Elements	CMS	✓	✓	19.10%	22.81%
LTSS-CAU	LTSS Comprehensive Assessment and Update: Assessment of Supplemental Elements	CMS	✓	✓	17.53%	21.26%
LTSS-CPU	LTSS Comprehensive Care Plan and Update: Assessment of Core Elements	CMS	✓	✓	10.12%	20.58%

Goal 5—Enhance care in LTSS settings						
Objective 12—Enhance community integration/reintegration of LTSS beneficiaries Objective 13—Enhance nursing facility and Home and Community Based Services (HCBS); prevent or delay progression to nursing facility level of care						
PM Code	**Performance Measure Name**	**Measure Steward**	**Objective**		**RY 2024 Target**	**RY 2024 Result**
			12	**13**		
LTSS-CPU	LTSS Comprehensive Care Plan and Update: Assessment of Supplemental Elements	CMS	✓	✓	10.12%	19.93%
LTSS-ILOS	LTSS Minimizing Institutional Length of Stay: Observed Rate	CMS	✓	✓	17.36%	16.37%
LTSS-ILOS	LTSS Minimizing Institutional Length of Stay: O/E Ratio	CMS	✓	✓	0.5487	0.4447
LTSS-PCP	LTSS Shared Care Plan with Primary Care Practitioner: LTSS Shared Care Plan with Primary Care Practitioner	CMS	✓	✓	18.77%	15.43%
LTSS-TRAN	LTSS Successful Transition After Long-Term Institutional Stay: Observed Rate	CMS	✓	✓	69.85%	51.29%
LTSS-TRAN	LTSS Successful Transition After Long-Term Institutional Stay: O/E Ratio	CMS	✓	✓	1.0739	0.8186
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment after Inpatient Discharge	CMS	✓	✓	10.84%	7.49%
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment and Care Plan after Inpatient Discharge	CMS	✓	✓	1.34%	3.57%

Goal 6—Maintain access to appropriate care						
Objective 14—Maintain or enhance access to care Objective 15—Increase coordination of care and decrease inappropriate care						
PM Code	**Performance Measure Name**	**Measure Steward**	**Objective**		**RY 2024 Target**	**RY 2024 Result**
			14	**15**		
AAP	Adults' Access to Preventive/Ambulatory Health Services: Total	NCQA	✓		72.89%	65.98%
ACP	Advance Care Planning: Medicaid ABD—40-64 Years	NCQA	✓	✓	NT	16.91%
ACP	Advance Care Planning: Medicaid ABD—65+ Years	NCQA	✓	✓	0.35%	50.07%
ACP	Advance Care Planning: Medicaid non-ABD—40-64 Years	NCQA	✓	✓	5.82%	5.02%
ACP	Advance Care Planning: Medicaid non-ABD—65+ Years	NCQA	✓	✓	1.46%	35.29%

Goal 6—Maintain access to appropriate care						
Objective 14—Maintain or enhance access to care Objective 15—Increase coordination of care and decrease inappropriate care						
PM Code	**Performance Measure Name**	**Measure Steward**	**Objective**		**RY 2024 Target**	**RY 2024 Result**
			14	**15**		
ACP	Advance Care Planning: LTSS—18+ Years	NCQA	✓	✓	7.05%	43.70%
AMR	Asthma Medication Ratio	NCQA		✓	63.71%	58.76%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing	NCQA		✓	41.92%	53.18%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing	NCQA		✓	23.10%	30.43%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing	NCQA		✓	22.11%	29.43%
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA		✓	62.77%	46.73%
BPD	Blood Pressure Control for Patients With Diabetes	NCQA		✓	59.65%	64.13%
COB-AD	Concurrent Use of Opioids and Benzodiazepines▼	PQA		✓	12.99%	13.02%
DMH	Diagnosed Mental Health Disorders	NCQA		✓	NT	17.94%
EED	Eye Exam for Patients With Diabetes	NCQA		✓	61.55%	60.41%
ENPA	Enrollment by Product Line—Total Medicaid: Enrollment by Product Line—Total Medicaid member-months	NCQA	✓		NA	5,283,557
FUA	Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence: 30-Day Follow-Up (Total)	NCQA		✓	25.71%	41.48%
FUA	Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence: 7-Day Follow-Up (Total)	NCQA		✓	18.05%	26.64%
FUH	Follow-Up After Hospitalization for Mental Illness: 30-Day Follow-Up	NCQA		✓	61.68%	60.00%
FUH	Follow-Up After Hospitalization for Mental Illness: 7-Day Follow-Up	NCQA		✓	40.81%	45.97%
FUM	Follow-Up After Emergency Department Visit for Mental Illness: 30-Day Follow-Up (Total)	NCQA		✓	49.18%	46.87%
FUM	Follow-Up After Emergency Department Visit for Mental Illness: 7-Day Follow-Up (Total)	NCQA		✓	32.77%	30.02%
HBD	Hemoglobin A1c Control for Patients With Diabetes: HbA1c Control (<8%)	NCQA		✓	51.94%	55.54%

Goal 6—Maintain access to appropriate care

Objective 14—Maintain or enhance access to care
Objective 15—Increase coordination of care and decrease inappropriate care

PM Code	Performance Measure Name	Measure Steward	Objective		RY 2024 Target	RY 2024 Result
			14	15		
HBD	Hemoglobin A1c Control for Patients With Diabetes: HbA1c Poor Control (>9%)▼	NCQA		✓	37.84%	35.43%
HPCMI-AD	Diabetes Care for People with SMI: HbA1c Poor Control (>9.0%)▼	NCQA		✓	49.20%	42.78%
IET	Initiation and Engagement of AOD Abuse or Dependence Treatment: Initiation of AOD Treatment (Total)	NCQA		✓	37.82%	35.41%
IET	Initiation and Engagement of AOD Abuse or Dependence Treatment: Engagement of AOD Treatment (Total)	NCQA		✓	11.31%	9.81%
OHD-AD	Use of Opioids at High Dosage in Persons Without Cancer▼	PQA		✓	10.41%	6.81%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Total (Rate 1)	CMS		✓	51.43%	56.71%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Buprenorphine (Rate 2)	CMS		✓	31.83%	34.39%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Oral Naltrexone (Rate 3)	CMS		✓	1.00%	1.23%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Long-Acting, Injectable Naltrexone (Rate 4)	CMS		✓	0.27%	0.19%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Methadone (Rate 5)	CMS		✓	20.60%	22.81%
PCR	Plan All-Cause Readmissions: Index Total Stays—Observed/Expected Ratio—Total▼	NCQA		✓	0.8452	0.8197
PQI01	PQI 01: Diabetes Short-Term Complications Admission Rate▼	AHRQ		✓	8.26	9.45
PQI03	PQI 03: Diabetes Long-Term Complications Admission Rate▼	AHRQ		✓	15.24	17.31
PQI05	PQI 05: COPD or Asthma in Older Adults Admission Rate▼	AHRQ		✓	18.49	23.21
PQI07	PQI 07: Hypertension Admission Rate▼	AHRQ		✓	3.32	4.07
PQI08	PQI 08: Heart Failure Admission Rate▼	AHRQ		✓	44.74	46.08
PQI14	PQI 14: Uncontrolled Diabetes Admission Rate▼	AHRQ		✓	1.97	1.98
PQI15	PQI 15: Asthma in Younger Adults Admission Rate▼	AHRQ		✓	2.53	2.70
PQI16	PQI 16: Lower-Extremity Amputation among Patients with Diabetes Admission Rate▼	AHRQ		✓	4.42	5.47
LTSS-PCP	LTSS Shared Care Plan with Primary Care Practitioner	CMS		✓	18.77%	15.43%

PM Code	Performance Measure Name	Measure Steward	Objective 14	Objective 15	RY 2024 Target	RY 2024 Result
Goal 6—Maintain access to appropriate care						
Objective 14—Maintain or enhance access to care Objective 15—Increase coordination of care and decrease inappropriate care						
LTSS-TRAN	LTSS Successful Transition After Long-Term Institutional Stay: Observed Rate	CMS		✓	69.85%	51.29%
LTSS-TRAN	LTSS Successful Transition After Long-Term Institutional Stay: O/E Ratio	CMS		✓	1.0739	0.8186
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment after Inpatient Discharge	CMS		✓	10.84%	7.49%
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment and Care Plan after Inpatient Discharge	CMS		✓	1.34%	3.57%
CAHPS 5.1H	Composite Measure: Getting Needed Care: CHIP	AHRQ	✓	✓	79.69%	78.05%
CAHPS 5.1H	Composite Measure: Getting Needed Care: Adults	AHRQ	✓	✓	80.78%	79.28%
CAHPS 5.1H	Composite Measure: Getting Needed Care: Child	AHRQ	✓	✓	77.37%	80.76%
CAHPS 5.1H	Composite Measure: Getting Care Quickly: CHIP	AHRQ	✓	✓	79.29%	80.75%
CAHPS 5.1H	Composite Measure: Getting Care Quickly: Adults	AHRQ	✓	✓	77.32%	76.87%
CAHPS 5.1H	Composite Measure: Getting Care Quickly: Child	AHRQ	✓	✓	80.50%	79.32%
CAHPS 5.1H	Composite Measure: How Well Doctors Communicate: CHIP	AHRQ		✓	96.56%	95.75%
CAHPS 5.1H	Composite Measure: How Well Doctors Communicate: Adults	AHRQ		✓	92.41%	91.77%
CAHPS 5.1H	Composite Measure: How Well Doctors Communicate: Child	AHRQ		✓	94.33%	95.81%

PM Code	Performance Measure Name	Measure Steward	Objective 14	Objective 15	RY 2024 Target	RY 2024 Result
Goal 6—Maintain access to appropriate care						
Objective 14—Maintain or enhance access to care Objective 15—Increase coordination of care and decrease inappropriate care						
CAHPS 5.1H	Individual Measures: Coordination of Care: CHIP	AHRQ		✓	87.87%	85.92%
CAHPS 5.1H	Individual Measures: Coordination of Care: Adults	AHRQ		✓	83.33%	86.70%
CAHPS 5.1H	Individual Measures: Coordination of Care: Child	AHRQ		✓	86.25%	80.77%
CAHPS 5.1H	Global Rating Measure: Rating of Health Plan: CHIP	AHRQ	✓		76.15%	74.60%
CAHPS 5.1H	Global Rating Measure: Rating of Health Plan: Adults	AHRQ	✓		62.83%	63.92%
CAHPS 5.1H	Global Rating Measure: Rating of Health Plan: Child	AHRQ	✓		74.13%	73.45%
CAHPS 5.1H	Global Rating Measure: Rating of All Health Care: CHIP	AHRQ	✓		66.16%	70.59%
CAHPS 5.1H	Global Rating Measure: Rating of All Health Care: Adults	AHRQ	✓	✓	59.57%	57.72%
CAHPS 5.1H	Global Rating Measure: Rating of All Health Care: Child	AHRQ	✓		69.49%	76.51%
CAHPS 5.1H	Global Rating Measure: Rating of Specialist Seen Most Often: CHIP	AHRQ	✓		77.47%	72.34%
CAHPS 5.1H	Global Rating Measure: Rating of Specialist Seen Most Often: Adults	AHRQ	✓		71.50%	67.13%
CAHPS 5.1H	Global Rating Measure: Rating of Specialist Seen Most Often: Child	AHRQ	✓		76.15%	76.19%
CAHPS 5.1H	Global Rating Measure: Rating of Personal Doctor: CHIP	AHRQ	✓		78.48%	78.13%

PM Code	Performance Measure Name	Measure Steward	Objective 14	Objective 15	RY 2024 Target	RY 2024 Result
Goal 6—Maintain access to appropriate care						
Objective 14—Maintain or enhance access to care Objective 15—Increase coordination of care and decrease inappropriate care						
CAHPS 5.1H	Global Rating Measure: Rating of Personal Doctor: Adults	AHRQ	✓		66.40%	66.02%
CAHPS 5.1H	Global Rating Measure: Rating of Personal Doctor: Child	AHRQ	✓		79.29%	80.18%

PM Code	Performance Measure Name	Measure Steward	Objective 16	Objective 17	RY 2024 Target	RY 2024 Result
Goal 7—Align payment structures to improve health outcomes						
Objective 16—Align payment structures to support work on social determinants of health Objective 17—Align payment structures to enhance quality and value of care						
CCS	Cervical Cancer Screening	NCQA		✓	56.93%	55.23%
CIS	Childhood Immunization Status: Combination 3	NCQA		✓	57.03%	58.38%
FUH	Follow-Up After Hospitalization for Mental Illness: 7-Day Follow-Up	NCQA		✓	40.81%	45.97%
HBD	Hemoglobin A1c Control for Patients With Diabetes: HbA1c Control (<8%)	NCQA		✓	51.94%	55.54%
PCR	Plan All-Cause Readmissions: Index Total Stays—Observed/Expected Ratio—Total ▼	NCQA		✓	0.8452	0.8197
PPC	Prenatal and Postpartum Care: Timeliness of Prenatal Care	NCQA		✓	85.46%	80.27%
PPC	Prenatal and Postpartum Care: Postpartum Care	NCQA		✓	79.11%	77.99%
W30	Well-Child Visits in the First 30 Months of Life: 15 Months	NCQA		✓	65.00%	64.97%
CAHPS 5.1H	Composite Measure: Getting Needed Care: CHIP	AHRQ		✓	79.69%	78.05%
CAHPS 5.1H	Composite Measure: Getting Needed Care: Adults	AHRQ		✓	80.78%	79.28%
CAHPS 5.1H	Composite Measure: Getting Needed Care: Child	AHRQ		✓	77.37%	80.76%

Goal 7—Align payment structures to improve health outcomes						
Objective 16—Align payment structures to support work on social determinants of health Objective 17—Align payment structures to enhance quality and value of care						
PM Code	**Performance Measure Name**	**Measure Steward**	**Objective**		**RY 2024 Target**	**RY 2024 Result**
			16	**17**		
CAHPS 5.1H	Global Rating Measure: Rating of Specialist Seen Most Often: CHIP	AHRQ		✓	77.47%	72.34%
CAHPS 5.1H	Global Rating Measure: Rating of Specialist Seen Most Often: Adults	AHRQ		✓	71.50%	67.13%
CAHPS 5.1H	Global Rating Measure: Rating of Specialist Seen Most Often: Child	AHRQ		✓	76.15%	76.19%
CAHPS 5.1H	Global Rating Measure: Rating of Personal Doctor: CHIP	AHRQ		✓	78.48%	78.13%
CAHPS 5.1H	Global Rating Measure: Rating of Personal Doctor: Adults	AHRQ		✓	66.40%	66.02%
CAHPS 5.1H	Global Rating Measure: Rating of Personal Doctor: Child	AHRQ		✓	79.29%	80.18%

▾ A lower rate indicates better performance for this measure.
Dash (—) indicates that the measure was not required to be reported, the measure was not available during the measurement year, or the measure was retired.
NA (not applicable) indicates that a data element was not applicable to the measure (i.e., no NQF number available, no PM code).
NT (no target) indicates that a target is not established/available.
[Green shading] Indicates that the RY 2024 performance measure rate was at or above the RY 2024 target.