State of Hawaii

Department of Human Services

Med-QUEST Division

2023 External Quality Review Report of Results

for the

QUEST Integration Health Plans

and the

Community Care Services Program

April 2024

HSAG HEALTH SERVICES ADVISORY GROUP

Contents

1. Executive Summary

Overview

The 2023 Hawaii External Quality Review Report of Results for the QUEST Integration (QI) Health Plans and the Community Care Services (CCS) program is presented to comply with the Code of Federal Regulations (CFR) at 42 CFR §438.364.[1-1] Health Services Advisory Group, Inc. (HSAG), is the external quality review organization (EQRO) for the Med-QUEST Division (MQD) of the State of Hawaii Department of Human Services (DHS), the single State agency responsible for the overall administration of Hawaii's Medicaid managed care program.

This report describes how data from activities conducted in accordance with 42 CFR §438.352 were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and access to, care furnished to Medicaid and Children's Health Insurance Program (CHIP) recipients in Hawaii. The QI health plans include five managed care organizations (MCOs) contracted with 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) 2023 are displayed in Table 1-1.

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

MCO Name	MCO Short Name
AlohaCare QUEST Integration	AlohaCare QI
Hawaii Medical Service Association QUEST Integration	HMSA QI
Kaiser Foundation Health Plan QUEST Integration	KFHP QI
ʻOhana Health Plan QUEST Integration	ʻOhana QI
UnitedHealthcare Community Plan QUEST Integration	UHC CP QI
PIHP Name	**PIHP Short Name**
ʻOhana Community Care Services	ʻOhana CCS

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 81, No. 88/Friday, May 6, 2016/Rules and Regulations. 42 CFR Parts 431, 433 and 438 with revisions released (or as amended) November 13, 2020, Final Rule.

Purpose of the Report

The CFR requires that states use an EQRO to prepare an annual technical report that describes how data from activities conducted, in accordance with the CFR, were aggregated and analyzed. The annual technical report also draws conclusions about the quality of, timeliness of, and access to healthcare services that managed care organizations (MCOs) provide.

To comply with these requirements, 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 revised external quality review (EQR) protocols update when preparing this report.[1-2]

This report provides:

- An overview of the QI and CCS programs.
- A description of the scope of EQR activities performed by HSAG and the manner in which the data from these activities were analyzed and aggregated, and conclusions were drawn.
- An assessment of each health plan's strengths and weaknesses for providing healthcare timeliness, access, and quality across CMS-required mandatory and optional activities for compliance with standards, network adequacy, performance measures, performance improvement projects (PIPs), consumer and provider 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 evaluated the health plans' compliance with State and federal requirements for organizational and structural performance. MQD contracts with the EQRO to conduct a review of one-half of the full set of standards in year 1 and year 2 to complete the cycle within a three-year period. HSAG conducted on-site compliance reviews in June 2023. The health plans submitted documentation that was in effect

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

July 1, 2022, through May 1, 2023. HSAG provided detailed, final audit reports to the health plans and MQD in September 2023.

- *Validation of performance measures*. HSAG validated each health plan's performance measure results for a set of Healthcare Effectiveness Data and Information Set (HEDIS)®[1-3] and non-HEDIS performance measures selected by 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™[1-4] guidelines and timeline, which occurred from January 2023 through July 2023. The final audited performance measure validation results for each health plan reflected the measurement period of January 1, 2022, through December 31, 2022. HSAG provided final audit reports to the health plans and MQD in July 2023.
- *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.[1-5] In CY 2023, the health plans submitted two PIPs each and those were reviewed and validated by HSAG. HSAG also provided PIP trainings to the health plans prior to the PIP submissions, and additional technical assistance was provided to the health plans upon request throughout the year.
- *Consumer Assessment of Healthcare Providers and Systems (CAHPS®)*[1-6] *surveys*. MQD contracted with HSAG to conduct CAHPS surveys of the child QI health plan members and Children's Health Insurance Program (CHIP) populations to learn more about members' experiences with care. The standardized survey instrument administered to parents/caretakers of child Medicaid members of the QI health plans and parents/caretakers of child members enrolled in CHIP was the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set (without the children with chronic conditions [CCC] measurement set). All parents/caretakers of sampled child members completed the surveys from February to May 2023. HSAG aggregated and produced final reports in September 2023.
- *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 January to April 2023. HSAG aggregated and produced a final report in August 2023.
- *Provider Survey*. MQD contracted with HSAG to conduct surveys of healthcare providers who serve QI members through one or more QI health plans to learn more about providers' perceptions of the

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

QI health plans. HSAG and MQD developed a survey instrument designed to acquire provider information and gain providers' insight into the QI health plans' performance and potential areas of performance improvement. Providers completed the surveys from June to August 2023. HSAG aggregated and produced a final report in November 2023.

- *Encounter data validation (EDV).* HSAG and MQD initiated an EDV study in 2023. This study will focus on evaluating the extent to which the encounter data in MQD's database are complete, accurate, and submitted by the MCOs in a timely manner through a comparative analysis between MQD's electronic encounter data and the actuarial files submitted by the MCOs to MQD's contracted actuary, Milliman. HSAG will also provide technical assistance sessions to the MCOs regarding the findings from the comparative analysis so that the MCOs can better identify the root cause(s) and take appropriate actions to improve MQD's encounter data quality. Lastly, HSAG will provide best practice recommendations to MQD in reference to MQD's encounter data submission companion guides and requirements. At the time of this report, the study was ongoing; therefore, results of the 2023 study will be presented in the 2024 Hawaii EQR Technical Report.

Overall Summary of Health Plan Performance

Compliance Monitoring Review

Calendar year (CY) 2023 began the second year of a three-year cycle of compliance reviews for the QI health plans and the CCS program.

For the 2023 evaluation of health plan compliance, HSAG performed two types of activities. First, HSAG conducted a review of select standards for the QI and CCS programs using monitoring tools to assess and document compliance with a set of federal and State requirements. The standards selected for review were related to the health plan's State contract requirements and the federal Medicaid managed care regulations in the CFR for seven areas of review, or standards. Both a pre-on-site desk review and an on-site review with interview sessions, system and process demonstrations, and record reviews were conducted. The second compliance review activity in 2023 involved HSAG's and MQD's follow-up monitoring of the QI health plans' and CCS' corrective actions related to findings from the 2022 and 2023 compliance reviews.

Findings, Conclusions, and Recommendations

Table 1-2 summarizes the results from the 2023 compliance monitoring reviews. This table contains high-level results used to compare the Hawaii Medicaid managed care health plans' performance on a set of requirements (federal Medicaid managed care regulations and State contract provisions) for each of the seven compliance standard areas selected for review this year. Scores have been calculated for each standard area statewide, and for each health plan for all standards. Health plan scores with red shading indicate performance below the statewide score.

Table 1-2—Standards and Compliance Scores

Standard Name	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI	'Ohana CCS	Statewide Score
I. Provider Selection	100%	100%	100%	100%	100%	100%	**100%**
II. Credentialing	98%	99%	100%	99%	100%	99%	**99%**
III. Subcontractual Relationships and Delegation	100%	92%	92%	100%	100%	100%	**97%**
IV. Health Information Systems	100%	100%	100%	100%	100%	100%	**100%**
V. Quality Assessment and Performance Improvement	100%	100%	100%	100%	100%	100%	**100%**
VI. Practice Guidelines	100%	100%	100%	100%	100%	100%	**100%**
VII. Enrollment and Disenrollment	100%	100%	100%	100%	100%	100%	**100%**
Totals	**99%**	**99%**	**99%**	**99%**	**100%**	**99%**	**99%**

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

In general, health plan performance suggested that all health plans had implemented the systems, policies and procedures, and staff to ensure their operational foundations support the core processes of providing care and services to Medicaid members in Hawaii. Five standards were found to be fully compliant (i.e., 100 percent of standards/elements met) across all health plans—Provider Selection, Health Information Systems, Quality Assessment and Performance Improvement, Practice Guidelines, and Enrollment and Disenrollment. The Credentialing and Subcontractual Relationships and Delegation standards were the only standards identified as having opportunities for improvement, with four health plans having at least one element scored *Partially Met* in the Credentialing standard and two health plans having one element scored *Partially Met* in the Subcontractual Relationships and Delegation standard.

Individual health plan performance revealed the following:

- AlohaCare QI's performance across all standards was strong, meeting or exceeding the statewide compliance score for all standards.
  - AlohaCare QI had a total compliance score of 99 percent, with six of the standards scoring 100 percent. Two elements in the Credentialing standard were found to be noncompliant.
  - AlohaCare QI was required to develop a corrective action plan (CAP) to address and resolve deficiencies identified in the review. HSAG and MQD provided feedback and will continue to monitor AlohaCare QI's CAP activities until the health plan is found to be in full compliance.
- HMSA QI's performance across all standards was strong, meeting or exceeding the statewide compliance score for all standards except Subcontractual Relationships and Delegation.
  - HMSA QI had a total compliance score of 99 percent, with five of the standards scoring 100 percent. One element in the Credentialing standard and one element in the Subcontractual Relationships and Delegation standard were found to be noncompliant.
  - HMSA QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and MQD provided feedback and will continue to monitor HMSA QI's CAP activities until the health plan is found to be in full compliance.

- KFHP QI's performance across all standards was strong, meeting or exceeding the statewide compliance score for all standards except Subcontractual Relationships and Delegation.
  - KFHP QI had a total compliance score of 99 percent, with six of the standards scoring 100 percent. One element in the Subcontractual Relationships and Delegation standard was found to be noncompliant.
  - KFHP QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and MQD provided feedback and will continue to monitor KFHP QI's CAP activities until the health plan is found to be in full compliance.
- 'Ohana QI's performance across all standards was strong, meeting or exceeding the statewide compliance score for all standards.
  - 'Ohana QI had a total compliance score of 99 percent, with six of the standards scoring 100 percent. One element in the Credentialing standard was found to be noncompliant.
  - 'Ohana QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and MQD provided feedback and will continue to monitor 'Ohana QI's CAP activities until the health plan is found to be in full compliance.
- UHC CP QI's performance across all standards was strong, meeting or exceeding the statewide compliance score for all standards.
  - UHC CP QI had a total compliance score of 100 percent in all standards; therefore, UHC CP QI was not required to implement a CAP.
- 'Ohana CCS' performance across all standards was strong, meeting or exceeding the statewide compliance score for all standards.
  - 'Ohana CCS had a total compliance score of 99 percent with six of the standards scoring 100 percent. One element in the Credentialing standard was found to be noncompliant.
  - 'Ohana CCS was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and MQD provided feedback and will continue to monitor 'Ohana CCS' CAP activities until the health plan is found to be in full compliance.

With the completion of compliance monitoring reviews and initiation of the corrective action process, the health plans and CCS have demonstrated their structural and operational compliance and ability to support the provision of quality, timely, and accessible services.

The QI health plans' and CCS' CAP implementation resulting from HSAG's 2022 compliance review was also monitored by HSAG and MQD in 2023. Deficiencies from the 2023 compliance reviews are currently under CAPs and continue to be monitored by HSAG and MQD.

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) 2022 Volume 5, HEDIS Compliance*

Audit: Standards, Policies and Procedures.[1-7] The audit procedures were also consistent with the CMS protocol for performance measure validation (PMV): *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023.[1-8] The health plans that contracted with MQD during MY 2022 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 CY 2022 (January 1, 2022, through December 31, 2022), and the audit activities were conducted concurrently with the HEDIS MY 2022 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 2022 reporting, the State selected a set of performance measures from NCQA's *HEDIS Measurement Year 2022 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 2022 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 2022 Reporting; CMS' Measures for Medicaid Long Term Services and Supports Plans, Technical Specifications and Resource Manual, July 2022,* and NCQA's *HEDIS Measurement Year 2021 & Measurement Year 2022, Technical Specifications for Long-Term Services and Supports Measures.* For measures that were both HEDIS and Core Set, health plans were required to follow NCQA's *HEDIS Measurement Year 2022 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 19 measures for the QI population, yielding a total of 67 measure indicators. 'Ohana CCS was required to report on eight measures, yielding 37 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)

[1-7] National Committee for Quality Assurance. *HEDIS Measurement Year 2022 Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures.* Washington, DC: NCQA; 2021.

[1-8] 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: Apr 7, 2023.

Findings, Conclusions, and Recommendations

NCQA HEDIS Compliance Audit

HSAG evaluated each QI and CCS health plan's measure data collection and reporting processes to determine compliance with NCQA's IS and HD standards during the MY 2022 NCQA HEDIS Compliance Audits. HSAG determined four of the five 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 8.0 for assessing case management data for LTSS measures. HMSA QI was not compliant with IS standard 8.0, which significantly impacted its ability to report the LTSS measure rates that required case management record review. Overall, the health plans followed the measure specifications required by the State to calculate the required HEDIS and non-HEDIS performance measure rates, and except for the LTSS measure rates for one QI health plan, all rates were determined to be *Reportable*.

Performance Measure Results

HSAG analyzed the HEDIS MY 2022 performance measure results for each health plan, and where applicable, HSAG compared the results to NCQA's 2022 Quality Compass®,[1-9] national Medicaid health maintenance organization (HMO) percentiles for HEDIS MY 2021 (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—Total)*, HSAG reversed the order of the benchmarks for performance level evaluation to be consistently applied.[1-10]

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.

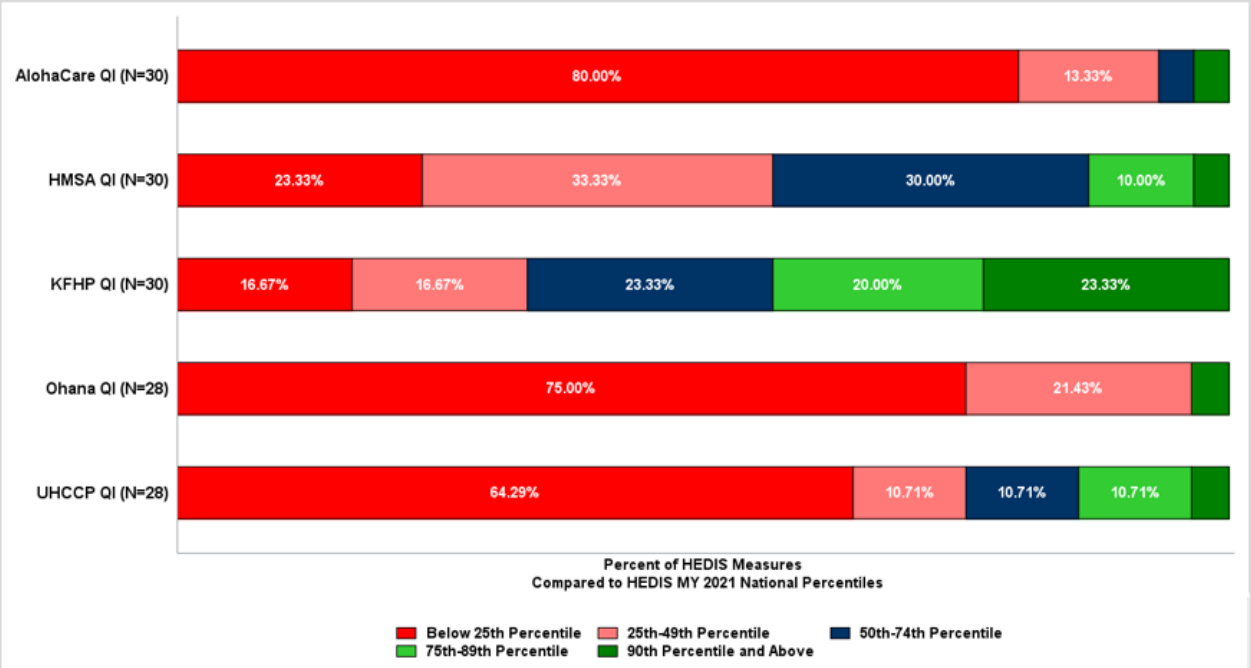
In the following figures, "N" indicates, by health plan, the total number of performance measure indicators that were compared to the benchmarks for QI and CCS. Rates for which comparisons to benchmarks were not appropriate or rates that were not reportable (e.g., small denominator, biased rate) were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

Figure 1-1 displays the QI health plans' HEDIS MY 2022 performance compared to benchmarks, where applicable. HSAG analyzed results from 19 performance measures for HEDIS MY 2022 (a total of 67 indicator rates), of which 30 indicators were comparable to benchmarks. Of note, all the health plans had at least one measure indicator receive a status of *NA* (i.e., small denominator).

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

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

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



As presented in Figure 1-1, KFHP QI was the highest-performing plan for HEDIS MY 2022, with 20 of 30 (66.7 percent) measure rates ranking at or above the 50th percentile, including six rates (20.0 percent) meeting or exceeding the 75th percentile and seven rates (23.3 percent) meeting or exceeding the 90th percentile. Conversely, 10 of KFHP QI's measure rates (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.

HMSA QI was the second-highest performing health plan, with 13 of 30 (43.3 percent) measure rates ranking 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. Conversely,17 of HMSA QI's 30 (56.7 percent) measure rates ranked below the 50th percentile, with seven of these rates (23.3 percent) falling below the 25th percentile.

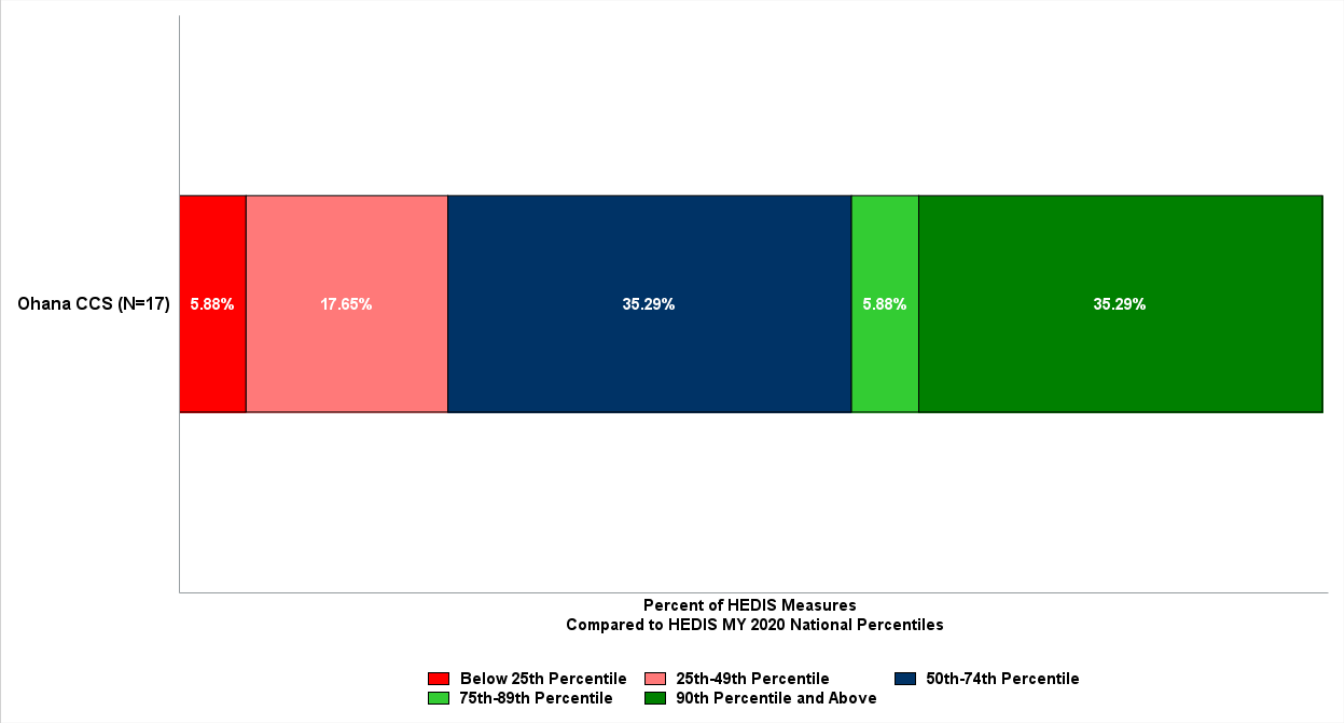
For UHC CP QI, seven out of 28 (25.0 percent) measure rates met or exceeded the 50th percentile, with three of these rates (10.7 percent) meeting or exceeding the 75th percentile, and one rate (3.6 percent) meeting or exceeding the 90th percentile. Conversely, 21 of UHC CP QI's 28 (75.0 percent) measure rates fell below the 50th percentile, with 18 of these rates (64.3 percent) falling below the 25th percentile.

For AlohaCare QI, 28 of 30 measure rates (93.3 percent) fell below the 50th percentile, with 24 of these rates (80.0 percent) falling below the 25th percentile. Conversely, AlohaCare QI met or exceeded the 50th percentile for two measure rates (6.7 percent), with one of these rates (3.3 percent) ranking at or above the 90th percentile.

'Ohana QI was the lowest-performing plan for HEDIS MY 2022, with 27 of 28 (96.4 percent) measure rates ranking below the 50th percentile, with 21 of these rates (75.0 percent) falling below the 25th percentile. Conversely, 'Ohana QI met or exceeded the 90th percentile for one (3.6 percent) measure rate.

Figure 1-2 displays 'Ohana CCS' HEDIS MY 2022 performance compared to benchmarks, where applicable. HSAG analyzed results from 17 performance measures for HEDIS MY 2022 (a total of 37 indicator rates), of which 17 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 13 of 17 (76.5 percent) measure rates ranking at or above the 50th percentile, including one rate (5.9 percent) that met or exceeded the 75th percentile and six rates (35.3 percent) that met or exceeded the 90th percentile. Additionally, 'Ohana CCS met eight MQD Quality Strategy targets in HEDIS MY 2022. Conversely, four of 17 (23.5 percent) measure rates fell below the 50th percentile, including one rate (5.9 percent) that fell below the 25th percentile.

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

Performance Improvement Projects

In CY 2023, HSAG validated two PIPs for each of the five QUEST Integration health plans and one PIHP—'Ohana CCS. The PIP topics for all the QI plans were a non-clinical PIP topic, *Behavioral Health Coordination* and a clinical PIP topic, *Plan All-Cause Readmissions*. The PIP topics for 'Ohana CCS were a non-clinical PIP topic, *Behavioral Health Coordination* and a clinical PIP topic, *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 2023 submission, the health plans progressed to the Design and Implementation stages of the PIPs and submitted Steps 1 through 8 in the PIP Submission Form.

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

- Four QI health plans received an overall *Met* status for both the PIPs. Ohana QI received a *Partially Met* status for the *Behavioral Health Coordination* PIP, and HMSA QI received a *Not Met* status for the *Plan All-Cause Readmissions* PIP.
- 'Ohana CCS received an overall *Met* status for both PIPs.

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

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

Health Plan	*Behavioral Health Coordination*			*Plan All-Cause Readmissions*		
	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
AlohaCare QI	100%	100%	*Met*	100%	100%	*Met*
HMSA QI	95%	100%	*Met*	63%	56%	*Not Met*
KFHP QI	95%	100%	*Met*	95%	100%	*Met*
'Ohana QI	84%	90%	*Partially Met*	95%	100%	*Met*
UHC CP QI	100%	100%	*Met*	95%	100%	*Met*

Behavioral Health Coordination

The third quarter of CY 2022 was the Remeasurement 1 period for this PIP, and the PIP included two performance indicators. AlohaCare QI achieved statistically significant improvement over the baseline during Remeasurement 1 for both performance indicators. HMSA QI, KFHP QI, Ohana QI, and UHC CP 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 and UHC CP QI

also documented achievement of significant programmatic improvement due to changes made in workflows and staff training on the PIP regarding identification of shared members for performing combined reviews. As a note, not all the health plans reported achievement of clinical and programmatic improvement because this is optional reporting and is not required to be documented in the PIP Submission Form.

Plan All-Cause Readmissions

CY 2022 was the Remeasurement 1 period for this PIP, and the PIP includes one performance indicator. AlohaCare QI and UHC CP QI achieved non-statistically significant improvement in the Remeasurement 1 rate over the baseline. KFHP QI and 'Ohana QI demonstrated a decline in performance with an increase in the observed readmission rate. AlohaCare QI also demonstrated achievement of significant programmatic improvement with its Transition of Care (TOC) Services from the TOC Team to the Post Discharge Program intervention.

HMSA QI could not be assessed for improvement in PIP outcomes during Remeasurement 1 due to missing data. It appears that the health plan erroneously missed reporting Remeasurement 1 data, and the reported baseline rate were inaccurate.

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

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

Health Plan	*Behavioral Health Coordination*			*7-Day Follow–Up After Emergency Department Visit for Mental Illness*		
	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
'Ohana CCS	95%	100%	*Met*	100%	100%	*Met*

For *Behavioral Health Coordination* PIP outcomes, 'Ohana CCS documented 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 remeasurement period.

'Ohana CCS reported Remeasurement 1 data for the *7-Day Follow-up After Emergency Department Visit for Mental Illness* PIP. The health plan achieved non-statistically significant improvement in the *FUM* rate over the baseline.

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

- The health plans should continually work on the PIPs throughout the year.
- For the *Behavioral Health Coordination* PIP:

  - The health plans should continue to work toward improving their data sharing and care coordination efforts with the State of Hawaii, Department of Health (DOH) Behavioral Health Services Administration agencies.
  - The health plans should continue to capture the informal combined reviews based on the systems/data that they have and document how they are defining and capturing these data. The health plans should explore the possibilities of updating systems to capture more detailed information as part of this PIP for long-term care coordination needs.
  - The data included in the PIP Submission Form must include information about all eligible members for each performance indicator, as available. If the health plans have not yet initiated data sharing activities with a specific partnering agency, the denominator count must still include the count of shared members with that agency.
  - The health plans must also include quantitative data to document the effectiveness of the interventions. For example, in the next annual submission, for the data sharing agreement (DSA) intervention, the health plans should include how much improvement in data sharing with the DOH agencies was noted after the DSAs are executed.
- For the *Plan All-Cause Readmissions* PIP:
  - In Step 8 of the PIP Submission Form, the health plans should document the barriers, interventions, and QI activities undertaken as part of the Readmissions Collaborative workgroup to improve the HEDIS *Plan All-Cause Readmissions* (*PCR)* measure rate.
- The health plans must continue to 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. The health plans should consider using science-based quality improvement tools, such as process mapping and failure modes and effects analyses (FMEA) for barrier analysis.
- The health plans must have a process in place for evaluating each PIP intervention and its impact on the performance indicator. Interventions must be adapted or revised as needed.
- 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 plans must address the validation feedback associated with any *Met* score and the *Partially 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 Child Medicaid Survey and Statewide CHIP Survey

The CAHPS health plan surveys are standardized survey instruments which measure patients' experience with their healthcare. For 2023, HSAG administered the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set (without the CCC measurement set) to child Medicaid members of the QI health plans and a statewide sample of CHIP members who met age and enrollment criteria. All parents/caretakers of sampled child Medicaid and CHIP members completed the

surveys from February to May 2023 and received an English version of the survey with the option to complete the survey in one of four non-English languages predominant in the State of Hawaii: Chinese, Ilocano, Korean, or Vietnamese.[1-11] Standard survey administration protocols were followed in accordance with NCQA specifications. These standard protocols promote the comparability of resulting health plan and/or state-level CAHPS data.

For each survey, the results of nine measures of experience were reported. These measures included four global ratings (Rating of Health Plan, Rating of All Health Care, Rating of Personal Doctor, and Rating of Specialist Seen Most Often); four composite measures (Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, and Customer Service); and one individual item measure (Coordination of Care). The scoring of the global ratings, composite measures, and individual item measure involved assigning top-box responses a score of one, with all other responses receiving a score of zero. After applying this scoring methodology, the proportion (i.e., percentage) of top-box responses was calculated in order to determine the top-box scores.

Findings, Conclusions, and Recommendations

Table 1-5 presents the 2023 percentage of top-box responses (i.e., top-box scores) for the QI Program aggregate compared to the 2022 NCQA child Medicaid national averages and the corresponding 2021 top-box scores.[1-12,1-13] Additionally, the overall member experience ratings (i.e., star ratings) resulting from the QI Program aggregate's 2023 top-box scores compared to NCQA's 2022 Quality Compass Benchmark and Compare Quality Data are displayed below.[1-14]

Table 1-5—QI Program Child CAHPS Results

Measure	2021 Scores	2023 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	75.1%	73.4%	★★★
Rating of All Health Care	74.9%	68.8% ▼	★★
Rating of Personal Doctor	81.8%	78.5% ▼	★★★
Rating of Specialist Seen Most Often	76.4%	75.4%	★★★

[1-11] Please note that administration of the CAHPS survey in these alternate non-English languages (i.e., Chinese, Ilocano, Korean, and Vietnamese) deviates from standard NCQA protocol. The CAHPS 5.1H Adult Medicaid Health Plan Survey and 5.1H Child Medicaid Health Plan Survey are made available by NCQA in English and Spanish only. NCQA's approval of this survey protocol enhancement was required in order to allow adult members and parents/caretakers the option to complete the CAHPS survey questionnaire in these alternate languages.

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

[1-13] The child population was last surveyed in 2021; therefore, the 2023 child CAHPS scores are compared to the corresponding 2021 scores.

[1-14] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2022.* Washington, DC: NCQA, September 2022.

Measure	2021 Scores	2023 Scores	Star Ratings
Composite Measures			
Getting Needed Care	83.6%	76.6% ▼	★
Getting Care Quickly	81.9%	79.7%	★
How Well Doctors Communicate	95.4%	93.4% ▼	★★
Customer Service	88.3%	86.9%	★★
Individual Item Measure			
Coordination of Care	88.4%	85.4%	★★★

Cells highlighted in yellow represent scores that are statistically significantly higher than the 2022 NCQA child Medicaid national averages.
Cells highlighted in red represent scores that are statistically significantly lower than the 2022 NCQA child Medicaid national averages.

▲ *Indicates the 2023 score is statistically significantly higher than the 2021 score.*

▼ *Indicates the 2023 score is statistically significantly lower than the 2021 score.*
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
Star Ratings based on percentiles:
★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

Comparison of the QI Program aggregate's 2023 scores to the 2022 NCQA child Medicaid national averages revealed the following summary results:

- The QI Program aggregate's scores were not statistically significantly higher than the national averages for any of the measures.
- The QI Program aggregate's scores were statistically significantly lower than the national averages on two measures: *Getting Needed Care* and *Getting Care Quickly*.

Comparison of the QI Program aggregate's 2023 scores to the corresponding 2021 scores revealed the following summary results:

- The 2023 QI Program aggregate's scores were not statistically significantly higher than the 2021 scores on any measures.
- The 2023 QI Program's scores were statistically significantly lower than the 2021 scores on four measures: *Rating of All Health Care, Rating of Personal Doctor*, *Getting Needed Care*, and *How Well Doctors Communicate.*

Comparison of the QI Program's 2023 scores to the 2022 NCQA child Medicaid Quality Compass data revealed the following:

- The QI Program aggregate did not score at or above the 75th percentile on any measures.

- The QI Program aggregate scored between the 50th and 74th percentile on four measures: *Rating of Health Plan, Rating of Personal Doctor*, *Rating of Specialist Seen Most Often*, and *Coordination of Care*.
- The QI Program aggregate scored between the 25th and 49th percentile on three measures: *Rating of All Health Care*, *How Well Doctors Communicate*, and *Customer Service*.
- The QI Program aggregate scored below the 25th percentile on two measures: *Getting Needed Care* and *Getting Care Quickly.*

Table 1-6 presents the 2023 percentage of top-box responses (i.e., top-box scores) for the Hawaii CHIP population compared to the 2022 NCQA child Medicaid national averages and the corresponding 2022 top-box scores. As NCQA does not publish separate benchmarking data for the CHIP population, the NCQA national averages for the child Medicaid population were used for comparison. Additionally, the overall member experience ratings (i.e., star ratings) resulting from the 2023 top-box scores compared to NCQA's 2022 Quality Compass Benchmark and Compare Quality Data are displayed below.[1-15]

Table 1-6—CHIP CAHPS Results

	2022 Scores	2023 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	72.3%	75.4%	★★★
Rating of All Health Care	68.9%	65.5%	★
Rating of Personal Doctor	79.5%	77.7%	★★★
Rating of Specialist Seen Most Often	71.8%+	76.7%+	★★★★
Composite Measures			
Getting Needed Care	80.8%	78.9%	★
Getting Care Quickly	83.1%	78.5%	★
How Well Doctors Communicate	94.4%	95.6%	★★★
Customer Service	90.0%+	89.1%+	★★★
Individual Item Measure			
Coordination of Care	92.6%+	87.0%	★★★

Cells highlighted in yellow represent scores that are statistically significantly higher than the 2022 NCQA child Medicaid national averages.
Cells highlighted in red represent scores that are statistically significantly lower than the 2022 NCQA child Medicaid national averages.

▲ *Indicates the 2023 score is statistically significantly higher than the 2022 score.*

▼ *Indicates the 2023 score is statistically significantly lower than the 2022 score.*

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

Star Ratings based on percentiles:

★★★★★ 90th or Above ★★★★ 75th–89th ★★★ 50th–74th ★★ 25th–49th ★ Below 25th

[1-15] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2022.* Washington, DC: NCQA, September 2022.

Comparison of the CHIP population's 2023 scores to the 2022 NCQA child Medicaid national averages revealed the following summary results:

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

Comparison of the CHIP population's 2023 scores to the corresponding 2022 scores revealed the following summary results:

- The CHIP population's 2023 scores were not statistically significantly higher or lower than the 2022 scores on any measures.

Comparison of the CHIP population's 2023 scores to the 2022 NCQA child Medicaid Quality Compass data revealed the following:

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

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

Home and Community-Based Services CAHPS Survey

HSAG administered the HCBS CAHPS Survey to eligible adult members enrolled in all five QI health plans. Table 1-7 presents the 2023 HCBS CAHPS mean scores for the HI HCBS Program using a scale from 0 to 100. A higher mean score indicates a positive response (i.e., no unmet need) and a lower mean score indicates a negative response. Higher scores indicate that members reported more positive healthcare experiences.

Findings, Conclusions, and Recommendations

Table 1-7—HI HCBS Program Results

Measure	2023 Mean Scores
Global Ratings	
Rating of Personal Assistance and Behavioral Health Staff	90.3
Rating of Homemaker	91.1+
Rating of Case Manager	87.6
Composite Measures	
Reliable and Helpful Staff	86.6
Staff Listen and Communicate Well	84.9
Helpful Case Manager	86.3
Choosing the Services that Matter to You	83.0
Transportation to Medical Appointments	81.8
Personal Safety and Respect	89.2
Planning Your Time and Activities	65.8
Recommendation Measures	
Recommend Personal Assistance/Behavioral Health Staff	86.2
Recommend Homemaker	81.8+
Recommend Case Manager	84.5
Unmet Need and Physical Safety Measures	
No Unmet Need in Dressing/Bathing	32.7+
No Unmet Need in Meal Preparation/Eating	20.5+
No Unmet Need in Medication Administration	40.6+
No Unmet Need in Toileting	94.9
No Unmet Need with Household Tasks	NA
Not Hit or Hurt by Staff	100.0

+ 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 HI HCBS Program's 2023 mean scores across all performance measures revealed the following summary results:

- The HI HCBS Program's 2023 mean score (100.0) for the *Not Hit or Hurt by Staff* measure was higher compared to the other Unmet Need and Physical Safety measures.
- The HI HCBS Program's 2023 mean score (65.8) for the *Planning Your Time and Activities* composite measure was lower compared to the other composite measures.

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

Provider Survey

HSAG conducted a provider survey during 2023 at the request of MQD. The objective of this activity was to provide meaningful information to MQD and the QI health plans about providers' perceptions of the QI health plans. The results of the 2023 Hawaii Provider Survey questions were presented by six domains of satisfaction (general positions, providing quality care, non-formulary, health coordinators, specialists, and substance abuse). Response options to each question (i.e., measure) within the six domains were classified into one of three response categories: satisfied, neutral, and dissatisfied; or positive impact, neutral impact, and negative impact. For each measure, the proportion (i.e., percentage) of responses in each response category was calculated. As is standard in most survey implementations, a top-box score is defined by a positive or satisfied response.[1-16]

Findings, Conclusions, and Recommendations

Table 1-8 presents the 2023 percentage of top-box scores for the QI Program aggregate compared to the corresponding 2021 top-box scores, where applicable.[1-17]

Table 1-8—QI Program Provider Survey Results

	2021 Top-Box Score	2023 Top-Box Score	Trend Analysis Significance
General Positions			
Compensation Satisfaction	27.6%	38.6%	▲
Timeliness of Claims Payments	47.0%	43.8%	—
Providing Quality Care			
Formulary	14.9%	29.7%	▲
Prior Authorization Process	17.2%	19.8%	—
Non-Formulary			
Adequate Access to Non-Formulary Drugs	22.2%	41.4%	▲

[1-16] For this report, only the top-box scores are displayed. For more detailed results on the other response categories, please see the 2023 Hawaii Provider Survey full report located at: https://medquest.hawaii.gov/en/resources/consumer-guides.html.

[1-17] The QI Program aggregate results were derived from the combined results of the five participating QI health plans: AlohaCare QI, HMSA QI, KFHP QI, 'Ohana QI, and UHC CP QI.

	2021 Top-Box Score	2023 Top-Box Score	Trend Analysis Significance
Health Coordinators			
Helpfulness of Health Coordinators	31.8%	44.8%	▲
Specialists			
Adequacy of Specialists	24.5%	36.2%	▲
Availability of Mental Health Providers	13.6%	18.0%	—
Substance Abuse			
Access to Substance Abuse Treatment	19.2%	30.4%	▲

▲ *Indicates the 2023 top-box score is statistically significantly higher than the 2021 top-box score.*
▼ *Indicates the 2023 top-box score is statistically significantly lower than the 2021 top-box score.*
— *Indicates the 2023 top-box score is not statistically significantly different than the 2021 top-box score.*

Comparison of the 2023 QI Program's top-box scores to the corresponding 2021 top-box scores revealed the following summary results:

- The QI Program scored higher in 2023 than in 2021 on all but one measure (*Timeliness of Claims Payments*).
- The QI Program's 2023 scores were not statistically significantly lower than the 2021 scores on any measures.
- The QI Program's 2023 scores were statistically significantly higher than the 2021 scores on six measures: *Compensation Satisfaction, Formulary, Adequate Access to Non-Formulary Drugs, Helpfulness of Health Coordinators, Adequacy of Specialists,* and *Access to Substance Abuse Treatment.*

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

- HSAG recommends engaging the QI health plans and providers in a time-limited workgroup designed to:
  - Identify and define specific factors influencing providers' level of satisfaction in key survey domains.
  - Identify differences in QI health plan reimbursement strategies and how those strategies impact providers' level of satisfaction with reimbursement.

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

- Regarding providers' dissatisfaction with the prior authorization process as a whole, HSAG recommends that MQD, in collaboration with the QI health plans:
  - Conduct a comparative analysis of the prior authorization process implemented by each QI health plan to determine why providers expressed continued dissatisfaction.
  - Review each health plan's list of services and procedures requiring prior authorization to determine if a QI health plan is requiring prior authorization for services that the other health plans do not or should not require prior authorization.

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

Encounter Data Validation

At the time of this report, the study was ongoing, and the analysis of the data obtained from the 2023 EDV activities will be completed in 2024. As such, findings, conclusions, and recommendations will be included in the 2024 Hawaii EQR Technical Report.

2. Introduction

Purpose of the Report

As required by 42 CFR §438.364,[2-1] MQD contracts with HSAG, an EQRO, to prepare an annual, independent, technical report. As described in the CFR, the independent report must summarize findings on access and quality of care, including:

- A description of the manner in which the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of, and access to the care furnished by the MCO, prepaid inpatient health plan (PIHP), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity.
- For each EQR-related activity conducted in accordance with §438.358:
  - Objectives
  - Technical methods of data collection and analysis
  - Description of data obtained, including validated performance measurement data for each activity conducted in accordance with §438.358(b)(1)(i) and (ii)
  - Conclusions drawn from the data
- An assessment of each MCO, PIHP, PAHP, or PCCM entity's strengths and weaknesses for the quality and timeliness of, and access to healthcare services furnished to Medicaid beneficiaries.
- Recommendations for improving the quality of healthcare services furnished by each MCO, PIHP, PAHP, and PCCM entity, including how the State can target goals and objectives in the quality strategy, under §438.340, to better support improvement in the quality and timeliness of, and access to healthcare services furnished to Medicaid beneficiaries.
- Methodologically appropriate, comparative information about all MCOs, PIHPs, PAHPs, and PCCM entities, consistent with guidance included in the EQR protocols issued in accordance with §438.352(e).
- An assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.

Quality Strategy Annual Assessment

In accordance with 42 CFR §438.340, each state contracting with an MCO, PIHP, or PAHP, as defined in §438.2 or with a PCCM entity as described in §438.310(c) must draft and implement a written quality

[2-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 81, No. 88/Friday, May 6, 2016/Rules and Regulations. 42 CFR Parts 431, 433 and 438 with revisions released (or as amended) November 13, 2020, Final Rule. Available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf. Accessed on: Jun 15, 2023.

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

Compliance Reviews

In accordance with 42 CFR §438.358, the state or its designee must conduct a review within the previous three-year period to determine the MCO's, PIHP's, PAHP's, or PCCM entity's compliance with federal standards and associated state-specific requirements, when applicable. The EQR technical report must include information on the reviews conducted within the previous three-year period to determine the health plans' compliance with the standards established by the state.

Performance Measure Validation

In accordance with 42 CFR §438.330(c), states must require that MCOs, PIHPs, PAHPs, and PCCM entities submit performance measurement data as part of the MCOs', PIHPs', PAHPs', and PCCM entities' quality assessment and performance improvement (QAPI) programs. Validating performance measures is one of the mandatory EQR activities described in §438.358(b)(2). The EQR technical report must include information on the validation of MCO, PIHP, PAHP, or PCCM entity performance measures (as required by the state) or MCO, PIHP, PAHP, and PCCM entity performance measures calculated by the state during the preceding 12 months. To comply with §438.358, MQD contracted with HSAG to conduct an independent validation, through NCQA HEDIS Compliance Audits and PMV for non-HEDIS measures, of MQD-selected performance measures calculated and submitted by the QI MCOs and the CCS PIHP.

Performance Improvement Project (PIP) Validation

Validating PIPs is one of the mandatory external quality review activities described at 42 CFR §438.358(b)(1). In accordance with §438.330 (d), MCOs, PIHPs, PAHPs, and PCCM entities are required to have a quality program that (1) includes ongoing PIPs designed to have a favorable effect on health outcomes and beneficiary satisfaction and (2) focuses on both clinical and nonclinical areas that involve the following:

- Measuring performance using objective quality indicators
- Implementing interventions to achieve improvement in the access to and quality of care
- Evaluating effectiveness of the interventions
- Planning and initiating activities for increasing and sustaining improvement

The EQR technical report must include information on the validation of performance improvement projects required by the state and underway during the preceding 12 months.

Consumer Surveys

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

Encounter Data Validation

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

Technical Assistance

At the state's direction, the EQRO may provide technical guidance to groups of MCOs, PIHPs, PAHPs, or PCCM entities to assist them in conducting activities related to the mandatory and optional activities described in this section that provide information for the EQR and the resulting EQR technical report.

Summary of Report Content

Encompassing a review period from January 1, 2023, through December 31, 2023, 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, one optional activity, and the technical assistance provided to MQD as set forth in 42 CFR §438.358:
  - Mandatory activities:
    - Compliance monitoring reviews
    - Validation of performance measures
    - Validation of PIPs
  - Optional activities:
    - Administration of consumer surveys
    - Administration of provider survey
    - Validation of encounter data
    - Technical assistance
- A description of the methodologies used to conduct EQR activities included as an appendix.

Overview of the Hawaii Medicaid Service Delivery System

The Hawaii Medicaid Program

Medicaid covers more than 470,000[2-2] 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."[2-3] 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 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:

[2-2] All Medicaid enrollment statistics cited in this section are as of November 2023, as cited in the Eligibility Enrollment Snapshot provided by MQD.

[2-3] Hawaii Department of Human Services, Med-QUEST Division. Mission Statement. Available at: https://medquest.hawaii.gov/en/about/mission-statement.html. Accessed on: June 15, 2023.

- Improve the healthcare status of the member population.
- Minimize administrative burdens, streamline access to care for members with changing health status, and improve health outcomes by integrating programs and benefits.
- Align the program with the Affordable Care Act (ACA) of 2010.
- Improve care coordination by establishing a "provider home" for members through the use of assigned primary care providers (PCPs).
- Expand access to home and community-based services (HCBS) and allow members choice between institutional services and HCBS.
- Maintain a managed care delivery system that assures access to high quality, cost-effective care that is provided, whenever possible, in the members' community.
- Establish contractual accountability among the State, the health plans, and healthcare providers.
- Continue the predictable and slower rate of expenditure growth associated with managed care.
- Expand and strengthen a sense of member responsibility and promote independence and choice among members that leads to a more appropriate utilization of the healthcare system.

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 84,000 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 230,000 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 54,000 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 39,000 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 59,000 Medicaid members in Hawaii, UHC CP also administers Medicare dual-eligible special needs plans and commercial health plans. UHC CP initially began operating as a QExA health plan in Hawaii on February 1, 2009, and then also as a QUEST plan on July 1, 2012.

'Ohana CCS

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

The State's Quality Strategy[2-4]

In keeping with the requirements specified by CFR §438.340, the Hawaii Quality Strategy was filed with and approved by CMS in 2020. The *purpose* of the strategy is:

- Monitoring that services provided to members conform to professionally recognized standards of practice and code of ethics.
- Identifying and pursuing opportunities for improvements in health outcomes, accessibility, efficiency, member and provider satisfaction with care and service, safety, and equitability.
- Providing a framework for 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.

[2-4] Hawai'i Quality Strategy 2020. State of Hawaii, Department of Human Services, Med-QUEST Division. Available at: https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/MQD_Quality_Strategy_Master_FINAL.pdf. Accessed on: Jun 15, 2023.

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.

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. 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 2023 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. In CY 2023, HSAG provided technical assistance to MQD for the development and implementation of a P4P program for its PIHP in alignment with its Quality Strategy and the CCS population. 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 2022 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

2022 EQRO Recommendations	2023 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. To improve program-wide performance in support of Goal 1 Objectives, HSAG recommends that MQD: • Encourage health plans to implement innovative approaches to promote adult preventive care and pediatric well-child visits. • Conduct a program-wide focus group of women on Medicaid who have recently given birth or are pregnant to determine potential barriers to timely access to prenatal care.	MQD has a multi-pronged strategy to increase timely prenatal and postnatal care. Pregnancy care related measures (i.e., *PPC*) are included as part of the health plan P4P pool and therefore incentivized with payments for achieving performance improvements as well as for meeting or exceeding quality benchmarks. A perinatal quality collaborative designed to improve the quality of care for mothers and babies in hospitals is included in a Hospital P4P Program. This collaborative joined the American College of Obstetricians and Gynecologists (ACOG) Alliance for Innovation on Maternal Health (AIM). "AIM is a national data-driven maternal safety and quality improvement initiative based on interdisciplinary consensus-based practices to improving maternal safety and outcomes. The program provides implementation and data support for the adoption of evidence-based patient safety bundles." (https://www.acog.org/practice-management/patient-safety-and-quality/partnerships/alliance-for-innovation-on-maternal-health-aim). MQD is using a

2022 EQRO Recommendations	2023 MQD Actions
	secret shopper to assess appointment availability for a variety of providers across all health plans. These data will provide valuable insight on the experiences of members making appointments and potential barriers by type of provider, type of appointment, and island. Finally, the access to care measures *Child and Adolescent Well-Care Visits* (*WCV*) and *Well-Child Visits in the First 30 Months of Life* (*W30*) included in the State's P4P. The health plans' QAPI reports demonstrate some activities in primary care targeted at adult and child preventative care.
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 SUDs. To improve program-wide performance in support of Objectives 5 and 6, HSAG recommends that MQD: • Identify barriers (real or perceived) that inhibit members from seeking SUD treatment and implement solutions at the State and health plan level. • Continue to encourage information sharing, collaboration, and care coordination among QI health plans, the CCS program, and State agencies that provide services to Medicaid members. • Consider implementing incentive programs to encourage advanced practice registered nurses (APRNs) and PCPs to obtain advanced mental health training or certifications.	The University of Hawaii Evaluation team conducted a landscape assessment of behavioral health services, including SUD, which consisted of interviews with key stakeholders in the community. They found low provider availability in rural areas, need for increased capacity for residential and inpatient programs, need for coordination across siloed agencies, and limited targeted services to special populations including those with intellectual or developmental disabilities (ID/DD). To improve care coordination for individuals who receive behavioral health services through DOH, MQD contractually requires health plans to develop joint policies and procedures and coordinate closely on the provision of care to their beneficiaries with the DOH. Beginning in 2022, QI health plans started working on a PIP that seeks to improve the coordination of care of Medicaid members enrolled in one of the five MCOs that are also receiving behavioral health services from the PIHP CCS program and/or from DOH behavioral health agencies. The DOH agencies include the Adult Mental Health Division (AMHD), Child & Adolescent Mental Health Division (CAMHD), Alcohol & Drug Abuse Division (ADAD), and the Developmental Disabilities Division (DDD).

2022 EQRO Recommendations	2023 MQD Actions
	Finally, SBIRT is a covered benefit as of 2022 and training resources as well as island trainings have allowed providers, including APRNs and PCPs, to obtain behavioral health training.
Goal 3: Improve outcomes for high-need, high-cost individuals. **Objective 8:** Provide team-based care for beneficiaries with high-need, high-cost conditions. To improve program-wide performance in support of Objective 8, HSAG recommends that MQD: • Encourage communication and collaboration among health plans, providers, and State agencies in coordinating care among beneficiaries with high-need, high-cost conditions.	To improve care coordination for individuals who receive behavioral health services, including high-need high-cost conditions, through DOH, MQD contractually requires health plans to develop joint policies and procedures and coordinate closely on the provision of care to their beneficiaries with the DOH. Beginning 2022, QI health plans started working on a PIP that seeks to improve the coordination of care of Medicaid members enrolled in one of the five MCOs that are also receiving behavioral health services from the PIHP CCS program and/or from DOH behavioral health agencies. The DOH agencies include AMHD, CAMHD, ADAD, and DDD.
Goal 3: Improve outcomes for high-need, high-cost individuals. **Objective 10:** Provide supportive housing to homeless beneficiaries with complex health needs. To improve program-wide performance in support of Objective 10, HSAG recommends that MQD: • Continue efforts to implement community integration and transition services for members with complex health needs and housing insecurity.	MQD evaluates the CIS program using an RCA approach through external evaluation support, with frequent and ongoing assessments of implementation progress. A series of key performance indicators (KPIs) designed to measure progressive implementation and achievement of short, intermediate, and long-term outcomes are included in health plan reporting requirements to track project progress and performance improvement. Quarterly, health plans, MQD, and housing service providers are brought together to discuss the results and next steps. Through these efforts, CIS has undergone major program enhancements. Finally, select measures may be incentivized through P4P programs or other value-based strategies in the future.
Goal 4: Support community initiatives to improve population health. **Objective 11:** Assess and address SDOH needs. To improve program-wide performance in support of Objective 11, HSAG recommends that MQD:	As identified in the State's SDOH transformation plan, which was released in 2023, MQD has identified the collection of standardized and robust SDOH data as a priority.

2022 EQRO Recommendations	2023 MQD Actions
• Consider rewarding or recognizing creative care coordination programs/initiatives that strive to ensure members receive timely assessments and healthcare services that prevent and treat identified conditions, assess and refer members to appropriate community partners to address SDOH, and connect members to timely care and services. • Encourage the health plans to invest in community health through community-based partnerships by supporting proven interventions that address SDOH and healthy lifestyles that improve population health. • Ensure that health plan information systems can collect, store, and analyze SDOH data to support population health management, care coordination, and improved quality measurement and outcomes.	Additionally, health plans submit progress reports on their QAPIs on a quarterly basis that contain quality improvement activities addressing social risk factors and other key drivers of health.
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. To improve program-wide performance in support of Objectives 12 and 13, HSAG recommends that MQD: • Identify and implement solutions to barriers that impact reintegration of LTSS beneficiaries. For example, to address workforce shortages, MQD could consider increasing payments or incentives to direct care workers providing HCBS services in an effort to recruit and retain them. • Increase education to beneficiaries and family members about HCBS options to promote informed choice. • Encourage health plans to implement policies that reduce barriers for hospital discharge planners to obtain approval for HCBS and ensure HCBS providers are available to deliver services immediately upon discharge.	In 2022, MQD conducted an HCBS rate study. Starting in 2023, MQD held additional stakeholder meetings and the report was submitted to the legislature for consideration. Although no rate increases were funded, they will be considered again in 2024. MQD has also required person-centered trainings for HCBS staff. The State has reviewed the recommendations. The EQRO recommendation is under review for the State's determination of additional appropriate actions or interventions.
Goal 6: Maintain access to appropriate care. **Objective 14:** Maintain or enhance access to care. To improve program-wide performance in support of Objective 14, HSAG recommends that MQD: • Critically evaluate and refine network adequacy reporting and oversight, and enhance Hawaii-specific	The State implemented revised provider network adequacy reports in July 2021. These reports contain 47 KPIs. Additionally, MQD started provider network adequacy validation activities with the State's EQRO in 2023. MQD has a provider group to discuss findings from the provider network adequacy report,

2022 EQRO Recommendations	2023 MQD Actions
minimum network requirements to reflect the State's unique geography. • Work with the health plans to develop a plan to address network gaps, particularly in rural and neighbor island communities, that considers increased payments or incentives to providers that travel to the neighbor islands to provide services, single case agreements for needed care, and telehealth services.	including health plan directory inaccuracies, and develop joint solutions to network gaps and inadequacies.
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. To improve program-wide performance in support of Objectives 16 and 17, HSAG recommends that MQD: • Encourage the health plans to evaluate their payment structures to providers and increase payments to providers that improve health outcomes for members experiencing social risk factors. • Consider developing and implementing an incentive measure program specifically for the CCS program to improve the quality and value of care provided to its SMI/serious and persistent mental illness (SPMI) members.	In 2023, MQD released the statewide SDOH transformation plan that identifies payment as funding as one key goal. Some suggested activities include exploring social risk adjusted payments and different value-based payment arrangements. In 2023, MQD started working on developing the framework for a CCS incentive program.

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 2020 Measures Appendix and is categorized by the State's associated goals and objectives, along with MY 2022 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. Note: Process measures are not included in the summary table below.

Table 2-4—MY 2022 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	49	27	41	6	20	56	19
Rates with an established target	49	27	41	6	16	55	18
Rates achieving the target	**17**	**17**	**24**	**5**	**5**	**23**	**3**
Percentage of rates achieving the target	**34.69%**	**62.96%**	**58.54%**	**83.33%**	**31.25%**	**41.82%**	**16.67%**

In addition to standard performance measures, MQD also included the following process measures in its Quality Strategy:

- Social Determinants of Health Collaborative: Design and implement a program to track the SDOH associated with patients
- Perinatal Collaborative: Design and implement a program to improve the quality of care for mothers and babies
- Telehealth Plan: Design and implement a statewide telehealth plan

At the end of the reporting year, MQD scored progress on these measures with a rating of *Met* or *Not Met*. All three process measures received a rating of *Met*.

Table 2-5 summarizes health plan performance relative to MQD Quality Strategy targets. The performance measures in the table below represent the MY 2022 measures audited by HSAG.

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

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Access and Risk-Adjusted Utilization					
Heart Failure Admission Rate (per 100,000 member months)—Total	Met	Met	Met	Not Met	Not Met
Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Total	Met	Met	Met	Met	Met
Children's Preventive Health					
Child and Adolescent Well-Care Visits—Total	Not Met	Met	Not Met	Not Met	Not Met
Childhood Immunization Status—Combination 3	Not Met	Not Met	Not Met	Not Met	Not Met

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Childhood Immunization Status—Combination 7	Not Met	Not Met	Met	Not Met	Not Met
Childhood Immunization Status—Combination 10	Not Met	Not Met	Met	Not Met	Not Met
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	Not Met	Not Met	Not Met	Not Met	Not Met
Women's Health					
Cervical Cancer Screening	Not Met	Not Met	Met	Not Met	Not Met
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Not Met	Not Met	Met	Not Met	Not Met
Prenatal and Postpartum Care—Postpartum Care	Met	Met	Met	Met	Met
Care for Chronic Conditions					
Concurrent Use of Opioids and Benzodiazepines—Total	Met	Met	Met	Not Met	Met
Controlling High Blood Pressure—Total	Not Met	Not Met	Met	Not Met	Met
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	Not Met	Met	Met	Not Met	Met
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	Not Met	Met	Met	Not Met	Met
Initiation and Engagement of Substance Use Disorder Treatment—Initiation—Total—Total	Not Met	Not Met	Not Met	Not Met	Not Met
Initiation and Engagement of Substance Use Disorder Treatment—Engagement—Total—Total	Not Met	Not Met	Not Met	Not Met	Not Met
Use of Pharmacotherapy for Opioid Use Disorder—Total	Met	Met	Met	Met	Met
Use of Pharmacotherapy for Opioid Use Disorder—Buprenorphine	Met	Met	Met	Not Met	Not Met
Use of Pharmacotherapy for Opioid Use Disorder—Oral Naltrexone	Not Met	Met	Not Met	Not Met	Not Met
Use of Pharmacotherapy for Opioid Use Disorder—Long-Acting, Injectable 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—Methadone	Met	Not Met	Not Met	Met	Met
Total MQD Targets Met	**7**	**11**	**13**	**4**	**9**
Percent MQD Targets Met	**33.33%**	**52.38%**	**61.90%**	**19.05%**	**42.86%**

Table 2-6 summarizes CCS' performance relative to MQD Quality Strategy targets. The performance measures in the table below represent the MY 2022 measures audited by HSAG.

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

Measure	'Ohana CCS
Access and Risk-Adjusted Utilization	
Ambulatory Care—Total (per 1,000 Member Months) ED Visits—Total	Not Met
Ambulatory Care—Total (per 1,000 Member Months) Outpatient Visits—Total	Met
Behavioral Health	
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	Not Met
Antidepressant Medication Management—Effective Acute Phase Treatment	Met
Antidepressant Medication Management—Effective Continuation Phase Treatment	Met
Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total	Met
Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total	Met
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total	Met
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total	Met
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	Met
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	Met
Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation—Total—Total	Not Met
Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement—Total—Total	Not Met
Total MQD Targets Met	**9**
Percent MQD Targets Met	**69.23%**

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, and HEDIS 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 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.

Progress was also made toward achieving Goal 3—Improve outcomes for high-need, high-cost individuals, as performance measure results showed that more than 50 percent of the established Quality Strategy statewide targets were achieved. Of note, five of the six follow-ups after emergency department visit or hospitalization for mental illness/SUD measure rates far exceeded the statewide targets. Timely and effective outpatient care, along with care coordination for members with special healthcare needs, will support continued improvement in this program area.

Goal 4—Support community initiatives to improve population health, contains six managed long-term services and supports (MLTSS) measures where reporting year (RY) 2022 was the first year these measures were reported by the MCOs. RY 2022 measure rates were used as the baseline to create the RY 2023 Quality Strategy targets for those measures. Five of the six MLTSS Quality Strategy statewide targets were achieved in RY 2023. While progress was made in the reporting of these measures, measure rates remain low and indicate continued room for improvement.

At the health plan level, KFHP QI, HMSA QI, and 'Ohana CCS met more than half of the RY 2023 Quality Strategy targets. AlohaCare QI and 'Ohana QI have the greatest room for improvement, as they met one-third or less of the Quality strategy targets.

As required by 42 CFR §438.340, MQD updated its Quality Strategy and submitted it to CMS for comment and feedback in October 2023.

Recommendations

The EQRO has identified the following recommendations to target improvement:

- 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 implement improvement activities to increase utilization of adult and pediatric preventive care services.
- Since only one-third of Quality Strategy targets were met for Goal 5—Enhance care in LTSS settings, HSAG recommends that technical assistance be provided to support the health plans in calculating the MLTSS measures, as RY 2023 was only the second year that health plans reported rates for these complex measures.
- Given that 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, nursing facility measures, and CAHPS measures.
- To target improvement in Goal 7—Align payment structures to improve health outcomes, 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.

3. Assessment of Health Plan Performance

Introduction

This section of the report describes the results of HSAG's 2023 EQR activities and conclusions as to the strengths and weaknesses of each health plan about the quality of, timeliness of, and access to care furnished by the Hawaii Medicaid health plans serving QI members. Additionally, recommendations are offered to each health plan to facilitate continued quality improvement in the Medicaid program.

Methodology

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

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

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

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

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 81, No. 88/Friday, May 6, 2016/Rules and Regulations. 42 CFR Parts 431, 433 and 438 with revisions released (or as amended) November 13, 2020, Final Rule. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438. Accessed on: June 15, 2023.
[3-2] Ibid.

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

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 2023 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 2023 compliance monitoring review activity included evaluation of the health plan's compliance with State and federal requirements for organizational and structural performance.

Findings

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

[3-3] National Committee for Quality Assurance. 2023 Standards and Guidelines for Accreditation of Health Plans.
[3-4] Agency for Healthcare Research and Quality. *National Healthcare Quality and Disparities Report.* AHRQ Publication No. 16-0015-5-EF. May 2016.
[3-5] Ibid.

Table 3-1—Standards and Compliance Scores—AlohaCare QUEST Integration

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Provider Selection	17	16	16	0	0	1	100%
II	Credentialing	44	41	39	2	0	3	98%
III	Subcontractual Relationships and Delegation	6	6	6	0	0	0	100%
IV	Health Information Systems	9	9	9	0	0	0	100%
V	Quality Assessment and Performance Improvement	7	7	7	0	0	0	100%
VI	Practice Guidelines	6	6	6	0	0	0	100%
VII	Enrollment and Disenrollment	5	5	5	0	0	0	100%
	Totals	**94**	**90**	**88**	**2**	**0**	**4**	**99%**

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

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

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

Strengths

AlohaCare QI was found to be fully compliant in six of the seven standards reviewed in 2023.

Provider Selection—AlohaCare QI had a comprehensive process for the selection of its network providers to sufficiently meet the needs of its QI members. Additionally, the health plan had a comprehensive compliance plan, including policies and procedures to assist AlohaCare QI in guarding against fraud, waste, and abuse. The health plan demonstrated effective processes for monitoring, auditing, and identifying compliance risks.

Subcontractual Relationships and Delegation—AlohaCare QI had appropriate subcontracts in place and had adequate oversight and monitoring processes to ensure its delegates are meeting their contractual obligations.

Health Information Systems—AlohaCare QI maintained a health information system that collects, analyzes, integrates, and reports data on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility.

Quality Assessment and Performance Improvement—AlohaCare QI's QAPI program was supported by a comprehensive program description, work plan, and evaluation of the prior year's quality improvement program achievements. The QAPI program provided the framework to systematically measure and analyze performance and impart essential information that aided management in decision-making to improve organizational functions, structures, and processes to improve QI member outcomes.

Practice Guidelines—AlohaCare QI adopted evidence-based practice guidelines, disseminated its practice guidelines to all affected providers, and rendered utilization management and coverage of services decisions consistent with its practice guidelines.

Enrollment and Disenrollment—AlohaCare QI had systems, processes, and workflows to accept all individuals enrolled into its health plan without restrictions. AlohaCare QI did not request disenrollment of members for reasons other than those permitted under the contract and had processes in place to notify the State when it becomes aware of a change in a member's circumstance that might affect the member's eligibility.

Areas for Improvement

Credentialing—AlohaCare QI was found to be 98 percent compliant with this standard, with two elements scoring *Partially Met*. AlohaCare QI demonstrated that its credentialing program had well-defined processes in place for credentialing and recredentialing individual providers that effectively evaluated providers and complied with the NCQA credentialing standards and guidelines. A review of credentialing and recredentialing files revealed that some organizational provider files were missing required verification and exclusion checks, as well as on-site quality assessments. AlohaCare QI staff members cited a CMS waiver that was issued during the coronavirus disease 2019 (COVID-19) public health emergency as the reason for not conducting the on-site quality assessments. However, this waiver was not applicable to credentialing on-site quality assessments conducted by health plans. The corrective action required by AlohaCare QI was to ensure that all providers are in good standing with State and federal regulatory bodies and that non-accredited organizational providers receive an on-site quality assessment prior to making initial credentialing and recredentialing decisions.

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 8.0 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 2022 performance measure rates. HSAG determined one data source to be non-standard 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 2022 reporting.

AlohaCare QI was required to undergo convenience sample validation for the *Prenatal and Postpartum Care—Postpartum Care* and *Childhood Immunization Status—Combination 10* measure indicators, as well as all medical record exclusions. AlohaCare QI had no numerator positive cases to provide for the *Childhood Immunization Status—Combination 10* measure indicator. All *Prenatal and Postpartum*

Care—Postpartum Care and medical record exclusion cases successfully passed the validation process. The final statistical medical record review validation (MRRV) was conducted for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care*, *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)*, *Childhood Immunization Status—Combination 10*, and *Eye Exam for Patients With Diabetes* 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. A status of NA (i.e., small denominator) was assigned for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up* and *30-Day Follow-Up* indicators for the ages 65 years and older stratification; AlohaCare QI followed the required specifications, but the denominators were too small (i.e., <30) to report a valid rate.

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. The *Plan All-Cause Readmissions—Index Total Stays—O/E Ratio—Total* measure indicator rate met or exceeded the 90th percentile. All other measure indicators in this domain did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented. Both measures in this domain had an MQD Quality Strategy target (*Heart Failure Admission Rate—Total* and *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Total)*, and AlohaCare QI met the established targets for HEDIS MY 2022.

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

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Heart Failure Admission Rate (per 100,000 member months)*				
18–64 Years	41.87	46.19	10.31%	NC
65 Years and Older	138.55	158.70	14.55%	NC
Total (18 Years and Older)	50.84	56.59	11.31%	NC
Plan All-Cause Readmissions				
*Index Total Stays—Observed Readmissions—Total**	8.90%	7.47%	-16.07%	NC
Expected Readmissions—Total	9.95%	9.97%	0.20%	NC
*Index Total Stays—O/E Ratio—Total**	0.8946	0.7499	-16.17%	★★★★★

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.
MY 2022 performance levels represent the following percentile comparisons:

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

Children's Preventive Health Performance Measure Results

AlohaCare QI's Children's Preventive Health performance measure results are shown in Table 3-3. AlohaCare QI did not meet MQD's established Quality Strategy targets for any measures in this domain. All combination rates for the *Childhood Immunization Status* measure demonstrated a relative increase of more than 35 percent for MY 2022, and all vaccination rates, except for *Influenza*, demonstrated a relative increase; of note, *Hepatitis B* showed a relative increase of more than 20 percent. Conversely, 18 measure indicator rates fell below the 50th percentile, with 15 of these rates falling below the 25th percentile.

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

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Child and Adolescent Well-Care Visits				
3–11 Years	49.63%	46.91%	-5.48%	★
12–17 Years	46.03%	44.78%	-2.72%	★★
18–21 Years	16.04%	15.78%	-1.62%	★
Total (3-21 Years)	42.47%	40.26%	-5.20%	★
Childhood Immunization Status				
Combination 3	35.77%	50.36%	40.79%	★
Combination 7	30.41%	43.31%	42.42%	★
Combination 10	21.90%	29.93%	36.67%	★★
Diphtheria, tetanus, pertussis (DTaP)	51.34%	54.50%	6.16%	★
Hepatitis A	67.64%	70.32%	3.96%	★
Hepatitis B	61.31%	75.43%	23.03%	★
Haemophilus influenzae type b (HiB)	65.94%	72.99%	10.69%	★
Influenza	46.47%	43.07%	-7.32%	★★
Inactivated polio vaccine (IPV)	69.59%	74.94%	7.69%	★
Measles, mumps, rubella (MMR)	61.07%	69.83%	14.34%	★
Pneumococcal Conjugate	52.80%	56.69%	7.37%	★
Rotavirus	56.45%	60.34%	6.89%	★
Varicella-zoster virus (VZV)	69.83%	70.80%	1.39%	★
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	59.57%	57.82%	-2.94%	★★★

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	59.23%	56.19%	-5.13%	★

MY 2022 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Women's Health Performance Measure Results

AlohaCare QI's Women's Health performance measure results are shown in Table 3-4. All three measure indicator rates in this domain demonstrated a relative decrease of more than 5 percent and ranked below the 50th percentile, two of which fell below the 25th percentile. Additionally, all three measure rates in this domain had an MQD Quality Strategy target for HEDIS MY 2022; AlohaCare QI met the quality target for the *Prenatal and Postpartum Care—Postpartum Care* measure rate.

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

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Cervical Cancer Screening				
Cervical Cancer Screening	53.77%	50.36%	-6.34%	★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	82.48%	77.37%	-6.20%	★
Postpartum Care	77.62%	73.24%	-5.64%	★★

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by MQD.
MY 2022 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Care for Chronic Conditions Performance Measure Results

AlohaCare QI's Care for Chronic Conditions performance measure results are shown in Table 3-5. The *Concurrent Use of Opioids and Benzodiazepines* measure rates showed a relative decrease of more than 5 percent, indicating better performance for this measure; of note, the *Total* rate met MQD's Quality Strategy target for MY 2022. Overall, the remaining rates in this domain remained consistent with the prior year's rates; however, the one measure rate that could be compared to national benchmarks (i.e., *Controlling High Blood Pressure—Total)* ranked below the 25th percentile.

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

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Hemoglobin A1c Control for Patients With Diabetes				
*HbA1c Poor Control (>9.0%)—Total**	40.15%	38.93%	-3.04%	NC
HbA1c Control (<8.0%)—Total	48.66%	52.31%	7.50%	NC
Eye Exam for Patients With Diabetes				
Eye Exam for Patients With Diabetes	53.28%	52.80%	-0.90%	NC
Blood Pressure Control for Patients With Diabetes				
Blood Pressure Control for Patients With Diabetes	55.72%	60.10%	7.86%	NC
Concurrent Use of Opioids and Benzodiazepines*				
18–64 Years	9.86%	9.27%	-5.98%	NC
65+ Years	10.81%	6.38%	-40.98%	NC
Total	9.98%	8.88%	-11.02%	NC
Controlling High Blood Pressure				
18–64 Years	56.09%	52.12%	-7.08%	NC
65–85 Years	53.54%	54.81%	2.37%	NC
Total (18–85 Years)	55.47%	52.80%	-4.81%	★

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.
MY 2022 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Behavioral Health Performance Measure Results

AlohaCare QI's Behavioral Health performance measure results are shown in Table 3-6. The *Screening for Depression and Follow-Up Plan* measure rates showed a relative increase of more than 40 percent from the prior MY, with the exception of the *65 Years and Older* stratification. For the *Use of Pharmacotherapy for Opioid Use Disorder* measure, the *Total, Buprenorphine,* and *Methadone* rates demonstrated a relative increase of more than 10 percent. Additionally, these three indicators met the established MQD Quality Strategy targets. For the one measure in this domain that could be compared to national benchmarks, *Follow-Up After Hospitalization for Mental Illness,* six of the eight rates ranked below the 25th percentile. In addition, the *65 Years and Older* stratifications for this measure were assigned a status of *NA* due to not enough members in the eligible population (i.e., <30) to report valid rates. NCQA recommended a break in trending for the *Initiation and Engagement of Substance Use Disorder Treatment* measure due to significant changes made to the MY 2022 specifications; therefore, the prior year's rates and benchmarks are not displayed.

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

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—6–17 Years	24.32%	30.00%	23.36%	★
7-Day Follow-Up—18–64 Years	22.28%	22.22%	-0.27%	★
7-Day Follow-Up—65 Years and Older	NA	NA	—	NC
7-Day Follow-Up—Total	22.12%	24.05%	8.73%	★
30-Day Follow-Up—6–17 Years	56.76%	52.50%	7.51%	★
30-Day Follow-Up—18–64 Years	47.28%	36.11%	-23.63%	★
30-Day Follow-Up—65 Years and Older	NA	NA	—	NC
30-Day Follow-Up—Total	48.23%	39.69%	-17.71%	★
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation—Total—13–17 Years	—	27.63%	—	NC
Initiation—Total—18+ Years	—	35.14%	—	NC
Initiation—Total—Total	—	36.57%	—	NC
Engagement—Total—13–17 Years	—	1.32%	—	NC
Engagement—Total—18+ Years	—	11.94%	—	NC
Engagement—Total—Total	—	6.85%	—	NC
Screening for Depression and Follow-Up Plan				
12–17 Years	20.99%	31.63%	50.69%	NC
18–64 Years	12.86%	19.65%	52.80%	NC
65 Years and Older	20.91%	20.33%	-2.77%	NC
Total Adult (18 Years and Older)	13.73%	19.74%	43.77%	NC
Use of Pharmacotherapy for Opioid Use Disorder				
Total (Rate 1)	51.36%	57.18%	11.33%	NC
Buprenorphine (Rate 2)	30.86%	34.73%	12.54%	NC
Oral Naltrexone (Rate 3)	0.99%	0.78%	-21.21%	NC
Long-acting, Injectable Naltrexone (Rate 4)	0.00%	0.00%	—	NC
Methadone (Rate 5)	22.22%	24.28%	9.27%	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 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 2022 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Long-Term Services and Supports Performance Measure Results

AlohaCare QI's Long-Term Services and Supports performance measure results are shown in Table 3-7. The measures in this domain did not have applicable benchmarks; therefore, no comparison to national benchmarks is presented. Further, no MQD Quality Strategy targets were established. The *Long-Term Services and Supports Comprehensive Care Plan and Update* measure rates showed a relative increase of more than 70 percent, demonstrating AlohaCare QI's dedication to providing its LTSS members with comprehensive care plans with the required core and supplemental elements appropriately documented.

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

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Long-Term Services and Supports Comprehensive Care Plan and Update				
Care Plan with Core Elements Documented	40.63%	69.79%	71.77%	NC
Care plan with Supplemental Elements Documented	40.63%	69.79%	71.77%	NC
Long-Term Services and Supports Comprehensive Assessment and Update				
Assessment of Core Elements Documented	—	78.13%	—	NC
Assessment of Supplemental Elements Documented	—	78.13%	—	NC
Long-Term Services and Supports Minimizing Institutional Length of Stay				
Observed Discharge Rate	5.91%	7.62%	28.93%	NC
Expected Discharge Rate	25.35%	26.95%	6.31%	NC
Observed/Expected Ratio	0.2321	0.2829	21.89%	NC

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

Conclusions and Recommendations

Based on HSAG's analyses of AlohaCare QI's 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

Validation of Performance Improvement Projects

In CY 2023, the health plans continued the two PIPs initiated in 2022. The selected PIP topics were *Behavioral Health Coordination* and *Plan All-Cause Readmissions*. For the CY 2023 submission, the health plans progressed to the Design, Implementation, and Outcomes stages of the PIPs and submitted Steps 1 through 8 in the PIP Submission Form and were assessed for improvement in outcomes (Step 9).

Table 3-8 displays the topics, progression status, and measurement periods reported for the PIPs.

Table 3-8—CY 2022 Health Plan 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 Stage (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 Stage (Steps 1 through 9)	CY 2021	CY 2022 (Remeasurement 1)

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

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

Findings

Table 3-9 illustrates the validation results for the two PIPs submitted by AlohaCare QI for the CY 2023 validation.

Table 3-9—CY 2023 PIP Validation Results for AlohaCare QI

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

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

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

Design (Steps 1-6)

Behavioral Health Coordination

AlohaCare QI met 100 percent of the requirements in the Design stage for the BH PIP. The selected PIP topic was required by MQD and MQD held workgroup sessions with HSAG, health plans, and DOH Behavioral Health Services Administration divisions to discuss the PIP design. The PIP Aim statement, the PIP population, and the two performance indicators were also discussed during the workgroup sessions. AlohaCare QI documented the PIP design accurately and as discussed during the workgroup

meetings. AlohaCare QI's data collection process 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 Data Sharing Agreement (DSA) by the DOH Behavioral Health Services Administration divisions.

Plan All-Cause Readmissions

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

Implementation (Steps 7-8)

Behavioral Health Coordination

AlohaCare QI reported and analyzed the Remeasurement 1 rates for the two performance indicators. AlohaCare QI documented its QI 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 DSAs with the DOH Behavioral Health Services Administration divisions.

Plan All-Cause Readmissions

AlohaCare QI accurately reported and analyzed the Remeasurement 1 rate for the performance indicator. AlohaCare QI conducted appropriate QI processes to identify barriers, and it deployed interventions that were logically linked to the identified barriers. The interventions appeared to positively impact performance indicator outcomes.

Outcomes (Step 9)

Behavioral Health Coordination

AlohaCare QI reported third quarter of CY 2022 as the Remeasurement 1 period for this PIP. The health plan achieved statistically significant improvement over the baseline during the Remeasurement 1 period for both performance indicators.

Plan All-Cause Readmissions

AlohaCare QI reported CY 2022 as the Remeasurement 1 period for this PIP. The health plan achieved non-statistically significant improvement in the Remeasurement 1 rate over the baseline. Additionally,

the health plan demonstrated achievement of significant programmatic improvement with its Transition of Care (TOC) Services from the TOC Team to the Post Discharge Program intervention.

Analysis of Results

Table 3-10 displays the data that the health plan reported for the *Behavioral Health Coordination* PIP.

Table 3-10—Performance Improvement Project Outcomes for the *Behavioral Health Coordination* PIP

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

*Baseline data were updated by the health plan in the CY 2023 PIP submission. The health plans were in the initial stages of defining their data collection processes when the baseline data were reported in the previous year's submission. The health plans were allowed to update the baseline data in the CY 2023 PIP submission, as applicable for the defined data collection processes.
**Rate demonstrates statistically significant improvement over the baseline rate. N–Numerator D–Denominator

The rate for the percentage of shared members with eligible trigger events who received a combined review during the baseline measurement period (third quarter of 2021) was 12.0 percent. During Remeasurement 1, the rate increased to 33.0 percent, which represents a statistically significant improvement over the baseline. The health plan documented that only formal combined reviews were counted in the numerator for Performance Indicator 1 during the baseline period; however, during Remeasurement 1, both formal and informal combined reviews were captured. This may impact the comparability of the data. Therefore, the improvement in results 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 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. During Remeasurement 1, the Performance Indicator 2 rate increased to 2.0 percent, which represents a statistically significant improvement over the baseline. The health plan documented that it shared daily data reports with CCS for shared members who were hospitalized for medical reasons. The data sharing for members who are high utilizers of emergency department (ED) visits began in January 2023. Data sharing with the DOH Behavioral Health Services Administration divisions had not yet started and was pending the approval of the DSAs by the concerned authorities.

Table 3-11 displays the data that the health plan reported for the *Plan All-Cause Readmissions* PIP.

Table 3-11—Performance Improvement Project 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)		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 D: 2,000	8.9%	N: 161 D: 2,154	7.5%	

N–Numerator D–Denominator

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. During Remeasurement 1, there was an improvement of 1.4 percentage points in the performance indicator rate (decrease in the readmission rate is favorable); however, the improvement was not statistically significant.

Barriers/Interventions

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

Table 3-12 displays the barriers and interventions as documented by the health plan for both PIPs.

Table 3-12—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 Memorandums of Understanding (MOUs) 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.

Barriers	Interventions
Plan All-Cause Readmissions	
1. Barrier to access to care on neighbor islands due to lack of providers. 2. Unable to quickly identify which members are at high risk for readmission. 3. Unclear process or program to identify all discharges from acute facilities and member discharge needs.	1. Expansion of the transition of care (TOC) services in the post-discharge program; increase in staff to provide outreach to more members and enable the assessment and procurement of member's immediate needs. 2. Creation of a predictive analytics tool by Health Catalyst. Creation of an interdepartmental TOC workflow for referrals and outreach beginning at admission to follow up post-discharge. 3. Health Catalyst tool created for TOC program includes the status of members who are inpatient with only a 24-hour possible lag time. 4. Develop a TOC referral workflow that includes notification of anticipated discharge date and supports if known. 5. Interdepartmental clinical rounds and behavioral health rounds (two per week) to discuss discharge dates, needs, risks, community resources, and ways to prevent member readmissions. 6. Each member will have a change in condition assessment performed by health coordinators/community health workers within three days of discharge.

* The documented interventions are required by MQD.

Strengths

- For both PIPs, AlohaCare QI received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 100 percent of overall evaluation elements across all steps completed and validated.
- For the *Behavioral Health Coordination* PIP, during Remeasurement 1, the health plan achieved statistically significant improvement in the rates of both performance indicators.
- For the *Plan All-Cause Readmissions* PIP, the health plan achieved non-statistically significant improvement in the Remeasurement 1 rate over the baseline and demonstrated significant programmatic improvement with its TOC Services from the TOC Team to the Post Discharge Program intervention.

Areas for Improvement

- For the *Behavioral Health Coordination* PIP, the health plan had initiated data sharing with CCS; however, the data sharing with DOH Behavioral Health Services Administration divisions had not yet started.

- 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 continue to work toward improving its data sharing and care coordination efforts with the DOH Behavioral Health Services Administration divisions.
  - The health plan should continue to capture the informal combined reviews based on the systems/data that it has and document how it is defining and capturing these data. The health plan should explore the possibilities of updating systems to capture more detailed information as part of this PIP for long-term care coordination needs.
  - The data included in the PIP Submission Form must include information about all eligible members for each performance indicator, as available. If the health plan has not yet initiated data sharing activities with a specific partnering agency, the denominator count must still include the count of shared members with that agency.
- For the *Plan All-Cause Readmissions* PIP:
  - In Step 8 of the PIP Submission Form, the health plan must clearly document QI activities undertaken as part of the Readmissions Collaborative workgroup to improve the *PCR* rate.
- 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 must have a process in place for evaluating each PIP intervention and its impact on the performance indicator. Interventions must be adapted or revised as needed.
- The health plan should reference the PIP Completion Instructions to ensure that all requirements have been addressed when completing the PIP Submission Form.
- The health plan should seek technical assistance from HSAG and MQD throughout the PIP process to address any questions or concerns.

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

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

Findings

Table 3-13 presents the 2023 percentage of top-box responses (i.e., top-box scores) for AlohaCare QI compared to the 2022 NCQA child Medicaid national averages and the corresponding 2021 scores.[3-6, 3-7] Additionally, the overall member experience ratings (i.e., star ratings) resulting from AlohaCare QI's 2023 top-box scores compared to NCQA's 2022 Quality Compass Benchmark and Compare Quality Data are displayed below.[3-8]

Table 3-13—Child Medicaid CAHPS Results for AlohaCare QI

Measure	2021 Scores	2023 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	75.3%	81.2%	★★★★★
Rating of All Health Care	73.9%	70.1%	★★
Rating of Personal Doctor	82.2%	80.3%	★★★★
Rating of Specialist Seen Most Often	78.6%+	70.0%+	★★
Composite Measures			
Getting Needed Care	80.1%+	74.9%+	★
Getting Care Quickly	79.2%+	77.7%+	★
How Well Doctors Communicate	94.1%	91.8%	★
Customer Service	83.9%+	89.5%+	★★★
Individual Item Measure			
Coordination of Care	87.2%+	81.8%+	★

Cells highlighted in yellow represent scores that are statistically significantly higher than the 2022 NCQA child Medicaid national averages.
Cells highlighted in red represent scores that are statistically significantly lower than the 2022 NCQA child Medicaid national averages.

▲ *Indicates the 2023 score is statistically significantly higher than the 2021 score.*

▼ *Indicates the 2023 score is statistically significantly lower than the 2021 score.*

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

Star Ratings based on percentiles:

★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th

3-6 The child population was last surveyed in 2021; therefore, the 2023 child CAHPS scores are compared to the corresponding 2021 scores.

3-7 National Committee for Quality Assurance. *HEDIS® Measurement Year 2022, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2022.

3-8 National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2022.* Washington, DC: NCQA, September 2022.

Strengths

For AlohaCare QI's child Medicaid population, the following measure scored statistically significantly higher in 2023 than in 2021 and met or exceeded the 90th percentile:

- *Rating of Health Plan*

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

- *Rating of Personal Doctor*

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

Areas for Improvement

HSAG performed an analysis of key drivers of member experience for the following three global ratings: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*. AlohaCare QI should consider determining whether potential quality improvement activities could improve member experience on each of the key drivers identified. Table 3-14 provides a summary of the key drivers identified for AlohaCare QI.

Table 3-14—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.

Home and Community-Based CAHPS Survey

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

Findings

Table 3-15 presents the 2023 mean scores compared to the HI HCBS Program for AlohaCare QI.[3-9]

Table 3-15—HCBS Survey Results for AlohaCare QI

Measure	2023 AlohaCare QI Mean Scores	2023 HI HCBS Program Mean Scores	Plan Comparison Significance
Global Ratings			
Rating of Personal Assistance and Behavioral Health Staff	83.0+	90.3	—
Rating of Homemaker	NA	91.1+	NA
Rating of Case Manager	88.8+	87.6	—
Composite Measures			
Reliable and Helpful Staff	84.7+	86.6	—
Staff Listen and Communicate Well	80.9+	84.9	—
Helpful Case Manager	90.0+	86.3	—
Choosing the Services that Matter to You	80.0+	83.0	—
Transportation to Medical Appointments	77.9+	81.8	—
Personal Safety and Respect	88.2+	89.2	—

[3-9] For this report, only the composite measure mean scores are displayed. For more detailed results on the other response categories, please see the 2023 Hawaii HCBS CAHPS Survey full report.

Measure	2023 AlohaCare QI Mean Scores	2023 HI HCBS Program Mean Scores	Plan Comparison Significance
Planning Your Time and Activities	65.7+	65.8	—
Recommendation Measures			
Recommend Personal Assistance/Behavioral Health Staff	73.7+	86.2	↓
Recommend Homemaker	NA	81.8+	NA
Recommend Case Manager	84.1+	84.5	—
Unmet Need and Physical Safety Measures			
No Unmet Need in Dressing/Bathing	NA	32.7+	NA
No Unmet Need in Meal Preparation/Eating	NA	20.5+	NA
No Unmet Need in Medication Administration	NA	40.6+	NA
No Unmet Need in Toileting	91.3+	94.9	—
No Unmet Need with Household Tasks	NA	NA	NA
Not Hit or Hurt by Staff	100.0+	100.0	—

↑ Indicates the mean score is statistically significantly higher than the HI HCBS Program.
↓ Indicates the mean score is statistically significantly lower than the HI HCBS Program.
— Indicates the mean score is not statistically significantly different than the HI 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 mean scores for the following two measures were higher than the HI HCBS Program mean scores, although no measure's mean score was statistically significantly higher:

- *Rating of Case Manager*
- *Helpful Case Manager*

Areas for Improvement

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*

Provider Survey

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

Findings

Table 3-16 presents the 2023 top-box scores compared to the QI Program aggregate and the corresponding 2021 top-box scores, where applicable, on the six domains of satisfaction for AlohaCare QI.[3-10]

Table 3-16—Provider Survey Results for AlohaCare QI

	2021 Top-Box Score	2023 Top-Box Score	2023 QI Program Top-Box Score	Plan Comparison Significance	Trend Analysis Significance
General Positions					
Compensation Satisfaction	34.4%	40.0%	38.6%	—	—
Timeliness of Claims Payments	52.8%	44.0%	43.8%	—	—
Providing Quality Care					
Formulary	17.9%	30.1%	29.7%	—	—
Prior Authorization Process	21.7%	21.7%	19.8%	—	—
Non-Formulary					
Adequate Access to Non-Formulary Drugs	28.1%	43.6%	41.4%	—	—

[3-10] For this report, only the top-box scores are displayed. For more detailed results on the other response categories, please see the 2023 Hawaii Provider Survey full report.

	2021 Top-Box Score	2023 Top-Box Score	2023 QI Program Top-Box Score	Plan Comparison Significance	Trend Analysis Significance
Health Coordinators					
Helpfulness of Health Coordinators	35.4%	44.4%	44.8%	—	—
Specialists					
Adequacy of Specialists	20.6%	29.8%	36.2%	↓	—
Availability of Mental Health Providers	15.5%	15.6%	18.0%	↓	—
Substance Abuse					
Access to Substance Abuse Treatment	23.0%	9.1%	30.4%	↓	—

↑ Indicates the QI health plan's top-box score is statistically significantly higher than the QI Program.
↓ Indicates the QI health plan's top-box score is statistically significantly lower than the QI Program.
▲ Indicates the 2023 top-box score is statistically significantly higher than the 2021 top-box score.
▼ Indicates the 2023 top-box score is statistically significantly lower than the 2021 top-box score.
— Indicates the 2023 top-box score is not statistically significantly different than the 2021 top-box score.
Results based on fewer than 11 respondents were suppressed and noted as "NA".

Strengths

While none of the 2023 top-box scores were statistically significantly higher than the QI Program aggregate or the 2021 top-box scores for any measure, the following six measures were higher in 2023 than in 2021, although no measure's top-box score was statistically significantly higher:

- *Compensation Satisfaction*
- *Formulary*
- *Adequate Access to Non-Formulary Drugs*
- *Helpfulness of Health Coordinators*
- *Adequacy of Specialists*
- *Availability of Mental Health Providers*

Areas for Improvement

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*

Overall Assessment of Quality, Accessibility, and Timeliness of Care

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

Conclusions

In general, AlohaCare QI's performance results illustrate mixed performance across the six EQR activities. While the compliance monitoring review activity revealed that AlohaCare QI has established an operational foundation to support the quality of, access to, and timeliness of care and service delivery, performance on outcome and process measures showed considerable room for improvement.

AlohaCare QI showed that it has systems, policies, and staff in place to ensure its structure and operations support core processes for providing care and services and promoting quality outcomes. AlohaCare QI's performance during the 2023 compliance review was above average, meeting or exceeding the statewide compliance score for all seven standards. AlohaCare QI achieved 100 percent compliance in six standards and 98 percent in the Credentialing standard. AlohaCare QI was required to develop a CAP to address and resolve the deficiencies identified in the review. HSAG and MQD provided feedback and will continue to monitor AlohaCare QI's CAP activities until the health plan is found to be in full compliance.

Overall, more than three quarters (93.3 percent) of AlohaCare QI's performance measure rates fell below the 50th percentile across all domains, with more than half (80.0 percent) falling below the 25th percentile. While some measures showed improvement from HEDIS MY 2022, AlohaCare QI's performance suggested several areas in need of improvement, including the Children's Preventive Health and Behavioral Health domains. Only seven of AlohaCare QI's measure rates met MQD Quality Strategy targets.

AlohaCare QI's CAHPS results illustrate opportunities for improvement in members' experience. While none of the measures scored statistically significantly lower in 2023 than in 2021, the following two measures were statistically significantly lower than the 2022 NCQA child Medicaid national averages: *Getting Needed Care* and *Getting Care Quickly*. Additionally, the following six 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*, and *Coordination of Care*. These results indicate the need for AlohaCare QI to implement improvement strategies to ensure members have high-

quality care and timely access to care.

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

AlohaCare QI's HCBS CAHPS Survey results illustrate opportunities for improvement in members' experience. While none of the measures scored statistically significantly higher than the HI HCBS Program, the *Recommend Personal Assistance/Behavioral Health Staff* measure scored statistically significantly lower than the HI HCBS Program. Additionally, the following 10 measures had mean scores that were lower than the HI HCBS Program: *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 Personal Assistance/Behavioral Health Staff*, *Recommend Case Manager*, and *No Unmet Need in Toileting,* indicating a need for AlohaCare QI to implement strategies to ensure members have timely access to high-quality care.

AlohaCare QI's Provider Survey results demonstrated areas for improvement. AlohaCare QI's providers expressed dissatisfaction with *Adequacy of Access to Specialists*, *Availability of Mental Health Providers*, and *Access to Substance Abuse Treatment*, with the top-box scores for these measures falling below the QI Program aggregate. In addition, the top-box scores for *Timeliness of Claims Payments* and *Access to Substance Abuse Treatment* were lower in 2023 than in 2021, indicating a need for AlohaCare QI to implement strategies to ensure members have access to care.

Finally, AlohaCare QI progressed to the Outcomes stage of the two PIPs that were initiated in CY 2022. 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 an overall *Met* validation status. During Remeasurement 1, the health plan achieved statistically significant improvement in the rates of both performance indicators. The health plan had initiated data sharing with CCS; however, the data sharing with DOH Behavioral Health Services Administration divisions had not yet started.

For the *Plan All-Cause Readmissions* PIP, AlohaCare QI received an overall *Met* validation status. The documented PIP design and data were accurate. The health plan conducted appropriate quality improvement processes to identify barriers, and it deployed interventions that were logically linked to the identified barriers. The health plan achieved non-statistically significant improvement in the Remeasurement 1 rate over the baseline and demonstrated significant programmatic improvement with its TOC Services from the TOC Team to the Post Discharge Program intervention.

Hawaii Medical Service Association QUEST Integration (HMSA QI) Results

Compliance Monitoring Review

The 2023 compliance monitoring review activity included evaluation of the health plan's compliance with State and federal requirements for organizational and structural performance.

Findings

Table 3-17 presents the standards and compliance scores for HMSA QI.

Table 3-17—Standards and Compliance Scores—Hawaii Medical Service Association QUEST Integration

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Provider Selection	17	16	16	0	0	1	100%
II	Credentialing	44	42	41	1	0	2	99%
III	Subcontractual Relationships and Delegation	6	6	5	1	0	0	92%
IV	Health Information Systems	9	9	9	0	0	0	100%
V	Quality Assessment and Performance Improvement	7	7	7	0	0	0	100%
VI	Practice Guidelines	6	6	6	0	0	0	100%
VII	Enrollment and Disenrollment	5	5	5	0	0	0	100%
	Totals	**94**	**91**	**89**	**2**	**0**	**3**	**99%**

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

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

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

Strengths

HMSA QI was found to be fully compliant in five of the seven standards reviewed in 2023.

Provider Selection—HMSA QI maintained policies and procedures for the selection, retention, and recruitment of providers for HMSA QI's provider network. Additionally, the health plan had a comprehensive compliance plan, including policies and procedures to assist HMSA QI in guarding against fraud, waste, and abuse. The health plan demonstrated effective processes for monitoring, auditing, and identifying compliance risks.

Health Information Systems—HMSA QI maintained a health information system that collects, analyzes, integrates, and reports data on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility.

Quality Assessment and Performance Improvement—HMSA QI's QAPI program was supported by a comprehensive program description, work plan, and evaluation of the prior year's quality improvement program achievements. The QAPI program provided the framework to systematically measure and analyze performance and impart essential information that aided management in decision-making to improve organizational functions, structures, and processes to improve QI member outcomes.

Practice Guidelines—HMSA QI adopted evidence-based practice guidelines, disseminated its practice guidelines to all affected providers, and rendered utilization management and coverage of services decisions consistent with its practice guidelines.

Enrollment and Disenrollment—HMSA QI had systems, processes, and workflows to accept all individuals enrolled into its health plan without restrictions. HMSA QI did not request disenrollment of members for reasons other than those permitted under the contract and had processes in place to notify the State when it becomes aware of a change in a member's circumstance that might affect the member's eligibility.

Areas for Improvement

Credentialing—HMSA QI was found to be 99 percent compliant with this standard, with one element scoring *Partially Met*. HMSA QI had comprehensive policies, procedures, and processes for the credentialing and recredentialing of practitioners, facilities/organizations, ancillary services, and allied professionals providing care to the health plan's QUEST members that aligned with National Committee for Quality Assurance (NCQA) credentialing standards. While HMSA QI's policies and procedures identified the correct time frame for conducting recredentialing of individual practitioners, three of the 10 individual practitioner credentialing files did not meet the required recredentialing time frame of 36 months. The corrective action required by HMSA QI was to ensure that processes were implemented to ensure that all eligible practitioners are recredentialed within the required 36-month time frame.

Subcontractual Relationships and Delegation—HMSA QI was found to be 92 percent compliant with this standard, with one element scoring *Partially* Met. While HMSA QI had processes in place to monitor its delegates, the organizational structure and the staff members ultimately responsible for the delegate monitoring activities appeared to be fragmented. Additionally, the current categorization of vendors/subcontractors and associated risk scores resulted in a situation where not all subcontractors were receiving ongoing monitoring and/or formal audits to ensure that performance standards and contract requirements were being met. The corrective action required by HMSA QI was to implement processes to ensure that all subcontractors performing managed care administrative functions on behalf of the health plan are subject to ongoing monitoring and formal review.

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. With the exception of IS standard 8.0 for assessing case management data for LTSS measures, HMSA QI was found to be fully compliant with all HEDIS IS standards. HMSA QI's compliance with IS standards 1.0 through 7.0 demonstrates that HMSA QI had effective IS processes and control procedures in place for reporting the required performance measure rates. Conversely, HMSA QI did not provide case management records for the required LTSS measures and as a result, case management record review was not conducted. This significantly impacted HMSA QI's ability to report rates for the two LTSS measures requiring case management record review.

HMSA QI presented 10 supplemental data sources for consideration to use for supplementing its MY 2022 performance measure rates. HSAG determined four data sources to be non-standard supplemental data; the remaining six were considered standard supplemental data. HSAG reviewed all data sources and conducted primary source verification on the four non-standard data sources. Three of the non-standard data sources passed the primary source verification process with no issues; however, two critical errors were identified in the proof-of-service documentation for HMSA QI's Payment Transformation (PT) data source, and it was not approved for use for MY 2022 reporting. The remaining six standard and three non-standard supplemental data sources were approved for HEDIS MY 2022 reporting.

HMSA QI did not have any significant changes to its medical record review processes from the prior year and passed MRRV for all required hybrid measures in MY 2022; therefore, HMSA QI was not required to undergo convenience sample validation. The final statistical MRRV was conducted for the *Blood Pressure Control for Patients With Diabetes, Prenatal and Postpartum Care—Postpartum Care,* and *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* measures, as well as the *Childhood Immunization Status—Combination 10* and *Hepatitis B* indicators. All selected cases passed the final MRRV without any critical errors.

All measures under the scope of the audit were determined to be *Reportable,* except for the three LTSS measures, and HMSA QI was determined to be fully compliant with HEDIS IS standards 1.0 through 7.0. 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.

Access and Risk-Adjusted Utilization Performance Measure Results

HMSA QI's Access and Risk-Adjusted Utilization performance measure results are shown in Table 3-18. The *Plan All-Cause Readmissions—Index Total Stays—O/E Ratio—Total* measure indicator rate met or exceeded the 75th percentile. All other measure indicators in this domain did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented. Both measures

in this domain had an MQD Quality Strategy target (*Heart Failure Admission Rate—Total* and *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Total*), and HMSA QI met the established targets for HEDIS MY 2022.

Table 3-18—HMSA QI's HEDIS Results for QI Measures Under Access and Risk-Adjusted Utilization

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Heart Failure Admission Rate (per 100,000 member months)*				
18-64 Years	22.09	27.57	24.82%	NC
65 Years and Older	94.66	97.06	2.53%	NC
Total (18 Years and Older)	26.49	32.32	22.00%	NC
Plan All-Cause Readmissions				
*Index Total Stays—Observed Readmissions—Total**	7.72%	8.29%	7.38%	NC
Expected Readmissions—Total	9.44%	9.68%	2.54%	NC
*Index Total Stays—O/E Ratio—Total**	0.8180	0.8564	4.69%	★★★★

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.
MY 2022 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Children's Preventive Health Performance Measure Results

HMSA QI's Children's Preventive Health performance measure results are shown in Table 3-19. HMSA QI met MQD's established Quality Strategy target for the *Child and Adolescent Well-Care Visits—Total* rate. Additionally, all of the *Child and Adolescent Well-Care Visits* rates ranked at or above the 50th percentile. The *Well-Child Visits in the First 30 Months of Life* rates ranked at or above the 75th percentile, one of which ranked at or above the 90th percentile. For the *Childhood Immunization Status* measure, although the *Combination 10* and *Influenza* rates demonstrated a relative decrease of more than 10 percent, both measure rates ranked at or above the 50th percentile.

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

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Child and Adolescent Well-Care Visits				
3–11 Years	56.18%	58.79%	4.65%	★★★
12–17 Years	56.36%	56.48%	0.21%	★★★

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
18–21 Years	26.69%	28.21%	5.70%	★★★
Total (3–21 Years)	51.06%	52.41%	2.64%	★★★
Childhood Immunization Status				
Combination 3	61.31%	58.64%	-4.35%	★★
Combination 7	51.09%	49.88%	-2.37%	★★
Combination 10	40.15%	35.52%	-11.53%	★★★
DTaP	69.34%	69.59%	0.36%	★★
Hepatitis A	78.35%	78.10%	-0.32%	★★
Hepatitis B	75.91%	71.53%	-5.77%	★
HiB	79.81%	80.05%	0.30%	★★
Influenza	55.47%	49.64%	-10.51%	★★★
IPV	78.59%	79.81%	1.55%	★
MMR	79.08%	78.10%	-1.24%	★
Pneumococcal Conjugate	69.59%	68.37%	-1.75%	★★
Rotavirus	64.96%	64.48%	-0.74%	★
VZV	78.10%	77.86%	-0.31%	★
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	67.56%	69.57%	2.98%	★★★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	72.86%	72.98%	0.16%	★★★★

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by MQD.
MY 2022 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Women's Health Performance Measure Results

HMSA QI's Women's Health performance measure results are shown in Table 3-20. For the *Prenatal and Postpartum Care* measure, the *Timeliness of Prenatal Care* and *Postpartum Care* rates showed a relative decrease of more than 5 percent and ranked below the 25th percentile. Conversely, the *Postpartum Care* rate met MQD's established Quality Strategy target. The *Cervical Cancer Screening* rate remained consistent with the prior MY and benchmarked below the 50th percentile.

Table 3-20—HMSA QI's HEDIS Results for QI Measures Under Women's Health

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Cervical Cancer Screening				
Cervical Cancer Screening	57.11%	57.49%	0.67%	★★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	84.48%	77.70%	-8.03%	★
Postpartum Care	76.72%	67.54%	-11.97%	★

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by MQD.
MY 2022 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Care for Chronic Conditions Performance Measure Results

HMSA QI's Care for Chronic Conditions performance measure results are shown in Table 3-21. The one measure rate in this domain that could be compared to national benchmarks (i.e., *Controlling High Blood Pressure—Total)* benchmarked below the 50th percentile. The *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)—Total* measure showed a relative increase of more than 10 percent. All other measure rates in this domain remained consistent with the prior MY. HMSA QI met MQD's established Quality Strategy target for the *Concurrent Use of Opioids and Benzodiazepines—Total* rate.

Table 3-21—HMSA QI's HEDIS Results for QI Measures Under Care for Chronic Conditions

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Hemoglobin A1c Control for Patients With Diabetes				
*HbA1c Poor Control (>9.0%)—Total**	39.76%	37.16%	-6.54%	NC
HbA1c Control (<8.0%)—Total	48.05%	54.52%	13.47%	NC
Eye Exam for Patients With Diabetes				
Eye Exam for Patients With Diabetes	64.63%	59.66%	-7.69%	NC
Blood Pressure Control for Patients With Diabetes				
Blood Pressure Control for Patients With Diabetes	54.39%	56.97%	4.74%	NC
Concurrent Use of Opioids and Benzodiazepines*				
18–64 Years	13.10%	13.28%	1.37%	NC
65 Years and Older	9.42%	9.80%	4.03%	NC
Total (18 Years and Older)	12.90%	13.06%	1.24%	NC

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Controlling High Blood Pressure				
18–64 Years	53.80%	57.51%	6.90%	NC
65–85 Years	55.38%	50.79%	-8.29%	NC
Total (18–85 Years)	54.05%	56.48%	4.50%	★★

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.
MY 2022 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Behavioral Health Performance Measure Results

HMSA QI's Behavioral Health performance measure results are shown in Table 3-22. For the one measure in this domain that could be compared to national benchmarks, *Follow-Up After Hospitalization for Mental Illness*, four of the eight rates ranked at or above the 50th percentile, including one rate that ranked at or above the 75th percentile. In addition, two rates fell below the 50th percentile. Further, the *65 Years and Older* stratifications for this measure were assigned a status of *NA* due to not enough members in the eligible population (i.e., <30) to report valid rates. Of note, the *7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* rates met MQD's established Quality Strategy targets. NCQA recommended a break in trending for the *Initiation and Engagement of Substance Use Disorder Treatment* measure due to significant changes made to the MY 2022 specifications; therefore, the prior year's rates and benchmarks are not displayed. For the *Use of Pharmacotherapy for Opioid Use Disorder* measure, the *Total, Buprenorphine, Oral Naltrexone, and Long-acting Injectable Naltrexone* rates showed a relative increase from the prior MY and met MQD's established Quality Strategy targets. Conversely, the *Methadone* rate demonstrated a relative decrease and did not meet MQD's established Quality Strategy target. The *Screening for Depression and Follow-Up Plan* measure rates remained relatively consistent with the prior MY.

Table 3-22—HMSA QI's HEDIS Results for QI Measures Under Behavioral Health

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—6–17 Years	46.11%	54.04%	17.20	★★★
7-Day Follow-Up—18–64 Years	35.80%	42.16%	17.77%	★★★★
7-Day Follow-Up—65 Years and Older	NA	NA	—	NC
7-Day Follow-Up—Total	38.48%	44.51%	15.67%	★★★

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
30-Day Follow-Up—6–17 Years	67.22%	63.64%	-5.33%	★★
30-Day Follow-Up—18–64 Years	58.56%	55.31%	-5.55%	★★★
30-Day Follow-Up—65 Years and Older	NA	NA	—	NC
30-Day Follow-Up—Total	60.66%	56.84%	-6.30%	★★
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation—Total—13–17 Years	—	41.00%	—	NC
Initiation—Total—18+ Years	—	32.47%	—	NC
Initiation—Total—Total	—	35.47%	—	NC
Engagement—Total—13–17 Years	—	16.74%	—	NC
Engagement—Total—18+ Years	—	6.65%	—	NC
Engagement—Total—Total	—	11.96%	—	NC
Screening for Depression and Follow-Up Plan				
12–17 Years	48.81%	47.92%	-1.82%	NC
18–64 Years	27.28%	27.27%	-0.04%	NC
65 Years and Older	29.20%	25.75%	-11.82%	NC
Total Adult (18 Years and Older)	27.40%	27.16%	-0.88%	NC
Use of Pharmacotherapy for Opioid Use Disorder				
Total (Rate 1)	50.91%	67.68%	32.94%	NC
Buprenorphine (Rate 2)	33.88%	53.03%	56.52%	NC
Oral Naltrexone (Rate 3)	1.09%	3.03%	177.98%	NC
Long-acting, Injectable Naltrexone (Rate 4)	0.36%	1.01%	180.56%	NC
Methadone (Rate 5)	17.39%	12.63%	-27.37%	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 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 2022 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Long-Term Services and Supports Performance Measure Results

HMSA QI's Long-Term Services and Supports performance measure results are shown in Table 3-23. HMSA QI did not attempt to abstract case management records or data for the two LTSS measures that required case management record review; therefore, no rates are displayed for these measures for MY 2022. For the *LTSS Minimizing Institutional Length of Stay* measure, HMSA QI did not have enough members in its eligible population to report a valid rate; therefore, a status of *NA* (i.e., small

denominator) was assigned. There were no measure rates in this domain with Quality Strategy targets established by MQD.

Table 3-23—HMSA QI's HEDIS Results for QI Measures Under Long-Term Services and Supports

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Long-Term Services and Supports Comprehensive Care Plan and Update				
Care Plan with Core Elements Documented	3.13%	0.00%	-100.00%	NC
Care plan with Supplemental Elements Documented	3.13%	0.00%	-100.00%	NC
Long-Term Services and Supports Comprehensive Assessment and Update				
Assessment of Core Elements Documented	—	0.00%	—	NC
Assessment of Supplemental Elements Documented	—	0.00%	—	NC
Long-Term Services and Supports Minimizing Institutional Length of Stay				
Observed Discharge Rate	NA	NA	—	NC
Expected Discharge Rate	NA	NA	—	NC
Observed/Expected Ratio	NA	NA	—	NC

NA indicates that the QI health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.
— Indicates that the plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.

Conclusions and Recommendations

Based on HSAG's analyses of HMSA QI's 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*

Validation of Performance Improvement Projects

In CY 2022, MQD selected two new PIPs—*Behavioral Health Coordination* and *Plan All-Cause Readmissions* for all the health plans to complete. For the CY 2023 submission, the health plans progressed to the Design, Implementation, and Outcomes stages of the PIPs and submitted Steps 1 through 8 in the PIP Submission Form and were assessed for improvement in outcomes (Step 9).

Table 3-24 displays the topics, progression status, and measurement periods reported for the PIPs.

Table 3-24—CY 2023 Health Plan PIP Topics and Status

PIP Topic	PIP Progression Status	Baseline Measurement Period	Measurement Period Reported in CY 2022
Behavioral Health Coordination	PIP Design, Implementation, and Outcomes Stage (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 Stage (Steps 1 through 9)	CY 2021	CY 2022 (Remeasurement 1)

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

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

Findings

Table 3-25 illustrates the validation results for the two PIPs submitted by HMSA QI for CY 2023 validation.

Table 3-25—CY 2023 PIP Validation Results for HMSA QI

PIP Topic	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Behavioral Health Coordination	95%	100%	*Met*
Plan All-Cause Readmissions	63%	56%	*Not Met*

For the *Behavioral Health Coordination* PIP, HMSA QI received an overall *Met* validation status, with a *Met* score of 100 percent for critical evaluation elements and 95 percent for overall evaluation elements across all steps completed and validated.

For the *Plan All-Cause Readmissions* PIP, HMSA QI received an overall *Not Met* validation status, with a *Met* score for 56 percent of critical evaluation elements and 63 percent of overall evaluation elements across all steps completed and validated.

Implementation (Steps 7-8)

Behavioral Health Coordination

HMSA QI reported and analyzed the Remeasurement 1 rates for the two performance indicators. HMSA QI documented its QI efforts toward identifying barriers and implementing the interventions, which were logically linked to the identified barriers. The health plan completed a key driver diagram for barrier analysis and implemented two additional interventions in the PIP in addition to the three State-recommended interventions. The interventions could reasonably be expected to positively impact performance indicator outcomes.

Plan All-Cause Readmissions

HMSA QI did not report Remeasurement 1 (CY 2022) data in the final PIP Submission Form, and there was an error in the reported baseline data. The health plan had reported Remeasurement 1 data in the initial submission; however, the health plan deleted Remeasurement 1 data in the resubmission. HMSA QI conducted appropriate QI processes during the baseline measurement period to identify barriers, and it deployed interventions that were logically linked to the identified barriers; however, the QI narrative for Remeasurement 1 was not included. The interventions could reasonably be expected to positively impact performance indicator outcomes; however, it was unclear which interventions, if any, were part of the readmission's collaborative workgroup.

Outcomes (Step 9)

Behavioral Health Coordination

During Remeasurement 1, 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

HMSA QI did not report Remeasurement 1 (CY 2022) data in the final PIP Submission Form, and there was an error in the reported baseline rate. HSAG could not assess the PIP for improvement in outcomes.

Analysis of Results

Table 3-26 displays the data that the health plan reported for the *Behavioral Health Coordination* PIP.

Table 3-26—Performance Improvement Project Outcomes for the *Behavioral Health Coordination* PIP

Performance Indicator	Baseline (07/01/2021–09/30/2021)		Remeasurement 1 (07/01/2022–09/30/2022)		Sustained Improvement
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%*	
Percent of shared members whose data are actively shared at a regular frequency with partner agencies.	N: 206 D: 1,071	19.2%	N: 100 D: 1,190	8.4%	

* Rate demonstrates statistically significant improvement over the baseline rate. N–Numerator D–Denominator

The rate for the percentage of eligible members with eligible trigger events who received a combined review during the baseline measurement period (third quarter of 2021) was 2.1 percent. During Remeasurement 1, the rate increased to 12.7 percent, which represents a statistically significant improvement of 10.6 percentage points over the baseline. HMSA QI documented that only formal combined reviews were counted in the numerator of the baseline rate; however, during Remeasurement 1, with system enhancements made to the health plan's care management platform Coreo, 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 19.2 percent. The health plan documented that at

the time of the PIP submission, the health plan did not have a mechanism in place to actively share data with all the partnering agencies. During Remeasurement 1, a decline of 10.8 percentage points from the baseline rate was noted in the Performance Indicator 2 rate. It appears that for the Performance Indicator 2 denominator, the health plan had shared members' information for CAMHD and CCS only. The health plan indicated that it is unable to accurately identify all shared members with AMHD, ADAD, or DDD until the time when data sharing agreements and member identification mechanisms are in place.

Table 3-27 displays the data that the health plan reported for the *Plan All-Cause Readmissions* PIP.

Table 3-27—Performance Improvement Project 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)		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	7.8%	N: Did Not Report	Did Not Report	
	D: 4,247		D: Did Not Report		

N–Numerator D–Denominator

The baseline (CY 2021) rate for the percentage of eligible discharges for which members 18–64 years of age had at least one acute readmission for any diagnosis within 30 days of the index discharge date was 7.8 percent. The health plan did not report Remeasurement 1 data in the final PIP submission.

Barriers/Interventions

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

Table 3-28 displays the barriers and interventions as documented by the health plan for both PIPs.

Table 3-28—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.	1. Drafting data sharing agreement with the partnering agencies. 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.*

Barriers	Interventions
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.	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 QI'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.	1. Work with discharge planners and internal HMSA QI case management to educate members on importance of managing chronic conditions. *2.* Ensure member's attributed PCP is correct. Members might be unaware if auto assigned and do not have a designated PCP. Educate members on the importance of managing chronic conditions provide appointment reminders to members.

* The documented interventions are required by MQD.

Strengths

- For *Behavioral Health Coordination* PIP, HMSA QI received an overall *Met* validation status.
- For the *Behavioral Health Coordination* PIP, during Remeasurement 1, the health plan achieved statistically significant improvement in the Performance Indicator 1 rate.

Areas for Improvement

- For the *Behavioral Health Coordination* PIP, a decline from the baseline rate was noted in the Performance Indicator 2 rate.
- For the *Plan All-Cause Readmissions* PIP, HMSA QI did not report data or the QI activities for the Remeasurement 1 period.

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 must continue to document its progress toward implementing the interventions and expanding the data sharing efforts with all the partnering agencies.
  - The health plan must also include quantitative data to document the effectiveness of the interventions. For example, in the next annual submission, for the DSA intervention, the health plan should include how much improvement in data sharing with the DOH agencies was noted after the DSAs were executed.
- For the *Plan All-Cause Readmissions* PIP:
  - The health plan must report data pertaining to all applicable measurement periods due at the time of the PIP submission. The health plan should have reported CY 2022 (Remeasurement 1) data in this year's submission.
  - The health plan must accurately report the baseline rate in the Step 7 data table. The PIP performance indicator data must match the health plan's final measurement year 2021 HEDIS final Interactive Data Submission System (IDSS) file for the *PCR* rate. This feedback was also provided in last year's report.
  - The health plan should have reported the QI activities that were conducted during Remeasurement 1. 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.
- The health plan must have a process in place for evaluating each PIP intervention and its impact on the performance indicator. Interventions should be adapted or revised as needed.
- The health plan must address the *Validation Feedback* associated with any *Met* score and the *Partially Met* comments in the next annual submission.
- The health plan should reference the PIP Completion Instructions to ensure that all requirements have been addressed when completing the PIP Submission Form.
- The health plan should seek technical assistance from HSAG and MQD throughout the PIP process to address any questions or concerns.

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

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

Findings

Table 3-29 presents the 2023 percentage of top-box responses (i.e., top-box scores) for HMSA QI compared to the 2022 NCQA child Medicaid national averages and the corresponding 2021 scores.[3-11, 3-

[3-11] The child population was last surveyed in 2021; therefore, the 2023 child CAHPS scores are compared to the corresponding 2021 scores.

[12] Additionally, the overall member experience ratings (i.e., star ratings) resulting from HMSA QI's 2023 top-box scores compared to NCQA's 2022 Quality Compass Benchmark and Compare Quality Data are displayed below.[3-13]

Table 3-29—Child Medicaid CAHPS Results for HMSA QI

Measure	2021 Scores	2023 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	76.1%	72.1%	★★
Rating of All Health Care	72.0%	68.6%	★★
Rating of Personal Doctor	82.9%	80.6%	★★★★
Rating of Specialist Seen Most Often	68.6%+	78.6%+	★★★★
Composite Measures			
Getting Needed Care	84.2%	72.7% ▼	★
Getting Care Quickly	82.9%	78.2%	★
How Well Doctors Communicate	95.2%	94.0%	★★
Customer Service	87.2%+	84.3%+	★
Individual Item Measure			
Coordination of Care	82.3%+	84.7%+	★★

Cells highlighted in yellow represent scores that are statistically significantly higher than the 2022 NCQA child Medicaid national averages.
Cells highlighted in red represent scores that are statistically significantly lower than the 2022 NCQA child Medicaid national averages.

▲ *Indicates the 2023 score is statistically significantly higher than the 2021 score.*

▼ *Indicates the 2023 score is statistically significantly lower than the 2021 score.*

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

Star Ratings based on percentiles:

★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th

Strengths

For HMSA QI's child Medicaid population, the following measures met or exceeded the 75th percentile:

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

[3-12] National Committee for Quality Assurance. *HEDIS® Measurement Year 2022, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2022.

[3-13] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2022.* Washington, DC: NCQA, September 2022.

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 3-30 provides a summary of the key drivers identified for HMSA QI.

Table 3-30—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.

Home and Community-Based CAHPS Survey

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

Findings

Table 3-31 presents the 2023 mean scores compared to the HI HCBS Program for HMSA QI.[3-14]

Table 3-31—HCBS Survey Results for HMSA QI

Measure	2023 HMSA QI Mean Scores	2023 HI HCBS Program Mean Scores	Plan Comparison Significance
Global Ratings			
Rating of Personal Assistance and Behavioral Health Staff	79.4+	90.3	—
Rating of Homemaker	NA	91.1+	NA
Rating of Case Manager	77.8+	87.6	—
Composite Measures			
Reliable and Helpful Staff	NA	86.6	NA
Staff Listen and Communicate Well	NA	84.9	NA
Helpful Case Manager	NA	86.3	NA
Choosing the Services that Matter to You	73.5+	83.0	—
Transportation to Medical Appointments	70.7+	81.8	↓
Personal Safety and Respect	86.5+	89.2	—
Planning Your Time and Activities	54.8+	65.8	↓
Recommendation Measures			
Recommend Personal Assistance/Behavioral Health Staff	83.3+	86.2	—
Recommend Homemaker	NA	81.8+	NA
Recommend Case Manager	66.7+	84.5	↓
Unmet Need and Physical Safety Measures			
No Unmet Need in Dressing/Bathing	NA	32.7+	NA
No Unmet Need in Meal Preparation/Eating	NA	20.5+	NA
No Unmet Need in Medication Administration	NA	40.6+	NA
No Unmet Need in Toileting	NA	94.9	NA
No Unmet Need with Household Tasks	NA	NA	NA

[3-14] For this report, only the composite measure mean scores are displayed. For more detailed results on the other response categories, please see the 2023 Hawaii HCBS CAHPS Survey full report.

Measure	2023 HMSA QI Mean Scores	2023 HI HCBS Program Mean Scores	Plan Comparison Significance
Not Hit or Hurt by Staff	100.0+	100.0	—

↑ Indicates the mean score is statistically significantly higher than the HI HCBS Program.
↓ Indicates the mean score is statistically significantly lower than the HI HCBS Program.
— Indicates the mean score is not statistically significantly different than the HI 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 the 2023 mean scores were higher than/statistically significantly higher than the HI HCBS Program for any measure; therefore, no substantial strengths were identified.

Areas for Improvement

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*

Provider Survey

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

Findings

Table 3-32 presents the 2023 top-box scores compared to the QI Program aggregate and the corresponding 2021 top-box scores, where applicable, on the six domains of satisfaction for HMSA QI.[3-15]

Table 3-32—Provider Survey Results for HMSA QI

	2021 Top-Box Score	2023 Top-Box Score	2023 QI Program Top-Box Score	Plan Comparison Significance	Trend Analysis Significance
General Positions					
Compensation Satisfaction	32.4%	41.2%	38.6%	—	—
Timeliness of Claims Payments	55.7%	55.0%	43.8%	↑	—
Providing Quality Care					
Formulary	18.1%	31.8%	29.7%	—	—
Prior Authorization Process	23.0%	24.0%	19.8%	↑	—
Non-Formulary					
Adequate Access to Non-Formulary Drugs	20.3%	40.1%	41.4%	—	—
Health Coordinators					
Helpfulness of Health Coordinators	31.1%	43.4%	44.8%	—	—
Specialists					
Adequacy of Specialists	37.0%	49.4%	36.2%	↑	—
Availability of Mental Health Providers	15.5%	21.2%	18.0%	—	—
Substance Abuse					
Access to Substance Abuse Treatment	20.8%	28.5%	30.4%	↓	—

↑ *Indicates the QI health plan's top-box score is statistically significantly higher than the QI Program.*
↓ *Indicates the QI health plan's top-box score is statistically significantly lower than the QI Program.*
▲ *Indicates the 2023 top-box score is statistically significantly higher than the 2021 top-box score.*
▼ *Indicates the 2023 top-box score is statistically significantly lower than the 2021 top-box score.*
— *Indicates the 2023 top-box score is not statistically significantly different than the 2021 top-box score.*

[3-15] For this report, only the top-box scores are displayed. For more detailed results on the other response categories, please see the 2023 Hawaii Provider Survey full report.

Strengths

For HMSA QI, the 2023 top-box scores for the following three measures were statistically significantly higher than the QI Program aggregate:

- *Timeliness of Claims Payments*
- *Prior Authorization Process*
- *Adequacy of Specialists*

For HMSA QI, the top-box scores for the following eight measures were higher in 2023 than in 2021, although no measure's top-box score was statistically significantly higher:

- *Compensation Satisfaction*
- *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*

Areas for Improvement

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*

Overall Assessment of Quality, Accessibility, and Timeliness of Care

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

Conclusions

In general, HMSA QI's performance results illustrate mixed performance across the six EQR activities. While the compliance monitoring review activity revealed that HMSA QI has established an operational foundation to support the quality of, access to, and timeliness of care and service delivery, performance on outcome and process measures showed considerable room for improvement.

HMSA QI showed that it has systems, policies, and staff in place to ensure its structure and operations support core processes for providing care and services and promoting quality outcomes. HMSA QI's performance during the 2023 compliance review was average, meeting or exceeding the statewide compliance score for six of the seven standards. HMSA QI achieved 100 percent compliance in five standards, 99 percent in the Credentialing standard, and 92 percent in the Subcontractual Relationships and Delegation standard. HMSA QI was required to develop a CAP to address and resolve the deficiencies identified in the review. HSAG and MQD provided feedback and will continue to monitor HMSA QI's CAP activities until the health plan is found to be in full compliance.

Overall, more than half (56.7 percent) of HMSA QI's performance measures fell below the 50th percentile across all domains. While some measures showed improvement from HEDIS MY 2020, HMSA QI's performance suggested several areas in need of improvement, including the Children's Preventive Health and Women's Health domains. While 11 MQD Quality Strategy targets were met in HEDIS MY 2022, 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' experience. The following measure scored statistically significantly lower in 2023 than in 2021: *Getting Needed Care*. The following seven measures were below the 50th percentiles: *Rating of Health Plan*, *Rating of All Health Care*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Coordination of Care*. Additionally, two of the nine measures scored statistically significantly lower than the 2022 NCQA child Medicaid national averages: *Getting Needed Care* and *Getting Care Quickly*. These results indicate the need for HMSA QI to implement improvement strategies to ensure members have high-quality care and timely access to care.

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

HMSA QI's HCBS Survey results illustrate opportunities for improvement in members' experience. While none of the measures scored statistically significantly higher than the HI HCBS Program, the *Transportation to Medical Appointments, Planning Your Time and Activities,* and *Recommend Case Manager* measures scored statistically significantly lower than the HI HCBS Program. Additionally, the following eight measures had mean scores that were lower than the HI HCBS Program: *Rating of Personal Assistance and Behavioral Health Staff, Rating of Case Manager, Choosing the Services that Matter to You, Transportation to Medical Appointments, Personal Safety and Respect, Planning Your Time and Activities, Recommend Personal Assistance/Behavioral Health Staff,* and *Recommend Case*

Manager, indicating a need for HMSA QI to implement improvement strategies to ensure members have high-quality care and timely access to care.

HMSA QI's Provider Survey results demonstrated both positive results and areas for improvement. Top-box scores for three measures were statistically significantly higher than the QI Program aggregate rates. However, providers noted dissatisfaction with *Adequacy of Access to Non-Formulary Drugs*, *Helpfulness of Health Coordinators*, and *Access to Substance Abuse Treatment*, with top-box scores for these measures falling below the QI Program aggregate rate, as well as statistically significantly lower than the QI Program aggregate rate for *Access to Substance Abuse Treatment*. In addition, the top-box score for the *Timeliness of Claims Payments* measure was lower in 2023 than in 2021, indicating a need for HMSA QI to implement strategies to ensure members have high-quality care and access to care.

Finally, HMSA QI progressed to the Outcomes stage of the two PIPs that were initiated in CY 2022. 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 an overall *Met* validation status. The reported data were not comprehensive. Besides CCS and CAMHD, the health plan could not identify shared members with the remaining DOH partnering agencies. During Remeasurement 1, 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.

For the *Plan All-Cause Readmissions* PIP, HMSA QI received an overall *Not Met* validation status. The documented PIP design was accurate; however, the health plan did not report data or the QI activities for the Remeasurement 1 period. HSAG could not assess the PIP for improvement in outcomes.

Kaiser Foundation Health Plan QUEST Integration (KFHP QI) Results

Compliance Monitoring Review

The 2023 compliance monitoring review activity included evaluation of the health plan's compliance with State and federal requirements for organizational and structural performance.

Findings

Table 3-33 presents the standards and compliance scores for KFHP QI.

Table 3-33—Standards and Compliance Scores—Kaiser Foundation Health Plan QUEST Integration

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Provider Selection	17	17	17	0	0	0	100%
II	Credentialing	44	36	36	0	0	8	100%
III	Subcontractual Relationships and Delegation	6	6	5	1	0	0	92%
IV	Health Information Systems	9	9	9	0	0	0	100%
V	Quality Assessment and Performance Improvement	7	7	7	0	0	0	100%
VI	Practice Guidelines	6	6	6	0	0	0	100%
VII	Enrollment and Disenrollment	5	5	5	0	0	0	100%
	Totals	**94**	**86**	**85**	**1**	**0**	**8**	**99%**

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

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

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

Strengths

KFHP QI was found to be fully compliant in six of the seven standards reviewed in 2023.

Provider Selection—KFHP QI maintained policies and procedures for the selection, retention, and recruitment of providers for KFHP QI's provider network. Additionally, the health plan had a comprehensive compliance and ethics plan, including policies and procedures to assist KFHP QI in guarding against fraud, waste, and abuse. KFHP QI demonstrated effective processes for monitoring, auditing, and identifying compliance risks.

Credentialing—KFHP QI had comprehensive policies, procedures, and processes in place for the credentialing and recredentialing of licensed practitioners, allied health professionals, facilities/organizations, and LTSS providers delivering care to the health plan's QUEST members that aligned with NCQA credentialing standards.

Health Information Systems—KFHP QI maintained a health information system that collects, analyzes, integrates, and reports data on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility.

Quality Assessment and Performance Improvement—KFHP QI's QAPI program was supported by a comprehensive program description, work plan, and evaluation of the prior year's quality improvement program achievements. The QAPI program provided the framework to systematically measure and analyze performance and impart essential information that aided management in decision-making to improve organizational functions, structures, and processes to improve QI member outcomes.

Practice Guidelines—KFHP QI adopted evidence-based practice guidelines, disseminated its practice guidelines to all affected providers, and rendered utilization management and coverage of services decisions consistent with its practice guidelines.

Enrollment and Disenrollment—KFHP QI had systems, processes, and workflows to accept all individuals enrolled into its health plan without restrictions. KFHP QI did not request disenrollment of members for reasons other than those permitted under the contract and had processes in place to notify the State when it becomes aware of a change in a member's circumstance that might affect the member's eligibility.

Areas for Improvement

Subcontractual Relationships and Delegation—KFHP QI was found to be 92 percent compliant with this standard, with one element scoring *Partially* Met. While KFHP QI had delegation oversight policies and processes for ongoing monitoring of its delegates, KFHP QI was not conducting routine monitoring and formal audits of all delegates. KFHP QI did not appear to have designated a department with overall responsibility for management of delegation contracts and oversight to ensure all delegates are receiving ongoing monitoring and formal reviews according to a periodic schedule that is documented within the delegation agreements. The corrective action required by KFHP QI was to implement processes to ensure that all subcontractors performing managed care administrative functions on behalf of the health plan are subject to ongoing monitoring and formal review.

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 8.0 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 2022 performance measure rates. HSAG determined one data source to be non-standard supplemental data, and the remaining three were considered standard supplemental data. No concerns were identified, and all four supplemental data sources were approved for HEDIS MY 2022 reporting.

KFHP QI's medical record review processes did not change from the prior MY and passed all hybrid measures for MRRV in the prior MY; therefore, KFHP QI was not required to undergo convenience sample validation. The final statistical MRRV was conducted for the *Controlling High Blood Pressure, Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care,* and *Eye Exam for Patients With Diabetes* measures, 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 3-34. The *Plan All-Cause Readmissions—Index Total Stays—O/E Ratio—Total* measure indicator rate met or exceeded the 50th percentile. All other measure indicators in this domain did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented. Both measures in this domain had an MQD Quality Strategy target (*Heart Failure Admission Rate—Total* and *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Total*), and KFHP QI met the established targets for HEDIS MY 2022.

Table 3-34—KFHP QI's HEDIS Results for QI Measures Under Access and Risk-Adjusted Utilization

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Heart Failure Admission Rate (per 100,000 member months)*				
18–64 Years	36.75	31.62	-13.96%	NC
65 Years and Older	88.05	109.16	23.98%	NC
Total (18 Years and Older)	40.56	38.04	-6.21%	NC

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Plan All-Cause Readmissions				
*Index Total Stays—Observed Readmissions—Total**	7.56%	8.79%	16.27%	NC
Expected Readmissions—Total	9.85%	9.56%	-2.94%	NC
*Index Total Stays—O/E Ratio—Total**	0.7678	0.9192	19.72%	★★★

** 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.
MY 2022 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Children's Preventive Health Performance Measure Results

KFHP QI's Children's Preventive Health performance measure results are shown in Table 3-35. KFHP QI met MQD's established Quality Strategy targets for the *Childhood Immunization Status—Combination 7* and *Combination 10* measure rates. Nine of 19 measure rates that could be compared to national benchmarks ranked at or above the 50th percentile, including two rates that ranked at or above the 75th percentile and five rates that ranked at or above the 90th percentile. Conversely, 10 rates ranked below the 50th percentile, five of which fell below the 25th percentile. All of the *Well-Child Visits in the First 30 Months of Life* and *Childhood Immunization Status* rates, except for the *Influenza* rate, remained consistent with the prior MY. For the *Child and Adolescent Well-Care Visits* measure, all rates except for the *18–21 Years* stratification, showed a relative increase from the prior MY. Conversely, all *Child and Adolescent Well-Care Visits* rates fell below the 25th percentile for MY 2022.

Table 3-35—KFHP QI's HEDIS Results for QI Measures Under Children's Preventive Health

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Child and Adolescent Well-Care Visits				
3–11 Years	41.63%	49.69%	19.36%	★
12–17 Years	42.49%	44.62%	5.01%	★
18–21 Years	12.84%	10.44%	-18.69%	★
Total (3–21 Years)	36.94%	41.15%	11.40%	★
Childhood Immunization Status				
Combination 3	72.10%	69.46%	-3.66%	★★★★
Combination 7	69.86%	66.96%	-4.15%	★★★★★
Combination 10	60.81%	56.85%	-6.51%	★★★★★

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
DTaP	75.93%	72.39%	-4.66%	★★★
Hepatitis A	85.30%	80.98%	-5.06%	★★★
Hepatitis B	90.31%	86.09%	-4.67%	★★
HiB	79.98%	77.28%	-3.38%	★
Influenza	72.10%	65.11%	-9.69%	★★★★★
IPV	88.07%	84.67%	-3.86%	★★
MMR	85.09%	82.61%	-2.91%	★★
Pneumococcal Conjugate	73.06%	70.87%	-3.00%	★★
Rotavirus	84.45%	79.57%	-5.78%	★★★★★
VZV	85.20%	82.17%	-3.56%	★★
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	73.09%	70.41%	-3.67%	★★★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	80.51%	73.05%	-9.27%	★★★★

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by MQD.
MY 2022 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Women's Health Performance Measure Results

KFHP QI's Women's Health performance measure results are shown in Table 3-36. All three measure rates in this domain remained consistent with the prior MY. Additionally, two measure rates benchmarked at or above the 75th percentile, and one rate benchmarked at or above the 90th percentile. Further, all three measure rates in this domain had an MQD Quality Strategy target for HEDIS MY 2022, and KFHP QI met or exceeded all three of the established MQD Quality Strategy targets.

Table 3-36—KFHP QI's HEDIS Results for QI Measures Under Women's Health

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Cervical Cancer Screening				
Cervical Cancer Screening	67.36%	63.61%	-5.57%	★★★★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	89.62%	90.32%	0.78%	★★★★
Postpartum Care	84.62%	86.38%	2.08%	★★★★★

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by MQD.
MY 2022 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Care for Chronic Conditions Performance Measure Results

KFHP QI's Care for Chronic Conditions performance measure results are shown in Table 3-37. All measure rates in this domain remained consistent with the prior MY, except for *Eye Exam for Patients With Diabetes,* which demonstrated a relative increase of more than 20 percent from the prior MY. The *Concurrent Use of Opioids and Benzodiazepines—Total* rate met MQD's established Quality Strategy target for MY 2022. Additionally, the *Controlling High Blood Pressure—Total* rate met MQD's established target and ranked at or above the 75th percentile.

Table 3-37—KFHP QI's HEDIS Results for QI Measures Under Care for Chronic Conditions

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Hemoglobin A1c Control for Patients With Diabetes				
*HbA1c Poor Control (>9.0%)—Total**	35.64%	37.47%	5.13%	NC
HbA1c Control (<8.0%)—Total	52.64%	51.41%	-2.34%	NC
Eye Exam for Patients With Diabetes				
Eye Exam for Patients With Diabetes	55.12%	66.83%	21.24%	NC
Blood Pressure Control for Patients With Diabetes				
Blood Pressure Control for Patients With Diabetes	64.15%	66.84%	4.19%	NC
Concurrent Use of Opioids and Benzodiazepines*				
18–64 Years	6.75%	7.20%	6.67%	NC
65 Years and Older	9.09%	6.25%	-31.24%	NC
Total (18 Years and Older)	7.11%	7.04%	-0.98%	NC
Controlling High Blood Pressure				
18–64 Years	64.86%	68.87%	6.18%	NC
65–85 Years	73.00%	67.94%	-6.93%	NC
Total (18–85 Years)	67.02%	68.56%	2.30%	★★★★

** 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.
MY 2022 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Behavioral Health Performance Measure Results

KFHP QI's Behavioral Health performance measure results are shown in Table 3-38. For the *Use of Pharmacotherapy for Opioid Use Disorder* measure, the *Total* and *Buprenorphine* rates demonstrated a relative decrease of more than 5 percent from the prior MY. Conversely, both rates met MQD's established Quality Strategy targets. NCQA recommended a break in trending for the *Initiation and Engagement of Substance Use Disorder Treatment* measure due to significant changes made to the MY 2022 specifications; therefore, the prior year's rates and benchmarks are not displayed. For the one measure in this domain that could be compared to national benchmarks, *Follow-Up After Hospitalization for Mental Illness,* six of the eight rates ranked at or above the 50th percentile, including one rate that benchmarked at or above the 75th percentile and one rate that benchmarked at or above the 90th percentile. Additionally, the *7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* rates met MQD's established Quality Strategy targets. The *65 Years and Older* stratifications for this measure were assigned a status of *NA* due to not enough members in the eligible population (i.e., <30) to report valid rates.

Table 3-38—KFHP QI's HEDIS Results for QI Measures Under Behavioral Health

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—6–17 Years	NA	77.14%	—	★★★★★
7-Day Follow-Up—18–64 Years	45.04%	40.00%	-11.19%	★★★
7-Day Follow-Up—65 Years and Older	NA	NA	—	NC
7-Day Follow-Up—Total	49.69%	50.00%	0.62%	★★★★
30-Day Follow-Up—6–17 Years	NA	77.14%	—	★★★
30-Day Follow-Up—18–64 Years	63.36%	55.79%	-11.95%	★★★
30-Day Follow-Up—65 Years and Older	NA	NA	—	NC
30-Day Follow-Up—Total	67.70%	61.54%	-9.10%	★★★
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation—Total—13–17 Years	—	26.32%	—	NC
Initiation—Total—18+ Years	—	33.68%	—	NC
Initiation—Total—Total	—	32.52%	—	NC
Engagement—Total—13–17 Years	—	2.63%	—	NC
Engagement—Total—18+ Years	—	5.80%	—	NC
Engagement—Total—Total	—	6.62%	—	NC
Screening for Depression and Follow-Up Plan				
12–17 Years	1.70%	1.44%	-15.29%	NC
18–64 Years	7.56%	5.77%	-23.68%	NC
65 Years and Older	9.16%	7.47%	-18.45%	NC
Total Adult (18 Years and Older)	7.71%	5.94%	-22.96%	NC

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Use of Pharmacotherapy for Opioid Use Disorder				
Total (Rate 1)	62.16%	56.25%	-9.51%	NC
Buprenorphine (Rate 2)	59.46%	50.00%	-15.91%	NC
Oral Naltrexone (Rate 3)	2.70%	0.00%	-100.00%	NC
Long-acting, Injectable Naltrexone (Rate 4)	0.00%	0.00%	—	NC
Methadone (Rate 5)	0.00%	8.33%	—	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 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 2022 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Long-Term Services and Supports Performance Measure Results

KFHP QI's Long-Term Services and Supports performance measure results are shown in Table 3-39. The measures in this domain did not have applicable benchmarks; therefore, no comparison to national benchmarks is presented. Further, there were no MQD Quality Strategy targets established. The *Long-Term Services and Supports Comprehensive Care Plan and Update* measure rates showed a relative increase of more than 300 percent, demonstrating KFHP QI's dedication to providing its LTSS members with comprehensive care plans, which address the required core and supplemental elements. All measures in this domain were determined to be *Reportable.*

Table 3-39—KFHP QI's HEDIS Results for QI Measures Under Long-Term Services and Supports

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Long-Term Services and Supports Comprehensive Care Plan and Update				
Care Plan with Core Elements Documented	10.11%	42.71%	322.45%	NC
Care plan with Supplemental Elements Documented	10.11%	40.63%	301.88%	NC
Long-Term Services and Supports Comprehensive Assessment and Update				
Assessment of Core Elements Documented	—	34.38%	—	NC
Assessment of Supplemental Elements Documented	—	30.21%	—	NC

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Long-Term Services and Supports Minimizing Institutional Length of Stay				
Observed Discharge Rate	NA	25.94%	—	NC
Expected Discharge Rate	NA	35.22%	—	NC
Observed/Expected Ratio	NA	0.7366	—	NC

NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.
NA indicates that the health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
— Indicates that the plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.

Conclusions and Recommendations

Based on HSAG's analyses of KFHP QI's 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*

Validation of Performance Improvement Projects

In CY 2022, MQD selected two new PIPs—*Behavioral Health Coordination* and *Plan All-Cause Readmissions* for all the health plans to complete. For the CY 2023 submission, the health plans progressed to the Design, Implementation, and Outcomes stages of the PIPs and submitted Steps 1 through 8 in the PIP Submission Form and were assessed for improvement in outcomes (Step 9).

Table 3-40 displays the topics, progression status, and measurement periods reported for the PIPs.

Table 3-40—CY 2023 Health Plan PIP Topics and Status

PIP Topic	PIP Progression Status	Baseline Measurement Period	Measurement Period Reported in CY 2022
Behavioral Health Coordination	PIP Design, 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)

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

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

Findings

Table 3-41 illustrates the validation results for the two PIPs submitted by KFHP QI for CY 2023 validation.

Table 3-41—CY 2023 PIP Validation Results for KFHP QI

PIP Topic	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Behavioral Health Coordination	95%	100%	*Met*
Plan All-Cause Readmissions	95%	100%	*Met*

For both PIPs, KFHP QI received an overall *Met* validation status, with a *Met* score of 100 percent for critical evaluation elements and 95 percent for overall evaluation elements across all steps completed and validated.

Design (Steps 1-6)

Behavioral Health Coordination

KFHP QI met 100 percent of the requirements in the Design stage. The selected PIP topic was required by MQD and MQD held workgroup meetings with health plans, DOH Behavioral Health Services Administration divisions, and HSAG to discuss the PIP design. The PIP Aim statement, the PIP population, and the two performance indicators were also discussed during the workgroup sessions. KFHP QI documented the PIP design accurately and as discussed during the workgroup meetings. KFHP QI's data collection process 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.

Plan All-Cause Readmissions

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

Implementation (Steps 7-8)

Behavioral Health Coordination

KFHP QI accurately reported and analyzed the Remeasurement 1 rates for the two performance indicators. KFHP QI documented its QI efforts toward identifying barriers and implementing interventions, which were logically linked to the identified barriers. KFHP QI documented that it continues to meet with partnering agencies to define accountabilities, identify needed workflows for a standard structure for information sharing to occur, and provide further clarity on measure indicators as issues arise. KFHP QI also drafted and shared DSAs with the DOH Behavioral Health Services Administration divisions.

Plan All-Cause Readmissions

KFHP QI accurately reported and analyzed the Remeasurement 1 data for the performance indicator. KFHP QI also conducted appropriate QI processes. As part of the Readmissions Collaborative workgroup, the health plan identified 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.

Outcomes (Step 9)

Behavioral Health Coordination

During Remeasurement 1, 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. Additionally, the health plan documented achievement of significant programmatic improvement due to changes made in workflows and staff training on the PIP. The health plan, however, did not provide adequate details about the programmatic changes that were made.

Plan All-Cause Readmissions

During Remeasurement, 1 the health plan demonstrated a non-statistically significant decline in performance with an increase in the observed readmission rate.

Analysis of Results

Table 3-42 displays the data that the health plan reported for the *Behavioral Health Coordination* PIP.

Table 3-42—Performance Improvement Project Outcomes for the *Behavioral Health Coordination* PIP

Performance Indicator	Baseline* (07/01/2021–09/30/2021)		Remeasurement 1 (07/01/2022–09/30/2022)		Sustained Improvement
Percent of shared members with eligible trigger events who received a combined review in the past three months.	N: 3 D: 38	7.9%	N: 18 D: 48	37.5%**	
Percent of shared members whose data are actively shared at a regular frequency with partner agencies.	N: 84 D: 223	37.7%	N: 96 D: 460	20.9%	

*Baseline data were updated by the health plan in the CY 2023 PIP submission. The health plans were in the initial stages of defining their data collection processes when the baseline data were reported in the previous year's submission. The health plans were allowed to update the baseline data in the CY 2023 PIP submission, as applicable for the defined data collection processes.
**Rate demonstrates statistically significant improvement over the baseline rate. N–Numerator D–Denominator

The rate for the percentage of shared members with eligible trigger events who received a combined review during the baseline measurement period (third quarter of 2021) was 7.9 percent. Out of the 38 members with eligible trigger events, two combined reviews were for members shared with CCS and one for a member shared with CAMHD of the Hawaii DOH. During Remeasurement 1, the Performance Indicator 1 rate increased to 37.5 percent, which represents a statistically significant improvement over the baseline. The health plan documented that out of a total of 18 combined reviews, 14 reviews were completed with CCS, three reviews were with CAMHD, and one review was with DDD.

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. During Remeasurement 1, a decline of 16.8 percentage points from the baseline was noted in the Performance Indicator 2 rate. The health plan indicated that data sharing on an ongoing basis with the DOH Behavioral Health Services Administration divisions was pending the approval of the DSAs by the concerned authorities.

Table 3-43 displays the data that the health plan reported for the *Plan All-Cause Readmissions* PIP.

Table 3-43—Performance Improvement Project 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)		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 D: 780	7.6%	N: 74 D: 842	8.8%	

N–Numerator D–Denominator

The baseline (CY 2021) rate for the percentage of eligible discharges for which members 18–64 years of age had at least one unplanned acute readmission for any diagnosis within 30 days of the index discharge date was 7.6 percent. During Remeasurement 1, the health plan demonstrated a non-statistically significant decline in performance with an increase of 1.2 percentage points in the observed readmission rate.

Barriers/Interventions

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

Table 3-44 displays the barriers and interventions as documented by the health plan for both PIPs.

Table 3-44—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. Based on feedback from the DOH agencies, the DSAs were revised to a single MOU to include all DOH agencies. The new MOU

Barriers	Interventions
	was submitted to DOH for review and approval in December 2023.* 2. Having a workgroup with partnering agencies that meets at least on a quarterly basis.* 3. Develop a workflow for ongoing communication between health plan and partnering agencies.*
Plan All-Cause Readmissions	
1. Inconsistent patient engagement. 2. Location of Transitional Care Center (TCC) clinic. 3. Health coordinator assignment.	1. Road shows and training of patient care coordinators (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 ≥23.

* The documented interventions are required by MQD.

Strengths

- For both PIPs, KFHP QI received an overall *Met* validation status.
- For the *Behavioral Health Coordination* PIP, during Remeasurement 1, the health plan achieved statistically significant improvement in the Performance Indicator 1 rate.

Areas for Improvement

- For the *Behavioral Health Coordination* PIP, during Remeasurement 1, a decline from the baseline rate was noted in the Performance Indicator 2 rate.
- For the *Plan All-Cause Readmissions* PIP, the health plan demonstrated a decline in performance 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 *Behavioral Health Coordination* PIP:
  - The health plan must continue to document its progress toward implementing the interventions and expanding the data sharing efforts with all the partnering agencies.
  - The health plan must also include quantitative data to document the effectiveness of the interventions. For example, in the next annual submission, for the DSA intervention, the health

plan should include how much improvement in data sharing with the DOH agencies was noted after the DSAs were executed.

- For the *Plan All-Cause Readmissions* PIP:
  - In Step 8 of the PIP Submission Form, the health plan must continue to document its QI activities undertaken as part of the Readmissions Collaborative workgroup to improve the *PCR* rate.
- The health plan should continue to revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- The health plan must have a process in place for evaluating each PIP intervention and its impact on the performance indicator. Interventions should be adapted or revised as needed.
- The health plan must address the *Validation Feedback* in the next annual submission.
- The health plan should reference the PIP Completion Instructions to ensure that all requirements have been addressed when completing the PIP Submission Form.
- The health plan should seek technical assistance from HSAG and MQD throughout the PIP process to address any questions or concerns.

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

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

Findings

Table 3-45 presents the 2023 percentage of top-box responses (i.e., top-box scores) for KFHP QI compared to the 2022 NCQA child Medicaid national averages and the corresponding 2021 scores.[3-16, 3-17] Additionally, the overall member experience ratings (i.e., star ratings) resulting from KFHP QI's 2023 top-box scores compared to NCQA's 2022 Quality Compass Benchmark and Compare Quality Data are displayed below.[3-18]

Table 3-45—Child Medicaid CAHPS Results for KFHP QI

Measure	2021 Scores	2023 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	78.4%	74.9%	★★★

[3-16] The child population was last surveyed in 2021; therefore, the 2023 child CAHPS scores are compared to the corresponding 2021 scores.

[3-17] National Committee for Quality Assurance. *HEDIS® Measurement Year 2022, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2022.

[3-18] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2022.* Washington, DC: NCQA, September 2022.

Measure	2021 Scores	2023 Scores	Star Ratings
Rating of All Health Care	82.1%	68.1% ▼	★★
Rating of Personal Doctor	86.4%	77.6% ▼	★★★
Rating of Specialist Seen Most Often	75.9%+	76.0%+	★★★
Composite Measures			
Getting Needed Care	86.6%	78.6%	★
Getting Care Quickly	88.8%	81.9%	★
How Well Doctors Communicate	97.0%	94.6%	★★★
Customer Service	92.4%+	90.6%+	★★★★
Individual Item Measure			
Coordination of Care	95.8%+	91.5%	★★★★★

Cells highlighted in yellow represent scores that are statistically significantly higher than the 2022 NCQA child Medicaid national averages.
Cells highlighted in red represent scores that are statistically significantly lower than the 2022 NCQA child Medicaid national averages.
▲ *Indicates the 2023 score is statistically significantly higher than the 2021 score.*
▼ *Indicates the 2023 score is statistically significantly lower than the 2021 score.*
+ *Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.*
Star Ratings based on percentiles:
★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th

Strengths

For KFHP QI's child Medicaid population, the following measure scored statistically significantly higher than the 2022 NCQA child Medicaid national average:

- *Coordination of Care*

For KFHP QI's child Medicaid population, the following measures met or exceeded the 75th percentile:

- *Customer Service*
- *Coordination of Care*

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 3-46 provides a summary of the key drivers identified for KFHP QI.

Table 3-46—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.

Home and Community-Based CAHPS Survey

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

Findings

Table 3-47 presents the 2023 mean scores compared to the HI HCBS Program for KFHP QI.[3-19]

[3-19] For this report, only the composite measure mean scores are displayed. For more detailed results on the other response categories, please see the 2023 Hawaii HCBS CAHPS Survey full report.

Table 3-47—HCBS Survey Results for KFHP QI

Measure	2023 KFHP QI Mean Scores	2023 HI HCBS Program Mean Scores	Plan Comparison Significance
Global Ratings			
Rating of Personal Assistance and Behavioral Health Staff	95.2+	90.3	↑
Rating of Homemaker	NA	91.1+	NA
Rating of Case Manager	92.5+	87.6	—
Composite Measures			
Reliable and Helpful Staff	90.1+	86.6	—
Staff Listen and Communicate Well	89.1+	84.9	—
Helpful Case Manager	90.8+	86.3	—
Choosing the Services that Matter to You	90.2+	83.0	↑
Transportation to Medical Appointments	90.8+	81.8	↑
Personal Safety and Respect	92.1+	89.2	—
Planning Your Time and Activities	74.2+	65.8	↑
Recommendation Measures			
Recommend Personal Assistance/Behavioral Health Staff	92.6+	86.2	↑
Recommend Homemaker	NA	81.8+	NA
Recommend Case Manager	93.8+	84.5	↑
Unmet Need and Physical Safety Measures			
No Unmet Need in Dressing/Bathing	NA	32.7+	NA
No Unmet Need in Meal Preparation/Eating	NA	20.5+	NA
No Unmet Need in Medication Administration	NA	40.6+	NA
No Unmet Need in Toileting	100.0+	94.9	—
No Unmet Need with Household Tasks	NA	NA	NA
Not Hit or Hurt by Staff	100.0+	100.0	—

↑ Indicates the mean score is statistically significantly higher than the HI HCBS Program.
↓ Indicates the mean score is statistically significantly lower than the HI HCBS Program.
— Indicates the mean score is not statistically significantly different than the HI 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 mean scores for the following six measures were statistically significantly higher than the HI HCBS Program mean scores:

- *Rating of Personal Assistance and Behavioral Health Staff*
- *Choosing the Services that Matter to You*
- *Transportation to Medical Appointments*
- *Planning Your Time and Activities*
- *Recommend Personal Assistance/Behavioral Health Staff*
- *Recommend Case Manager*

In addition, the mean scores for the following six measures were higher than the HI HCBS Program mean scores:

- *Rating of Case Manager*
- *Reliable and Helpful Staff*
- *Staff Listen and Communicate Well*
- *Helpful Case Manager*
- *Personal Safety and Respect*
- *No Unmet Need in Toileting*

Areas for Improvement

None of the mean scores were lower/statistically significantly lower than the HI HCBS Program; therefore, no substantial weaknesses were identified.

Provider Survey

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

Findings

Table 3-48 presents the 2023 top-box scores compared to the QI Program aggregate and the corresponding 2021 top-box scores, where applicable, on the six domains of satisfaction for KFHP QI.[3-20]

[3-20] For this report, only the top-box scores are displayed. For more detailed results on the other response categories, please see the 2023 Hawaii Provider Survey full report.

Table 3-48—Provider Survey Results for KFHP QI

	2021 Top-Box Score	2023 Top-Box Score	2023 QI Program Top-Box Score	Plan Comparison Significance	Trend Analysis Significance
General Positions					
Compensation Satisfaction	NA	62.2%	38.6%	↑	—
Timeliness of Claims Payments	NA	52.9%	43.8%	—	—
Providing Quality Care					
Formulary	51.6%	48.9%	29.7%	↑	—
Prior Authorization Process	38.5%	28.0%	19.8%	—	—
Non-Formulary					
Adequate Access to Non-Formulary Drugs	87.5%	82.4%	41.4%	↑	—
Health Coordinators					
Helpfulness of Health Coordinators	77.4%	82.4%	44.8%	↑	—
Specialists					
Adequacy of Specialists	78.8%	74.0%	36.2%	↑	—
Availability of Mental Health Providers	36.7%	31.9%	18.0%	↑	—
Substance Abuse					
Access to Substance Abuse Treatment	56.7%	52.3%	30.4%	↑	—

↑ Indicates the QI health plan's top-box score is statistically significantly higher than the QI Program.
↓ Indicates the QI health plan's top-box score is statistically significantly lower than the QI Program.
▲ Indicates the 2023 top-box score is statistically significantly higher than the 2021 top-box score.
▼ Indicates the 2023 top-box score is statistically significantly lower than the 2021 top-box score.
— Indicates the 2023 top-box score is not statistically significantly different than the 2021 top-box score.
Results based on fewer than 11 respondents were suppressed and noted as "NA".

Strengths

For KFHP QI, the 2023 top-box scores for the following seven measures were statistically significantly higher than the QI Program aggregate:

- *Compensation Satisfaction*
- *Formulary*
- *Adequate Access to Non-Formulary Drugs*
- *Helpfulness of Health Coordinators*
- *Adequacy of Specialists*
- *Availability of Mental Health Providers*
- *Access to Substance Abuse Treatment*

In addition, the top-box score for the following measure was higher in 2023 than in 2021, although the measure's top-box score was not statistically significantly higher:

- *Helpfulness of Health Coordinators*

Areas for Improvement

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*

Overall Assessment of Quality, Accessibility, and Timeliness of Care

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

Conclusions

In general, KFHP QI's performance results illustrate mixed performance across the six EQR activities. KFHP QI showed that it has systems, policies, and staff in place to ensure that its structure and operations support core processes for providing care and services and promoting quality outcomes. KFHP QI's performance during the 2023 compliance review was average, meeting or exceeding the statewide compliance score for six of the seven standards. KFHP QI achieved 100 percent compliance in six standards and 92 percent in the Subcontractual Relationships and Delegation standard. KFHP QI was

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

KFHP QI continued to show strong performance in quality, performance, and outcome measures. Overall, more than half (66.7 percent) of KFHP QI's measure rates ranked at or above the 50th percentile across all domains, with nearly one quarter (20.0 percent) of the measure rates ranking at or above the 75th percentile. Conversely, 10 of KFHP QI's measure rates (33.3 percent) fell below the 50th percentile. KFHP QI's performance demonstrated a few areas for improvement, including the Children's Preventive Health domain. KFHP QI's measure rates met 13 MQD Quality Strategy targets.

KFHP QI's CAHPS results illustrate opportunities for improvement in members' experience. While none of the measures scored statistically significantly lower than the 2022 NCQA child Medicaid national averages, the following three measures were below the 50th percentiles: *Rating of All Health Care*, *Getting Needed Care,* and *Getting Care Quickly.* The following two measures were statistically significantly lower in 2023 than in 2021: *Rating of All Health Care* and *Rating of Personal Doctor*. These results indicate the need for KFHP QI to implement improvement strategies to ensure that members have high-quality care and timely access to care.

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

KFHP QI's HCBS Survey results illustrated positive results. KFHP QI's mean scores were statistically significantly higher than the HI HCBS Program for six measures: *Rating of Personal Assistance and Behavioral Health Staff, Choosing the Services that Matter to You, Transportation to Medical Appointments, Planning Your Time and Activities, Recommend Personal Assistance/Behavioral Health Staff,* and *Recommend Case Manager.* In addition, the mean scores for 11 measures were higher than the HI HCBS Program. None of the measures scored lower/scored statistically significantly lower than the HI HCBS Program, indicating that KFHP QI is effectively managing improvement efforts.

KFHP QI's Provider Survey results demonstrated high levels of satisfaction among providers across all domains. Top-box scores for seven measure results were statistically significantly higher than the QI Program aggregate rates. KFHP scored lower in 2023 than in 2021 in the *Formulary, Prior Authorization Process, Adequate Access to Non-Formulary Drugs, Helpfulness of Health Coordinators, Adequacy of Specialists, Availability of Mental Health Providers,* and *Access to Substance Abuse Treatment* measures, indicating a need for KFHP QI to implement strategies to ensure members have high-quality care and timely access to care.

Finally, KFHP QI progressed to the Outcomes stage of the two PIPs initiated in CY 2022. The topics addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services. For the *Behavioral Health Coordination* PIP, KFHP QI received an overall *Met* validation status. The health plan is continuing its efforts to improve data sharing with the partnering agencies. During Remeasurement 1, 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.

For the *Plan All-Cause Readmissions* PIP, KFHP QI received an overall *Met* validation status. The documented PIP design and data were accurate. The health plan conducted appropriate quality improvement processes to identify barriers, and it deployed interventions that were logically linked to the identified barriers. During Remeasurement 1, the health plan demonstrated a non-statistically significant decline in performance with an increase in the observed readmission rate.

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

Compliance Monitoring Review

The 2023 compliance monitoring review activity included evaluation of the health plan’s compliance with State and federal requirements for organizational and structural performance.

Findings

Table 3-49 presents the standards and compliance scores for ‘Ohana QI.

Table 3-49—Standards and Compliance Scores—‘Ohana Health Plan QUEST Integration

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Provider Selection	17	16	16	0	0	1	100%
II	Credentialing	44	43	42	1	0	1	99%
III	Subcontractual Relationships and Delegation	6	6	6	0	0	0	100%
IV	Health Information Systems	9	9	9	0	0	0	100%
V	Quality Assessment and Performance Improvement	7	7	7	0	0	0	100%
VI	Practice Guidelines	6	6	6	0	0	0	100%
VII	Enrollment and Disenrollment	5	5	5	0	0	0	100%
	Totals	**94**	**92**	**91**	**1**	**0**	**2**	**99%**

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

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

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

Strengths

‘Ohana QI was found to be fully compliant in six of the seven standards reviewed in 2023.

Provider Selection—‘Ohana QI had a comprehensive process for the selection of its network providers to sufficiently meet the needs of its QI members. Additionally, the health plan had a compliance program description and plan, including policies and procedures to assist ‘Ohana QI in guarding against fraud, waste, and abuse. The health plan demonstrated effective processes for monitoring, auditing, and identifying compliance risks.

Subcontractual Relationships and Delegation—'Ohana QI had appropriate subcontracts in place and had adequate oversight and monitoring processes to ensure its delegates are meeting their contractual obligations.

Health Information Systems—'Ohana QI maintained a health information system that collects, analyzes, integrates, and reports data on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility.

Quality Assessment and Performance Improvement—'Ohana QI's QAPI program was supported by a comprehensive program description, work plan, and evaluation of the prior year's quality improvement program achievements. The QAPI program provided the framework to systematically measure and analyze performance and impart essential information that aided management in decision-making to improve organizational functions, structures, and processes to improve QI member outcomes.

Practice Guidelines—'Ohana QI adopted evidence-based practice guidelines, disseminated its practice guidelines to all affected providers, and rendered utilization management and coverage of services decisions consistent with its practice guidelines.

Enrollment and Disenrollment—'Ohana QI had systems, processes, and workflows to accept all individuals enrolled into its health plan without restrictions. 'Ohana QI did not request disenrollment of members for reasons other than those permitted under the contract and had processes in place to notify the State when it becomes aware of a change in a member's circumstance that might affect the member's eligibility.

Areas for Improvement

Credentialing—'Ohana QI was found to be 99 percent compliant with this standard, with one element scoring *Partially Met*. 'Ohana QI demonstrated that its credentialing program had well-defined processes in place for credentialing and recredentialing individual providers that effectively evaluated providers and complied with the NCQA credentialing standards and guidelines. A review of credentialing and recredentialing files revealed that some organizational provider files were missing on-site quality assessments. 'Ohana QI staff members cited a CMS waiver that was issued during the COVID-19 public health emergency as the reason for not conducting the on-site quality assessment. However, this waiver was not applicable to credentialing on-site quality assessments conducted by health plans. The corrective action required by 'Ohana QI was to ensure that non-accredited organizational providers receive an on-site quality assessment prior to making initial credentialing and recredentialing decisions.

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 8.0 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. While ‘Ohana QI had adequate controls and processes in place to maintain its data needed to calculate performance measure rates, the health plan experienced notable decreases in rates with a provider specialty requirement due to changes in the way provider specialty data was collected and interpreted in MY 2022. ‘Ohana QI presented 34 supplemental data sources for consideration to use for supplementing its MY 2022 performance measure rates. HSAG determined 15 data sources to be standard supplemental data and the remaining 19 were considered non-standard supplemental data. ‘Ohana withdrew 21 of the 34 supplemental data sources, leaving eight standard data sources and five non-standard data sources. No concerns were identified, and the five standard and eight non-standard data sources were approved for HEDIS MY 2022 reporting.

‘Ohana QI’s medical record review processes did not change significantly from the prior MY and passed MRRV for all measures in the prior MY; therefore, ‘Ohana QI was not required to undergo convenience sample validation for MY 2022. The final statistical MRRV was conducted for the *Blood Pressure for Patients With Diabetes, Prenatal and Postpartum Care—Postpartum Care, Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%), Childhood Immunization Status—Combination 10,* and *Eye Exam for Patients With Diabetes* 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*. ‘Ohana QI was determined to be fully compliant with all IS standards, including IS standard 8.0 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 3-50. The *Plan All-Cause Readmissions—Index Total Stays—O/E Ratio—Total* measure indicator rate met or exceeded the 90th percentile. All other measure indicators in this domain did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented. Both measures in this domain had an MQD Quality Strategy target (*Heart Failure Admission Rate—Total* and *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Total*), and ‘Ohana QI met the established target for the *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Total* rate for HEDIS MY 2022.

Table 3-50—‘Ohana QI’s HEDIS Results for QI Measures Under Access and Risk-Adjusted Utilization

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Heart Failure Admission Rate (per 100,000 member months)*				
18–64 Years	91.62	55.20	-39.75%	NC
65 Years and Older	155.76	110.11	-29.31%	NC
Total (18 Years and Older)	102.84	63.11	-38.63%	NC

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Plan All-Cause Readmissions				
*Index Total Stays—Observed Readmissions—Total**	9.61%	9.94%	3.43%	NC
Expected Readmissions—Total	11.65%	11.83%	1.55%	NC
*Index Total Stays—O/E Ratio—Total**	0.8251	0.8401	1.82%	★★★★★

** 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.
MY 2022 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Children's Preventive Health Performance Measure Results

'Ohana QI's Children's Preventive Health performance measure results are shown in Table 3-51. 'Ohana QI did not meet MQD's established Quality Strategy targets for any measures in this domain. All combination rates and the *Hepatitis B, HiB, IPV,* and *MMR* vaccination rates for the *Childhood Immunization Status* measure demonstrated an increase of more than 5 percent for MY 2022. Conversely, 19 measure indicator rates fell below the 50th percentile, with 18 of these rates falling below the 25th percentile. The *Childhood Immunization Status—Influenza* rate benchmarked at or below the 25th percentile. All other measure rates in this domain fell below the 25th percentile, indicating opportunities for improvement across all measure rates.

Table 3-51—'Ohana QI's HEDIS Results for QI Measures Under Children's Preventive Health

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Child and Adolescent Well-Care Visits				
3–11 Years	45.60%	30.05%	-34.10%	★
12–17 Years	39.77%	27.87%	-29.92%	★
18–21 Years	16.76%	12.51%	-25.36%	★
Total (3–21 Years)	39.15%	26.41%	-32.54%	★
Childhood Immunization Status				
Combination 3	48.66%	36.50%	-24.99%	★
Combination 7	42.09%	31.87%	-24.28%	★
Combination 10	36.01%	25.06%	-30.41%	★
DTaP	51.82%	44.53%	-14.07%	★
Hepatitis A	63.99%	60.34%	-5.70%	★

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Hepatitis B	69.10%	59.12%	-14.44%	★
HiB	66.18%	60.10%	-9.19%	★
Influenza	51.58%	40.15%	-22.16%	★★
IPV	68.86%	62.77%	-8.84%	★
MMR	65.21%	58.64%	-10.08%	★
Pneumococcal Conjugate	52.55%	45.99%	-12.48%	★
Rotavirus	55.23%	52.55%	-4.85%	★
VZV	65.21%	58.15%	-10.83%	★
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	51.86%	33.24%	-35.90%	★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	59.82%	36.68%	-38.68%	★

MY 2022 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Women's Health Performance Measure Results

'Ohana QI's Women's Health performance measure results are shown in Table 3-52. All three measure indicator rates in this domain fell below the 25th percentile. Conversely, 'Ohana QI met MQD's established Quality Strategy target for the *Prenatal and Postpartum Care—Postpartum Care* measure rate.

Table 3-52—'Ohana QI's HEDIS Results for QI Measures Under Women's Health

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Cervical Cancer Screening				
Cervical Cancer Screening	43.55%	41.36%	-5.03%	★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	79.58%	67.02%	-15.78%	★
Postpartum Care	71.48%	66.67%	-6.73%	★

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by MQD.
MY 2022 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*

★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

Care for Chronic Conditions Performance Measure Results

'Ohana QI's Care for Chronic Conditions performance measure results are shown in Table 3-53. 'Ohana QI did not meet MQD's established Quality Strategy targets for any measures in this domain. Additionally, the one measure rate that could be compared to national benchmarks (i.e., *Controlling High Blood Pressure—Total)* benchmarked at or below the 50th percentile. With the exception of the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* measure, the remaining rates overall remained consistent with the prior MY.

Table 3-53—'Ohana QI's HEDIS Results for QI Measures Under Care for Chronic Conditions

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Hemoglobin A1c Control for Patients With Diabetes				
*HbA1c Poor Control (>9.0%)—Total**	37.47%	41.36%	10.38%	NC
HbA1c Control (<8.0%)—Total	52.55%	46.23%	-12.03%	NC
Eye Exam for Patients With Diabetes				
Eye Exam for Patients With Diabetes	54.01%	53.28%	-1.35%	NC
Blood Pressure Control for Patients With Diabetes				
Blood Pressure Control for Patients With Diabetes	53.28%	52.80%	-0.90%	NC
Concurrent Use of Opioids and Benzodiazepines*				
18–64 Years	19.90%	19.26%	-3.22%	NC
65 Years and Older	16.60%	18.72%	12.77%	NC
Total (18 Years and Older)	19.14%	19.14%	0.00%	NC
Controlling High Blood Pressure				
18–64 Years	57.20%	52.73%	-7.81%	NC
65–85 Years	61.49%	63.24%	2.85%	NC
Total (18-85 Years)	58.88%	56.20%	-4.55%	★★

** 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.
MY 2022 performance levels represent the following percentile comparisons:
★★★★★ = *90th percentile and above*
★★★★ = *75th to 89th percentile*
★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

Behavioral Health Performance Measure Results

'Ohana QI's Behavioral Health performance measure results are shown in Table 3-54. For the one measure in this domain that could be compared to national benchmarks, *Follow-Up After Hospitalization for Mental Illness,* four of the eight rates benchmarked below the 50th percentile. In addition, the *6–17* and *65 Years and Older* age stratifications for this measure were assigned a status of *NA* due to not enough members in the eligible population (i.e., <30) to report valid rates. Of note, the *7 Day Follow-Up—Total* rate demonstrated a relative decrease of more than 40 percent from the prior MY. NCQA recommended a break in trending for the *Initiation and Engagement of Substance Use Disorder Treatment* measure due to significant changes made to the MY 2022 specifications; therefore, the prior year's rates and benchmarks are not displayed. For the *Use of Pharmacotherapy for Opioid Use Disorder* measure, the *Total* and *Methadone* rates met MQD's established Quality Strategy targets for MY 2022.

Table 3-54—'Ohana QI's HEDIS Results for QI Measures Under Behavioral Health

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—6–17 Years	NA	NA	—	NC
7-Day Follow-Up—18–64 Years	54.96%	31.25%	-43.14%	★★
7-Day Follow-Up—65 Years and Older	NA	NA	—	NC
7-Day Follow-Up—Total	53.15%	31.25%	-41.20%	★★
30-Day Follow-Up—6–17 Years	NA	NA	—	NC
30-Day Follow-Up—18–64 Years	68.70%	51.14%	-25.56%	★★
30-Day Follow-Up—65 Years and Older	NA	NA	—	NC
30-Day Follow-Up—Total	67.13%	52.08%	-22.42%	★★
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation—Total—13–17 Years	—	NA	—	NC
Initiation—Total—18+ Years	—	35.30%	—	NC
Initiation—Total—Total	—	32.66%	—	NC
Engagement—Total—13–17 Years	—	NA	—	NC
Engagement—Total—18+ Years	—	9.53%	—	NC
Engagement—Total—Total	—	6.70%	—	NC
Screening for Depression and Follow-Up Plan				
12–17 Years	15.87%	19.19%	20.92%	NC
18–64 Years	7.86%	9.54%	21.37%	NC
65 Years and Older	23.27%	26.71%	14.78%	NC
Total Adult (18 Years and Older)	11.61%	13.14%	13.18%	NC
Use of Pharmacotherapy for Opioid Use Disorder				
Total (Rate 1)	50.70%	54.04%	6.59%	NC
Buprenorphine (Rate 2)	22.54%	20.35%	-9.72%	NC

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Oral Naltrexone (Rate 3)	0.35%	0.70%	100.00%	NC
Long-acting, Injectable Naltrexone (Rate 4)	0.00%	0.00%	—	NC
Methadone (Rate 5)	31.69%	35.44%	11.83%	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 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 2022 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Long-Term Services and Supports Performance Measure Results

'Ohana QI's Long-Term Services and Supports performance measure results are shown in Table 3-55. The measures in this domain did not have applicable benchmarks; therefore, no comparison to national benchmarks is presented. Further, there were no MQD Quality Strategy targets established.

Table 3-55—'Ohana QI's HEDIS Results for QI Measures Under Long-Term Services and Supports

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Long-Term Services and Supports Comprehensive Care Plan and Update				
Care Plan with Core Elements Documented	12.50%	8.33%	-33.36%	NC
Care plan with Supplemental Elements Documented	12.50%	8.33%	-33.36%	NC
Long-Term Services and Supports Comprehensive Assessment and Update				
Assessment of Core Elements Documented	—	19.79%	—	NC
Assessment of Supplemental Elements Documented	—	17.71%	—	NC
Long-Term Services and Supports Minimizing Institutional Length of Stay				
Observed Discharge Rate	8.95%	1.40%	-84.36%	NC
Expected Discharge Rate	29.01%	37.73%	30.06%	NC
Observed/Expected Ratio	0.3085	0.0371	-87.97%	NC

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

Conclusions and Recommendations

Based on HSAG's analyses of 'Ohana QI's 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*

Validation of Performance Improvement Projects

In CY 2022, MQD selected two new PIPs—*Behavioral Health Coordination* and *Plan All-Cause Readmissions* for all the health plans to complete. For the CY 2023 submission, the health plans progressed to the Design, Implementation, and Outcomes stages of the PIPs and submitted Steps 1 through 8 in the PIP Submission Form and were assessed for improvement in outcomes (Step 9).

Table 3-56 displays the topics, progression status, and measurement periods reported for the PIPs.

Table 3-56—CY 2023 Health Plan PIP Topics and Status

PIP Topic	PIP Progression Status	Baseline Measurement Period	Measurement Period Reported in CY 2022
Behavioral Health Coordination	PIP Design, 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)

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

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

Findings

Table 3-57 illustrates the validation results for the two PIPs submitted by ‘Ohana QI for CY 2023 validation.

Table 3-57—CY 2023 PIP Validation Results for ‘Ohana QI

PIP Topic	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Behavioral Health Coordination	84%	90%	*Partially Met*
Plan All-Cause Readmissions	95%	100%	*Met*

For the *Behavioral Health Coordination* PIP, ‘Ohana QI received an overall *Partially Met* validation status, with a *Met* score of 90 percent for critical evaluation elements and 84 percent for overall evaluation elements across all steps completed and validated.

For the *Plan All-Cause Readmissions* PIP, ‘Ohana QI received an overall *Met* validation status, with a *Met* score for 100 percent of critical evaluation elements and 95 percent of overall evaluation elements across all steps completed and validated.

Design (Steps 1-6)

Behavioral Health Coordination

‘Ohana QI met 100 percent of the evaluation elements in the Design stage. The selected PIP topic was required by MQD and MQD held workgroup sessions with HSAG, health plans, and DOH Behavioral Health Services Administration divisions to discuss the PIP design. The PIP Aim statement, the PIP population, and the two performance indicators were also discussed during the workgroup sessions. ‘Ohana QI documented the PIP design accurately and as discussed during the workgroup meetings. ‘Ohana QI’s data collection process as documented 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.

Plan All-Cause Readmissions

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

Implementation (Steps 7-8)

Behavioral Health Coordination

‘Ohana QI reported the Remeasurement 1 rates for the two performance indicators. There were errors in the reported data. HSAG could not calculate the documented remeasurement rates based on the numerator and denominator data included in the PIP Submission Form. Also, the health plan did not document whether there were any factors that may impact the comparability of the remeasurement data to the baseline. ‘Ohana QI documented its QI efforts, which included partnering with other health plans and working with its leadership team to determine a workflow for ongoing communication and information sharing. ‘Ohana QI also drafted DSAs with the DOH Behavioral Health Services Administration divisions.

Plan All-Cause Readmissions

‘Ohana QI accurately reported and analyzed the Remeasurement 1 rate for the performance indicator. ‘Ohana QI conducted appropriate QI 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.

Outcomes (Step 9)

Behavioral Health Coordination

During Remeasurement 1, the health plan documented statistically significant improvement over the baseline in the Performance Indicator 1 rate; however, there was a decline in the Performance Indicator 2 rate.

Plan All-Cause Readmissions

During Remeasurement 1, there was a decline in performance, and the readmission rate increased compared to the baseline.

Analysis of Results

Table 3-58 displays the data that the health plan reported for the *Behavioral Health Coordination* PIP.

Table 3-58—Performance Improvement Project Outcomes for the *Behavioral Health Coordination* PIP

Performance Indicator	Baseline* (07/01/2021–09/30/2021)		Remeasurement 1 (07/01/2022–09/30/2022)		Sustained Improvement
Percent of shared members with eligible trigger events who received a combined review in the past three months.	N: 2 D: 113	1.7%	N: 40 D: 108	37.0%**,^	
Percent of shared members whose data are actively shared at a regular frequency with partner agencies.	N: 113 D: 4,797	2.4%	N: 65 D: 4,563	1.4%^	

*Baseline data were updated by the health plan in the CY 2023 PIP submission. The health plans were in the initial stages of defining their data collection processes when the baseline data were reported in the previous year's submission. The health plans were allowed to update the baseline data in the CY 2023 PIP submission, as applicable for the defined data collection processes.

**Rate demonstrates statistically significant improvement over the baseline rate.

^The documented rate was calculated by HSAG based on the numerator and denominator in the PIP Submission Form. The health plan had reported an incorrect rate. N–Numerator D–Denominator

The baseline rate for the percentage of shared members with eligible trigger events who received a combined review during the baseline measurement period was 1.7 percent. For Remeasurement 1, the Performance Indicator 1 rate increased by 35.3 percentage points to 37.0 percent and represented a statistically significant improvement over the baseline.

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. For Remeasurement 1, the Performance Indicator 2 rate decreased to 1.4 percent.

Due to errors in the data reported by the health plan in the PIP Submission Form, the PIP results should be interpreted with caution.

Table 3-59 displays the data that the health plan reported for the *Plan All-Cause Readmissions* PIP.

Table 3-59—Performance Improvement Project 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)		Sustained Improvement
The observed Plan All-Cause Readmission Rate for all QUEST Integration members ages 18–64 years of age with an unplanned acute readmission for any diagnosis within 30 days	N: 133 D: 1,384	9.6%	N: 102 D: 1,026	9.9%	

N–Numerator D–Denominator

The baseline (CY 2021) rate for the percentage of eligible discharges for which members 18–64 years of age had at least one unplanned acute readmission for any diagnosis within 30 days of the index discharge date was 9.6 percent. During Remeasurement 1, there was a decline in performance and the readmission rate increased to 9.9 percent.

Barriers/Interventions

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

Table 3-60 displays the barriers and interventions as documented by the health plan for both PIPs.

Table 3-60—Interventions Implemented/Planned for 'Ohana QI 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 among health plans and CCS.	1. Drafting and executing Memorandums of Understanding (MOUs) with the partnering agencies regarding data sharing. 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.*

Barriers	Interventions
	2. Having a workgroup with partnering agencies that meets at least on a quarterly basis.* 3. Develop a workflow for ongoing communication between health plan and partnering agencies.*
Plan All-Cause Readmissions	
1. High utilizers with readmissions within 30 days or difficult discharges with no viable discharge plan. 2. Members readmitting due to avoidable reasons; members lost to contact upon leaving hospital. 3. Members readmitting due to avoidable reasons. 4. Members readmitting due to Congestive Heart Failure (CHF).	1. Multidisciplinary rounds within health plan to discuss high utilizers. *2.* Contact with all members post-discharge via transition of care process. 3. 7-Day Readmission Report that identifies the top readmitting diagnosis and top readmitting facilities. *4.* Adding CHF on Disease Management Program, and member outreach will be conducted.

* The documented interventions are required by MQD.

Strengths

- For *Plan All-Cause Readmissions* PIP, 'Ohana QI received an overall *Met* validation status.
- For the *Behavioral Health Coordination* PIP, during Remeasurement 1, the health plan documented statistically significant improvement over the baseline in the Performance Indicator 1 rate.

Areas for Improvement

- For the *Behavioral Health Coordination* PIP, during Remeasurement 1, there was a decline in the Performance Indicator 2 rate.
- For the *Behavioral Health Coordination* PIP, there were errors in the Performance Indicator 1 data reported by the health plan in the PIP Submission Form. The PIP results should be interpreted with caution.
- For the *Plan All-Cause Readmissions* PIP, during Remeasurement 1, 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 *Behavioral Health Coordination* PIP:
  - The health plan should continue to work toward improving its data sharing and care coordination efforts with the DOH Behavioral Health Services Administration divisions.

  - The health plan should continue with its efforts to capture the informal combined reviews based on the systems/data that it has and document how it is defining and capturing these data. The health plan should explore the possibilities of updating systems to capture more detailed information as part of this PIP for long-term care coordination needs.
  - The health plan must document whether there were any factors that threatened the comparability of the remeasurement data to the baseline data.
  - The health plan must also include quantitative data demonstrating intervention effectiveness. For example, for the DSAs, the health plan must provide data about improvement in 'Ohana QI data sharing with partnering agencies after the DSAs were executed.
  - The health plan must ensure that the intervention evaluation information pertains to the data sharing efforts by QUEST (not CCS) for this PIP submission.
- For the *Plan All-Cause Readmissions* PIP:
  - In Step 8 of the PIP Submission Form, the health plan must continue to document QI activities undertaken as part of the Readmissions Collaborative workgroup to improve the *PCR* rate.
- The health plan should continue to revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers, and to see if any new barriers exist that require the development of interventions.
- The health plan should have a process in place for evaluating each PIP intervention and its impact on the performance indicator. Interventions should be adapted or revised as needed.
- The health plan must address the *Validation Feedback* associated with any *Met* score and *Partially Met* comments in the next annual submission.
- The health plan should reference the PIP Completion Instructions to ensure that all requirements have been addressed when completing the PIP Submission Form.
- The health plan should seek technical assistance from HSAG and MQD throughout the PIP process to address any questions or concerns.

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

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

Findings

Table 3-61 presents the 2023 percentage of top-box responses (i.e., top-box scores) for 'Ohana QI compared to the 2022 NCQA child Medicaid national averages and the corresponding 2021 scores.[3-21, 3-22] Additionally, the overall member experience ratings (i.e., star ratings) resulting from 'Ohana QI's

[3-21] The child population was last surveyed in 2021; therefore, the 2023 child CAHPS scores are compared to the corresponding 2021 scores.

[3-22] National Committee for Quality Assurance. *HEDIS® Measurement Year 2022*, *Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2022.

2023 top-box scores compared to NCQA's 2022 Quality Compass Benchmark and Compare Quality Data are displayed below.[3-23]

Table 3-61—Child Medicaid CAHPS Results for 'Ohana QI

Measure	2021 Scores	2023 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	70.3%	67.6%	★
Rating of All Health Care	68.2%	69.4%	★★
Rating of Personal Doctor	73.3%	74.7%	★★
Rating of Specialist Seen Most Often	80.5%+	78.9%+	★★★★
Composite Measures			
Getting Needed Care	84.9%+	77.9%+	★
Getting Care Quickly	80.3%+	80.1%+	★
How Well Doctors Communicate	95.8%	90.6% ▼	★
Customer Service	91.3%+	81.7%+ ▼	★
Individual Item Measure			
Coordination of Care	88.0%+	77.4%+	★

Cells highlighted in yellow represent scores that are statistically significantly higher than the 2022 NCQA child Medicaid national averages.
Cells highlighted in red represent scores that are statistically significantly lower than the 2022 NCQA child Medicaid national averages.

▲ *Indicates the 2023 score is statistically significantly higher than the 2021 score.*

▼ *Indicates the 2023 score is statistically significantly lower than the 2021 score.*

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

Star Ratings based on percentiles:

★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th

Strengths

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

- *Rating of Specialist Seen Most Often*

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

[3-23] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2022.* Washington, DC: NCQA, September 2022.

should consider determining whether potential quality improvement activities could improve member experience on each of the key drivers identified. Table 3-62 provides a summary of the key drivers identified for ‘Ohana QI.

Table 3-62—’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.

Home and Community-Based CAHPS Survey

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

Findings

Table 3-63 presents the 2023 mean scores compared to the HI HCBS Program for ‘Ohana QI.[3-24]

Table 3-63—HCBS Survey Results for ‘Ohana QI

Measure	2023 ‘Ohana QI Mean Scores	2023 HI HCBS Program Mean Scores	Plan Comparison Significance
Global Ratings			
Rating of Personal Assistance and Behavioral Health Staff	94.7+	90.3	↑
Rating of Homemaker	93.8+	91.1+	—
Rating of Case Manager	86.5+	87.6	—
Composite Measures			
Reliable and Helpful Staff	87.2+	86.6	—
Staff Listen and Communicate Well	87.6+	84.9	↑
Helpful Case Manager	87.6+	86.3	—
Choosing the Services that Matter to You	88.6	83.0	↑
Transportation to Medical Appointments	80.9+	81.8	—
Personal Safety and Respect	89.0	89.2	—
Planning Your Time and Activities	63.4	65.8	—
Recommendation Measures			
Recommend Personal Assistance/Behavioral Health Staff	91.3+	86.2	↑
Recommend Homemaker	71.7+	81.8+	—
Recommend Case Manager	86.5+	84.5	—
Unmet Need and Physical Safety Measures			
No Unmet Need in Dressing/Bathing	NA	32.7+	NA
No Unmet Need in Meal Preparation/Eating	NA	20.5+	NA
No Unmet Need in Medication Administration	NA	40.6+	NA
No Unmet Need in Toileting	98.0+	94.9	—
No Unmet Need with Household Tasks	NA	NA	NA
Not Hit or Hurt by Staff	100.0	100.0	—

↑ Indicates the mean score is statistically significantly higher than the HI HCBS Program.
↓ Indicates the mean score is statistically significantly lower than the HI HCBS Program.
— Indicates the mean score is not statistically significantly different than the HI 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".

[3-24] For this report, only the composite measure mean scores are displayed. For more detailed results on the other response categories, please see the 2023 Hawaii HCBS CAHPS Survey full report.

Strengths

For ‘Ohana QI, the mean scores for the following four measures were statistically significantly higher than the HI HCBS Program mean scores:

- *Rating of Personal Assistance and Behavioral Health Staff*
- *Staff Listen and Communicate Well*
- *Choosing the Services that Matter to You*
- *Recommend Personal Assistance/Behavioral Health Staff*

In addition, the mean scores for the following five measures were higher than the HI HCBS Program mean scores:

- *Rating of Homemaker*
- *Reliable and Helpful Staff*
- *Helpful Case Manager*
- *Recommend Case Manager*
- *No Unmet Need in Toileting*

Areas for Improvement

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*

Provider Survey

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

Findings

Table 3-64 presents the 2023 top-box scores compared to the QI Program aggregate and the corresponding 2021 top-box scores, where applicable, on the six domains of satisfaction for ‘Ohana QI.[3-25]

[3-25] For this report, only the top-box scores are displayed. For more detailed results on the other response categories, please see the 2023 Hawaii Provider Survey full report.

Table 3-64—Provider Survey Results for 'Ohana QI

	2021 Top-Box Score	2023 Top-Box Score	2023 QI Program Top-Box Score	Plan Comparison Significance	Trend Analysis Significance
General Positions					
Compensation Satisfaction	18.7%	24.0%	38.6%	↓	—
Timeliness of Claims Payments	36.2%	31.7%	43.8%	↓	—
Providing Quality Care					
Formulary	7.0%	24.9%	29.7%	↓	—
Prior Authorization Process	8.3%	14.6%	19.8%	↓	—
Non-Formulary					
Adequate Access to Non-Formulary Drugs	15.8%	34.6%	41.4%	↓	—
Health Coordinators					
Helpfulness of Health Coordinators	28.2%	34.1%	44.8%	↓	—
Specialists					
Adequacy of Specialists	9.7%	15.1%	36.2%	↓	—
Availability of Mental Health Providers	9.2%	15.1%	18.0%	↓	—
Substance Abuse					
Access to Substance Abuse Treatment	11.3%	29.6%	30.4%	↓	—

↑ Indicates the QI health plan's top-box score is statistically significantly higher than the QI Program.
↓ Indicates the QI health plan's top-box score is statistically significantly lower than the QI Program.
▲ Indicates the 2023 top-box score is statistically significantly higher than the 2021 top-box score.
▼ Indicates the 2023 top-box score is statistically significantly lower than the 2021 top-box score.
— Indicates the 2023 top-box score is not statistically significantly different than the 2021 top-box score.
Results based on fewer than 11 respondents were suppressed and noted as "NA".

Strengths

For 'Ohana QI, the top-box scores for the following eight measures were higher in 2023 than in 2021, although no measure's top-box score was statistically significantly higher:

- *Compensation Satisfaction*
- *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*

Areas for Improvement

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*

Overall Assessment of Quality, Accessibility, and Timeliness of Care

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

Conclusions

In general, ‘Ohana QI’s performance results illustrate mixed performance across the six EQR activities. While the compliance monitoring review activity revealed that ‘Ohana QI has established an operational foundation to support the quality of, access to, and timeliness of care and service delivery, performance on outcome and process measures showed considerable room for improvement.

‘Ohana QI showed that it has systems, policies, and staff in place to ensure that its structure and operations support core processes for providing care and services and promoting quality outcomes.

'Ohana QI's performance during the 2023 compliance review was above average, meeting or exceeding the statewide compliance score for all seven standards. 'Ohana QI achieved 100 percent compliance in six standards and 99 percent in the Credentialing standard. 'Ohana QI was required to develop a CAP to address and resolve the deficiencies identified in the review. HSAG and MQD provided feedback and will continue to monitor 'Ohana QI's CAP activities until the health plan is found to be in full compliance.

Overall, more than two-thirds (96.4 percent) of 'Ohana QI's performance measures fell below the 50th percentile across all domains, with three-fourths (75.0 percent) of the measure rates falling below the 25th percentile. While some measures showed improvement from HEDIS MY 2022, '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, Chronic Conditions, and Behavioral Health domains. Additionally, 'Ohana QI should continue to evaluate the impact of the changes in its approach to managing provider specialty information. Four MQD Quality Strategy targets were met or exceeded in HEDIS MY 2022.

'Ohana QI's CAHPS results illustrate opportunities for improvement in members' experience. The following two measures scored statistically significantly lower in 2023 than in 2021: *How Well Doctors Communicate* and *Customer Service*. The following measure scored statistically significantly lower than the 2022 NCQA child Medicaid national average: *How Well Doctors Communicate*. Additionally, the following eight measures were below the 50th percentiles: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Personal Doctor*, *Getting Needed Care*, *Getting Care Quickly*, *How Well Doctors Communicate*, *Customer Service*, and *Coordination of Care*. These results indicate the need for 'Ohana QI to implement improvement strategies to ensure that members have high-quality care and timely access to care.

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

'Ohana QI's HCBS Survey results illustrated positive results and opportunities for improvement in members' experience. The following mean scores were statistically significantly higher than the HI HCBS Program: *Rating of Personal Assistance and Behavioral Health Staff*, *Staff Listen and Communicate Well, Choosing the Services that Matter to You,* and *Recommend Personal Assistance/Behavioral Health Staff.* Additionally, the following nine measures were higher than the HI HCBS Program: *Rating of Personal Assistance and Behavioral Health Staff, Rating of Homemaker, Reliable and Helpful Staff, Staff Listen and Communicate Well, Helpful Case Manager, Choosing the Services that Matter to You, Recommend Personal Assistance/Behavioral Health Staff, Recommend Case Manager,* and *No Unmet Need in Toileting.* While none of the measures scored statistically significantly lower than the HI HCBS Program, the *Rating of Case Manager, Transportation to Medical Appointments, Personal Safety and Respect, Planning Your Time and Activities,* and *Recommend Homemaker* measures scored lower than the HI HCBS Program, indicating a need for 'Ohana QI to implement strategies to ensure members have high-quality care and timely access to care.

The 2023 Provider Survey results illustrate the need for ‘Ohana QI to investigate the reasons for significant provider dissatisfaction and implement quality improvement strategies to address the areas of concern. None of the top-box scores were statistically significantly higher than the QI Program or 2021 top-box scores. The 2023 top-box scores for all nine measures were statistically significantly lower than the QI Program aggregate rates. These results indicate that providers are experiencing significant difficulties in providing high-quality and timely services and care to ‘Ohana QI members.

Finally, ‘Ohana QI progressed to the Outcomes stage of the two PIPs initiated in CY 2022. The topics addressed CMS’ requirements related to quality outcomes—specifically, the timeliness of and access to care and services. For the *Behavioral Health Coordination* PIP, ‘Ohana QI received an overall *Partially Met* validation status. During Remeasurement 1, the health plan documented statistically significant improvement over the baseline in the Performance Indicator 1 rate; however, there was a decline in the Performance Indicator 2 rate. The health plan had been sharing data with 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 *Met* validation status. The documented PIP design and data were accurate. The health plan conducted appropriate quality improvement processes to identify barriers, and it deployed interventions that were logically linked to the identified barriers. During Remeasurement 1, the health plan did not achieve any improvement over the baseline.

UnitedHealthcare Community Plan QUEST Integration (UHC CP QI) Results

Compliance Monitoring Review

The 2023 compliance monitoring review activity included evaluation of the health plan's compliance with State and federal requirements for organizational and structural performance.

Findings

Table 3-65 presents the standards and compliance scores for UHC CP QI.

Table 3-65—Standards and Compliance Scores—UnitedHealthcare Community Plan QUEST Integration

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Provider Selection	17	17	17	0	0	0	100%
II	Credentialing	44	44	44	0	0	0	100%
III	Subcontractual Relationships and Delegation	6	6	6	0	0	0	100%
IV	Health Information Systems	9	9	9	0	0	0	100%
V	Quality Assessment and Performance Improvement	7	7	7	0	0	0	100%
VI	Practice Guidelines	6	6	6	0	0	0	100%
VII	Enrollment and Disenrollment	5	5	5	0	0	0	100%
	Totals	**94**	**94**	**94**	**0**	**0**	**0**	**100%**

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

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

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

Strengths

UHC CP QI was found to be fully compliant in all seven standards reviewed in 2023.

Provider Selection—UHC CP QI had a comprehensive process for the selection of its network providers to sufficiently meet the needs of its QI members. Additionally, the health plan had a comprehensive compliance and ethics plan, including policies and procedures to assist UHC CP QI in guarding against fraud, waste, and abuse. The health plan demonstrated effective processes for monitoring, auditing, and identifying compliance risks.

Credentialing—UHC CP QI had comprehensive policies, procedures, and processes in place for the credentialing and recredentialing of licensed practitioners, allied health professionals, facilities/organizations, and LTSS providers delivering care to the health plan's QUEST members that aligned with NCQA credentialing standards.

Subcontractual Relationships and Delegation—UHC CP QI had appropriate subcontracts in place and had adequate oversight and monitoring processes to ensure that its delegates are meeting their contractual obligations.

Health Information Systems—UHC CP QI maintained a health information system that collects, analyzes, integrates, and reports data on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility.

Quality Assessment and Performance Improvement—UHC CP QI's QAPI program was supported by a comprehensive program description, work plan, and evaluation of the prior year's quality improvement program achievements. The QAPI program provided the framework to systematically measure and analyze performance and impart essential information that aided management in decision-making to improve organizational functions, structures, and processes to improve QI member outcomes.

Practice Guidelines—UHC CP QI adopted evidence-based practice guidelines, disseminated its practice guidelines to all affected providers, and rendered utilization management and coverage of services decisions consistent with its practice guidelines.

Enrollment and Disenrollment—UHC CP QI had systems, processes, and workflows to accept all individuals enrolled into its health plan without restrictions. UHC CP QI did not request disenrollment of members for reasons other than those permitted under the contract and had processes in place to notify the State when it becomes aware of a change in a member's circumstance that might affect the member's eligibility.

Areas for Improvement

HSAG did not identify any areas for improvement, as UHC CP QI achieved 100 percent compliance in all standards reviewed in 2023.

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 8.0 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 19 supplemental data sources for consideration to use for supplementing its MY 2022 performance measure rates. HSAG determined nine

data sources to be non-standard supplemental data, and the remaining 10 were considered standard supplemental data. UHC CP QI withdrew one of the non-standard data sources from reporting. HSAG reviewed the remaining 18 data sources, and no concerns were identified. All 18 supplemental data sources were approved for HEDIS MY 2022 reporting.

UHC CP QI was required to undergo convenience sample validation for the *Prenatal and Postpartum Care—Postpartum Care* and *Childhood Immunization Status—Combination 10* measure indicators, as well as medical record exclusions. All cases successfully passed the validation process. The final statistical MRRV was conducted for the *Blood Pressure Control for Patients With Diabetes, Hemoglobin A1c Control for Patients With Diabetes—Hemoglobin A1c Control (<8.0%), Childhood Immunization Status—Combination 3,* and *Eye Exam for Patients With Diabetes* 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 3-66. The *Plan All-Cause Readmissions—Index Total Stays—O/E Ratio—Total* measure indicator rate fell below the 50th percentile. All other measure indicators in this domain did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented. Both measures in this domain had an MQD Quality Strategy target (*Heart Failure Admission Rate—Total* and *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Total*), and UHC CP QI met the established target for the *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Total* rate for HEDIS MY 2022.

Table 3-66—UHC CP QI's HEDIS Results for QI Measures Under Access and Risk-Adjusted Utilization

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Heart Failure Admission Rate (per 100,000 member months)*				
18–64 Years	46.28	48.16	4.07%	NC
65 Years and Older	121.71	117.89	-3.14%	NC
Total (18 Years and Older)	66.62	69.70	4.62%	NC
Plan All-Cause Readmissions				
*Index Total Stays—Observed Readmissions—Total**	11.73%	11.35%	-3.24%	NC
Expected Readmissions—Total	11.06%	11.06%	0.00%	NC
*Index Total Stays—O/E Ratio—Total**	1.0604	1.0256	-3.28%	★★

** 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.
MY 2022 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Children's Preventive Health Performance Measure Results

UHC CP QI's Children's Preventive Health performance measure results are shown in Table 3-67. UHC CP QI did not meet MQD's established Quality Strategy targets for any measures in this domain. 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* rate ranked at or above the 50th percentile. The *Childhood Immunization Status—Combination 10* and *Influenza* rates benchmarked below the 50th percentile. All remaining rates fell below the 25th percentile. Overall, the rates in this domain remained consistent with the prior MY; however, of note, 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* rate demonstrated a relative increase of more than 10 percent from the prior MY.

Table 3-67—UHC CP QI's HEDIS Results for QI Measures Under Children's Preventive Health

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Child and Adolescent Well-Care Visits				
3–11 Years	41.74%	45.95%	10.09%	★
12–17 Years	36.51%	36.11%	-1.10%	★
18–21 Years	14.08%	16.71%	18.68%	★
Total (3-21 Years)	35.16%	38.61%	9.81%	★
Childhood Immunization Status				
Combination 3	51.58%	49.88%	-3.30%	★
Combination 7	44.53%	45.01%	1.08%	★
Combination 10	35.28%	30.90%	-12.41%	★★
DTaP	54.74%	53.77%	-1.77%	★
Hepatitis A	67.88%	68.61%	1.08%	★
Hepatitis B	75.18%	75.67%	0.65%	★
HiB	71.53%	73.72%	3.06%	★
Influenza	50.36%	44.04%	-12.55%	★★
IPV	72.75%	75.43%	3.68%	★
MMR	69.59%	70.07%	0.69%	★
Pneumococcal Conjugate	55.47%	55.47%	0.00%	★
Rotavirus	59.61%	62.53%	4.90%	★
VZV	68.86%	70.07%	1.76%	★

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 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	49.58%	56.67%	14.30%	★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	52.88%	53.62%	1.40%	★

MY 2022 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Women's Health Performance Measure Results

UHC CP QI's Women's Health performance measure results are shown in Table 3-68. Overall, the rates in this domain remained consistent with the prior MY. All three measure rates in this domain had an MQD Quality Strategy target for HEDIS MY 2022. UHC CP QI met the quality target for the *Prenatal and Postpartum Care—Postpartum Care* measure rate and benchmarked at or above the 50th percentile. Conversely, the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Cervical Cancer Screening* rates fell below the 25th percentile.

Table 3-68—UHC CP QI's HEDIS Results for QI Measures Under Women's Health

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Cervical Cancer Screening				
Cervical Cancer Screening	50.85%	45.26%	-10.99%	★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	78.35%	73.24%	-6.52%	★
Postpartum Care	78.10%	79.08%	1.25%	★★★

Cells highlighted yellow indicate that the health plan met or exceeded the target threshold established by MQD.
MY 2022 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Care for Chronic Conditions Performance Measure Results

UHC CP QI's Care for Chronic Conditions performance measure results are shown in Table 3-69. The *Concurrent Use of Opioids and Benzodiazepines—Total* and *Controlling High Blood Pressure—Total*

rates met MQD's established Quality Strategy targets for MY 2022. Additionally, the *Controlling High Blood Pressure—Total* rate benchmarked at or above the 90th percentile. The *Hemoglobin A1c Control—HbA1c Poor Control (>9.0%), Eye Exam for Patients With Diabetes, Blood Pressure Control for Patients With Diabetes,* and *Concurrent Use of Opioids and Benzodiazepines* rates remained consistent with the prior MY; however, of note, the *HbA1c Control for Patients With Diabetes—HbA1c Control (<8.0%)* and *Controlling High Blood Pressure* measure rates demonstrated a relative increase of more than 10 percent from the prior MY.

Table 3-69—UHC CP QI's HEDIS Results for QI Measures Under Care for Chronic Conditions

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Hemoglobin A1c Control for Patients With Diabetes				
*HbA1c Poor Control (>9.0%)—Total**	29.20%	27.25%	-6.68%	NC
HbA1c Control (<8.0%)—Total	57.42%	63.26%	10.17%	NC
Eye Exam for Patients With Diabetes				
Eye Exam for Patients With Diabetes	63.26%	60.34%	-4.62%	NC
Blood Pressure Control for Patients With Diabetes				
Blood Pressure Control for Patients With Diabetes	69.59%	68.61%	-1.41%	NC
Concurrent Use of Opioids and Benzodiazepines*				
18–64 Years	14.20%	12.05%	-15.14%	NC
65 Years and Older	14.52%	16.50%	13.64%	NC
Total (18 Years and Older)	14.33%	14.09%	-1.67%	NC
Controlling High Blood Pressure				
18–64 Years	53.33%	61.76%	15.81%	NC
65–85 Years	73.15%	81.33%	11.18%	NC
Total (18–85 Years)	63.75%	73.24%	14.89%	★★★★★

** 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.
MY 2022 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Behavioral Health Performance Measure Results

UHC CP QI's Behavioral Health performance measure results are shown in Table 3-70. Four of the *Follow-Up After Hospitalization for Mental Illness* measure rates that could be compared to national benchmarks ranked at or above the 50th percentile, with three of these rates ranking at or above the 75th percentile. The *Screening for Depression and Follow-Up Plan—Total Adult* rate showed a relative

increase of more than 50 percent, and the *Use of Pharmacotherapy for Opioid Use Disorder—Total, Long-acting, Injectable Naltrexone,* and *Methadone* measure rates demonstrated a relative increase of more than 9 percent. UHC CP QI met or exceeded the established MQD Quality Strategy target for five measure rates for HEDIS MY 2022.

Table 3-70—UHC CP QI's HEDIS Results for QI Measures Under Behavioral Health

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—6–17 Years	NA	NA	—	NC
7-Day Follow-Up—18–64 Years	47.67%	51.19%	7.38%	★★★★
7-Day Follow-Up—65 Years and Older	NA	NA	—	NC
7-Day Follow-Up—Total	47.37%	48.54%	2.47%	★★★★
30-Day Follow-Up—6–17 Years	NA	NA	—	NC
30-Day Follow-Up—18–64 Years	63.21%	67.86%	7.36%	★★★★
30-Day Follow-Up—65 Years and Older	NA	NA	—	NC
30-Day Follow-Up—Total	62.72%	64.56%	2.93%	★★★
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation—Total—13–17 Years	—	NA	—	NC
Initiation—Total—18+ Years	—	35.50%	—	NC
Initiation—Total—Total	—	36.51%	—	NC
Engagement—Total—13–17 Years	—	NA	—	NC
Engagement—Total—18+ Years	—	11.71%	—	NC
Engagement—Total—Total	—	7.07%	—	NC
Screening for Depression and Follow-Up Plan				
12–17 Years	16.43%	16.99%	3.41%	NC
18–64 Years	7.65%	13.13%	71.63%	NC
65 Years and Older	27.74%	36.97%	33.27%	NC
Total Adult (18 Years and Older)	14.81%	22.76%	53.68%	NC
Use of Pharmacotherapy for Opioid Use Disorder				
Total (Rate 1)	45.78%	50.15%	9.55%	NC
Buprenorphine (Rate 2)	23.43%	22.94%	-2.09%	NC
Oral Naltrexone (Rate 3)	0.82%	0.31%	-62.20%	NC
Long-acting, Injectable Naltrexone (Rate 4)	0.27%	0.31%	14.81%	NC
Methadone (Rate 5)	23.71%	28.44%	19.95%	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 QI health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
— Indicates that the plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.
MY 2022 performance levels represent the following percentile comparisons:

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

Long-Term Services and Supports Performance Measure Results

UHC CP QI's Long-Term Services and Supports performance measure results are shown in Table 3-71. The measures in this domain did not have applicable benchmarks; therefore, no comparison to national benchmarks is presented. Further, there were no MQD Quality Strategy targets established for the measures in this domain. All rates were determined to be *Reportable.*

Table 3-71—UHC CP QI's HEDIS Results for QI Measures Under Long-Term Services and Supports

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Long-Term Services and Supports Comprehensive Care Plan and Update				
Care Plan with Core Elements Documented	6.25%	13.54%	116.64%	NC
Care plan with Supplemental Elements Documented	6.25%	13.54%	116.64%	NC
Long-Term Services and Supports Comprehensive Assessment and Update				
Assessment of Core Elements Documented	—	11.46%	—	NC
Assessment of Supplemental Elements Documented	—	11.46%	—	NC
Long-Term Services and Supports Minimizing Institutional Length of Stay				
Observed Discharge Rate	19.88%	27.68%	39.24%	NC
Expected Discharge Rate	33.16%	33.44%	0.84%	NC
Observed/Expected Ratio	0.5994	0.8276	38.12%	NC

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

Conclusions and Recommendations

Based on HSAG's analyses of UHC CP QI's 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*

Validation of Performance Improvement Projects

In CY 2022, MQD selected two new PIPs—*Behavioral Health Coordination* and *Plan All-Cause Readmissions* for all the health plans to complete. For the CY 2023 submission, the health plans progressed to the Design, Implementation, and Outcomes stages of the PIPs and submitted Steps 1 through 8 in the PIP Submission Form and were assessed for improvement in outcomes (Step 9).

Table 3-72 displays the topics, progression status, and measurement periods reported for the PIPs.

Table 3-72—CY 2022 Health Plan 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)

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

MQD in consultation with the health plans, DOH Behavioral Health Services Administration divisions, and HSAG.

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

Findings

Table 3-73 illustrates the validation results for the two PIPs submitted by UHC CP QI for CY 2023 validation.

Table 3-73—CY 2023 PIP Validation Results for UHC CP QI

PIP Topic	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Behavioral Health Coordination	100%	100%	*Met*
Plan All-Cause Readmissions	95%	100%	*Met*

For both PIPs, UHC CP QI received an overall *Met* validation status.

Design (Steps 1-6)

Behavioral Health Coordination

UHC CP QI met 100 percent of the requirements in the Design stage. The selected PIP topic was required by MQD and MQD held workgroup meetings with health plans, DOH Behavioral Health Services Administration divisions, and HSAG to discuss the PIP design. The PIP Aim statement, the PIP population, and the two performance indicators were also discussed during the workgroup sessions. UHC CP QI documented the PIP design accurately and as discussed during the workgroup meetings. UHC CP QI's data collection process 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.

Plan All-Cause Readmissions

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

Implementation (Steps 7-8)

Behavioral Health Coordination

UHC CP QI reported and analyzed the Remeasurement 1 rates as available for the two performance indicators. UHC CP QI documented its QI efforts toward implementing MQD-required interventions for this PIP. UHC CP QI drafted DSAs with the DOH Behavioral Health Services Administration divisions and CCS for review to enable and establish an automated process that allows real-time information to be shared. The health plan also implemented a new documentation process for combined reviews and completed a training on the new process for its clinical and BH teams.

Plan All-Cause Readmissions

UHC CP QI accurately reported and analyzed the Remeasurement 1 rate for the performance indicator. UHC CP QI conducted appropriate QI 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.

Outcomes (Step 9)

Behavioral Health Coordination

UHC CP QI reported the third quarter of CY 2022 as the Remeasurement 1 period for this PIP. The health plan achieved statistically significant improvement over the baseline during the Remeasurement 1 period for Performance Indicator 1. A decline from the baseline rate was noted in the Performance Indicator 2 rate. Additionally, the health plan documented that significant programmatic improvement was achieved by providing training to all case management staff regarding the identification of shared members for performing combined reviews.

Plan All-Cause Readmissions

UHC CP QI reported CY 2022 as the Remeasurement 1 period for this PIP. The health plan achieved non-statistically significant improvement in the Remeasurement 1 rate over the baseline.

Analysis of Results

Table 3-74 displays the data that the health plan reported for the *Behavioral Health Coordination* PIP.

Table 3-74—Performance Improvement Project Outcomes for the *Behavioral Health Coordination* PIP

Performance Indicator	Baseline (07/01/2021–09/30/2021)		Remeasurement 1 (07/01/2022–09/30/2022)		Sustained Improvement
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%*	
Percent of shared members whose data are actively shared at a regular frequency with partner agencies.	N: 849 D: 2634	32.2%	N: 854 D: 2,768	30.9%	

*Rate demonstrates statistically significant improvement over the baseline rate. N–Numerator D–Denominator

The baseline rate for the percentage of shared members with eligible trigger events who received a combined review during the baseline measurement period (third quarter of 2021) was 20.6 percent. During Remeasurement 1, the rate increased to 38.1 percent, which represents a statistically significant improvement over the baseline.

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. During Remeasurement 1, UHC CP QI documented a Performance Indicator 2 rate of 30.9 percent, which represents a decrease of 1.3 percentage points from the baseline.

Table 3-75 displays the data that the health plan reported for the *Plan All-Cause Readmissions* PIP.

Table 3-75—Performance Improvement Project 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)		Sustained Improvement
For members 18–64 years of age, the number of acute inpatient and observation stay discharges during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days.	N: 133 D: 1,134	11.7%	N: 128 D: 1,128	11.4%	

N–Numerator D–Denominator

The baseline (CY 2021) rate for the percentage of eligible discharges for which members 18–64 years of age had at least one unplanned acute readmission for any diagnosis within 30 days of the index discharge date was 11.7 percent. During Remeasurement 1, there was an improvement of 0.3 percentage points in the performance indicator rate (a decrease in the readmission rate is favorable); however, the improvement was not statistically significant.

Barriers/Interventions

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

Table 3-76 displays the barriers and interventions as documented by the health plan for both PIPs.

Table 3-76—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/BH staff. 5. Draft standard operating procedures (SOP) on workflow processes for data sharing and execute upon agreement with partnering agencies. 6. Develop a workflow for ongoing communication between health plan and partnering agencies.* 7. Having a workgroup with partnering agencies that meets at least on a quarterly basis.* 8. Drafting and executing Memorandums of Understanding (MOUs) with the partnering agencies regarding data sharing. 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.* 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.	1. Expand member engagement to include family and/or other natural supports to promote the importance of follow-up care.

Barriers	Interventions
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.). 6. Lack of resources or inadequate or limited (untimely) access to services/support post-discharge. 7. Members with an underlying, untreated BH condition. 8. Untimely notification of discharges/discharge summary to the PCP and health plan (from the hospital). 9. Limited/inadequate resources to conduct follow-up (e.g., staffing shortages). 10. Lack of clarity in processes and workflows across entities (health plans, hospitals, PCPs).	2. Develop process to obtain information from the member before discharge and collaborate with the PCP or other provider(s) to obtain information after discharge. 3. Member outreach program to include culturally appropriate education or materials to reiterate discharge instructions and medication plan with the member, family, or other natural supports. 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. Early identification of services and supports needed and develop contingency plans. 7. Create a process with specific parameters for when to assess or screen for underlying, untreated BH conditions and coordinate with DOH agencies on providing services and supports for the member. 8. Provider education for hospitals on timely notification of discharges. 9. Collaborate with providers (e.g., accountable care organizations) to conduct follow-up after discharge, such as appointment reminders and scheduling. 10. Collaborative workgroup with hospitals and health plans to align activities and processes across entities.

* The documented interventions are required by MQD.

Strengths

- For both PIPs, UHC CP QI received an overall *Met* validation status.
- For the *Behavioral Health Coordination* PIP, the health plan achieved statistically significant improvement over the baseline during the Remeasurement 1 period for Performance Indicator 1.
- For the *Plan All-Cause Readmissions* PIP, the health plan achieved non-statistically significant improvement in the performance indicator rate during Remeasurement 1.

Areas for Improvement

- For the *Behavioral Health Coordination* PIP, decline from the baseline rate was noted in the Performance Indicator 2 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 must continue to document its progress toward implementing the interventions and expanding the data sharing efforts with all the partnering agencies.
- For the *Plan All-Cause Readmissions* PIP:
  - In Step 8 of the PIP Submission Form, the health plan must continue to document QI activities undertaken as part of the Readmissions Collaborative workgroup to improve the PCR rate.
- 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 QI tool(s) used to complete its causal/barrier analysis.
- The health plan must have a process in place for evaluating each PIP intervention and its impact on the performance indicator. Interventions should be adapted or revised as needed. Quantitative intervention evaluation data for each intervention must be included.
- The health plan must address any validation feedback provided in the final PIP Submission Form in the next annual submission.
- The health plan should reference the PIP Completion Instructions to ensure that all requirements have been addressed when completing the PIP Submission Form.
- The health plan should seek technical assistance from HSAG and MQD throughout the PIP process to address any questions or concerns.

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

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

Findings

Table 3-77 presents the 2023 percentage of top-box responses (i.e., top-box scores) for UHC CP QI compared to the 2022 NCQA child Medicaid national averages and the corresponding 2021 scores.[3-26, 3-27] Additionally, the overall member experience ratings (i.e., star ratings) resulting from UHC CP QI's

[3-26] The child population was last surveyed in 2021; therefore, the 2023 child CAHPS scores are compared to the corresponding 2021 scores.

[3-27] National Committee for Quality Assurance. *HEDIS® Measurement Year 2022*, *Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2022.

2023 top-box scores compared to NCQA's 2022 Quality Compass Benchmark and Compare Quality Data are displayed below.[3-28]

Table 3-77—Child Medicaid CAHPS Results for UHC CP QI

Measure	2021 Scores	2023 Scores	Star Ratings
Global Ratings			
Rating of Health Plan	73.3%	66.2%	★
Rating of All Health Care	78.2%	67.8%+	★★
Rating of Personal Doctor	80.3%	78.4%	★★★
Rating of Specialist Seen Most Often	83.7%+	66.7%+	★
Composite Measures			
Getting Needed Care	80.7%+	79.0%+	★
Getting Care Quickly	76.0%+	80.0%+	★
How Well Doctors Communicate	94.6%	96.0%+	★★★★
Customer Service	87.7%+	90.6%+	★★★★
Individual Item Measure			
Coordination of Care	86.7%+	88.2%+	★★★★

Cells highlighted in yellow represent scores that are statistically significantly higher than the 2022 NCQA child Medicaid national averages.

Cells highlighted in red represent scores that are statistically significantly lower than the 2022 NCQA child Medicaid national averages.

▲ *Indicates the 2023 score is statistically significantly higher than the 2021 score.*

▼ *Indicates the 2023 score is statistically significantly lower than the 2021 score.*

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

Star Ratings based on percentiles:

★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th

Strengths

For UHC CP QI's child Medicaid population, the following measures met or exceeded the 75th percentile:

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

[3-28] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2022.* Washington, DC: NCQA, September 2022.

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

Areas for Improvement

HSAG performed an analysis of the key drivers of member experience for the following three global ratings: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*. UHC CP QI should consider determining whether potential quality improvement activities could improve member experience on each of the key drivers identified. Table 3-78 provides a summary of the key drivers identified for UHC CP QI.

Table 3-78—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.

Home and Community-Based CAHPS Survey

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

Findings

Table 3-79 presents the 2023 mean scores compared to the HI HCBS Program for UHC CP QI.[3-29]

Table 3-79—HCBS Survey Results for UHC CP QI

Measure	2023 UHC CP QI Mean Scores	2023 HI HCBS Program Mean Scores	Plan Comparison Significance
Global Ratings			
Rating of Personal Assistance and Behavioral Health Staff	91.1	90.3	—
Rating of Homemaker	94.0+	91.1+	—
Rating of Case Manager	88.6	87.6	—
Composite Measures			
Reliable and Helpful Staff	87.1+	86.6	—
Staff Listen and Communicate Well	86.3+	84.9	↑
Helpful Case Manager	88.1+	86.3	—
Choosing the Services that Matter to You	81.2	83.0	—
Transportation to Medical Appointments	83.6	81.8	—
Personal Safety and Respect	89.6	89.2	—
Planning Your Time and Activities	67.5	65.8	—
Recommendation Measures			
Recommend Personal Assistance/Behavioral Health Staff	86.6	86.2	—
Recommend Homemaker	87.7+	81.8+	—
Recommend Case Manager	84.9	84.5	—
Unmet Need and Physical Safety Measures			
No Unmet Need in Dressing/Bathing	33.3+	32.7+	—
No Unmet Need in Meal Preparation/Eating	NA	20.5+	NA

[3-29] For this report, only the composite measure mean scores are displayed. For more detailed results on the other response categories, please see the 2023 Hawaii HCBS CAHPS Survey full report.

Measure	2023 UHC CP QI Mean Scores	2023 HI HCBS Program Mean Scores	Plan Comparison Significance
No Unmet Need in Medication Administration	NA	40.6+	NA
No Unmet Need in Toileting	98.0+	94.9	—
No Unmet Need with Household Tasks	NA	NA	NA
Not Hit or Hurt by Staff	100.0	100.0	—

↑ Indicates the mean score is statistically significantly higher than the HI HCBS Program.
↓ Indicates the mean score is statistically significantly lower than the HI HCBS Program.
— Indicates the mean score is not statistically significantly different than the HI 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 UHC CP QI, the mean score for the following measure was statistically significantly higher than the HI HCBS Program mean scores:

- *Staff Listen and Communicate Well*

In addition, the mean scores for the following 12 measures were higher than the HI HCBS Program mean scores:

- *Rating of Personal Assistance and Behavioral Health Staff*
- *Rating of Homemaker*
- *Rating of Case Manager*
- *Reliable and Helpful Staff*
- *Helpful Case Manager*
- *Transportation to Medical Appointments*
- *Personal Safety and Respect*
- *Planning Your Time and Activities*
- *Recommend Personal Assistance/Behavioral Health Staff*
- *Recommend Homemaker*
- *Recommend Case Manager*
- *No Unmet Need in Dressing/Bathing*
- *No Unmet Need in Toileting*

Areas for Improvement

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*

Provider Survey

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

Findings

Table 3-80 presents the 2023 top-box scores compared to the QI Program aggregate and the corresponding 2021 top-box scores, where applicable, on the six domains of satisfaction for UHC CP QI.[3-30]

Table 3-80—Provider Survey Results for UHC CP QI

	2021 Top-Box Score	2023 Top-Box Score	2023 QI Program Top-Box Score	Plan Comparison Significance	Trend Analysis Significance
General Positions					
Compensation Satisfaction	23.4%	39.8%	38.6%	—	—
Timeliness of Claims Payments	41.8%	40.2%	43.8%	—	—
Providing Quality Care					
Formulary	13.6%	28.5%	29.7%	—	—
Prior Authorization Process	13.8%	17.0%	19.8%	—	—
Non-Formulary					
Adequate Access to Non-Formulary Drugs	17.7%	31.9%	41.4%	↓	—
Health Coordinators					
Helpfulness of Health Coordinators	27.6%	35.1%	44.8%	↓	—

[3-30] For this report, only the top-box scores are displayed. For more detailed results on the other response categories, please see the 2023 Hawaii Provider Survey full report.

	2021 Top-Box Score	2023 Top-Box Score	2023 QI Program Top-Box Score	Plan Comparison Significance	Trend Analysis Significance
Specialists					
Adequacy of Specialists	21.0%	22.5%	36.2%	↓	—
Availability of Mental Health Providers	13.2%	16.1%	18.0%	—	—
Substance Abuse					
Access to Substance Abuse Treatment	21.0%	29.6%	30.4%	↓	—

↑ *Indicates the QI health plan's top-box score is statistically significantly higher than the QI Program.*
↓ *Indicates the QI health plan's top-box score is statistically significantly lower than the QI Program.*
▲ *Indicates the 2023 top-box score is statistically significantly higher than the 2021 top-box score.*
▼ *Indicates the 2023 top-box score is statistically significantly lower than the 2021 top-box score.*
— *Indicates the 2023 top-box score is not statistically significantly different than the 2021 top-box score.*
Results based on fewer than 11 respondents were suppressed and noted as "NA".

Strengths

For UHC CP QI, the 2023 top-box score for the following measure was higher than the QI Program aggregate, although no measure's top-box score was statistically significantly higher:

- *Compensation Satisfaction*

In addition, the top-box score for the following eight measures was higher in 2023 than in 2021, although no measure's top-box score was statistically significantly higher:

- *Compensation Satisfaction*
- *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*

Areas for Improvement

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*

Overall Assessment of Quality, Accessibility, and Timeliness of Care

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

Conclusions

In general, UHC CP QI's performance results illustrate mixed performance across the six EQR activities. While the compliance monitoring review activity revealed that UHC CP QI has established an operational foundation to support the quality of, access to, and timeliness of care and service delivery, performance on outcome and process measures showed considerable room for improvement.

UHC CP QI showed that it has systems, policies, and staff in place to ensure that its structure and operations support core processes for providing care and services and promoting quality outcomes. UHC CP QI's performance during the 2023 compliance review was above average, meeting or exceeding the statewide compliance score for all seven standards.

While UHC CP QI performed well on the Care for Chronic Conditions performance measures, nearly two-thirds (75.0 percent) of UHC CP QI's measure rates fell below the 50th percentile, with more than half (64.3 percent) of the measure rates falling below the 25th percentile. While some measures showed improvement from HEDIS MY 2022, UHC CP QI's performance demonstrated the need to improve process and outcome measures across most domains. In particular, UHC CP QI should address performance in the Children's Preventive Health, Women's Health, and Access and Risk-Adjusted Utilization domains. Overall, nine MQD Quality Strategy targets were met in HEDIS MY 2022.

UHC CP QI's CAHPS results illustrate opportunities for improvement in members' experience. While none of the measures scored statistically significantly lower in 2023 than in 2021, and none of the measures scored statistically significantly lower than the 2022 NCQA child Medicaid national averages, the following five measures were below the 50th percentiles: *Rating of Health Plan*, *Rating of All Health Care*, *Rating of Specialist Seen Most Often*, *Getting Needed Care*, and *Getting Care Quickly*. These results indicate the need for UHC CP QI to implement improvement strategies to ensure that members have high-quality care and timely access to care.

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

UHC CP QI's HCBS Survey results illustrate positive results and opportunities for improvement in members' experience. While the mean score for the *Staff Listen and Communicate Well* measure was the only measure that scored statistically significantly higher than the HI HCBS Program, the mean scores for 13 measures scored higher than the HI HCBS Program. While none of the measures scored statistically significantly lower than the HI HCBS Program, the *Choosing the Services that Matter to You* measure scored lower than the HI HCBS Program, indicating a need for UHC CP QI to implement strategies to ensure members have high-quality care and access to care.

The 2023 Provider Survey results illustrate the need for UHC CP QI to investigate the reasons for provider dissatisfaction and implement quality improvement strategies to address the areas of concern. None of the top-box scores were statistically significantly higher in 2023 than in 2021. Top-box scores for four of the measure rates—*Adequate Access to Non-Formulary Drugs, Helpfulness of Health Coordinators, Adequacy of Specialists,* and *Access to Substance Abuse Treatment*—were statistically significantly lower than the QI Program aggregate rates. These results indicate that providers are experiencing difficulties in providing high-quality and timely services and care to UHC CP QI members.

Finally, UHC CP QI progressed to the Outcomes stage of the two PIPs initiated in CY 2022. The topics addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services. For the *Behavioral Health Coordination* PIP, UHC CP QI received an overall *Met* validation status. The reported data were accurate, and the health plan achieved statistically significant improvement over the baseline during the Remeasurement 1 period for Performance Indicator 1. A decline from the baseline rate was noted in the Performance Indicator 2 rate.

For the *Plan All-Cause Readmissions* PIP, UHC CP QI received an overall *Met* validation status. The documented PIP design and data were accurate. The health plan conducted appropriate QI processes to identify barriers, and it deployed interventions that were logically linked to the identified barriers. The health plan achieved non-statistically significant improvement in the performance indicator rate during Remeasurement 1.

'Ohana Community Care Services ('Ohana CCS) Results

Compliance Monitoring Review

The 2023 compliance monitoring review activity included evaluation of the health plan's compliance with State and federal requirements for organizational and structural performance.

Findings

Table 3-81 presents the standards and compliance scores for 'Ohana CCS.

Table 3-81—Standards and Compliance Scores—'Ohana Health Plan Community Care Services Program

Standard #	Standard Name	Total # of Elements	Total # of Applicable Elements	# *Met*	# *Partially Met*	# *Not Met*	# *NA*	Total Compliance Score
I	Provider Selection	17	16	16	0	0	1	100%
II	Credentialing	44	42	41	1	0	2	99%
III	Subcontractual Relationships and Delegation	6	6	6	0	0	0	100%
IV	Health Information Systems	9	9	9	0	0	0	100%
V	Quality Assessment and Performance Improvement	6	6	6	0	0	0	100%
VI	Practice Guidelines	6	6	6	0	0	0	100%
VII	Enrollment and Disenrollment	5	5	5	0	0	0	100%
	Totals	**93**	**90**	**89**	**1**	**0**	**3**	**99%**

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

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

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

Strengths

'Ohana QI was found to be fully compliant in six of the seven standards reviewed in 2023.

Provider Selection—'Ohana CC had a comprehensive process for the selection of its network providers to sufficiently meet the needs of its CCS members. Additionally, the BHO had a compliance program description and plan, including policies and procedures to assist 'Ohana CCS in guarding against fraud, waste, and abuse. The BHO demonstrated effective processes for monitoring, auditing, and identifying compliance risks.

Subcontractual Relationships and Delegation—'Ohana CCS had appropriate subcontracts in place and had adequate oversight and monitoring processes to ensure its delegates are meeting their contractual obligations.

Health Information Systems—'Ohana CCS maintained a health information system that collects, analyzes, integrates, and reports data on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollment for other than loss of Medicaid eligibility.

Quality Assessment and Performance Improvement—'Ohana CCS' QAPI program was supported by a comprehensive program description, work plan, and evaluation of the prior year's quality improvement program achievements. The QAPI program provided the framework to systematically measure and analyze performance and impart essential information that aided management in decision-making to improve organizational functions, structures, and processes to improve CCS member outcomes.

Practice Guidelines—'Ohana CCS adopted evidence-based practice guidelines, disseminated its practice guidelines to all affected providers, and rendered utilization management and coverage of services decisions consistent with its practice guidelines.

Enrollment and Disenrollment—'Ohana CCS had systems, processes, and workflows to accept all individuals enrolled into the BHO without restrictions. 'Ohana CCS did not request disenrollment of members for reasons other than those permitted under the contract and had processes in place to notify the State when it becomes aware of a change in a member's circumstance that might affect the member's eligibility.

Areas for Improvement

Credentialing—'Ohana CCS was found to be 99 percent compliant with this standard, with one element scoring *Partially Met*. 'Ohana CCS demonstrated that its credentialing program had well-defined processes in place for credentialing and recredentialing individual providers that effectively evaluated providers and complied with the NCQA credentialing standards and guidelines. A review of credentialing and recredentialing files revealed that some organizational provider files were missing on-site quality assessments. 'Ohana CCS staff members cited a CMS waiver that was issued during the COVID-19 public health emergency as the reason for not conducting the on-site quality assessment. However, this waiver was not applicable to credentialing on-site quality assessments conducted by health plans. The corrective action required by 'Ohana CCS was to ensure that non-accredited organizational providers receive an on-site quality assessment prior to making initial credentialing and recredentialing decisions.

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 seven supplemental data sources for consideration to use for supplementing its MY 2022 performance measure rates. HSAG determined one data source to be non-standard 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 2022 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

'Ohana CCS' Access and Risk-Adjusted Utilization performance measure results are shown in Table 3-82. The *Ambulatory Care—Total* measure was the only measure in this domain that could be compared to national benchmarks. The *Emergency Department Visits* rate fell below the 50th percentile and the *Outpatient Visits Including Telehealth* rate fell below the 25th percentile. Of note, 'Ohana CCS met MQD's established Quality Strategy target for the *Ambulatory Care—Total—Outpatient Visits Including Telehealth* rate.

Table 3-82—'Ohana CCS' HEDIS Results for QI Measures Under Access and Risk-Adjusted Utilization

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Ambulatory Care—Total (per 1,000 member years)				
*Emergency Department Visits**	584.40	596.36	2.05%	★★
Outpatient Visits Including Telehealth	2,547.60	2,657.62	4.32%	★
Diagnosed Mental Health Disorders				
1–17 Years	—	NA	—	NC
18–64 Years	—	99.30%	—	NC
65+ Years	—	99.29%	—	NC
Total	—	99.30%	—	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 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 2022 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Behavioral Health Performance Measure Results

'Ohana CCS' Behavioral Health performance measure results are shown in Table 3-83. Two measure rates within this domain reported a relative improvement of more than 10 percent in HEDIS MY 2022. Additionally, 13 measure rates ranked at or above the 50th percentile, one of which met or exceeded the 75th percentile and six of which met or exceeded the 90th percentile. Conversely, two measure rates ranked below the 50th percentile. Additionally, two measure rates in this domain had a relative decline of more than 10 percent in HEDIS MY 2022. 'Ohana CCS met or exceeded the HEDIS MY 2022 MQD established Quality Strategy for eight measure rates in this domain.

Table 3-83—'Ohana CCS' HEDIS Results for QI Measures Under Behavioral Health

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	69.65%	67.28%	-3.40%	★★★★
Antidepressant Medication Management				
Effective Acute Phase Treatment	51.69%	58.87%	13.89%	★★
Effective Continuation Phase Treatment	40.68%	46.75%	14.92%	★★★
Follow-Up After ED Visit for Substance Use				
7-Day Follow-Up—13–17 Years	—	NA	—	NC
7-Day Follow-Up—18+ Years	—	42.46%	—	NC
7-Day Follow-Up—Total (13+ Years)	—	42.46%	—	NC
30-Day Follow-Up—13–17 Years	—	NA	—	NC
30-Day Follow-Up—18+ Years	—	68.16%	—	NC
30-Day Follow-Up—Total (13+ Years)	—	68.16%	—	NC
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—6–17 Years	NA	NA	—	NC
7-Day Follow-Up—18-64 Years	69.79%	73.03%	4.64%	★★★★★
7-Day Follow-Up—65 Years and Older	NA	60.61%	—	★★★★★
7-Day Follow-Up—Total (6+ Years)	69.91%	72.07%	3.09%	★★★★★
30-Day Follow-Up—6–17 Years	NA	NA	—	NC
30-Day Follow-Up—18-64 Years	88.29%	90.08%	2.03%	★★★★★
30-Day Follow-Up—65 Years and Older	NA	87.88%	—	★★★★★

Measure	HEDIS MY 2021 Rate	HEDIS MY 2022 Rate	Relative Difference	MY 2022 Performance Level
30-Day Follow-Up—Total (6+ Years)	88.72%	89.91%	1.34%	★★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—6–17 Years	NA	NA	—	NC
7-Day Follow-Up—18-64 Years	72.73%	38.50%	-47.06%	★★★
7-Day Follow-Up—65 Years and Older	NA	30.30%	—	★★★
7-Day Follow-Up—Total	71.97%	37.88%	-47.37%	★★
30-Day Follow-Up—6–17 Years	NA	NA	—	NC
30-Day Follow-Up—18-64 Years	88.94%	62.00%	-30.29%	★★★
30-Day Follow-Up—65 Years and Older	NA	54.55%	—	★★★
30-Day Follow-Up—Total	88.12%	61.43%	-30.29%	★★★
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation—Total—13–17 Years	—	NA	—	NC
Initiation—Total—18+ Years	—	NA	—	NC
Initiation—Total—Total	—	30.38%	—	NC
Engagement—Total—13–17 Years	—	NA	—	NC
Engagement—Total—18+ Years	—	NA	—	NC
Engagement—Total—Total	—	5.63%	—	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 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 2022 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Conclusions and Recommendations

Based on HSAG's analyses of the 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*

Validation of Performance Improvement Projects

In CY 2022, MQD selected two new PIPs—*Behavioral Health Coordination* and *7-Day Follow-up After Emergency Department Visit for Mental Illness (FUM)*—for ʻOhana CCS to complete. For the CY 2023 submission, the health plan progressed to the Outcomes stage of the PIPs and submitted Steps 1 through 8 in the PIP Submission Form and were assessed for improvement in outcomes (Step 9).

Table 3-84 displays the topics, progression status, and measurement periods reported for the PIPs.

Table 3-84—CY 2023 Health Plan PIP Topics and Status

PIP Topic	PIP Progression Status	Baseline Measurement Period	Measurement Period Reported in CY 2022
Behavioral Health Coordination	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	07/01/2021 to 09/30/2021	07/01/2022 to 09/30/2022 (Remeasurement 1)
7-Day Follow-up After Emergency Department Visit for Mental Illness	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	CY 2021	CY 2022 (Remeasurement 1)

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

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

Findings

Table 3-85 illustrates the validation results for the two PIPs submitted by ‘Ohana CCS for CY 2023 validation.

Table 3-85—CY 2023 PIP Validation Results for ‘Ohana CCS

PIP Topic	Percentage Score of Evaluation Elements *Met*	Percentage Score of Critical Elements *Met*	Overall Validation Status
Behavioral Health Coordination	95%	100%	*Met*
7-Day Follow-up After Emergency Department Visit for Mental Illness	100%	100%	*Met*

For the *Behavioral Health Coordination* PIP, ‘Ohana CCS received an overall *Met* validation status, with a *Met* score of 100 percent for critical evaluation elements and 95 percent for overall evaluation elements across all steps completed and validated.

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

Design (Steps 1-6)

Behavioral Health Coordination

‘Ohana CCS met 100 percent of the evaluation elements in the Design stage. The selected PIP topic was required by MQD and MQD held workgroup sessions with the health plans, DOH Behavioral Health Services Administration divisions, and HSAG to discuss the PIP design. The PIP Aim statement, the PIP population, and the two performance indicators were also discussed during the workgroup sessions. ‘Ohana CCS documented the PIP design accurately and as discussed during the workgroup meetings. ‘Ohana CCS’ data collection process appeared methodologically sound. The health plan has ongoing monthly meetings with a few DOH Behavioral Health Services Administration divisions on an as need 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.

7-Day Follow-up After Emergency Department Visit for Mental Illness

‘Ohana CCS met 100 percent of the requirements in the Design stage. The selected PIP topic was required by MQD, and the plan-specific historical and baseline data showed an opportunity for improvement. ‘Ohana CCS’ Aim statement set the focus of the PIP and the framework for data collection and analysis of results. ‘Ohana CCS clearly defined the eligible population and the

performance indicator, which aligned with the HEDIS specifications. 'Ohana CCS' data collection process was also found to be methodologically sound.

Implementation (Steps 7-8)

Behavioral Health Coordination

'Ohana CCS accurately reported and analyzed the Remeasurement 1 (third quarter of CY 2022) rates for the two performance indicators. The health plan documented factors that threatened the validity of the reported data; however, the health plan did not document the factors that may threaten the comparability of the Remeasurement 1 data with the baseline. 'Ohana CCS documented its QI 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 DSAs with the DOH agencies.

7-Day Follow-up After Emergency Department Visit for Mental Illness

'Ohana CCS accurately reported and analyzed the Remeasurement 1 (CY 2022) rate for the performance indicator. 'Ohana CCS conducted appropriate QI 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.

Outcomes (Step 9)

Behavioral Health Coordination

During Remeasurement 1, the health plan documented 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 remeasurement period.

7-Day Follow-up After Emergency Department Visit for Mental Illness

During Remeasurement 1, the health plan achieved some improvement in the *FUM* rate; however, the improvement achieved was not statistically significant over the baseline. The health plan also did not document achievement of significant programmatic or clinical improvement.

Analysis of Results

Table 3-86 displays the data that the health plan reported for the *Behavioral Health Coordination* PIP.

Table 3-86—Performance Improvement Project Outcomes for the *Behavioral Health Coordination* PIP

Performance Indicator	Baseline* (07/01/2021–09/30/2021)		Remeasurement 1 (07/01/2022–09/30/2022)		Sustained Improvement
Percent of shared members with eligible trigger events who received a combined review in the past three months.	N: 4 D: 132	3.0%	N: 17 D: 144	11.8%**	
Percent of shared members whose data are actively shared at a regular frequency with partner agencies.	N: 4,558 D: 4,558	100%	N: 4,764 D: 4,764	100%	

*Baseline data were updated by the health plan in the CY 2023 PIP submission. The health plans were in the initial stages of defining their data collection processes when the baseline data were reported in the previous year's submission. The health plans were allowed to update the baseline data in the CY 2023 PIP submission, as applicable for the defined data collection processes.

**Rate demonstrates statistically significant improvement over the baseline rate. N–Numerator D–Denominator

The rate for the percentage of shared members with eligible trigger events who received a combined review during the baseline measurement period (third quarter of 2021) was 3.0 percent. Only formal reviews were included in the baseline data. For Remeasurement 1, the Performance Indicator 1 rate increased by 8.8 percentage points to 11.8 percent and represented a statistically significant improvement over the baseline. The health plan documented that it does not have the capability to capture informal combined reviews, therefore, the numerator is underreported.

For the rate for the percentage of shared members whose data were actively shared with the partner agencies during the baseline measurement period, the health plan updated the rate of 12.3 percent, which was reported in last year's PIP submission, to 100 percent. The health plan documented that at the time of initial submission, quality improvement staff members were not aware that CCS was sending the list of enrollment files of all shared members to all health plans. The enrollment files include information useful for BH 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 agencies, and data regarding a member were exchanged at the time of the meeting from both parties. For Remeasurement 1, the Performance Indicator 2 rate remained at 100 percent, and the data sharing process was the same as during the baseline.

Table 3-87 displays the data that the health plan reported for the *7-Day Follow-up After Emergency Department Visit for Mental Illness* PIP.

Table 3-87—Performance Improvement Project Outcomes for the *7-Day Follow-up After Emergency Department Visit for Mental Illness*

Performance Indicator	Baseline (01/01/2021–12/31/2021)		Remeasurement 1 (01/01/2022–12/31/2022)		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 D: 452	69.9%	N: 307 D: 426	72.1%	

N–Numerator D–Denominator

The baseline (CY 2021) rate for the percentage of ED visits for members (18+ years of age) with a principal diagnosis of mental illness or intentional self-harm who had a follow-up visit within seven days of the ED visit was 69.9 percent. During Remeasurement 1, the performance indicator rate increased by 2.2 percentage points to 72.1 percent; however, this increase did not demonstrate statistically significant improvement over the baseline.

Barriers/Interventions

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

Table 3-88 displays the barriers and interventions as documented by the health plan for both PIPs.

Table 3-88—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. Drafting and executing Memorandums of Understanding (MOUs) with the partnering agencies regarding data sharing. 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.* 2. Having a workgroup with partnering agencies that meets at least on a quarterly basis.* 3. Develop a workflow for ongoing communication between health plan and partnering agencies.*
7-Day Follow-up After Emergency Department Visit for Mental Illness	
1. ED facility is too busy, and it is not a priority for the facility to notify the	1. Educate ED facilities that are willing to work in collaboration with the 'Ohana CCS PIP team on the *FUM* PIP and establish

Barriers	Interventions
health plan of member's visit to the ED. 2. Members do not identify their case manager.	rapport to work toward the common goal of ED utilization reduction. 2. 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 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.

* The documented interventions are required by MQD.

Strengths

- For both PIPs, 'Ohana CCS received an overall *Met* validation status.
- For the *Behavioral Health Coordination* PIP, during Remeasurement 1, the health plan documented 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 period.

Areas for Improvement

- For the *7-Day Follow-up After Emergency Department Visit for Mental Illness PIP*, the health plan did not achieve statistically significant 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 *Behavioral Health Coordination* PIP:
  - The health plan should continue to work toward improving its data sharing and care coordination efforts with the DOH Behavioral Health Services Administration divisions.
  - The health plan should continue with its efforts to capture the informal combined reviews based on the systems/data that it has and document how it is defining and capturing these data. The health plan should explore the possibilities of updating systems to capture more detailed information as part of this PIP for long-term care coordination needs.
  - The data included in the PIP Submission Form must include information about all eligible members for each performance indicator, as available. If the health plan has not yet initiated data sharing activities with a specific partnering agency, the denominator count must still include the count of shared members with that agency.
  - The health plan must document whether there were any factors that threatened the comparability of the remeasurement data to the baseline data.

- 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 must have a process in place for evaluating each PIP intervention and its impact on the performance indicator. Interventions must be adapted or revised as needed.
- The health plan must address HSAG's validation feedback in the final PIP Validation Tool in the next annual submission.
- The health plan should reference the PIP Completion Instructions to ensure that all requirements have been addressed when completing the PIP Submission Form.
- The health plan should seek technical assistance from HSAG and MQD throughout the PIP process to address any questions or concerns.

Overall Assessment of Quality, Accessibility, and Timeliness of Care

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

Conclusions

In general, 'Ohana CCS' performance results illustrate mixed performance across the three EQR activities. 'Ohana CCS showed that it has systems, policies, and staff in place to ensure that its structure and operations support core processes for providing care and services and promoting quality outcomes. 'Ohana CCS' performance during the 2023 compliance review was above average, meeting or exceeding the statewide compliance score for all seven standards. 'Ohana CCS achieved 100 percent compliance in six standards and 99 percent in the Credentialing standard. 'Ohana CCS was required to develop a CAP to address and resolve the deficiencies identified in the review. HSAG and MQD provided feedback and will continue to monitor 'Ohana CCS' CAP activities until the health plan is found to be in full compliance.

Overall, nearly three-quarters (76.5 percent) of 'Ohana CCS' measure rates ranked at or above the 50th percentile, with four measure rates (23.5 percent) falling below the 50th percentile. 'Ohana CCS should address performance in the Behavioral Health domain, specifically the *Antidepressant Medication Management—Effective Acute Phase Treatment* and *Follow-Up After Hospitalization for Mental Illness 7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* performance measures. Overall, nine MQD Quality Strategy targets were met in HEDIS MY 2022.

Finally, 'Ohana CCS progressed to the Outcomes stage of the two PIPs initiated in CY 2022. The topics addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services. For the *Behavioral Health Coordination* PIP, 'Ohana CCS received an overall *Met* validation status. The health plan documented 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 period.

For the *7-Day Follow-up After Emergency Department Visit for Mental Illness* PIP, ‘Ohana CCS received an overall *Met* validation status. The documented PIP design and data were accurate. The health plan conducted appropriate quality improvement processes to identify barriers, and it deployed interventions that were logically linked to the identified barriers. During Remeasurement 1, the health plan did not achieve statistically significant 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 summarizes the results from the 2023 compliance monitoring reviews. This table contains high-level results used to compare Hawaii Medicaid managed care health plans' performance on a set of requirements (federal Medicaid managed care regulations and State contract provisions) for each of the eight compliance standard areas selected for review this year. Scores have been calculated for each standard area statewide and for each health plan for all standards. Health plan scores with red shading indicate performance below the statewide score.

Table 4-1—Compliance Standards and Scores

Standard Name	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI	'Ohana CCS	Statewide Score
I. Provider Selection	100%	100%	100%	100%	100%	100%	**100%**
II. Credentialing	98%	99%	100%	99%	100%	99%	**99%**
III. Subcontractual Relationships and Delegation	100%	92%	92%	100%	100%	100%	**97%**
IV. Health Information Systems	100%	100%	100%	100%	100%	100%	**100%**
V. Quality Assessment and Performance Improvement	100%	100%	100%	100%	100%	100%	**100%**
VI. Practice Guidelines	100%	100%	100%	100%	100%	100%	**100%**
VII. Enrollment and Disenrollment	100%	100%	100%	100%	100%	100%	**100%**
Totals	**99%**	**99%**	**99%**	**99%**	**100%**	**99%**	**99%**

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

In general, health plan performance suggested that all health plans had implemented the systems, policies and procedures, and staff to ensure that their operational foundations support the core processes of providing care and services to Medicaid members in Hawaii. Five standards were found to be fully compliant (i.e., 100 percent of standards/elements met) across all health plans—Provider Selection, Health Information Systems, Quality Assessment and Performance Improvement, Practice Guidelines, and Enrollment and Disenrollment. The Credentialing and Subcontractual Relationships and Delegation standards were the only standards identified as having opportunities for improvement, with four health plans having at least one element scored *Partially Met* in the Credentialing standard and two health plans having one element scored *Partially Met* in the Subcontractual Relationships and Delegation standard.

UHC CP QI achieved the highest total compliance score of 100 percent. Total compliance scores were 99 percent for the other five health plans. These results suggest an overall high degree of compliance with State and federal managed care requirements. Following the 2023 compliance monitoring reviews, each health plan received a detailed written report of findings and recommendations and was required to develop and implement a CAP for all items that were not scored *Met*. MQD and HSAG reviewed and approved the health plans' CAPs and will continue to provide follow-up monitoring until all identified deficiencies are corrected.

Validation of 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 2022 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 1.0—Medical Services Data	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*
IS 2.0—Enrollment Data	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*
IS 3.0—Practitioner Data	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*
IS 4.0—Medical Record Review Processes	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*
IS 5.0—Supplemental Data	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*
IS 6.0—Data Preproduction Processing	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*
IS 7.0—Data Integration and Reporting	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*
IS 8.0—Case Management Data	*Fully Compliant*	*Not Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*

HEDIS Performance Measure Results

This section of the report highlights health plans' performance for the current MY by domain of care. Each table illustrates the health plans' MY 2022 measure rates and their performance relative to NCQA's 2022 Quality Compass national Medicaid HMO percentiles for HEDIS MY 2021, 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. The *Plan All-Cause Readmissions—Index Total Stays—O/E Ratio—Total* was the only rate in this domain that could be compared to national benchmarks. Both measures in this domain had an MQD Quality Strategy target (*Heart Failure Admission Rate—Total* and *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Total).*

Table 4-3—HEDIS MY 2022 Comparison of Access and Risk-Adjusted Utilization Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Heart Failure Admission Rate (per 100,000 member months)*					
18–64 Years	46.19 —	27.57 —	31.62 —	55.20 —	48.16 —
65 Years and Older	158.70 —	97.06 —	109.16 —	110.11 —	117.89 —
Total (18 Years and Older)	56.59 —	32.32 —	38.04 —	63.11 —	69.70 —
Plan All-Cause Readmissions					
*Index Total Stays—Observed Readmissions—Total**	7.47% —	8.29% —	8.79% —	9.94% —	11.35% —
Expected Readmissions—Total	9.97% —	9.68% —	9.56% —	11.83% —	11.06% —
*Index Total Stays—O/E Ratio—Total**	0.7499 ★★★★★	0.8564 ★★★★	0.9192 ★★★	0.8401 ★★★★★	1.0256 ★★

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.

Within the Access and Risk-Adjusted Utilization performance measure domain, three of five QI health plans (AlohaCare QI, HMSA QI, and KFHP QI) met MQD's established target for *Heart Failure Admission Rate—Total*. For the *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Total* rate, all five QI health plans met MQD's established target.

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—HEDIS MY 2022 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					
3–11 Years	46.91% ★	58.79% ★★★	49.69% ★	30.05% ★	45.95% ★
12–17 Years	44.78% ★★	56.48% ★★★	44.62% ★	27.87% ★	36.11% ★
18–21 Years	15.78% ★	28.21% ★★★	10.44% ★	12.51% ★	16.71% ★
Total (3–21 Years)	40.26% ★	52.41% ★★★	41.15% ★	26.41% ★	38.61% ★
Childhood Immunization Status					
Combination 3	50.36% ★	58.64% ★★	69.46% ★★★★	36.50% ★	49.88% ★
Combination 7	43.31% ★	49.88% ★★	66.96% ★★★★★	31.87% ★	45.01% ★
Combination 10	29.93% ★★	35.52% ★★★	56.85% ★★★★★	25.06% ★	30.90% ★★
DTaP	54.50% ★	69.59% ★★	72.39% ★★★	44.53% ★	53.77% ★
Hepatitis A	70.32% ★	78.10% ★★	80.98% ★★★	60.34% ★	68.61% ★
Hepatitis B	75.43% ★	71.53% ★	86.09% ★★	59.12% ★	75.67% ★
HiB	72.99% ★	80.05% ★★	77.28% ★	60.10% ★	73.72% ★
Influenza	43.07% ★★	49.64% ★★★	65.11% ★★★★★	40.15% ★★	44.04% ★★
IPV	74.94% ★	79.81% ★	84.67% ★★	62.77% ★	75.43% ★
MMR	69.83% ★	78.10% ★	82.61% ★★	58.64% ★	70.07% ★
Pneumococcal Conjugate	56.69% ★	68.37% ★★	70.87% ★★	45.99% ★	55.47% ★

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Rotavirus	60.34% ★	64.48% ★	79.57% ★★★★★	52.55% ★	62.53% ★
VZV	70.80% ★	77.86% ★	82.17% ★★	58.15% ★	70.07% ★
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% ★★★	69.57% ★★★★★	70.41% ★★★★★	33.24% ★	56.67% ★★★
Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits	56.19% ★	72.98% ★★★★	73.05% ★★★★	36.68% ★	53.62% ★

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

Within the Children's Preventive Health performance measure domain, KFHP QI performed best among the health plans, with nine measure rates ranking at or above the 50th percentile, two of which met or exceeded the 75th percentile and five of which met or exceeded the 90th percentile. 'Ohana QI demonstrated the lowest performance among the health plans, with all 19 measure rates that could be compared to benchmarks ranking below the 50th percentile, 18 of which were under the 25th percentile.

HMSA QI met MQD's established target for the *Child and Adolescent Well-Care Visits—Total* rate, and KFHP QI met the targets for *Childhood Immunization Status—Combination 7* and *Combination 10.*

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—HEDIS MY 2022 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	50.36% ★	57.49% ★★	63.61% ★★★★	41.36% ★	45.26% ★
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	77.37% ★	77.70% ★	90.32% ★★★★	67.02% ★	73.24% ★
Postpartum Care	73.24% ★★	67.54% ★	86.38% ★★★★★	66.67% ★	79.08% ★★★

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

Within the Women's Health performance measure domain, KFHP QI performed best among the health plans, with all three measure rates meeting or exceeding the 75th percentile, one of which met or exceeded the 90th percentile. Additionally, KFHP QI reached MQD's established targets for all three

measure rates in this domain. UHC CP QI met or exceeded the 50th percentile for the *Prenatal and Postpartum Care—Postpartum Care* measure rate and met MQD's established Quality Strategy target. Conversely, UHC CP QI ranked below the 25th percentile for the *Cervical Cancer Screening* and *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure rates.

'Ohana QI demonstrated the worst performance, with all three measure rates ranking below the 25th percentile. Additionally, AlohaCare QI ranked below the 25th percentile for the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Cervical Cancer Screening* measure rates. HMSA QI ranked below the 25th percentile for both *Prenatal and Postpartum Care* measure rates.

For the *Prenatal and Postpartum Care—Postpartum Care* measure indicator rates, all QI health plans met MQD's established targets.

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—HEDIS MY 2022 Comparison of Care for Chronic Conditions Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Hemoglobin A1c Control for Patients With Diabetes					
*HbA1c Poor Control (>9.0%)—Total**	38.93% —	37.16% —	37.47% —	41.36% —	27.25% —
HbA1c Control (<8.0%)—Total	52.31% —	54.52% —	51.41% —	46.23% —	63.26% —
Eye Exam for Patients With Diabetes					
Eye Exam for Patients With Diabetes	52.80% —	59.66% —	66.83% —	53.28% —	60.34% —
Blood Pressure Control for Patients With Diabetes					
Blood Pressure Control for Patients With Diabetes	60.10% —	56.97% —	66.84% —	52.80% —	68.61% —
Concurrent Use of Opioids and Benzodiazepines*					
18–64 Years	9.27% —	13.28% —	7.20% —	19.26% —	12.05% —
65 Years and Older	6.38% —	9.80% —	6.25% —	18.72% —	16.50% —
Total (18 Years and Older)	8.88% —	13.06% —	7.04% —	19.14% —	14.09% —
Controlling High Blood Pressure					
18–64 Years	52.12% —	57.51% —	68.87% —	52.73% —	61.76% —

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
65–85 Years	54.81% —	50.79% —	67.94% —	63.24% —	81.33% —
Total (18–85 Years)	52.80% ★	56.48% ★★	68.56% ★★★★	56.20% ★★	73.24% ★★★★★

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.

Within the Care for Chronic Conditions performance measure domain, KFHP QI and UHC CP QI performed the best among the health plans, with the *Controlling High Blood Pressure—Total* measure indicator meeting or exceeding the 75th percentile and meeting or exceeding MQD's Quality Strategy target for that measure. All health plans except 'Ohana QI met or exceeded MQD's Quality Strategy target for the *Concurrent Use of Opioids and Benzodiazepines—Total* measure indicator in MY 2022.

Behavioral Health

Table 4-7 displays the Behavioral Health measure rates for each health plan compared to the national Medicaid percentiles.

Table 4-7—HEDIS MY 2022 Comparison of Behavioral Health Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up—6–17 Years	30.00% ★	54.04% ★★★	77.14% ★★★★★	NA	NA
7-Day Follow-Up—18–64 Years	22.22% ★	42.16% ★★★★	40.00% ★★★	31.25% ★★	51.19% ★★★★
7-Day Follow-Up—65 Years and Older	NA	NA	NA	NA	NA
7-Day Follow-Up—Total	24.05% ★	44.51% ★★★	50.00% ★★★★	31.25% ★★	48.54% ★★★★
30-Day Follow-Up—6–17 Years	52.50% ★	63.64% ★★	77.14% ★★★	NA	NA
30-Day Follow-Up—18–64 Years	36.11% ★	55.31% ★★★	55.79% ★★★	51.14% ★★	67.86% ★★★★
30-Day Follow-Up—65 Years and Older	NA	NA	NA	NA	NA
30-Day Follow-Up—Total	39.69% ★	56.84% ★★	61.54% ★★★	52.08% ★★	64.56% ★★★
Initiation and Engagement of Substance Use Disorder Treatment					
Initiation—Total—13–17 Years	27.63% —	41.00% —	26.32% —	NA	NA
Initiation—Total—18+ Years	35.14% —	32.47% —	33.68% —	35.30% —	35.50% —

Measure	AlohaCare QI	HMSA QI	KFHP QI	ʻOhana QI	UHC CP QI
Initiation—Total—Total	36.57% —	35.47% —	32.52% —	32.66% —	36.51% —
Engagement—Total—13–17 Years	1.32% —	16.74% —	2.63% —	NA	NA
Engagement—Total—18+ Years	11.94% —	6.65% —	5.80% —	9.53% —	11.71% —
Engagement—Total—Total	6.85% —	11.96% —	6.62% —	6.70% —	7.07% —
Screening for Depression and Follow-Up Plan					
12–17 Years	31.63% —	47.92% —	1.44% —	19.19% —	16.99% —
18–64 Years	19.65% —	27.27% —	5.77% —	9.54% —	13.13% —
65 Years and Older	20.33% —	25.75% —	7.47% —	26.71% —	36.97% —
Total Adult (18 Years and Older)	19.74% —	27.16% —	5.94% —	13.14% —	22.76% —
Use of Pharmacotherapy for Opioid Use Disorder					
Total (Rate 1)	57.18% —	67.68% —	56.25% —	54.04% —	50.15% —
Buprenorphine (Rate 2)	34.73% —	53.03% —	50.00% —	20.35% —	22.94% —
Oral Naltrexone (Rate 3)	0.78% —	3.03% —	0.00% —	0.70% —	0.31% —
Long-acting, Injectable Naltrexone (Rate 4)	0.00% —	1.01% —	0.00% —	0.00% —	0.31% —
Methadone (Rate 5)	24.28% —	12.63% —	8.33% —	35.44% —	28.44% —

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.

Within the Behavioral Health domain, nine measure indicator rates had MQD-established Quality Strategy targets. Three of five QI health plans (HMSA QI, KFHP QI, and UHC CP QI) reached the established targets for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total* measure rates. All five health plans did not have enough members in the eligible population for the *7-Day Follow-Up—65 Years and Older* and *30-Day Follow-Up—65 Years and Older* measure indicators and were assigned a status of *NA.* Two of five health plans (ʻOhana QI and UHC CP QI) did not have enough members in the eligible population for the *7-Day Follow-Up—6–17 Years* and *30-Day Follow-Up—6–17 Years* measure indicators and were assigned a status of *NA.*

AlohaCare QI demonstrated the worst performance among the health plans, only reaching the established targets for three measure rates, and all six measure rates that could be compared to national benchmarks ranked below the 25th percentile.

Long-Term Services and Supports

Table 4-8 displays the long-term services and supports measure rates for each health plan. The measures in this domain did not have applicable benchmarks; therefore, no comparison to national benchmarks is presented. Further, there were no MQD Quality Strategy targets established.

Table 4-8—HEDIS MY 2022 Comparison of LTSS Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Long-Term Services and Supports Comprehensive Care Plan and Update					
Care Plan with Core Elements Documented	69.79% —	0.00% —	42.71% —	8.33% —	13.54% —
Care plan with Supplemental Elements Documented	69.79% —	0.00% —	40.63% —	8.33% —	13.54% —
Long-Term Services and Supports Comprehensive Assessment and Update					
Assessment of Core Elements Documented	78.13% —	0.00% —	34.38% —	19.79% —	11.46% —
Assessment of Supplemental Elements Documented	78.13% —	0.00% —	30.21% —	17.71% —	11.46% —
Long-Term Services and Supports Minimizing Institutional Length of Stay					
Observed Discharge Rate	7.62% —	NA	25.94% —	1.40% —	27.68% —
Expected Discharge Rate	26.95% —	NA	35.22% —	37.73% —	33.44% —
Observed/Expected Ratio	0.2829 —	NA	0.7366 —	0.0371 —	0.8276 —

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.

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					
Heart Failure Admission Rate (per 100,000 member months)—Total	Met	Met	Met	Not Met	Not Met
Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Total	Met	Met	Met	Met	Met
Children's Preventive Health					
Child and Adolescent Well-Care Visits—Total	Not Met	Met	Not Met	Not Met	Not Met
Childhood Immunization Status—Combination 3	Not Met	Not Met	Not Met	Not Met	Not Met
Childhood Immunization Status—Combination 7	Not Met	Not Met	Met	Not Met	Not Met
Childhood Immunization Status—Combination 10	Not Met	Not Met	Met	Not Met	Not Met
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits	Not Met	Not Met	Not Met	Not Met	Not Met
Women's Health					
Cervical Cancer Screening	Not Met	Not Met	Met	Not Met	Not Met
Prenatal and Postpartum Care—Timeliness of Prenatal Care	Not Met	Not Met	Met	Not Met	Not Met
Prenatal and Postpartum Care—Postpartum Care	Met	Met	Met	Met	Met
Care for Chronic Conditions					
Concurrent Use of Opioids and Benzodiazepines—Total	Met	Met	Met	Not Met	Met
Controlling High Blood Pressure—Total	Not Met	Not Met	Met	Not Met	Met
Behavioral Health					
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	Not Met	Met	Met	Not Met	Met
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	Not Met	Met	Met	Not Met	Met
Initiation and Engagement of Substance Use Disorder Treatment—Initiation—Total—Total	Not Met	Not Met	Not Met	Not Met	Not Met

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Initiation and Engagement of Substance Use Disorder Treatment—Engagement—Total—Total	Not Met	Not Met	Not Met	Not Met	Not Met
Use of Pharmacotherapy for Opioid Use Disorder—Total	Met	Met	Met	Met	Met
Use of Pharmacotherapy for Opioid Use Disorder—Buprenorphine	Met	Met	Met	Not Met	Not Met
Use of Pharmacotherapy for Opioid Use Disorder—Oral Naltrexone	Not Met	Met	Not Met	Not Met	Not Met
Use of Pharmacotherapy for Opioid Use Disorder—Long-Acting, Injectable Naltrexone	Not Met	Met	Not Met	Not Met	Met
Use of Pharmacotherapy for Opioid Use Disorder—Methadone	Met	Not Met	Not Met	Met	Met
Total MQD Targets Met	**7**	**11**	**13**	**4**	**9**
Percent MQD Targets Met	**33.33%**	**52.38%**	**61.90%**	**19.05%**	**42.86%**

Validation of Performance Improvement Projects

Table 4-10 summarizes HSAG's key validation findings for the two PIPs conducted by the QI health plans.

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

Health Plan	Behavioral Health Coordination			Plan-All Cause Readmissions		
	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
AlohaCare QI	100%	100%	*Met*	100%	100%	*Met*
HMSA QI	95%	100%	*Met*	63%	56%	*Not Met*
KFHP QI	95%	100%	*Met*	95%	100%	*Met*
'Ohana QI	84%	90%	*Partially Met*	95%	100%	*Met*
UHC CP QI	100%	100%	*Met*	95%	100%	*Met*

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

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

Health Plan	Behavioral Health Coordination			Follow–Up After Emergency Department Visit for Mental Illness		
	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status	% of All Elements *Met*	% of Critical Elements *Met*	Validation Status
‘Ohana CCS	95%	100%	*Met*	100%	100%	*Met*

CY 2023 was the second validation year for the PIPs. All the PIP topics were required by MQD and address the CMS’ requirements related to quality outcomes—specifically quality of, timeliness of, and access to care and services. The PIP topics are also in alignment with the goals and the objectives included in MQD’s Quality Strategy. In addition to the PIPs, MQD also encouraged the health plans to participate in a collaborative and work together toward the common goal of achieving improvement in access, quality, and timeliness of care through these PIPs. Moving forward, HSAG recommends that MQD continue to engage with the health plans and DOH Behavioral Health divisions to ensure that progress is being made toward data sharing and an integrated care approach. The PIPs are submitted to the EQRO for annual validation; however, MQD may require the health plans to provide an update on the status of their interventions on a quarterly basis. Any system barriers to implementing interventions should be addressed in a timely manner. The health plans should also continue to report to MQD how they have implemented the lessons from the previous PIPs to improve the outcomes in the new PIPs. For the *Plan All-Cause Readmissions* PIP and the *Follow–Up After Emergency Department Visit for Mental Illness* PIP, the health plans may be encouraged to seek member input regarding barriers to accessing care.

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

Statewide Comparisons—QI Health Plans

Table 4-12 presents the 2023 top-box scores for each QI health plan and the QI Program aggregate.[4-1] Additionally, results comparing the QI health plans to the overall QI Program aggregate are displayed below.

[4-1] The QI Program aggregate results were derived from the combined results of the five participating QI health plans: AlohaCare QI, HMSA QI, KFHP QI, ‘Ohana QI, and UHC CP QI.

Table 4-12—Comparison of 2023 QUEST Integration Child CAHPS Results

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI	QI Program
Global Ratings						
Rating of Health Plan	81.2% ↑	72.1%	74.9%	67.6%	66.2%	73.4%
Rating of All Health Care	70.1%	68.6%	68.1%	69.4%	67.8%+	68.8%
Rating of Personal Doctor	80.3%	80.6%	77.6%	74.7%	78.4%	78.5%
Rating of Specialist Seen Most Often	70.0%+	78.6%+	76.0%+	78.9%+	66.7%+	75.4%
Composite Measures						
Getting Needed Care	74.9%+	72.7%	78.6%	77.9%+	79.0%+	76.6%
Getting Care Quickly	77.7%+	78.2%	81.9%	80.1%+	80.0%+	79.7%
How Well Doctors Communicate	91.8%	94.0%	94.6%	90.6%	96.0%+	93.4%
Customer Service	89.5%+	84.3%+	90.6%+	81.7%+	90.6%+	86.9%
Individual Item Measure						
Coordination of Care	81.8%+	84.7%+	91.5%	77.4%+	88.2%+	85.4%

Cells highlighted in green represent scores that are statistically significantly higher than the 2022 NCQA adult Medicaid national averages.
Cells highlighted in red represent scores that are statistically significantly lower than the 2022 NCQA adult Medicaid national averages.
↑ *Indicates the score is statistically significantly higher than the QI Program aggregate.*
+ *Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.*

Comparison of the QI Program aggregate and QI health plans' scores to the 2022 NCQA child Medicaid national averages revealed the following summary results:

- The QI Program aggregate scored statistically significantly lower than the national average on two measures: *Getting Needed Care* and *Getting Care Quickly*.
- AlohaCare QI scored statistically significantly higher than the national average on one measure: *Rating of Health Plan*.
- AlohaCare QI scored statistically significantly lower than the national average on two measures: *Getting Needed Care* and *Getting Care Quickly*.
- HMSA QI scored statistically significantly lower than the national average on two measures: *Getting Needed Care* and *Getting Care Quickly*.
- KFHP QI scored statistically significantly higher than the national average on one measure: *Coordination of Care*.
- 'Ohana QI scored statistically significantly lower than the national average on one measure: *How Well Doctors Communicate*.
- UHC CP QI did not score statistically significantly higher or lower than the national average on any of the measures.

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

- AlohaCare QI scored statistically significantly higher than the QI Program aggregate on one measure, *Rating of Health Plan*.

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

Table 4-13 presents the 2023 top-box scores for the Hawaii CHIP population.

Table 4-13—Comparison of 2023 CHIP CAHPS Results

Global Ratings	
Rating of Health Plan	75.4%
Rating of All Health Care	65.5%
Rating of Personal Doctor	77.7%
Rating of Specialist Seen Most Often	76.7%+
Composite Measures	
Getting Needed Care	78.9%
Getting Care Quickly	78.5%
How Well Doctors Communicate	95.6%
Customer Service	89.1%+
Individual Item Measure	
Coordination of Care	87.0%

Cells highlighted in red represent scores that are below the 2022 NCQA child Medicaid national averages.
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

Comparison of the CHIP population's 2023 scores to the 2022 NCQA child Medicaid national averages revealed the following summary results:

- The CHIP population did not score statistically significantly higher than the national averages on any of the measures.
- The CHIP population scored statistically significantly lower than the national averages on one measure, *Getting Care Quickly*.

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

- The CHIP population did not score statistically significantly higher or lower in 2023 than in 2022 on any of the measures.

NCQA Comparisons—QI Health Plans

Based on the comparison of the QI Program aggregate and each of the QI health plans' top-box scores to NCQA's 2022 Quality Compass Benchmark and Compare Quality Data, member experience ratings of one (★) to five (★★★★★) stars were determined for each CAHPS measure, where one is the lowest possible rating and five is the highest possible rating, as shown in Table 4-14.[4-2]

Table 4-14—Star Ratings

Stars	Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or between the 75th and 89th percentiles
★★★ Good	At or between the 50th and 74th percentiles
★★ Fair	At or between the 25th and 49th percentiles
★ Poor	Below the 25th percentile

Table 4-15 presents the QI Program aggregate scores and each participating QI health plan's member experience ratings and 2023 top-box scores for the four global ratings.

Table 4-15—NCQA Comparisons: Global Ratings

Program/Plan Name	*Rating of Health Plan*	*Rating of All Health Care*	*Rating of Personal Doctor*	*Rating of Specialist Seen Most Often*
QI Program	★★★ **73.4%**	★★ **68.8%**	★★★ **78.5%**	★★★ **75.4%**
AlohaCare QI	★★★★★ 81.2%	★★ 70.1%	★★★★ 80.3%	★★ 70.0%+
HMSA QI	★★ 72.1%	★★ 68.6%	★★★★ 80.6%	★★★★ 78.6%+
KFHP QI	★★★ 74.9%	★★ 68.1%	★★★ 77.6%	★★★ 76.0%+
'Ohana QI	★ 67.6%	★★ 69.4%	★★ 74.7%	★★★★ 78.9%+

[4-2] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2022*. Washington, DC: NCQA, September 2022.

Program/Plan Name	Rating of Health Plan	Rating of All Health Care	Rating of Personal Doctor	Rating of Specialist Seen Most Often
UHC CP QI	★ 66.2%	★★ 67.8%+	★★★ 78.4%	★ 66.7%+

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
Star Assignments Based on Percentiles:
★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th

Table 4-16 presents the QI Program aggregate scores and each participating QI health plan's member experience rating and 2023 top-box scores for the four composite measures and one individual item measure.

Table 4-16—NCQA Comparisons: Composite and Individual Item Measures

Program/Plan Name	Getting Needed Care	Getting Care Quickly	How Well Doctors Communicate	Customer Service	Coordination of Care
QI Program	★ **76.6%**	★ **79.7%**	★★ **93.4%**	★★ **86.9%**	★★★ **85.4%**
AlohaCare QI	★ 74.9%+	★ 77.7%+	★ 91.8%	★★★ 89.5%+	★ 81.8%+
HMSA QI	★ 72.7%	★ 78.2%	★★ 94.0%	★ 84.3%+	★★ 84.7%+
KFHP QI	★ 78.6%	★ 81.9%	★★★ 94.6%	★★★★ 90.6%+	★★★★★ 91.5%
'Ohana QI	★ 77.9%+	★ 80.1%+	★ 90.6%	★ 81.7%+	★ 77.4%+
UHC CP QI	★ 79.0%+	★ 80.0%+	★★★★ 96.0%+	★★★★ 90.6%+	★★★★ 88.2%+

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
Star Assignments Based on Percentiles:
★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th

Comparison of the 2023 QI Program's scores to the 2022 NCQA child Medicaid Quality Compass data revealed the following:

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

One of the goals MQD identified for the Hawaii Medicaid program is to improve member experience with health plan services. MQD selected the following three CAHPS measures as part of its Quality Strategy to monitor the QI health plans' performance on members' experience with these areas of

service compared to national benchmarks: *Rating of Health Plan*, *Getting Needed Care*, and *How Well Doctors Communicate*.

- AlohaCare QI's member experience ratings exceeded the 75th percentile for *Rating of Health Plan*.
- No QI health plans' member experience ratings met or exceeded the 75th percentile for *Getting Needed Care*.
- UHC CP QI's member experience ratings met or exceeded the 75th percentile for *How Well Doctors Communicate*.

NCQA Comparisons—CHIP

Table 4-17 presents the Hawaii CHIP population's member experience ratings and 2023 top-box scores for the four global ratings, four composite measures, and one individual item measure.[4-3]

Table 4-17—NCQA Comparisons

Measure	Score	Star Rating
Global Ratings		
Rating of Health Plan	75.4%	★★★
Rating of All Health Care	65.5%	★
Rating of Personal Doctor	77.7%	★★★
Rating of Specialist Seen Most Often	76.7%+	★★★★
Composite Measures		
Getting Needed Care	78.9%	★
Getting Care Quickly	78.5%	★
How Well Doctors Communicate	95.6%	★★★
Customer Service	89.1%+	★★★
Individual Item Measure		
Coordination of Care	87.0%	★★★

+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
Star Ratings based on percentiles:
★★★★★ 90th or Above ★★★★ 75th-89th ★★★ 50th-74th ★★ 25th-49th ★ Below 25th

Comparison of the CHIP population's scores to the NCQA's 2022 Quality Compass Benchmark and Compare Quality Data revealed the following:

- The CHIP population did not score at or above the 90th percentile on any of the measures.

[4-3] NCQA's benchmarks for the child Medicaid population were used to derive the overall member experience ratings; therefore, caution should be exercised when interpreting these results.

- The CHIP population scored below the 25th percentile on three measures: *Rating of All Health Care*, *Getting Needed Care*, and *Getting Care Quickly*.

Home and Community-Based Services CAHPS Survey

Table 4-18 presents a summary of the statistically significant differences in performance that exist between the QI health plans' 2023 mean scores.[4-4] Mean scores were transformed to a 0-to-100-point scale for each measure. HSAG coded each HCBS CAHPS Survey item to ensure that the most positive response(s) of each question were given the highest value(s) according to the topic and wording; therefore, higher mean scores are correlated with greater levels of experience.

Table 4-18—Plan Comparisons

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Global Ratings					
Rating of Personal Assistance and Behavioral Health Staff	—	—	↑	↑	—
Rating of Homemaker	NA	NA	NA	—	—
Rating of Case Manager	—	—	—	—	—
Composite Measures					
Reliable and Helpful Staff	—	NA	—	—	—
Staff Listen and Communicate Well	—	—	—	↑	↑
Helpful Case Manager	—	NA	—	—	—
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	NA	NA	NA	—	—
Recommend Case Manager	—	↓	↑	—	—
Unmet Need and Physical Safety Measures					
No Unmet Need in Dressing/Bathing	NA	NA	NA	NA	—

[4-4] For more detailed results on the plan comparisons analysis, please see the 2023 Hawaii HCBS CAHPS Survey full report.

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
No Unmet Need in Meal Preparation/Eating	NA	NA	NA	NA	NA
No Unmet Need in Medication Administration	NA	NA	NA	NA	NA
No Unmet Need in Toileting	—	NA	—	—	—
No Unmet Need with Household Tasks	NA	NA	NA	NA	NA
Not Hit or Hurt by Staff	—	—	—	—	—

↑ Indicates the QI health plan's mean score is statistically significantly higher than the HI HCBS Program.
↓ Indicates the QI health plan's mean score is statistically significantly lower than the HI HCBS Program.
— Indicates the QI health plan's mean score is not statistically significantly different than the HI HCBS Program.
*Results based on fewer than 11 respondents were suppressed and noted as "*NA*".*

- For *Rating of Personal Assistance and Behavioral Health Staff*, KFHP QI's and 'Ohana QI's 2023 mean scores were statistically significantly higher than the HI HCBS Program.
- For *Staff Listen and Communicate Well*, 'Ohana QI's and UHC CPO QI's 2023 mean scores were statistically significantly higher than the HI HCBS Program.
- For *Choosing the Services that Matter to You*, KFHP QI's and 'Ohana QI's 2023 mean scores were statistically significantly higher than the HI HCBS Program.
- For *Transportation to Medical Appointments*, KFHP QI's 2023 mean score was statistically significantly higher than the HI HCBS Program, while HMSA QI's 2023 mean score was statistically significantly lower than the HI HCBS Program.
- For *Planning Your Time and Activities*, KFHP QI's 2023 mean score was statistically significantly higher than the HI HCBS Program, while HMSA QI's 2023 mean score was statistically significantly lower than the HI HCBS Program.
- For *Recommend Personal Assistance/Behavioral Health Staff,* KFHP QI's and 'Ohana QI's 2023 mean scores were statistically significantly higher than the HI HCBS Program, while AlohaCare QI's 2023 mean score was statistically significantly lower than the HI HCBS Program.
- For *Recommend Case Manager*, KFHP QI's 2023 mean score was statistically significantly higher than the HI HCBS Program, while HMSA QI's 2023 mean score was statistically significantly lower than the HI HCBS Program.

Provider Survey

Plan Comparisons

Table 4-19 presents a summary of the statistically significant differences in performance that existed between the QI health plans' 2023 top-box scores (i.e., percent satisfied).[4-5]

[4-5] For more detailed results on the plan comparisons analysis, please see the 2023 Hawaii Provider Survey full report.

Table 4-19—Plan Comparisons

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
General Positions					
Compensation Satisfaction	—	—	↑	↓	—
Timeliness of Claims Payments	—	↑	—	↓	—
Providing Quality Care					
Formulary	—	—	↑	↓	—
Prior Authorization Process	—	↑	—	↓	—
Non-Formulary					
Adequate Access to Non-Formulary Drugs	—	—	↑	↓	↓
Health Coordinators					
Helpfulness of Health Coordinators	—	—	↑	↓	↓
Specialists					
Adequacy of Specialists	↓	↑	↑	↓	↓
Availability of Mental Health Providers	↓	—	↑	↓	—
Substance Abuse					
Access to Substance Abuse Treatment	↓	↓	↑	↓	↓

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

The following is a summary of the QI health plans' performance on the nine measures evaluated for statistical differences:

- For *Compensation Satisfaction*, KFHP QI's 2023 top-box score was statistically significantly higher than the QI Program aggregate, while 'Ohana QI's 2023 top-box score was statistically significantly lower than the QI Program aggregate.
- For *Timeliness of Claims Payments*, HMSA QI's 2023 top-box score was statistically significantly higher than the QI Program aggregate, while 'Ohana QI's 2023 top-box score was statistically significantly lower than the QI Program aggregate.
- For *Formulary*, KFHP QI's 2023 top-box score was statistically significantly higher than the QI Program aggregate, while 'Ohana QI's 2023 top-box score was statistically significantly lower than the QI Program aggregate.

- For *Prior Authorization Process*, HMSA QI's 2023 top-box score was statistically significantly higher than the QI Program aggregate, while 'Ohana QI's 2023 top-box score was statistically significantly lower than the QI Program aggregate.
- For *Adequate Access to Non-Formulary Drugs*, KFHP QI's 2023 top-box score was statistically significantly higher than the QI Program aggregate, while 'Ohana QI's and UHC CP QI's 2023 top-box scores were statistically significantly lower than the QI Program aggregate.
- For *Helpfulness of Health Coordinators*, KFHP QI's 2023 top-box score was statistically significantly higher than the QI Program aggregate, while 'Ohana QI's and UHC CP QI's 2023 top-box scores were statistically significantly lower than the QI Program aggregate.
- For *Adequacy of Specialists*, HMSA QI's and KFHP QI's 2023 top-box scores were statistically significantly higher than the QI Program aggregate, while AlohaCare QI's, 'Ohana QI's, and UHC CP QI's 2023 top-box scores were statistically significantly lower than the QI Program aggregate.
- For *Availability of Mental Health Providers*, KFHP QI's 2023 top-box score was statistically significantly higher than the QI Program aggregate, while AlohaCare QI's and 'Ohana QI's 2023 top-box scores were statistically significantly lower than the QI Program aggregate.
- For *Access to Substance Abuse Treatment*, KFHP QI's 2023 top-box score was statistically significantly higher than the QI Program aggregate, while AlohaCare QI's, HMSA QI's, 'Ohana QI's, and UHC CP QI's 2023 top-box scores were statistically significantly lower than the QI Program aggregate.

Trend Analysis

To evaluate trends in performance, HSAG compared the 2023 top-box scores to the corresponding 2021 top-box scores, where applicable. Table 4-20 presents a summary of the measures that had statistically significant differences between the 2023 and 2021 top-box scores.[4-6] Please note, there were no statistically significant differences for AlohaCare QI, HMSA QI, KFHP QI, 'Ohana QI, or KFHP QI.

Table 4-20—Trend Analysis

Measure	QI Program
General Positions	
Compensation Satisfaction	▲
Providing Quality Care	
Formulary	▲
Non-Formulary	
Adequate Access to Non-Formulary Drugs	▲

[4-6] For more detailed results on the trend analysis, please see the 2023 Hawaii Provider Survey full report.

Measure	QI Program
Health Coordinators	
Helpfulness of Health Coordinators	▲
Specialists	
Adequacy of Specialists	▲
Substance Abuse	
Access to Substance Abuse Treatment	▲
▲ *Indicates the 2023 top-box score is statistically significantly higher than the 2021 top-box score.*	

The following is a summary of the QI Program and the QI health plans' performance on the nine measures evaluated for statistical differences:

- The QI Program aggregate's 2023 top-box score was statistically significantly higher than the 2021 top-box score for the following measures: *Compensation Satisfaction, Formulary, Adequate Access to Non-Formulary Drugs, Helpfulness of Health Coordinators, Adequacy of Specialists,* and *Access to Substance Abuse Treatment.*

5. Assessment of Follow-Up to Prior Year Recommendations

Introduction

This section of the annual report presents an assessment of how effectively the health plans addressed the improvement recommendations made by HSAG in the prior year (2022) as a result of the EQR activity findings for compliance monitoring, NAV, 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 compliance reviews were carried over to 2023. The specific compliance review findings and recommendations were reported in the 2022 EQR Report of Results. As appropriate, HSAG conducted technical assistance for the health plans and conducted the follow-up assessments of compliance.

Performance Improvement Projects

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)

Network Adequacy Validation

Recommendations

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

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

Improvement Activities Implemented

While AlohaCare QI did not have a specific identifier for prenatal care providers, AlohaCare QI's analysis of Obstetrics & Gynecology and Midwife specialties indicates that over 90 percent of the entities that provide maternity-related services do also provide prenatal services. Providers are presented in the provider directory and lookup tools under the Obstetrics & Gynecology and Midwife categories.

BH providers are presented in AlohaCare QI's provider directory and lookup tools under the Behavioral Health category, which includes specialties such as Addiction Medicine, Behavioral Health Advanced Practice, Marriage & Family Therapy, Mental Health Counselor, Psychiatry, Pediatric – Psychiatry, Psychologist, and Social Work.

HCBS providers are presented in AlohaCare QI's provider directory and lookup tools under Adult Day Care, Adult Day Health, Adult Foster Care Home, Expanded Adult Residential Care Home (E-ARCH), Home Care, Home Delivered Meals, Personal Care Assistance, and Personal Emergency Response Systems.

SUD providers are presented in AlohaCare QI's provider directory and lookup tools under Addiction Medicine and Behavioral Health Clinic specialties.

AlohaCare QI believes the current setup with provider specialty and provider type allows AlohaCare QI and its members to identify providers in the appropriate category.

HSAG Assessment

HSAG has determined that AlohaCare QI has addressed the prior year recommendations.

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.

2022 HEDIS Performance Measure Recommendations

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

Conversely, 32 of AlohaCare QI's measure rates comparable to benchmarks (78.1 percent) fell below the 50th percentile, with 24 rates (58.5 percent) falling below the 25th percentile, suggesting considerable opportunities for improvement across most domains of care. Additionally, AlohaCare QI met eight MQD Quality Strategy targets for HEDIS MY 2021. HSAG recommends that AlohaCare QI focus on improving performance related to the following measures with rates that fell below the 25th percentile for the QI population:

- Children's Preventive Health
  - *Child and Adolescent Well-Care Visits—18–21 Years*
  - *Childhood Immunization Status—Combination 3, Combination 7, Combination 10, DTaP*, *Hepatitis A, Hepatitis B*, *HiB*, *IPV*, *MMR*, *Pneumococcal Conjugate*, *Rotavirus,* and *VZV*
  - *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Ages 15 Months to 30 Months—Two or More Well-Child Visits*
- Behavioral Health
  - *Follow-Up After Hospitalization for Mental Illness*—all *7-Day Follow-Up* and *30-Day Follow-Up* measure rates except for *30-Day Follow-Up—18–64 Years,* which ranked below the 50th percentile

- *Initiation and Engagement of Alcohol and Other Drug (AOD) Abuse or Dependence Treatment*—all rates except *Engagement—Total—18+ Years*, which ranked below the 50th percentile

Improvement Activities Implemented

In 2023, AlohaCare QI launched a mother/baby pilot program to address *Prenatal and Postpartum (PPC)* as well as *Well-Child Visits in the First 30 Months of Life (W30)* and *Childhood Immunization Status (CIS).* This pilot program has shown a 5 percent increase in well-child visits from 0–15 months in MY 2022, and *CIS* is trending higher than MY 2021 and MY 2022. AlohaCare QI's goal is to reach the NCQA 75th percentile in MY 2023 on *W30* 0–15 months as AlohaCare QI did pre-pandemic. For the children 3–21 years of age population, AlohaCare QI sends birthday cards with well-child visit reminders as well as offering member incentives to complete well-child visits. This age group is trending nearly 5 percent higher than this time last year. AlohaCare QI's largest increases are in the 3–11 and 12–17 age groups.

For *Follow-Up After Hospitalization for Mental Illness (FUH),* AlohaCare QI partnered with an Oahu-based behavioral health provider to create a program where the provider office connects with the patient prior to discharge and schedules follow-up appointments. AlohaCare QI saw a significant increase in its *FUH* rates for members on Oahu. AlohaCare QI is now looking to expand this program to the neighbor islands.

For *Initiation and Engagement of AOD Abuse or Dependence Treatment (IET)*, AlohaCare QI is in the final stages of developing an internal report to identify new SUD episodes. Once this report is complete, AlohaCare QI plans to partner with Federally Qualified Health Centers (FQHCs) and BH providers to encourage initiation and engagement in SUD treatment.

HSAG Assessment

While AlohaCare QI addressed the prior year recommendations and some improvements were seen in measure rates from MY 2021 to MY 2022, *Child and Adolescent Well-Care Visits*, *CIS,* and *PPC* measures are all ranking below the 50th percentile. Additionally, *FUH* and *IET* measure rates continue to have significant room for improvement. AlohaCare QI should continue to implement interventions aimed at improving member access to care and health outcomes.

CAHPS

2022 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*
Q6. Received appointment for a checkup or routine care as soon as needed	✓		
Q9. Ease of getting the care, tests, or treatment needed		✓	
Q17. Personal doctor seemed informed and up-to-date about care from other doctors or health providers	✓	✓	✓
Q20. Received appointment with a specialist as soon as needed	✓		**N/A**
Q24. Health plan's customer service gave the information or help needed	✓	✓	**N/A**
N/A indicates that this question was not evaluated for this measure.			

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

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

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

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

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

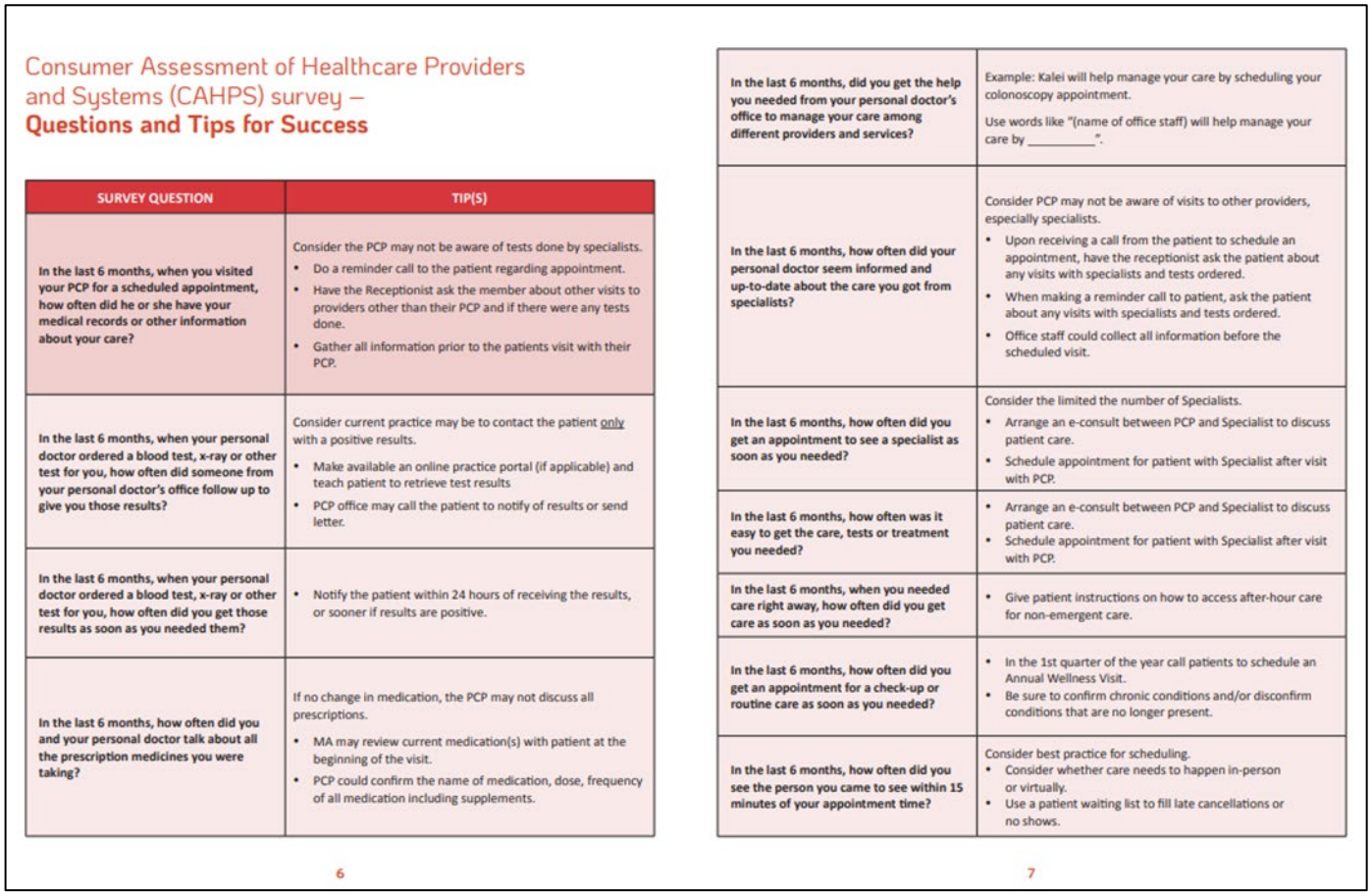
Improvement Activities Implemented

Customer Service (CS) extended the CS Quality program by increasing the frequency of feedback and monitoring oversight with the team. New coaching and interactive tools, such as team call calibrations, role play scenarios, side-by-side and live monitoring were introduced, allowing for more hands-on

participation from CS representatives in both group and individual settings. An improved SharePoint design was introduced with the intent of updating and creating materials, such as new job aids and processes, allowing for greater accessibility for CS representatives. Post-call surveys were also made accessible through the SharePoint site for representatives to enter real-time responses. In conjunction with the new SharePoint design, the training program and curriculum were also expanded to target areas of opportunity discovered during Quality monitoring.

AlohaCare QI implemented improvement activities with its network providers to improve member experience on each of the key drivers identified. Activities included initiating and conducting provider educational webinars statewide reviewing CAHPS survey questions with providers in its network. AlohaCare QI shared tips with providers and their staff (for their consideration), when interacting and communicating with AlohaCare QI members. This education effort continues in upcoming provider training sessions to remind providers of the importance of positive patient engagement.

To reinforce the tips provided, AlohaCare QI added CAHPS to the list of discussion topics to the Provider Servicing Plan for Provider Relations field staff. This plan focuses on targeted servicing to all contracted providers on a tier approach. Further, an article regarding CAHPS questions and tips was published in AlohaCare QI's provider newsletter, Ku`i Ka Lono, as a reference source for providers.



Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey –
Questions and Tips for Success

SURVEY QUESTION	TIP(S)
In the last 6 months, when you visited your PCP for a scheduled appointment, how often did he or she have your medical records or other information about your care?	Consider the PCP may not be aware of tests done by specialists. • Do a reminder call to the patient regarding appointment. • Have the Receptionist ask the member about other visits to providers other than their PCP and if there were any tests done. • Gather all information prior to the patients visit with their PCP.
In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did someone from your personal doctor's office follow up to give you those results?	Consider current practice may be to contact the patient only with a positive results. • Make available an online practice portal (if applicable) and teach patient to retrieve test results • PCP office may call the patient to notify of results or send letter.
In the last 6 months, when your personal doctor ordered a blood test, x-ray or other test for you, how often did you get those results as soon as you needed them?	• Notify the patient within 24 hours of receiving the results, or sooner if results are positive.
In the last 6 months, how often did you and your personal doctor talk about all the prescription medicines you were taking?	If no change in medication, the PCP may not discuss all prescriptions. • MA may review current medication(s) with patient at the beginning of the visit. • PCP could confirm the name of medication, dose, frequency of all medication including supplements.
In the last 6 months, did you get the help you needed from your personal doctor's office to manage your care among different providers and services?	Example: Kalei will help manage your care by scheduling your colonoscopy appointment. Use words like "(name of office staff) will help manage your care by _____".
In the last 6 months, how often did your personal doctor seem informed and up-to-date about the care you got from specialists?	Consider PCP may not be aware of visits to other providers, especially specialists. • Upon receiving a call from the patient to schedule an appointment, have the receptionist ask the patient about any visits with specialists and tests ordered. • When making a reminder call to patient, ask the patient about any visits with specialists and tests ordered. • Office staff could collect all information before the scheduled visit.
In the last 6 months, how often did you get an appointment to see a specialist as soon as you needed?	Consider the limited the number of Specialists. • Arrange an e-consult between PCP and Specialist to discuss patient care. • Schedule appointment for patient with Specialist after visit with PCP.
In the last 6 months, how often was it easy to get the care, tests or treatment you needed?	• Arrange an e-consult between PCP and Specialist to discuss patient care. • Schedule appointment for patient with Specialist after visit with PCP.
In the last 6 months, when you needed care right away, how often did you get care as soon as you needed?	• Give patient instructions on how to access after-hour care for non-emergent care.
In the last 6 months, how often did you get an appointment for a check-up or routine care as soon as you needed?	• In the 1st quarter of the year call patients to schedule an Annual Wellness Visit. • Be sure to confirm chronic conditions and/or disconfirm conditions that are no longer present.
In the last 6 months, how often did you see the person you came to see within 15 minutes of your appointment time?	Consider best practice for scheduling. • Consider whether care needs to happen in-person or virtually. • Use a patient waiting list to fill late cancellations or no shows.

6 7

HSAG Assessment

HSAG has determined that AlohaCare QI has addressed some of the areas for improvement; however, the health plan should continue to implement interventions to improve member satisfaction.

HMSA QUEST Integration (HMSA QI)

Network Adequacy Validation

Recommendations

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

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

Improvement Activities Implemented

To collect, store, and report on prenatal provider types, as well as provider panel capacity, HMSA QI evaluated its processes and systems to identify the following activities. The status of each of these efforts are reported below:

1. Update the provider application to collect the prenatal provider indicator and panel capacity
    - Status: On track for completion by October 9, 2023
2. Update the provider self-service tool to collect the prenatal provider indicator and panel capacity
    - Status: Dependent upon a project currently in progress. Expected timeframe for completion by mid November 2023
3. Determine fields within the provider database these new data points will be stored and be reported on.
    - Status: Complete

HSAG Assessment

HSAG has determined that HMSA QI has addressed the prior recommendations.

Validation of Performance Measures—NCQA HEDIS Compliance Audits

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

Improvement Activities Implemented

Not applicable.

2022 HEDIS Performance Measure Recommendations

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

Conversely, 24 of HMSA QI's measure rates comparable to benchmarks (58.5 percent) fell below the 50th percentile, with 14 rates (34.2 percent) falling below the 25th percentile, suggesting considerable opportunities for improvement across most domains of care. HSAG recommends that HMSA QI focus on improving performance related to the following measures with rates that fell below the 25th percentile for the QI population:

- Children's Preventive Health
  - *Childhood Immunization Status—Combination 3, Combination 7, DTAP, Hepatitis A, Hepatitis B, HiB, IPV, MMR, Pneumococcal Conjugate, Rotavirus,* and *VZV*
- Behavioral Health
  - *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation—Total—13–17 Years, Initiation—Total—18+ Years,* and *Initiation—Total—Total*

Improvement Activities Implemented

Children's Preventive Health

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.

Additionally, HMSA QI continues its two primary care provider programs, Payment Transformation and FQHC Pay-for-Quality, in which part of providers' compensation is tied to specific quality metrics. These quality payment programs continue to include measures for childhood immunizations, which encompass hepatitis B and all the vaccines grouped in combos 3 and 7.

Finally, as part of HMSA QI's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program, monthly, HMSA QI sends members age-specific mailers that remind them to complete their well-child exams. These reminders include applicable vaccinations aligned to the Bright Futures

screening and periodicity schedule. Beginning in 2023, HMSA moved the 15-month reminder to 12 months to allow for a more actionable time frame.

Behavioral Health

Last year, over 5,000 HMSA QI members were newly diagnosed with an SUD. Over 40 percent of members were diagnosed within a hospital. As a result, in 2023, HMSA QI focused on post-discharge support for facilities.

During the inpatient stay, clinicians from HMSA QI's behavioral health partner work concurrently with the facility to ensure all members have access to post-discharge appointments. Following the inpatient discharge, a behavioral health clinician conducts a Transitional Care Management appointment. This appointment helps ensure members have a follow-up appointment scheduled, barriers to care are addressed, and any potential risks are also addressed with the member. If a member has a hard time gaining access to a face-to-face appointment, the behavioral health clinicians promote the use of telehealth. On a quarterly basis, facilities are provided their average length of stay, readmission rates, and a preferred provider list for members without a current clinical provider. Additionally, emergency room social workers received lists of providers that are taking new members to treat substance use conditions.

HSAG Assessment

While HMSA QI has addressed the prior recommendations, *CIS* measure rates for *Combination 3, Combination 7, DTaP, Hepatitis A, Hepatitis B, HiB, IPV, MMR, Pneumococcal Conjugate, Rotavirus,* and *VZV* continue to rank below the 50th percentile. Due to changes in *Initiation and Engagement of AOD Abuse or Dependence Treatment* measure specifications, benchmarks and trending are not available. HMSA QI should continue to implement interventions aimed at improving member access to care and health outcomes.

CAHPS

2022 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. Received care as soon as needed when care was needed right away	✓	✓	
Q9. Ease of getting the care, tests, or treatment needed		✓	
Q17. Personal doctor seemed informed and up-to-date about care from other doctors or health providers			✓

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

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

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

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

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

Improvement Activities Implemented

In 2023, HMSA QI made member experience a focus of discussion in its provider organization workgroups. As a result, beginning with the 2024 program year, HMSA QI's Payment Transformation program will include incentives for provider organizations to improve CAHPS performance in areas including the following: *Getting Needed Care*, *Rating of All Health Care*, and *Care Coordination*, which includes a question that addresses how well-informed personal doctors seem about care received from specialists.

HSAG Assessment

While HMSA QI has addressed the prior recommendations with a general plan for the next calendar year, no improvement activities were implemented in 2023 to address the 2022 findings. The health plan should utilize quality improvement strategies to monitor implementation of interventions and develop a method for determining whether the interventions lead to improved member experience.

Kaiser Foundation Health Plan QUEST Integration (KFHP QI)

Network Adequacy Validation

Recommendations

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

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

Improvement Activities Implemented

KFHP QI has submitted the complete Provider Network Adequacy (PNA) report to meet MQD's reporting requirements and has received an approved status for the second quarter 2023 reporting period. The PNA reporting package contains all providers within the KFHP QI network, which includes SUD and HCBS providers. SUD providers are reported as a Behavioral Health Provider under the All Other Behavioral Health Providers PNA Provider category.

The PNA report is refreshed each quarter to meet the reporting period requirements and submission deadline. With the submission, the Provider Level Data File (PLDF) contains reported fields for panel capacity and patient acceptance for all provider types.

HSAG Assessment

HSAG has determined that KFHP QI has addressed the prior year recommendations.

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.

2022 HEDIS Performance Measure Recommendations

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

Conversely, 13 of KFHP QI's measure rates comparable to benchmarks (35.1 percent) fell below the 50th percentile, nine of which (24.3 percent) fell below the 25th percentile, suggesting that some opportunities for improvement exist. HSAG recommends that KFHP QI focus on improving performance related to the following measures with rates that fell below the 25th percentile for the QI population:

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

Improvement Activities Implemented

Children's Preventive Health

- *Child and Adolescent Well-Care Visits—3–11 Years, 18–21 Years,* and *Total*
- *Childhood Immunization Status—HiB* and *MMR*
  - Continue with Saturday Physical Exam fairs at various clinics across Oahu (implemented in 2023—ongoing)
  - Implemented outreach processes for well-child visits with targeted outreach every two to eight weeks based on age groups (implemented 2023)
  - As part of standard work, if schedule available, staff scheduling future next well-child visit if appointment has not already been scheduled (implemented 2023)
  - Availability of schedules seven months in advance to allow for booking next appointments (implemented 2023)
  - Continuing with immunization outreach for both combo 10 and combo 2, with both overdue and proactive outreach lists are sent to staff in clinics (implemented—ongoing)
  - Continuing with ongoing in-reach, when patient in clinic, informing/reminding patients/parents that they are due for vaccines and giving them at time patient is in clinic (implemented—ongoing)

Behavioral Health

- *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation—Total—18+ Years, Initiation—Total, Engagement—Total—18+ Years,* and *Engagement—Total—Total*

Kaiser Permanente Hawaii (KPHI) continues to prioritize improvement efforts of the *Initiation and Engagement of AOD Abuse or Dependence Treatment* HEDIS measure. The strategy of the Integrated Behavioral Health (IBH) program to improve this measure is to increase awareness of referrals to chemical dependency services and monitor/track cohort reports identifying Index Prescription Start Date (IPSD) patients to ensure timely appointments are scheduled. Initiatives are focused on increasing the care coordination of this targeted population as well as utilizing quality reports to provide timely feedback and education to providers. Increased care coordination for patients with AOD diagnosis through tracking of daily outreach reports will help ensure that referrals to treatment are achieved on timelier basis. This has been an ongoing effort.

Focused activities/interventions include:

- Active recruitment of Certified Substance Abuse Counselor position to fill vacant position throughout work strike August 2022–February 2023, which then resulted in vacancy with incumbent resignation. Position is in active recruitment phase with interviews being conducted with potential candidates (still underway).
- Daily outreach report to monitor and track newly identified index visits (still underway).
- Best practice alert in place for providers to refer patients for chemical dependency services when diagnosis is made (completed).
- As part of the Care Without Delay initiative, IBH collaborated with the Transitional Care Clinic (TCC) to create workflow for immediate referral and access to AOD treatment for members discharged from inpatient with AOD needs (competed).
- Identification of primary care departments with missed opportunities for initiation visits and continue to provide education and feedback on performance (ongoing).
- Tracking progress with monthly HEDIS proxy reports and providing feedback to departments (ongoing).

- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total*

MY 2021 results of 67.70 percent improved by 8.9 percentage points over the previous year (MY 2020), achieving the 75th percentile.

HSAG Assessment

While KFHP QI has addressed the prior recommendations, all *Child and Adolescent Well-Care Visits* measure rates continue to rank below the 25th percentile. Additionally, the *Initiation and Engagement of AOD Abuse or Dependence Treatment* measure rates for MY 2022 are still low. Because of changes in measure specification, benchmarks and trending are not available in 2023. While KFPH QI met MQD's

Quality Strategy target for *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total*, the MY 2022 rate decreased 9.10 percent from MY 2021 to MY 2022. KFHP QI should continue to implement interventions aimed at improving member access to care and health outcomes.

CAHPS

2022 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*
Q9. Ease of getting the care, tests, or treatment needed	✓	✓	
Q17. Personal doctor seemed informed and up-to-date about care from other doctors or health providers	✓	✓	✓

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

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

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

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

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

Improvement Activities Implemented

Ease of getting the care, tests, or treatment needed.

- KFHP QI has refined strategies to increase KP.org member enrollment and utilization. KFHP QI also continues to verify and reinforce KP.org enrollment at all touchpoints via mailers, during

appointment scheduling, filling prescriptions, and secure messaging with providers. KFHP QI has implemented communication with members that speak to staying connected with their provider and healthcare team, and timely access to test results using KP.org. KP.org has been updated to create a more personalized experience for members. What is pertinent to individual members will show up on their respective landing pages. This helps to address care gaps.

- KFHP QI continues to expand E-visits and E-tickets with more services being added.
- KFHP QI has expanded the date range for members using KP.org to book appointments from 14 days to 42 days.
- "Find Care Now" is being piloted at Maui Lani Urgent Care. Find Care Now helps find access and minimizes wait times.
- "Get Care Now" is a feature that allows members to connect with a physician 24/7 for urgent care via telephone or video. Providers in 40 states have been credentialed to help support KPHI members.

Personal doctor seemed informed and up-to-date about care from other doctors or health providers.

- KFHP QI has optimized scripting at all touchpoints for care coordination, including After Visit Summary (AVS) language updates, updates to medical assistant/licensed practical nurse (MA/LPN) scripting to support care coordination components as standard work addressing medication review, test results, and care coordination with specialists.
- Provider workflow for care delivery was assessed and updates to the workflow include scripting that guides their discussion and care coordination that involves other providers. In addition, a patient passport was developed and implemented to help support expectations members may have about their personal doctor being informed and up-to-date.

HSAG Assessment

While KFHP QI has addressed the prior recommendations, the health plan should utilize quality improvement strategies to monitor implementation of interventions and develop a method for determining whether the interventions lead to improved member experience.

‘Ohana Health Plan QUEST Integration (‘Ohana QI)

Network Adequacy Validation

Recommendations

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

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

Improvement Activities Implemented

‘Ohana QI does not collect data regarding provider panel capacity for any provider types or specialties; however, there are initiatives to proactively identify shortages or areas of concern:

- The use of VEDA software was implemented in 2023, which looks at various types of provider data and identifies any duplication or inconsistencies to ensure that the Find A Provider tool is as accurate as possible. ‘Ohana QI will double check any provider locations that are suppressed to ensure the directory suppression is valid. As the directory gets updated and if network adequacy issues are identified, the Network Contracting team would work to find additional providers in the respective area to contract with. For network adequacy/competitiveness/growth, the tools ‘Ohana Health Plan uses are Quest Analytics/Clarify/other HP Directories.
- Quality improvement provider practice coordinators or quality practice advisors along with provider relations representatives conduct regular provider performance meetings using reporting with member assignment to PCPs. The meetings review the potential for provider panel capacity by focusing on members without visits and members’ quality activities and engagement with their PCP(s) throughout the year. During these reviews, discussions explore potential resource issues with providers not having enough staff to reach out to members or scheduling difficulties for various reasons that may indicate providers are unable to accommodate their assigned panel. Quality Improvement and Provider Relations regularly work through these panel reviews to help providers prioritize or look for other PCPs or specialty providers that may be able to help with members’ specific needs.

HSAG Assessment

HSAG has determined that ‘Ohana QI has addressed the prior year recommendations.

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.

2022 HEDIS Performance Measure Recommendations

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

Conversely, 26 measure rates comparable to benchmarks (70.3 percent) ranked below the 50th percentile, with 17 measure rates (46.0 percent) falling below the 25th percentile, suggesting considerable opportunities for improvement across all domains. HSAG recommends that ‘Ohana QI focus on improving performance related to the following measures with rates that fell below the 25th percentile for the QI population:

- Children’s Preventive Health
  - *Child and Adolescent Well-Care Visits—18–21 Years* and *Total*
  - *Childhood Immunization Status—Combination 3, Combination 7*, *DTaP*, *Hepatitis A, Hepatitis B*, *HiB*, *IPV*, *MMR*, *Pneumococcal Conjugate, Rotavirus,* and *VZV*
  - *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits*
- Women’s Health
  - *Cervical Cancer Screening*
- Behavioral Health
  - *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation—Total—18+ Years* and *Initiation—Total—Total*

Improvement Activities Implemented

2023 Medicaid Partnership for Quality (P4Q) Program

- ‘Ohana QI’s 2023 Medicaid Partnership for Quality (P4Q) recognizes providers who deliver high quality care. Through the P4Q program, providers are able to obtain financial incentives to close care gaps addressing preventive care and chronic conditions. ‘Ohana QI supports providers by

educating them about the program, providing quality performance meetings to discuss current member/measure specific Quality Care Gap Reports (also available via the Provider Portal), reaching out to members on behalf of the provider to schedule appointments/discuss care needs and providing general educating on coding and standards of care. Childhood immunizations, well child visits, cervical cancer screening and diabetes A1c testing/control are included in the measures that are incentivized.

2023 My Health Pays

- The ‘Ohana QI provides incentives to members, in the form of visa cards, for completing healthy behaviors including annual wellness visits, well-child visits, cervical cancer screening, breast cancer screening, prenatal/postpartum care, and diabetes HbA1c testing. The visa cards can be used to pay for everyday items at Sam’s Club and Walmart, and can also be used to pay for utilities, rent, transportation, and childcare.

Member Newsletter

- Q1 2023
  - *Developmental Disabilities & Your Child*—Article describes developmental disabilities and why it is important to bring your child in for regular check-ups.
  - *Do You Take an Antidepressant?*—Article describes why it is important to take antidepressants as prescribed.
  - *Recovery Care for Behavioral Health and Substance Use Disorders*—Importance of getting help to make healthy life changes. Describes 4 elements that support recovery.
- Q2 2023
  - *Why Are Checkups Important?* Importance of getting regular check-ups toward a healthier life and information if you need help making an appointment.
  - *Important Health Screenings for Women*—Describes why screenings are important and how easy they are to get completed.
  - *Protect Your Child with Vaccines*—Talks about why vaccines in children are important in keeping them healthy and how vaccines work.
  - *Recovery Care for Behavioral Health and Substance Use Disorders*—Importance of getting help to make healthy life changes. Describes four elements that support recovery.
- Q3 2023
  - *Cancer Screening for Early Detection*—States why cancer screening is important and why you should talk to your doctor about the screenings.
  - *Annual Checkups Are Important*—Describes why annual check-ups are important and how to schedule an exam.
- Q4 2023
  - *Recovery Care for Behavioral Health and Substance Use Disorders*—Importance of getting help to make healthy life changes. Describes four elements that support recovery.

- *4 Ways to Stay Safe from Opioid Drug Misuse*—Article describes on how to keep yourself and others safe around opioid use.

Internal Process and Intervention

- *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation—Total—18+ Years and Initiation—Total—Total (IET)*
  - Leveraging ‘Ohana QI’s success with other measures and employing best practices. ‘Ohana Health Plan has added *IET* to the *FUH* intake form to better capture data and enable ‘Ohana QI to better follow up with members.
  - Joint workgroup sessions were created and involved ‘Ohana Health Plan’s vendor partner ChangeWorks, ‘Ohana QI UM, and the ‘Ohana CCS team on how quality can support the *IET* measure by combining *FUH* outreach with *IET*. Exchange of information between all departments improves engagement, identification, and tracking.
- ‘Ohana Health Plan focuses on *Antidepressant Medication Management (AMM)* and *Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)* through the 5 Minute Pharmacy medication adherence program. This program deploys a suite of services to drive behavioral health medication adherence. Tools such as Mobile Pharmacist are key with hard-to-reach populations or individuals who struggle to get care. In addition, the program employs the use of home delivery, member calls, compliance packaging, and medication synchronization.

HSAG Assessment

While ‘Ohana QI addressed the prior year recommendations by providing information about initiatives and interventions to address low performance measure rates, performance on all Children’s Preventive Health and Women’s Health measure rates decreased from MY 2021 to MY 2022. Additionally, the *Initiation and Engagement of AOD Abuse or Dependence Treatment* measure rates for MY 2022 are still low. Because of changes in measure specification, benchmarks and trending are not available in 2023. ‘Ohana QI should continue to implement interventions aimed at improving member access to care and health outcomes.

CAHPS

2022 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*
Q4. Received care as soon as needed when care was needed right away		✓	
Q9. Ease of getting the care, tests, or treatment needed	✓	✓	
Q20. Received appointment with a specialist as soon as needed	✓		**N/A**
Q24. Health plan's customer service gave the information or help needed	✓		**N/A**
N/A indicates that this question was not evaluated for this measure.			

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

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

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

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

Improvement Activities Implemented

Mock CAHPS Results

- 'Ohana QI distributed mock CAHPS reports to providers whose patients responded to the mock survey. The report results highlighted opportunities for providers to improve adult and child care coordination.

Hallmark Cards

- This initiative aimed to connect with members in a more meaningful way and have 'Ohana QI be viewed as a more of a "trusted friend/partner" in a member's healthcare journey. The notion is to build stronger member relationships and an "emotional connection" to 'Ohana QI in order to move members to take action through sending a Hallmark card, which is one of the most highly recognized brands nationwide. A Hallmark card from 'Ohana QI should be more like receiving a card from a caring friend versus the prescriptive tone usually conveyed by a letter or mailing from a health plan.

Internal Process and Intervention

- A primary barrier identified for access and timeliness to care was the administrative burden of prior authorizations. At the end of 2022, ‘Ohana QI piloted a Gold Card program with several specialists. The Gold Card program removed prior authorization requirements for certain provider specialty types, as long as the provider remained open panel and had a low denial rate of historical prior authorizations. At the beginning of 2023, a handful of other specialty types were explored within this program to which providers were very receptive. Starting in Q4 2023, ‘Ohana QI will be expanding the Gold Card program to all specialists who are open panel, thereby removing the administrative burden from these provider types, and intending to increase referral opportunities across the entire network.
- ‘Ohana QI audits Customer Service calls to ensure the information provided to members meets the health plan’s quality and accuracy goals. To support the highest quality of service and accuracy of information, the health plan’s Quality team audits live and/or recorded calls on a post-call basis. The audit examines each customer service representative’s (CSR’s) ability to work with members appropriately, effectively, and in a culturally competent manner, while prioritizing treatment and care based on need. Agents are evaluated a minimum of four times.

HSAG Assessment

While ‘Ohana QI has addressed the prior recommendations, the health plan should utilize quality improvement strategies to monitor implementation of interventions and develop a method for determining whether the interventions lead to improved member experience.

UnitedHealthcare Community Plan QUEST Integration (UHC CP QI)

Network Adequacy Validation

Recommendations

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

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

Improvement Activities Implemented

Not applicable.

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.

2022 HEDIS Performance Measure Recommendations

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

Conversely, 26 of UHC CP QI's 37 measure rates comparable to benchmarks (70.3 percent) fell below the 50th percentile, with 23 of these rates (62.2 percent) falling below the 25th percentile, suggesting considerable opportunities for improvement across all domains. HSAG recommends that UHC CP QI focus on improving performance related to the following measures with rates that fell below the 25th percentile for the QI population:

- Access and Risk-Adjusted Utilization
  - *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Total*
- Children's Preventive Health
  - *Child and Adolescent Well-Care Visits—3–11 Years, 12–17 Years, 18–21 Years,* and *Total*
  - *Childhood Immunization Status—Combination 3, Combination 7, DTaP, Hepatitis A, Hepatitis B, HiB, IPV, MMR, Pneumococcal Conjugate, Rotavirus,* and *VZV*
  - *Well-Child Visits in the First 30 Months of Life—Age 15 Months to 30 Months—Two or More Well-Child Visits*
- Women's Health
  - *Cervical Cancer Screening*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

Improvement Activities Implemented

- **Access and Risk-Adjusted Utilization**
  - *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Total*

Accountable care: UHC CP QI maintains an accountable care/value-based care program in partnership with various health clinics statewide to focus on reducing readmissions. As part of value-based care, UHC CP QI collaborates with clinics on programs such as ED Hotspotting to identify members with high utilizations (i.e., emergency room, admissions, readmissions, etc.) and enroll them in care management. The readmission rate is one of the key metrics for the clinics and the UHC CP QI Accountable Care Organization (ACO) team works closely with the clinics to reduce avoidable readmissions. UHC CP QI also has a Collaborative Care Model, which incorporates behavioral health in the primary care setting to deploy a multi-disciplinary care team consisting of a PCP, BH nurse care manager, and a consulting psychiatrist to assess both medical and behavioral health needs of members.

Case rounds: UHC CP QI holds continuum of care rounds twice weekly to review members who are wait-listed in the hospital or members identified as high utilizers or who have complex discharges. The case rounds are attended by an interdisciplinary team that consists of Health Coordination staff and managers, behavioral health field care advocates or other staff, health services directors, medical directors, and other clinical staff who support the program (e.g., Housing Coordination and Utilization Management). Members are reviewed in case rounds to discuss and explore interventions for best outcomes.

Transitions of care: UHC CP QI has a transitions of care program for dual-eligible special needs plan (DSNP) members who are experiencing a transition from the hospital to the home. Members in the program receive a 30-day transitional care manager who reviews medications, changes in care, and updates to assessments and care plans. The transitional case manager also assists with referrals to support coordination of care activities for the member.

Post-discharge calls: UHC CP QI developed a program to conduct post-discharge phone calls to QI members ages 18–64 who recently discharged from a hospital or facility. The purpose of the post-discharge calls is to evaluate member needs, assess for social determinants of health, share information about existing benefits, and assist with follow up appointments.

- **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*

EPSDT program: UHC CP QI runs an EPSDT program for children and adolescents up to the age of 21. The EPSDT program consists of an EPSDT coordinator, clinical practice consultants, population health disease management manager, clinical pediatric program manager, Health Coordination staff, Provider Advocacy staff, and other health plan personnel who support program activities such as member and provider education and outreach and coordination of care with other entities who support EPSDT members (e.g., Child and Adolescent Mental Health Division, Child Welfare Services, Developmental Disabilities Division, Vaccines for Children, etc.).

EIP program: UHC CP QI has an Early Intervention Program (EIP) that 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 3 if the family declined prior health coordination. As part of the EIP, the EIP case manager and health coordinators collaborate on complex care to support the member and family with EPSDT services as well as transition out of the program at 3 years old.

Member incentives: UHC CP QI created member incentive programs to encourage members with an open care gap to complete an EPSDT screening or well-child visit, or to take all their recommended childhood and adolescent immunizations. UHC CP QI has a Member Rewards Program that offers eligible members a gift card as a reward for closing a care gap. The program includes a reward for childhood immunizations and well-child visits. UHC CP QI also has targeted point-of-service member incentives that enable members to receive a gift card at the doctor's office after a screening or visit is completed. The point-of-service member incentive is conducted in partnership with various providers statewide. It includes a reward for EPSDT screenings and well-child visits.

Provider incentives: 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 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 related to well-child visits.

Child immunization program: UHC CP QI participates in a child immunization program sponsored by Pfizer. The program sends a reminder for missed dosed vaccines targeting parents or guardians of children at ages 6 months, 8 months, and 16 months. The reminders are completed using interactive voice recording (IVR) calls and/or postcards. The program is ongoing and runs year-round.

Omnichannel: UHC CP QI has an OmniChannel program that targets members with gaps in care, including *CIS*. The OmniChannel program performs member outreach using a member's preferred mode of communication: email, IVR calls, and/or text messages. The program is ongoing and runs year-round.

Wellness workshops: UHC CP QI hosts monthly wellness workshops to promote member wellness via its "Taking Charge" educational series on a variety of topics such as immunizations and well-child visits ("Taking Charge of Your Child's Health"). The wellness workshops are conducted virtually and open to all UHC CP QI members.

Live calls: UHC CP QI has a Live Agent Program with live agents who make outbound calls to members and assist with scheduling appointments. The live agent will make 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-care or well child visits. The program deployment is contingent on MQD approval.

- **Women's Health**
  - *Cervical Cancer Screening*
  - *Prenatal and Postpartum Care—Timeliness of Prenatal Care*

Hāpai Mālama: UHC CP QI has a maternity support program, Hāpai Mālama, 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 neonatal intensive care unit (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, or those who are at high risk or rising risk.

Healthy First Steps: UHC CP QI has an online wellness program, Healthy First Steps, offering rewards for obtaining prenatal, postpartum, and child's well-baby care (up to 15 months of age). Rewards include a diaper bag or Old Navy gift card, a nursing cover or teething rattle, a first aid kit or tabletop toy, a childproofing kit, or puzzles and books among other rewards to support the mother's well-being and the child/children's development.

WellHop: 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 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.

Email campaign: UHC CP QI deploys an annual email campaign focusing on women's health. The email campaign encourages women to complete their yearly wellness exam and preventive screenings for both breast cancer and cervical cancer.

Member incentives: UHC CP QI created member incentive programs to encourage members with an open care gap to complete a cervical cancer screening. UHC CP QI has a Member Rewards Program that offers eligible members a gift card as a reward for closing a care gap. The program includes a reward for cervical cancer screening and postpartum care. UHC CP QI also has targeted point-of-service member incentives that enable members to receive a gift card at the doctor's office after a screening or visit is completed. The point-of-service member incentive is conducted in partnership with various providers statewide. It includes a reward for postpartum care.

Provider incentives: UHC CP QI has provider incentive programs for qualifying physician practices for performance tied to addressing patient care opportunities for certain HEDIS measures. The CP-PCPi offers select providers with additional incentives for helping members become more engaged in their preventive healthcare. The CP-PCPi includes incentives for cervical cancer screening, timeliness of prenatal care, and postpartum care.

Omnichannel: UHC CP QI has an OmniChannel program that targets members with gaps in care, including for cervical cancer screening and postpartum care. The OmniChannel program performs member outreach using a member's preferred mode of communication: email, IVR calls, and/or text messages. The program is ongoing and runs year-round.

Live calls: UHC CP QI has a Live Agent Program with live agents who make outbound calls to members and assist with scheduling appointments. The live agent will make three attempts to connect with the member to schedule an appointment. The program targets members who were identified as noncompliant for cervical cancer screening, prenatal care, and postpartum care. The program deployment is contingent on MQD approval.

HSAG Assessment

While UHC CP QI addressed the prior year recommendations by providing information about initiatives and interventions to address low performance measure rates, *Child and Adolescent Well-Care Visits*, *Childhood Immunization Status,* and *Timeliness of Prenatal Care* measure rates continue to rank below the 50th percentile. UHC CP QI showed improvement in the *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Total* measure rate from MY 2021 to MY 2022. UHC CP QI should continue to implement interventions aimed at improving member access to care and health outcomes.

CAHPS

2022 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*
Q9. Ease of getting the care, tests, or treatment needed		✓	
Q17. Personal doctor seemed informed and up-to-date about care from other doctors or health providers	✓	✓	
Q24. Health plan's customer service gave the information or help needed	✓		**N/A**
N/A indicates that this question was not evaluated for this measure.			

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

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

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

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

Improvement Activities Implemented

UHC CP QI conducts CAHPS Medicaid adult and child surveys annually using an NCQA certified HEDIS survey vendor. UHC CP QI reviews survey results at quality committees as part of continuous quality improvement. UHC CP QI created a CAHPS workgroup that is comprised of key operational and functional areas that have an impact on member experience. The workgroup meets regularly to conduct barrier analysis and develop and implement interventions to raise performance in areas of member experience such as access, timeliness, and quality of care.

- **Access and timeliness:**

UHC Doctor Chat: UHC CP QI uses UHC Doctor Chat for 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.

NurseLine: UHC CP QI offers NurseLine, 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.

Telehealth hub: UHC CP QI is partnering with the Honolulu Police Department (HPD) to locate and engage members who are homeless in certain areas and in need of service. UHC CP QI is also working with HPD's Joint Outreach Center in Chinatown, offering a secure location for UHC CP QI's BH field care advocates to provide resources and connect members with virtual, telehealth services with a licensed provider. A member incentive is available to encourage follow-up visits.

Telehealth pilot: UHC CP QI secured commitments from several BH practitioners who agreed to reserve office time to complete follow-up BH appointments via telehealth. The program is ongoing to support access and timeliness of follow-up BH care.

Provider directory: UHC CP QI updated its provider directory to include a telehealth indicator for all network providers who offer telehealth or virtual. UHC CP QI conducts audits regularly to ensure that that telehealth data is captured and loaded accurately in its network database. All UHC CP QI members can review the provider directory on the website, mobile app, or on paper upon request.

Member newsletter: UHC CP QI publishes a quarterly member newsletter (HealthTalk) that includes information about member resources that are available to all UHC CP QI members, such as non-emergency medical transportation, NurseLine, and the mobile app. The Spring 2023 edition of the newsletter also included an article "Caring for you" that explained what to do to make sure you get the care you need when you need it. The article included information about the transportation benefit, urgent care centers, and virtual visits.

Member outreach: UHC CP QI started a member outreach program targeting members with no PCP visits on record. The purpose of the program is to assist members with finding a provider and scheduling an appointment.

- **Quality of care:**

Advocate4Me: UHC CP QI uses Advocate4Me (A4Me) as its operating model for its customer service department. A4Me enables customer service agents with the technology to assist members with their medical, behavioral, clinical, and pharmacy needs. The technology enables agents to assist members in real time with finding providers and scheduling appointments.

Staff training: UHC CP QI conducts continuous training for new and tenured staff to align with its A4Me model. UHC CP QI also performs individual retraining for agents based on the results of quality audits or experience surveys. UHC CP QI's customer service participates in a training program called Net Promoter Score (NPS) Academy. Customer service staff members who successfully complete the training receive NPS Champion certification.

Member Advisory Group: UHC CP QI hosts quarterly Member Advisory Group (MAG) meetings to solicit feedback from members on improvement opportunities related to various aspects of their healthcare experience. UHC CP QI regularly queries MAG members for their input on programs such as cultural competency or health equity as well as customer service. UHC CP QI takes action based on the feedback received.

Information exchange: UHC CP QI supports and promotes information exchange platforms such as Hawaii Health Information Exchange (HHIE). UHC CP QI promotes the platform with providers at its provider townhalls to encourage coordination of care between providers.

HSAG Assessment

While UHC CP QI has addressed the prior recommendations, the health plan should utilize quality improvement strategies to monitor implementation of interventions and develop a method for determining whether the interventions lead to improved member experience.

‘Ohana Community Care Services (‘Ohana CCS)

Network Adequacy Validation

Recommendations

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

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

Improvement Activities Implemented

‘Ohana CCS does not collect data regarding provider panel capacity for any provider types or specialties, however, there are initiatives to proactively identify shortages or areas of concern:

- ‘Ohana CCS continues to provide increased reimbursement rates for behavioral health APRNs with prescriptive authority as a means to incentivize this specialty area, which has traditionally been dominated by psychiatrists or MDs only with prescriptive authority. In addition to this initiative, there is also a focus on recruiting providers with telehealth capabilities, especially in reaching hard-to-access regions. In 2023, ‘Ohana Health Plan onboarded two provider groups who specialize in telehealth primary care and behavioral health care.
- The use of VEDA software was implemented in 2023, which looks at various types of provider data and identifies any duplication or inconsistencies to ensure that the Find A Provider tool is as accurate as possible. ‘Ohana Health Plan will double check any provider locations that are suppressed to ensure the directory suppression is valid. As the directory gets updated if network adequacy issues are identified, the Network Contracting team would work to find additional providers in the respective area to contract with. For Network Adequacy/Competitiveness/Growth the tools ‘Ohana Health Plan uses are Quest Analytics/Clarify/other HP Directories.
- Quality improvement provider practice coordinators or quality practice advisors along with provider relations representatives conduct regular provider performance meetings using reporting with member assignment to PCPs. The meetings review the potential for provider panel capacity by focusing on members without visits and members’ quality activities and engagement with their PCP(s) throughout the year. During these reviews, discussions explore potential resource issues with providers not having enough staff to reach out to members or scheduling difficulties for various reasons that may indicate providers are unable to accommodate their assigned panel. Quality Improvement and Provider Relations regularly work through these panel reviews to help providers prioritize or look for other PCPs or specialty providers that may be able to help with members’ specific needs.

HSAG Assessment

HSAG has determined that ‘Ohana CCS has addressed the prior year recommendations.

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.

2022 HEDIS Performance Measure Recommendations

Based on HSAG’s analyses of the 20 ‘Ohana CCS measure rates with comparable benchmarks, 14 of these measure rates (70.0 percent) ranked at or above the 50th percentile. Three of the 14 measure rates (15.0 percent) ranked at or above the 75th percentile but below the 90th percentile, and eight of the 14 measure rates (40.0 percent) met or exceeded the 90th percentile, indicating positive performance related to follow-up after a discharge for mental illness. ‘Ohana CCS met nine MQD Quality Strategy targets for HEDIS MY 2021.

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

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

Improvement Activities Implemented

Member Newsletter

- Q1 2023
  - *Do You Take an Antidepressant?* Article describes why it is important to take antidepressants as prescribed.
  - *Recovery Care for Behavioral Health and Substance Use Disorders*—Importance in getting help to make healthy life changes. Describes 4 elements that support recovery.
- Q2 2023
  - *Recovery Care for Behavioral Health and Substance Use Disorders*—Importance in getting help to make healthy life changes. Describes 4 elements that support recovery.

- Q4 2023
  - *Recovery Care for Behavioral Health and Substance Use Disorders*—Importance in getting help to make healthy life changes. Describes four elements that support recovery.
  - *4 Ways to Stay Safe from Opioid Drug Misuse*—Article describes on how to keep yourself and others safe around Opioid use.

Internal Processes and Intervention

- *Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation—Total—18+ Years and Initiation—Total—Total (IET)*
  - Leveraging success with other measures and employing best practices, ‘Ohana Health Plan has added *IET* to the *FUH* intake form to better capture data and enable us to better follow up with members.
  - Joint workgroup sessions were created and involved ‘Ohana CCS’ vendor partner ChangeWorks, ‘Ohana UM, and the ‘Ohana CCS team on how quality can support the *IET* measure by combining *FUH* outreach with *IET*. Exchange of information between all departments improves engagement, identification, and tracking.
- ‘Ohana CCS focuses on *Antidepressant Medication Management* (*AMM*) and *Adherence to Antipsychotic Medications for Individuals With Schizophrenia* (*SAA*) through the 5 Minute Pharmacy medication adherence program. This program deploys a suite of services to drive behavioral health medication adherence. Tools such as Mobile Pharmacist are key with hard-to-reach populations or individuals who struggle with getting care. In addition, the program employs the use of home delivery, member calls, compliance packaging, and medication synchronization.

HSAG Assessment

HSAG has determined that ‘Ohana CCS has addressed the prior year recommendations. ‘Ohana CCS showed improvement in *AMM,* with both measure rates meeting MQD’s Quality Strategy targets. The *Initiation and Engagement of AOD Abuse or Dependence Treatment* measure rates for MY 2022 are still low. Because of changes in measure specification, benchmarks and trending are not available in 2023. ‘Ohana CCS should continue to implement interventions aimed at improving member access to care and health outcomes.

Appendix A. Methodologies for Conducting EQR Activities

Introduction

In CY 2023, 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:

- A review of compliance with federal and State requirements for select standard areas
- Validation of performance measures (i.e., NCQA HEDIS Compliance Audits)
- Validation of PIPs
- A survey of child Medicaid members using the CAHPS survey
- A survey of a statewide sample of CHIP members using the child Medicaid CAHPS survey
- A survey of members receiving HCBS using the HCBS CAHPS survey
- A survey of QI providers
- Validation of encounter data

For each EQR activity conducted in 2023, this appendix presents the following information, as required by 42 CFR §438.364:

- Objectives
- Technical methods of data collection and analysis
- Descriptions of data obtained
- How conclusions were drawn

Compliance Monitoring Reviews

Table A-1 delineates the compliance review activities as well as the standards reviewed during the current three-year compliance review cycle (2022 through 2024).

Table A-1—Three-Year Compliance Review Schedule

	Year One (2022)	Year Two (2023)	Year Three (2024)
Standard	**Review of Standards**		**CAP Review**
Availability of Services	✓		Review of Standards/Elements that received a *Partially Met* or *Not*
Assurances of Adequate Capacity and Services	✓		
Coordination and Continuity of Care	✓		

	Year One (2022)	Year Two (2023)	Year Three (2024)
Standard	**Review of Standards**		**CAP Review**
Confidentiality	✓		*Met* score during the 2022 and 2023 reviews.
Coverage and Authorization of Services	✓		
Enrollee Information	✓		
Enrollee Rights and Protections	✓		
Grievance and Appeal System	✓		
Provider Selection		✓	
Subcontractual Relationships and Delegation		✓	
Credentialing		✓	
Quality Assessment and Performance Improvement		✓	
Health Information Systems		✓	
Practice Guidelines		✓	
Enrollment and Disenrollment		✓	

HSAG divided the federal regulations into 16 standards consisting of related regulations and contract requirements. Table A-2 describes the standards and associated regulations and requirements reviewed for each standard.

Table A-2—Compliance Standards and Regulations

Standard Title	Regulations Included
Availability of Services	438.68 438.206 438.14 42 USC §1396o(a)
Assurances of Adequate Capacity and Services	438.207
Confidentiality	438.224 45 CFR parts 160 and 164, subparts A & E 45 CFR 164.404 45 CFR 164.408 45 CFR 164.410
Coordination and Continuity of Care	438.208
Coverage and Authorization of Services	422.113 431.211 431.213 431.214 438.14 438.114

Standard Title	Regulations Included
	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	438.12 438.102 438.214 438.608 438.610 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—through its EQRO contract with MQD—

conducted a compliance evaluation of the health plans and the CCS program health plan. For the 2023 EQR compliance monitoring activity, the second year of MQD's three-year cycle of compliance review activities, HSAG conducted a desk audit and an on-site review of the health plans to assess the degree to which they met federal managed care and State requirements in select standard areas.

The primary objective for HSAG's reviews was to provide meaningful information to MQD and the health plans regarding the plans' compliance with requirements in seven select areas. HSAG assembled a team to:

- Collaborate with MQD to determine the scope of the review, standards to be evaluated, scoring methodology, data collection methods, schedules for the desk review and on-site review activities, and the agenda for the on-site review.
- Provide technical assistance to the health plans for participating in the compliance review process.
- Collect and review data and documents before and during the on-site review.
- Aggregate and analyze the data and information collected.
- Prepare the reports of its findings.

To accomplish its objective, and based on the results of its collaborative planning with MQD, HSAG developed and used a standardized data collection tool and processes to assess and document each organization's compliance with certain federal Medicaid managed care regulations, State rules, and the associated MQD contract requirements. The review tool included requirements that addressed the following seven performance areas:

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

Prior to the on-site portion of the review, HSAG also evaluated how each organization implemented a number of the requirements for certain managed care administrative functions by reviewing samples of the following:

- Initial credentialing of individual providers
- Recredentialing of individual providers
- Assessment of organizational providers
- Subcontractor/delegation contracts

The health plans were asked to prepare and provide a demonstration of their tracking and reporting systems for a number of managed care administrative functions related to the standards under review. This allowed HSAG to evaluate the soundness of the health plans' methods for data capture and reporting for select MQD-required reports.

The information and findings that resulted from HSAG's review of standards and files will be used by MQD and each health plan to:

- Evaluate the degree to which the health plan's operations are in compliance with the State contract and federal managed care requirements.
- Evaluate health plan organizational strengths and identify areas for improvement.
- Identify, implement, and monitor interventions to improve health plan compliance and the quality, accessibility, and timeliness of its services.

Technical Methods of Data Collection and Analysis

Prior to beginning the compliance monitoring and follow-up reviews, HSAG, in collaboration with MQD, developed a customized data collection tool to use in the review of each health plan. The content of the tool was based on applicable federal and State laws and regulations and the QI health plans' and CCS' current contracts. HSAG conducted the compliance monitoring reviews in accordance with the CMS protocol, *EQR Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, February 2023.[A-1]

Pre-on-Site Review Activities included:

- Developing the compliance review tool, worksheets, and file review tools.
- Scheduling the on-site reviews and sending an introductory letter with a schedule of key dates to each health plan.
- Generating file review samples based on data universes submitted by each health plan.
- Developing and forwarding to each health plan the on-site review agenda.
- Preparing and forwarding to each health plan a customized desk review form and instructions for submitting the requested documentation to HSAG for its desk review.
- Providing the data collection (compliance review) tool to each health plan to help facilitate its preparation for HSAG's review.
- Conducting technical assistance via Webinar for the health plans. The assistance included a PowerPoint presentation outlining the documentation submission processes, HSAG's desk review and on-site review processes, submission of documents for the file reviews, and expectations for logistics during the on-site review. HSAG answered questions during and after the technical

[A-1] 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.

assistance session and was available for further assistance via telephone and e-mail up to the date of each plan's on-site review.

- Conducting a pre-on-site desk review of documents. HSAG conducted a desk review of key documents obtained from the health plans. This desk review process enabled HSAG reviewers to increase their knowledge and understanding of each organization's operations, identify areas needing further clarification, and begin compiling interview questions before the on-site review.
- Conducting a pre-onsite review of the selected credentialing files and subcontractor/delegation contracts.

On-Site Activities during the reviews included:

- An opening session, with introductions and a review of the agenda and logistics.
- Interviews with the health plans' key administrative and program staff members.
- Observation of the select tracking and reporting systems the health plans were requested to demonstrate.
- A closing conference during which HSAG summarized its preliminary findings from the review.

HSAG reviewers documented their observations and findings for each health plan in the data collection (compliance review) tool. HSAG then analyzed the information to determine the health plan's performance for each of the individual requirements in the standards. HSAG rated each element as *Met*, *Partially Met*, or *Not Met* to document whether the health plans complied with the requirements. HSAG reviewers used the following scoring methodology for each requirement in the compliance review tool.

Met indicates full compliance, defined as both of the following:

- All documentation listed under a regulatory provision, or component thereof, must be present; and
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

Partially Met indicates partial compliance, defined as:

- There is compliance with all documentation requirements, but staff are unable to consistently articulate processes during interviews; or
- Staff can describe and verify the existence of processes during the interview, but documentation is found to be incomplete or inconsistent with practice.

Not Met indicates noncompliance, defined as:

- No documentation is present, and staff have little or no knowledge of processes or issues addressed by the regulatory provisions; or
- For those provisions with multiple components, key components of the provision could be identified, and any findings of *Not Met* or *Partially Met* would result in an overall finding of noncompliance, regardless of the findings noted for remaining components.

From the scores it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each of the seven standards and an overall percentage-of-compliance score across the seven standards. HSAG calculated the total score for each of the standards by adding the weighted score for each requirement in the standard receiving a score of *Met* (value: 1 point); *Partially Met* (value: 0.50 points); *Not Met* (value: 0.00 points); and *Not Applicable* (value: 0.00 points); and dividing the summed weighted scores by the total number of applicable requirements for that standard.

HSAG determined the overall compliance score across the seven standards by using the same method used to calculate the scores for each standard (i.e., by summing the weighted values of the scores and dividing them by the total number of applicable requirements).

To draw conclusions about the health plan's strengths and weaknesses related to the quality and timeliness of, and access to, the care and service provided to members, HSAG aggregated and analyzed the data resulting from its desk and on-site review activities. The data that HSAG aggregated and analyzed included for each health plan:

- Observations, demonstrations, interview responses, and file and document review findings regarding each health plan's performance in complying with the requirements.
- The scores assigned to the health plan's performance for each requirement.
- The health plan's total percentage-of-compliance score for each of the seven standards.
- The health plan's overall percentage-of-compliance score calculated across the seven standards.
- The actions required to bring the health plan's performance into compliance with the requirements that received a score of *Partially Met* or *Not Met*.

HSAG documented the overall strengths and opportunities for performance improvement based on its findings. Areas that were *Partially Met* or *Not Met* were also included in a required corrective action plan template for use by the health plan. HSAG prepared a draft report for each health plan that described the results of the compliance review. The reports were forwarded to MQD and the applicable health plan for their review and comment. Following MQD's approval of each draft report, HSAG issued the final reports to MQD and the applicable health plan.

Description of Data Obtained

To assess the health plans' compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by each organization, including the following:

- Committee meeting agendas, minutes, and handouts
- Written policies and procedures
- Program descriptions, work plans, and annual evaluations
- Management/monitoring reports related to the areas for review
- Provider and delegate contracts

- Provider manual
- Other provider and member communications
- Staff training materials and attendance logs
- Records and files related to credentialing and recredentialing of providers processed by the health plan

Additional information for the compliance review was obtained through interaction, discussions, observations, and interviews with each health plan's key staff members, and through demonstrations and presentations provided by the health plans.

Table A-3 lists the major data sources HSAG used in determining compliance with requirements by each health plan and the period to which the data applied.

Table A-3—Description of Health Plans' Data Sources

Data Obtained	Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation and interview information available to HSAG during the on-site review	July 1, 2022–May 1, 2023
Provider credentialing and recredentialing files	July 1, 2022–December 31, 2022

At the conclusion of each compliance review, HSAG provided the health plan and MQD with a report of findings and any required corrective actions. The plan-specific results are summarized in Section 3 of this report.

How Conclusions Were Drawn

To draw conclusions about the quality of, timeliness of, and access to care and services provided by the Medicaid health plans, HSAG assigned each of the standards reviewed in 2023 to one or more of those domains of care. Each standard may involve the assessment of more than one domain of care due to the combination of individual requirements within each standard. Table A-4 depicts assignment of the standards to the domains of care.

Table A-4—Assignment of Compliance Standards to the Quality, Timeliness, and Access Domains

Compliance Review Standard	Quality	Timeliness	Access
Provider Selection		✓	✓
Credentialing	✓		✓
Subcontractual Relationships and Delegation	✓		
Health Information Systems	✓		
Quality Assessment and Performance Improvement	✓	✓	

Compliance Review Standard	Quality	Timeliness	Access
Practice Guidelines	✓		
Enrollment and Disenrollment	✓		

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 2022 validation activities. Both HEDIS and non-HEDIS measures were validated using the same methodology, which is described in further detail in the following section.

Table A-5—Validated Performance Measures

Performance Measure	QI	CCS	Methodology
Access and Risk-Adjusted Utilization			
Ambulatory Care		✓	Admin
Diagnosed Mental Health Disorders		✓	Admin
*Heart Failure Admission Rate**	✓		Admin
Plan All-Cause Readmissions	✓		Admin
Children's Preventive Health			
Child and Adolescent Well-Care Visits	✓		Admin
Childhood Immunization Status	✓		Hybrid^
Well-Child Visits in the First 30 Months of Life	✓		Admin
Women's Health			
Cervical Cancer Screening	✓		Hybrid^
Prenatal and Postpartum Care	✓		Hybrid
Care for Chronic Conditions			
Blood Pressure Control for Patients With Diabetes	✓		Hybrid
*Concurrent Use of Opioids and Benzodiazepines**	✓		Admin

Performance Measure	QI	CCS	Methodology
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		✓	Admin
Follow-Up After ED Visit for Substance Use		✓	Admin
Follow-Up After ED Visit for Mental Illness		✓	Admin
Follow-Up After Hospitalization for Mental Illness	✓	✓	Admin
Initiation and Engagement of Substance Use Disorder Treatment	✓	✓	Admin
Screening for Depression and Follow-Up Plan	✓		Admin
Use of Pharmacotherapy for Opioid Use Disorder	✓		Admin
Long-Term Services and Supports (LTSS)			
LTSS Comprehensive 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 2022, Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures*. The measurement period reviewed for the health plans was CY 2022 and followed the NCQA HEDIS timeline for reporting rates.

The same process was followed for each performance measure validation conducted by HSAG and included (1) audit validation activities such as development of measure-specific worksheets, validation of sample frames for survey measures, a review of completed plan responses to the HEDIS Record of Administration, Data Management, and Processes (Roadmap), medical record review validation, supplemental data validation, source code review for non-HEDIS measures, planning for the virtual audit review, and preliminary rate review; (2) virtual audit review activities such as interviews with staff members, primary source verification, query review and inspection of dated job logs, and computer database and file structure review; and (3) follow-up and reporting activities including final rate review and submission of a final audit report.

HSAG validated the health plans' IS capabilities for accurate reporting. The review team focused specifically on aspects of the health plans' systems that could affect the selected measures. Items reviewed included coding and data capture, transfer, and entry processes for medical data and case management record data; data capture, transfer, and entry processes for membership data; data capture, transfer, and entry processes for provider data; medical record data abstraction processes; case management record review validation for the LTSS measures reported using the case management review methodology, the use of supplemental data sources; and data integration and measure calculation. If an area of noncompliance was noted with any IS standard, the audit team determined if the issue resulted in significant, minimal, or no impact to the final reported rate.

The measures verified by the HSAG review team received an audit result consistent with one of the seven NCQA categories listed in the following table.

Table A-6—NCQA Audit Results

NCQA Category for Measure Audit Result	Comment
R	*Reportable.* A reportable rate was submitted for the measure.
*NA**	*Small Denominator.* The health plan followed the specifications, but the denominator was too small (e.g., <30) to report a valid rate. a. For Effectiveness of Care (EOC) and EOC-like measures when the denominator is <30. b. For utilization measures that count member months when the denominator is fewer than 360 member months. c. For all risk-adjusted utilization measures when the denominator is fewer than 150. d. For 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 2022, 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 2022, are not presented within this report. Additionally, certain measures do not have applicable benchmarks. For these reasons, the HEDIS MY 2022 rate, relative difference, and MY 2022 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 2022. MQD Quality Strategy targets for the QI population and CCS program are defined in Table A-7 and Table A-8. For the following measures, lower rates indicate better performance: *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-7—MQD QI Quality Strategy Measures and Targets

Measure	MQD Quality Strategy Target
Access and Risk-Adjusted Utilization	
Heart Failure Admission Rate (per 100,000 member months)—Total	1% Improvement Goal

Measure	MQD Quality Strategy Target
Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Total	1% Improvement Goal
Children's Preventive Care	
Child and Adolescent Well-Care Visits—Total	1% Improvement Goal
Childhood Immunization Status—Combination 3	1% Improvement Goal
Childhood Immunization Status—Combination 7	1% Improvement Goal
Childhood Immunization Status—Combination 10	1% Improvement Goal
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	1% Improvement Goal
Women's Health	
Cervical Cancer Screening	1% Improvement Goal
Prenatal and Postpartum Care—Timeliness of Prenatal Care	1% Improvement Goal
Prenatal and Postpartum Care—Postpartum Care	1% Improvement Goal
Care for Chronic Conditions	
Concurrent Use of Opioids and Benzodiazepines—Total	1% Improvement Goal
Controlling High Blood Pressure—Total	1% Improvement Goal
Behavioral Health	
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	1% Improvement Goal
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	1% Improvement Goal
Initiation and Engagement of Substance Use Disorder Treatment—Initiation—Total—Total	1% Improvement Goal
Initiation and Engagement of Substance Use Disorder Treatment—Engagement—Total—Total	1% Improvement Goal
Use of Pharmacotherapy for Opioid Use Disorder—Total	1% Improvement Goal
Use of Pharmacotherapy for Opioid Use Disorder—Buprenorphine	1% Improvement Goal
Use of Pharmacotherapy for Opioid Use Disorder—Oral Naltrexone	1% Improvement Goal
Use of Pharmacotherapy for Opioid Use Disorder—Long-Acting, Injectable Naltrexone	1% Improvement Goal
Use of Pharmacotherapy for Opioid Use Disorder—Methadone	1% Improvement Goal

Table A-8—MQD CCS Quality Strategy Measures and Targets

Measure	MQD Quality Strategy Target
Access and Risk-Adjusted Utilization	
Ambulatory Care—Total (per 1,000 Member Months)	1% Improvement Goal

Measure	MQD Quality Strategy Target
ED Visits—Total	
Ambulatory Care—Total (per 1,000 Member Months) *Outpatient Visits—Total*	1% Improvement Goal
Behavioral Health	
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	1% Improvement Goal
Antidepressant Medication Management—Effective Acute Phase Treatment	1% Improvement Goal
Antidepressant Medication Management—Effective Continuation Phase Treatment	1% Improvement Goal
Follow-Up After Emergency Department for Substance Use—7-Day Follow-Up—Total	1% Improvement Goal
Follow-Up After Emergency Department for Substance Use—30-Day Follow-Up—Total	1% Improvement Goal
Follow-Up After Emergency Department for Mental Illness—7-Day Follow-Up—Total	1% Improvement Goal
Follow-Up After Emergency Department for Mental Illness—30-Day Follow-Up—Total	1% Improvement Goal
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	1% Improvement Goal
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	1% Improvement Goal
Initiation and Engagement of Substance Use Disorder Treatment—Initiation—Total—Total	1% Improvement Goal
Initiation and Engagement of Substance Use Disorder Treatment—Engagement—Total—Total	1% Improvement Goal

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to care provided by the health plans, HSAG assigned each of the validated performance measures to one or more of these three domains of care. This assignment to domains of care is depicted in Table A-9.

Table A-9—Assignment of Performance Measures to the Quality, Timeliness, and Access Domains

Performance Measure	Quality	Timeliness	Access
Access and Risk-Adjusted Utilization			
Ambulatory Care	NA	NA	NA
Diagnosed Mental Health Disorders	NA	NA	NA

Performance Measure	Quality	Timeliness	Access
Heart Failure Admission Rate	✓		
Plan All-Cause Readmissions	✓		
Children's Preventive Health			
Child and Adolescent Well-Care Visits	✓		✓
Childhood Immunization Status	✓		
Well-Child Visits in the First 30 Months of Life	✓		✓
Women's Health			
Cervical Cancer Screening	✓		
Prenatal and Postpartum Care	✓	✓	✓
Care for Chronic Conditions			
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 Emergency Department Visit for Substance Use	✓	✓	✓
Follow-Up After Emergency Department Visit for Mental Illness	✓	✓	✓
Follow-Up After Hospitalization for Mental Illness	✓	✓	✓
Initiation and Engagement of Substance Use Disorder 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 Performance Improvement Projects

Objectives

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

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

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

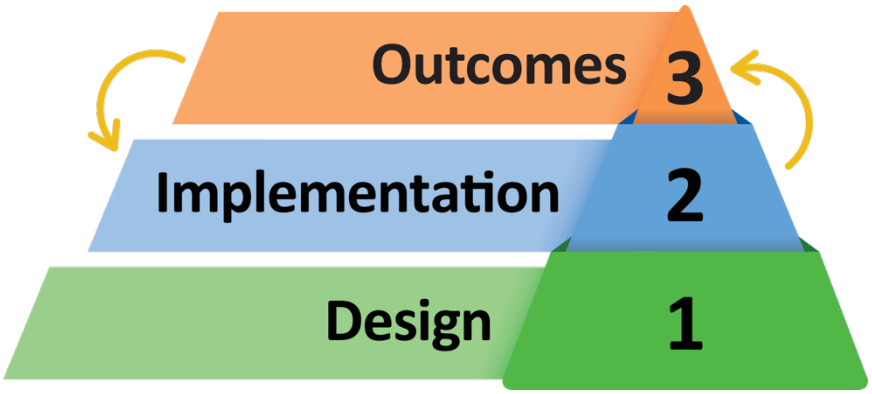
Technical Methods of Data Collection and Analysis

HSAG, as the State's EQRO, validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023.[A-2]

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.

[A-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: Feb 8, 2024.

Figure A-1—Stages



Once a plan establishes its PIP design, the PIP progresses into the Implementation stage (Steps 7 and 8). During this stage, the plan evaluates and analyzes its data, identifies barriers to performance, and develops interventions targeted to improve outcomes. The implementation of effective improvement strategies is necessary to improve outcomes. The Outcomes stage (Step 9) is the final stage, which involves the evaluation of statistically, clinically, or programmatically significant improvement, and sustained improvement based on reported results and statistical testing. Sustained improvement is achieved when outcomes exhibit statistically significant improvement over the baseline performance over comparable time periods. This stage is the culmination of the previous two stages. If the outcomes do not improve, plans should revise their causal/barrier analysis processes and adapt quality improvement strategies and interventions accordingly.

HSAG uses a standardized scoring methodology to rate a PIP's compliance with each of the nine steps listed in CMS Protocol 1. With MQD's input and approval, HSAG developed a PIP Validation Tool to ensure uniform assessment of PIPs. This tool is used to evaluate each of the PIPs for the following nine CMS Protocol 1 steps:

Table A-10—CMS Protocol Steps

Protocol Steps	
Step Number	**Description**
1	Review the Selected PIP Topic
2	Review the PIP Aim Statement
3	Review the Identified PIP Population
4	Review the Sampling Method
5	Review the Selected Performance Indicator(s)
6	Review the Data Collection Procedures
7	Review the Data Analysis and Interpretation of PIP Results
8	Assess the Improvement Strategies
9	Assess the Likelihood That Significant and Sustained Improvement Occurred

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in an overall validation rating for the PIP of *Not Met*. Plans would be given a *Partially Met* score if 60 percent to 79 percent of all evaluation elements were *Met* or one or more critical elements were *Partially Met*. HSAG provides *Validation Feedback* with a *Met* validation score when enhanced documentation would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements.

Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validations from the health plans' PIP Submission Forms. These forms provided detailed information about each health plan's PIPs. In 2023, the health plans 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 2023 are included in Table A-11.

Table A-11—PIP Topics in 2022

Health Plan	PIP Topic
All QI health plans	• *Behavioral Health Coordination* • *Plan All-Cause Readmissions*
'Ohana CCS	• *Behavioral Health Coordination* • *Follow-Up After Emergency Department Visit for Mental Illness*

How Conclusions Were Drawn

HSAG's methodology for assessing and documenting PIP findings provides a consistent, structured process and a mechanism for providing the plans with specific feedback and recommendations for the PIP. Using its PIP Validation Tool and standardized scoring, HSAG reports the overall validity and reliability of the findings as one of the following:

Met = high confidence/confidence in the reported findings.
Partially Met = low confidence in the reported findings.
Not Met = reported findings are not credible.

To draw conclusions about the quality and timeliness of, and access to services provided by the Medicaid health plans, HSAG assigned each component reviewed for validation of PIPs to one or more of these three domains. While the focus of a health plan's PIP may have been to improve performance related to healthcare quality, timeliness, or access, PIP validation activities were designed to evaluate the

validity and quality of the health plan's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. Other domains were assigned based on the content and outcome of the PIP. This assignment to domains is depicted in Table A-12.

Table A-12—Assignment of PIPs to the Quality, Timeliness, and Access Domains

Performance Improvement Project	Quality	Timeliness	Access
Behavioral Health Coordination	✓	✓	✓
Plan-All Cause Readmissions	✓	✓	✓
Follow-Up After Emergency Department Visit for Mental Illness	✓	✓	✓

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Objectives

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

The primary objective of the CHIP CAHPS survey was to obtain experience information from parents/caretakers of the Hawaii CHIP population to provide to MQD and to meet the State's obligation for CHIP 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 Child CAHPS survey and the CHIP CAHPS survey was accomplished through administration of the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set (without the CCC measurement set) to parents/caretakers of child Medicaid and CHIP members. Child Medicaid and CHIP members included as eligible for the survey were 17 years of age or younger as of December 31, 2022. All parents/caretakers of sampled child Medicaid and CHIP members completed the surveys from February to May 2023 and received an English version of the survey with the option to complete the survey in one of four non-English languages predominant in the State of Hawaii: Chinese, Ilocano, Korean, or Vietnamese. The cover letters provided with the English version of the CAHPS survey questionnaire included additional text in Chinese, Ilocano, Korean, and Vietnamese informing parents/caretakers of sampled members that they could call a toll-free number to request to complete the survey in one of these designated alternate languages. The toll-free line for alternate survey language requests directed callers to select their preferred language for completing the survey and leave a voice message for an interpreter service that would return their call and subsequently schedule an appointment to complete the survey via computer-assisted telephone interviewing (CATI). A reminder postcard was sent to all nonrespondents, followed by a second survey mailing, a second reminder postcard, and CATI. It is important to note that the CAHPS 5.1H Child Medicaid Health Plan Survey is

made available by NCQA in English and Spanish only.[A-3] Therefore, prior to the start of the CAHPS survey process, and in following NCQA HEDIS Specifications for Survey Measures, HSAG submitted a request for a survey protocol enhancement and received NCQA's approval to allow parents/caretakers of child members the option to complete the CAHPS survey in the designated alternate languages.[A-4]

The child CAHPS survey included a set of standardized items (41 questions) that assessed members' that assessed parents'/caretakers' perspectives on their child's care. To support the reliability and validity of the findings, HEDIS sampling and data collection procedures were followed to select the child Medicaid and CHIP members and distribute the surveys. These procedures were designed to capture accurate and complete information to promote both the standardized administration of the instruments and the comparability of the resulting data. Data from survey respondents were aggregated into a database for analysis. An analysis of the child Medicaid CAHPS survey results was conducted using NCQA HEDIS Specifications for Survey Measures.[A-5] NCQA requires a minimum of 100 responses on each item in order to report the item as a valid CAHPS survey result; however, for this report, results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Therefore, caution should be exercised when interpreting results for those measures with fewer than 100 respondents. If a minimum of 100 respondents for a measure was not achieved, the result of the measure was denoted with a cross (+).

The survey questions were categorized into nine measures of experience. These measures included four global rating questions, four composite measures, and one individual item measure. The global measures (also referred to as global ratings) reflect respondents' overall experience with the health plan, health care, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., *Getting Needed Care* or *Getting Care Quickly*). The individual item measure is an individual question that considers a specific area of care (i.e., *Coordination of Care*).

For each of the four global ratings, the percentage of respondents who chose the top experience rating (a response value of 9 or 10 on a scale of 0 to 10) was calculated. For each of the four composite measures, the percentage of respondents who chose a positive response was calculated. CAHPS composite and individual item measure questions' response choices were: (1) "Never," "Sometimes," "Usually," and "Always." A positive or top-box response for the composite measures and individual item measure was defined as a response of "Usually" or "Always." The final composite measure score was determined by calculating the average score across all questions within the composite measure (i.e., mean of the composite items' top-box scores).

[A-3] Administration of the CAHPS survey in these alternate non-English languages (i.e., Chinese, Ilocano, Korean, and Vietnamese) deviates from standard NCQA protocol. The CAHPS 5.1H Child Medicaid Health Plan Survey is made available by NCQA in English, Spanish, and Chinese only. The standard Chinese translation for the child Medicaid CAHPS survey can only be used for the mail survey protocol. NCQA's approval of this survey protocol enhancement was required in order to allow members the option to complete the CAHPS survey questionnaire in these alternate languages.

[A-4] National Committee for Quality Assurance. *HEDIS® Measurement Year 2022*, *Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2022.

[A-5] Ibid.

For each CAHPS measure, the resulting top-box scores were compared to NCQA's 2022 Quality Compass Benchmark and Compare Quality Data.[A-6] Based on this comparison, ratings of one (★) to five (★★★★★) stars were determined for each measure, with one being the lowest possible rating and five being the highest possible rating, using the percentile distributions shown in Table A-13.

Table A-13—Star Ratings

Stars	Percentiles
★★★★★ Excellent	At or above the 90th percentile
★★★★ Very Good	At or between the 75th and 89th percentiles
★★★ Good	At or between the 50th and 74th percentiles
★★ Fair	At or between the 25th and 49th percentiles
★ Poor	Below the 25th percentile

Additionally, HSAG performed a trend analysis of the child Medicaid and CHIP results. The child Medicaid 2023 scores were compared to their corresponding 2021 scores, and the CHIP 2023 scores were compared to their corresponding 2022 scores to determine whether there were statistically significant differences.[A-7] Statistically significant differences between the current year's top-box scores and the previous year's top-box scores are noted with directional triangles. Scores that were statistically significantly higher in the current year than the previous year are noted with black upward (▲) triangles. Scores that were statistically significantly lower in the current year than the previous year are noted with black downward (▼) triangles. Scores that were not statistically significantly different between years are not noted with triangles.

Also, HSAG performed plan comparisons of the child Medicaid results. Statistically significant differences between the QI health plans' top-box responses and the QI Program aggregate are noted with arrows. A QI health plan's top-box score that was statistically significantly higher than the QI Program aggregate is noted with a black upward (↑) arrow. A QI health plan's top-box score that was statistically significantly lower than the QI Program aggregate is noted with a black downward (↓) arrow. A QI health plan's top-box score that was not statistically significantly different than the QI Program aggregate is not denoted with an arrow.

Also, HSAG compared each of the child Medicaid QI health plan's and the QI Program aggregate's 2023 scores to the 2022 NCQA child Medicaid national averages, and CHIP's 2023 scores to the 2022

[A-6] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2022*. Washington, DC: NCQA, September 2022.

[A-7] The child Medicaid population was last surveyed in 2021; therefore, the 2023 child Medicaid CAHPS scores are compared to the corresponding 2021 scores.

NCQA child Medicaid national averages.[A-8] Scores that are statistically significantly higher than the 2022 NCQA child Medicaid national averages are represented by yellow highlighted cells. Scores that are statistically significantly lower than the 2022 NCQA child Medicaid national averages are represented by red highlighted cells. These comparisons are performed for the four global ratings, four composite measures, and one individual item measure.

Also, HSAG performed a key drivers of member experience analysis of the child Medicaid and CHIP populations for the following three global ratings: *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*. HSAG evaluated each of these areas to determine if specific CAHPS items (i.e., questions) are strongly correlated with one or more of these measures. These individual CAHPS items, which HSAG refers to as "key drivers," may be driving respondents' level of experience with each of the three measures; therefore, the key drivers of member experience analysis help decision makers identify specific aspects of care that will most benefit from quality improvement activities. The analysis provides information on:

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

Description of Data Obtained

The CAHPS survey asks respondents to report on and evaluate their experiences with their child's healthcare. The survey covers important topics such as the communication skills of providers and the accessibility of services. The surveys were administered from February to May 2023. The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. A survey was assigned a disposition code of "completed" if at least three of the designated five questions were completed. Eligible members included the entire sample minus ineligible members. Ineligible members met at least one of the following criteria: they were deceased, were invalid (they did not meet the eligible population criteria), or had a language barrier. Ineligible members were identified during the survey process. This information was recorded by the survey vendor and provided to HSAG in the data received.

Following the administration of the child CAHPS surveys, HSAG provided MQD with plan-specific reports and a statewide aggregate report of the child Medicaid results, as well as a statewide aggregate report of the CHIP survey results.

Plan-specific results of the child CAHPS survey are summarized in Section 3 and CHIP results of the child CAHPS survey are summarized in Section 1 of this report. Statewide comparison results of each child Medicaid QI health plan and the QI Program aggregate, as well as CHIP results, are provided in Section 4 of this report.

[A-8] NCQA national averages for the child Medicaid population were used for comparative purposes for the CHIP population since NCQA does not provide separate benchmarking data for this population. Therefore, caution should be exercised when interpreting these results.

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to services provided by the health plans, HSAG assigned each of the measures to one or more of these three domains. This assignment to domains is depicted in Table A-14.

Table A-14—Assignment of CAHPS Measures to the Quality, Timeliness, and Access Domains

CAHPS Topic	Quality	Timeliness	Access
Rating of Health Plan	✓		
Rating of All Health Care	✓		
Rating of Personal Doctor	✓		
Rating of Specialist Seen Most Often	✓		
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
How Well Doctors Communicate	✓		
Customer Service	✓		
Coordination of Care	✓		

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 frail 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 computer assisted telephone interviewing (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 the State of Hawaii, Department of Human Services, Med-QUEST Division (MQD). For the HCBS CAHPS Survey, adult members included as eligible for the

survey were 18 years of age or older as of September 30, 2022, and were continuously enrolled in one of the five QUEST Integration (QI) health plans during the three-month measurement period (July 1, 2022, to September 30, 2022), with no gaps in enrollment. They also must have had received at least one qualifying HCBS service, including self-directed services during the three-measurement period. [A-9]

The survey questions were categorized into various measures of member experience. The survey included 93 core questions that yielded 19 measures.[A-10] 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.

Description of Data Obtained

The HCBS CAHPS survey asks respondents to report on and evaluate their perceptions and experiences with the HCBS services they receive. The survey was administered to eligible adult members enrolled in one of the five QI health plans from January to April 2023. 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.[A-11] 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.

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.

[A-9] For more detailed information on the eligible population, please see the 2023 Hawaii HCBS CAHPS Survey full report.
[A-10] The three cognitive screening questions (questions 1-3) were removed after receiving approval from the CAHPS consortium, so the HI HCBS CAHPS survey only included 93 core questions.
[A-11] 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: Feb 8, 2024.

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to care and services that each QI health plan provided to members, HSAG calculated mean scores for each measure. Mean scores were transformed to a 0-to-100 scale for each measure, and plan-level results were compared to the HI HCBS Program to determine if the results were statistically significantly different than the HI HCBS Program. A higher mean score indicates a positive response (e.g., no unmet need), and a lower mean score indicates a negative response.

Table A-15—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	✓		

Provider Survey

Objectives

The objective of the Provider Survey was to provide feedback to MQD and the health plans about providers' perceptions of the QI health plans.

Technical Methods of Data Collection and Analysis

The method of data collection was through the administration of the 2023 Hawaii Provider Survey to a random sample of 1,500 providers: 200 KFHP providers (i.e., KFHP QI) and 1,300 non-KFHP providers (i.e., AlohaCare QI, HMSA QI, 'Ohana QI, and UHC CP QI). Providers eligible for sampling included those who served the Hawaii Medicaid population, provided services to QI members as of March 31, 2023, provided services to at least one of the QI health plans, and had the following credentials: Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), Physician Assistant (PA), Psychologist, Psychiatrist, or Advanced Practice Registered Nurse (APRN). The survey administration consisted of mailing sampled providers a survey questionnaire, cover letter, and business reply envelope. Providers were given two options by which they could complete the surveys: (1) complete the paper-based survey and return it using the pre-addressed, postage-paid return envelope; or (2) complete the Web-based survey by logging on to the survey website with a designated, provider-specific login. The survey was administered from June to August 2023. The survey administered to KFHP providers included 15 questions, and the survey administered to non-KFHP providers included 17 questions on a broad range of topics.

The 2021 and 2023 Hawaii Provider Survey results for participating QI health plans were presented on the following six domains of satisfaction:

- **General Positions:** Presents providers' level of satisfaction with the reimbursement rate (pay schedule) or compensation, and providers' level of satisfaction with the timeliness of claims payments.
- **Providing Quality Care:** Presents providers' level of satisfaction with the QI health plans' prior authorization process and formulary, in terms of having an impact on providers' ability to deliver quality care.
- **Non-Formulary:** Presents providers' level of satisfaction with access to nonformulary drugs.
- **Health Coordinators:** Presents providers' level of satisfaction with the helpfulness of health coordinators.
- **Specialists:** Presents providers' level of satisfaction with the QI health plans' number of specialists and availability of mental health providers, including psychiatrists.
- **Substance Abuse:** Presents providers' level of satisfaction with the QI health plans' access to substance abuse treatment for patients.

Response options to each question (i.e., measure) within these domains were classified into one of three response categories: satisfied, neutral, and dissatisfied; or positive impact, neutral impact, and negative

impact. For each measure, the proportion (i.e., percentage) of responses in each of the response categories was calculated.[A-12] Health plan survey responses were not limited to those providers who indicated they were currently accepting new patients for that health plan in Question 1 of the survey. For example, if providers indicated that they were not currently accepting new patients for AlohaCare in Question 1, the response would be included in the results pertaining to AlohaCare if a response had been provided. Therefore, providers may have rated a health plan on a survey question even if they were not currently accepting new patients for that plan. Furthermore, a provider associated with more than one health plan may have answered a question for multiple health plans.

A Hierarchical Latent Variable Model was used to determine if statistically significant differences in performance existed between the QI health plans' top-box scores and the QI Program aggregate, and between the 2023 and corresponding 2021 top-box scores. As is standard in most survey implementations, a top-box score was defined by a positive or satisfied response.

Statistically significant differences between the QI health plans' top-box responses and the QI Program aggregate are noted with arrows. A QI health plan's top-box score that was statistically significantly higher than the QI Program aggregate is noted with a black upward (↑) arrow. A QI health plan's top-box score that was statistically significantly lower than the QI Program aggregate is noted with a black downward (↓) arrow. A QI health plan's top-box score that was not statistically significantly different than the QI Program aggregate is not denoted with an arrow.

Statistically significant differences between the 2023 top-box scores and the corresponding 2021 top-box scores are noted with directional triangles. Scores that were statistically significantly higher in 2023 than in 2021 are noted with black upward (▲) triangles. Scores that were statistically significantly lower in 2023 than in 2021 are noted with black downward (▼) triangles. Scores in 2023 that were not statistically significantly different from scores in 2021 are not noted with triangles.

Description of Data Obtained

The survey covered topics for primary care and specialty providers, including the impact of plans' prior authorization procedures and formulary on the providers' ability to provide quality care. Additional survey questions elicited information about reimbursement satisfaction, adequacy of access to nonformulary drugs, health coordinators, adequacy of access to specialty providers, availability of mental health providers, and access to substance abuse treatment. The response rate was the total number of completed surveys divided by all eligible providers within the sample. Eligible providers included the entire sample minus ineligible providers, which included any providers who could not be surveyed due to incorrect or incomplete contact information or who had no current contract with any of the QI health plans.

[A-12] For this report, only the top-box scores are displayed. For more detailed results on the other response categories, please see the 2023 Hawaii Provider Survey full report.

Following the administration of the provider survey, HSAG provided MQD with an aggregate report of plan-specific findings. The plan-specific results are summarized in Section 3, and statewide comparisons of all plans' results are summarized in Section 4 of this report.

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to services provided by the health plans, HSAG assigned each of the measures to one or more of three domains. This assignment to domains is depicted in Table A-16.

Table A-16—Assignment of Provider Survey Measures to the Quality, Timeliness, and Access Domains

Provider Survey Topic	Quality	Timeliness	Access
Compensation Satisfaction	NA	NA	NA
Timeliness of Claims Payments	NA	NA	NA
Formulary	✓		
Prior Authorization Process	✓	✓	
Adequate Access to Non-Formulary Drugs	✓		
Helpfulness of Health Coordinators	✓		
Adequacy of Specialists			✓
Availability of Mental Health Providers			✓
Access to Substance Abuse Treatment			✓

NA *Indicates that the measure is not appropriate to classify into a performance domain (i.e., quality, timeliness, access).*

Encounter Data Validation

During CY 2023, MQD contracted with HSAG to conduct an EDV study. In alignment with the CMS External Quality Review (EQR) *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP [Children's Health Insurance Program] Managed Care Plan: An Optional EQR-Related Activity*, February 2023 (CMS EQR Protocol 5).[A-13] HSAG will conduct 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 MCOs to MQD's contracted actuary, Milliman.

[A-13] 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.

- Technical assistance with the MCOs regarding the findings from the comparative analysis so that the MCOs 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 MCOs 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 will provide technical assistance to assist the MCOs in addressing and resolving noteworthy encounter data issues from the comparative analysis. Lastly, HSAG will review the encounter submission companion guides and the encounter data requirements put forth by MQD and then make 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 will conduct a preliminary file review to ensure that the submitted data are adequate to conduct the evaluation. Based on the preliminary file review results, HSAG will generate a report that highlights major findings requiring any resubmissions (as needed).

Once final data have been received and processed, HSAG will conduct a series of analyses. To facilitate the presentation of findings, the comparative analysis will be divided into two analytic sections.

First, HSAG will assess record-level data completeness using the following metrics for each encounter data type:

- **Record Omission**: The number and percentage of records present in the actuarial data, but not in MQD's encounter data.
- **Record Surplus**: The number and percentage of records present in MQD's encounter data, but not in the actuarial data.

Second, based on the number of records present in both data sources, HSAG will evaluate the element-level completeness based on the following metrics for each key data element listed in Table A-17:

- **Element Omission**: The number and percentage of records with values present in the actuarial data, but not in MQD's encounter data.
- **Element Surplus**: The number and percentage of records with values present in MQD's encounter data, but not in the actuarial data.

- **Element Missing Values**: The number and percentage of records with values missing from both MQD's encounter data and the actuarial data.

Table A-17—List of Data Elements Included in the Comparative Analysis

Data Elements*	Professional	Institutional	Pharmacy
Member ID	✓	✓	✓
Header and Detail First Date of Service	✓	✓	✓
Header and Detail Last Date of Service	✓	✓	
Billing Provider NPI	✓	✓	✓
Billing Provider Type	✓	✓	
Servicing Provider NPI, MQD ID, and Type	✓	✓	
Facility CMS Certification Number (CCN)		✓	
Occurrence Span Codes	✓	✓	
Value Codes and Value Codes Amount	✓	✓	
Primary Diagnosis Code	✓	✓	
All Secondary Diagnosis Code(s)	✓	✓	
All Surgical Procedure Code(s)		✓	
Procedure Code	✓	✓	
Procedure Code Modifier(s)	✓	✓	
Units of Service	✓	✓	
Revenue Code		✓	
Diagnosis Related Group Code		✓	
Type of Bill Code		✓	
Admission Source, Admission Type, Admission Date, Admission Diagnosis Code, Primary Present on Admission (POA) Code, All Secondary POA Code(s), Discharge Date, Discharge Status, and Inpatient Hospital Days		✓	
Place of Service Code	✓		
National Drug Code	✓	✓	✓
Drug Quantity			✓
Days Supply			✓
Billed, Allowed, Paid, Third Party Liability (TPL), Copay, Coinsurance, Deductible, and Patient Paid Amount	✓	✓	✓
Dispensing Fee			✓
Ingredient Cost			✓
Claim Line Status	✓	✓	✓
Paid Date	✓	✓	✓
Encounter Flag	✓	✓	✓

* Upon MQD's approval, HSAG may add or remove data elements in the comparative analysis depending on whether a data element is comparative between MQD's and Milliman's data.

Element-level accuracy will be limited to those records with values present in both MQD's encounter data and the actuarial data. For each key data element, HSAG will determine the number and percentage of records with the same values in both MQD's encounter data and the actuarial data (i.e., **element accuracy**).

Finally, for the records present in both data sources, HSAG will evaluate the number and percentage of records with the same values for all key data elements relevant to each encounter data type (i.e., **all-element accuracy**).

Description of Data Obtained

HSAG will use 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 represent the same universe of encounters, the data will target final paid professional, institutional, and pharmacy encounters with MCO paid dates on or before March 31, 2023.[A-14]

Once HSAG receives data files from both data sources, the analytic team will conduct a preliminary file review to ensure that the submitted data are adequate to conduct the evaluation. The preliminary file review will include the following basic checks:

- Data extraction—Extracted based on the data requirements document.
- Percentage present—Required data fields are present in the file and have values in those fields.
- Percentage of valid values—The values are the expected values (e.g., valid ICD-10 codes in the diagnosis fields).
- Evaluation of matching claim numbers—The percentage of claim numbers matching between the two data sources.

Based on the preliminary file review results, HSAG will generate a report that highlights major findings requiring any resubmissions (as needed).

How Conclusions Were Drawn

Since MQD has not yet established standards in the MCO contract for results from the comparative analysis, HSAG will select results needing the MCOs' attention based on its experience. Table A-18 displays the criteria HSAG plans to use to determine rates needing the MCOs' review and investigation. However, depending on the study results, HSAG may adjust the criteria per approval from MQD.

[A-14] Since the actuarial data contains only paid encounters, HSAG will include "Accepted" and "Pended" encounters from MQD data for the comparative analysis. However, MQD may provide encounters under other statuses (e.g., Denied, Void, Replace) to HSAG since they may help investigate the difference between MQD data and the actuarial data.

Table A-18—Criteria Used to Determine Rates Needing the MCOs' Review

Measure	Criteria
Record Omission and Record Surplus	> 5.0%
Element Omission and Element Surplus	> 5.0%
Element Missing	Deviate from other MCOs by more than 10.0 percentage points. In addition, for data elements with a high percentage of missing values (e.g., *Surgical Procedure Codes* and *DRG*), HSAG may tighten the criteria to 5.0 percentage points.
Element Accuracy	< 95.0%

Based on these criteria, HSAG will provide technical assistance through the following steps:

- HSAG will draft MCO-specific encounter data discrepancy reports that will include a description of key issues for the MCOs to review and investigate and then review them with MQD and Milliman (as needed) for feedback.[A-15]
- Upon MQD's review and approval, HSAG will distribute the data discrepancy reports to the MCOs, along with data samples to assist the MCOs with their internal investigations. In addition, HSAG and MQD will conduct collaborative technical assistance sessions with each MCO to review and discuss the data issues identified in the study, whereby root causes of discrepancies can be determined.
- Based on the MCOs' internal investigations, the MCOs will provide written responses to the data discrepancy reports noting the potential root cause(s) and action plans, if applicable.
- HSAG and MQD will then review the written responses and follow up with the MCOs for any further clarification.
- Lastly, the final responses from the MCOs to the encounter data discrepancy reports will be noted in the aggregate report for documentation purposes.

For the best practice recommendations to MQD, HSAG will provide feedback via comments and track changes in the most recent editable encounter submission companion guides and the encounter data requirements documents. The comments will focus on the reasoning for the proposed edits. HSAG will use these documents to discuss the proposed changes with MQD. Upon MQD reviewing and approving these updated documents, HSAG will submit them to MQD as part of the final deliverables for MQD to take actions.

[A-15] Before drafting the encounter data discrepancy reports, HSAG will submit a template to MQD for review and approval. This will help ensure that the data discrepancy reports follow MQD's general process for action plans.

Appendix B. Hawaii Medicaid Goals Tracking Table

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 2023 Target**	**RY 2023 Result**
			1	**2**	**3**	**4**		
AAP	Adults' Access to Preventive/Ambulatory Health Services: Total	NCQA		✓	✓	✓	77.48%	67.50%
ABA-AD	Adult Body Mass Index Assessment	NCQA			✓		NT	—
ADD	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	NCQA	✓				66.86%	45.79%
ADD	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	NCQA	✓				54.14%	50.59%
AMR	Asthma Medication Ratio	NCQA	✓		✓	✓	52.74%	62.16%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing	NCQA	✓				40.39%	50.46%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing	NCQA	✓				17.80%	27.22%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing	NCQA	✓				20.88%	26.30%
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA	✓				64.30%	49.18%
AUD-CH	Audiological Diagnosis No Later Than 3 Months of Age	CDC	✓				NT	—
AWC	Adolescent Well-Care Visits	NCQA	✓				52.61%	—
CBP	Controlling High Blood Pressure (<140/90)	NCQA			✓	✓	59.80%	60.17%
CCP-AD; CCP-CH	Contraceptive Care—Postpartum Women: Long-Acting Reversible Method of Contraception (LARC)—3 Days	OPA	✓	✓			3.44%	3.99%

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 2023 Target**	**RY 2023 Result**
			1	**2**	**3**	**4**		
CCP-AD; CCP-CH	Contraceptive Care—Postpartum Women: Long-Acting Reversible Method of Contraception (LARC)—60 Days	OPA	✓	✓			18.88%	15.44%
CCP-AD; CCP-CH	Contraceptive Care—Postpartum Women: Most or Moderately Effective Contraception—3 Days	OPA	✓	✓			9.47%	10.33%
CCP-AD; CCP-CH	Contraceptive Care—Postpartum Women: Most or Moderately Effective Contraception—60 Days	OPA	✓	✓			44.65%	40.05%
CCS	Cervical Cancer Screening	NCQA			✓		61.95%	54.29%
CCW-AD; CW-CH	Contraceptive Care—All Women Ages 21 to 44: Most Effective or Moderately Effective Method of Contraception	OPA	✓	✓			24.28%	20.49%
CCW-AD; CW-CH	Contraceptive Care—All Women Ages 21 to 44: Long-Acting Reversible Method of Contraception (LARC)	OPA	✓	✓			5.57%	4.30%
CDC	Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	NCQA			✓	✓	68.61%	58.61%
CDC	Comprehensive Diabetes Care: HbA1c Control (<8%)	NCQA				✓	51.25%	54.56%
CDC	Comprehensive Diabetes Care: HbA1c Poor Control (>9%)*	NCQA				✓	37.21%	36.16%
CDC	Comprehensive Diabetes Care: HbA1c Testing	NCQA			✓	✓	91.73%	—
CDC	Comprehensive Diabetes Care: BP Control (<140/90 mm Hg)	NCQA				✓	61.15%	60.15%
CDF-CH; CDF-AD	Screening for Depression and Follow-Up Plan: Negative Screen for Depression During an Outpatient Visit Using a Standardized Tool	CMS	✓		✓		19.58%	24.82%
CHL	Chlamydia Screening in Women: Total	NCQA	✓		✓		54.31%	49.25%

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 2023 Target**	**RY 2023 Result**
			1	**2**	**3**	**4**		
CIS	Childhood Immunization Status: Combination 2	NCQA	✓				70.62%	—
CIS	Childhood Immunization Status: Combination 3	NCQA	✓				71.33%	56.11%
CIS	Childhood Immunization Status: Combination 4	NCQA	✓				66.59%	—
CIS	Childhood Immunization Status: Combination 5	NCQA	✓				57.33%	—
CIS	Childhood Immunization Status: Combination 6	NCQA	✓				51.04%	—
CIS	Childhood Immunization Status: Combination 7	NCQA	✓				56.44%	49.02%
CIS	Childhood Immunization Status: Combination 8	NCQA	✓				50.69%	—
CIS	Childhood Immunization Status: Combination 9	NCQA	✓				43.86%	—
CIS	Childhood Immunization Status: Combination 10	NCQA	✓				43.57%	35.84%
COL	Colorectal Cancer Screening	NCQA			✓		47.07%	37.67%
DEV-CH	Developmental Screening in the First Three Years of Life	OHSU	✓				22.86%	25.76%
Falls1	Falls: Screening for Future Fall Risk: Part 1: Screening	NCQA			✓		NT	—
Falls2	Falls: Screening for Future Fall Risk: Part 2: Risk Assessment	NCQA			✓		NT	—
Falls3	Falls: Screening for Future Fall Risk: Part 3: Plan of Care	NCQA			✓		NT	—
HVL-AD	HIV Viral Load Suppression: HIV Viral Load Suppression	HRSA			✓	✓	3.71%	7.71%
IMA	Immunizations for Adolescents: Combination 1 (Meningococcal, Tdap)	NCQA	✓				67.30%	61.91%
IMA	Immunizations for Adolescents: Combination 2 (Meningococcal, Tdap, HPV)	NCQA	✓				30.59%	36.54%
LBW-CH	Live Births Weighing Less Than 2,500 Grams	CDC	✓	✓			7.89%	8.85%
PPC	Prenatal and Postpartum Care: Timeliness of Prenatal Care	NCQA		✓			82.35%	78.00%
PPC	Prenatal and Postpartum Care: Postpartum Care	NCQA		✓			59.70%	71.38%
SBIRT	SBIRT Training	MQD			✓	✓	NT	—
NA	SBIRT Screening: SBIRT screenings provided to a % of Medicaid beneficiaries over age 15 years	MQD			✓	✓	5.72%	—

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 2023 Target**	**RY 2023 Result**
			1	**2**	**3**	**4**		
SSD	Diabetes Screening for People w/ Schizophrenia or Bipolar Dx using Antipsychotics	NCQA			✓		76.08%	71.48%
TOB	Preventive Care and Screening: Tobacco Use: Screening and Cessation	PCPI			✓		NT	—
W15	Well-Child Visits in the First 15 Months of Life: 6 or More Visits	NCQA	✓				74.85%	—
W30	Well-Child Visits in the First 30 Months of Life: 15 Months	NCQA	✓				65.06%	64.79%
W30	Well-Child Visits in the First 30 Months of Life: 30 Months	NCQA	✓				77.51%	65.67%
W34	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	NCQA	✓				73.60%	—
WCC	Weight Assessment and Counseling for Nutrition/Physical Activity: BMI Percentile Documentation	NCQA	✓				89.41%	79.47%
WCC	Weight Assessment and Counseling for Nutrition/Physical Activity: Counseling for Nutrition	NCQA	✓				80.29%	75.81%
WCC	Weight Assessment and Counseling for Nutrition/Physical Activity: Counseling for Physical Activity	NCQA	✓				75.71%	74.03%
WCV	Child and Adolescent Well-Care Visits	NCQA	✓				45.66%	46.56%
NA	Perinatal Collaborative: Design and implement a program to improve the quality of care for mothers and babies	MQD	✓	✓			Progress along continuum	Met
EPSDT	Screening Ratio: Observed: Expected ratio of number of screenings	CMS	✓				1.0	0.72
EPSDT	Participant Ratio: Observed: Expected ratio of eligibles receiving at least one initial or periodic screen	CMS	✓				88.74%	56.00%
EPSDT	Dental Care: Percent of eligibles receiving any dental or oral health services	CMS	✓				60.04%	52.95%
EPSDT	Dental Care: Percent of eligibles receiving preventive dental services	CMS	✓				45.49%	50.20%
CAHPS 5.0H	Composite Measure: Getting Needed Care (CHIP)	AHRQ	✓				79.04%	78.90%

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 2023 Target**	**RY 2023 Result**
			1	**2**	**3**	**4**		
CAHPS 5.0H	Composite Measure: Getting Care Quickly (CHIP)	AHRQ	✓				88.71%	78.50%
CAHPS 5.0H	Composite Measure: How Well Doctors Communicate (CHIP)	AHRQ	✓				99.63%	95.60%
CAHPS 5.0H	Composite Measure: Customer Service (CHIP)	AHRQ	✓				88.09%	89.10%
CAHPS 5.0H	Composite Measure: Shared Decision Making (CHIP)	AHRQ	✓				78.94%	—
CAHPS 5.0H	Individual Measures: Coordination of Care (CHIP)	AHRQ	✓				94.85%	87.00%
CAHPS 5.0H	Individual Measures: Health Promotion and Education (Adults)	AHRQ		✓	✓		81.27%	—
CAHPS 5.0H	Individual Measures: Health Promotion and Education (CHIP)	AHRQ	✓				78.31%	—

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 2023 Target**	**RY 2023 Result**
			5	**6**		
ADD	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	NCQA	✓	✓	66.86%	45.79%
ADD	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	NCQA	✓	✓	54.14%	50.59%
AMM	Antidepressant Medication Management: Effective Acute Phase Treatment	NCQA	✓	✓	54.91%	63.51%

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 2023 Target**	**RY 2023 Result**
			5	**6**		
AMM	Antidepressant Medication Management: Effective Continuation Phase Treatment	NCQA	✓	✓	38.30%	46.14%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing	NCQA	✓	✓	40.39%	50.46%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing	NCQA	✓	✓	17.80%	27.22%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing	NCQA	✓	✓	20.88%	26.30%
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA	✓	✓	64.30%	49.18%
BHA	Behavioral Health Assessment: Behavioral Health Assessment completion within 30 days of enrollment▼	MQD		✓	48.05%	—
CDF-CH; CDF-AD	Screening for Depression and Follow-Up Plan: Negative Screen for Depression During an Outpatient Visit Using a Standardized Tool	CMS	✓		19.58%	24.82%
COB-AD	Concurrent Use of Opioids and Benzodiazepines*	PQA		✓	14.30%	13.06%
FUA	Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence: 30-Day Follow-Up (Total)	NCQA	✓	✓	20.86%	42.44%
FUA	Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence: 7-Day Follow-Up (Total)	NCQA	✓	✓	12.98%	28.93%
FUH	Follow-Up After Hospitalization for Mental Illness: 30-Day Follow-Up	NCQA	✓	✓	55.43%	54.84%
FUH	Follow-Up After Hospitalization for Mental Illness: 7-Day Follow-Up	NCQA	✓	✓	35.70%	40.54%
FUM	Follow-Up After Emergency Department Visit for Mental Illness: 30-Day Follow-Up (Total)	NCQA	✓	✓	51.06%	51.79%
FUM	Follow-Up After Emergency Department Visit for Mental Illness: 7-Day Follow-Up (Total)	NCQA	✓	✓	33.60%	37.32%

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 2023 Target**	**RY 2023 Result**
			5	**6**		
FUP	Follow-up With Assigned PCP Following Hospitalization for Mental Illness	MQD	✓	✓	NT	—
HPCMI-AD	Diabetes Care for People with SMI: HbA1c Poor Control (>9.0%)*	NCQA	✓	✓	49.70%	46.69%
IET	Initiation and Engagement of AOD Abuse or Dependence Treatment: Initiation of AOD Treatment (Total)	NCQA	✓	✓	36.65%	35.33%
IET	Initiation and Engagement of AOD Abuse or Dependence Treatment: Engagement of AOD Treatment (Total)	NCQA	✓	✓	12.16%	9.34%
MPTA	Mental Health Utilization—Total Medicaid—telehealth/access: Mental Health Utilization—Total Medicaid (Any service)	NCQA	✓	✓	10.78%	—
OHD-AD	Use of Opioids at High Dosage in Persons Without Cancer*	PQA	✓	✓	10.98%	11.07%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Total (Rate 1)	CMS		✓	49.27%	56.24%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Buprenorphine (Rate 2)	CMS		✓	29.61%	31.83%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Oral Naltrexone (Rate 3)	CMS		✓	1.45%	0.97%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Long-Acting, Injectable Naltrexone (Rate 4)	CMS		✓	0.11%	0.24%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Methadone (Rate 5)	CMS		✓	20.27%	25.46%
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	NCQA	✓	✓	69.98%	67.15%
SBIRT	SBIRT Training	MQD	✓		NT	—
NA	SBIRT Screening: SBIRT screenings provided to a % of Medicaid beneficiaries over age 15 years	MQD	✓		5.72%	—
SSD	Diabetes Screening for People w/ Schizophrenia or Bipolar Dx using Antipsychotics	NCQA		✓	76.08%	71.48%

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 2023 Target**	**RY 2023 Result**
			7	**8**	**9**	**10**		
ACP	Advance Care Planning	NCQA			✓		1.98%	8.31%
ADD	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	NCQA	✓	✓			66.86%	45.79%
ADD	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	NCQA	✓	✓			54.14%	50.59%
AMM	Antidepressant Medication Management: Effective Acute Phase Treatment	NCQA		✓			54.91%	63.51%
AMM	Antidepressant Medication Management: Effective Continuation Phase Treatment	NCQA		✓			38.30%	46.14%
AMR	Asthma Medication Ratio	NCQA	✓				52.74%	62.16%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing	NCQA	✓				40.39%	50.46%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing	NCQA	✓				17.80%	27.22%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing	NCQA	✓				20.88%	26.30%
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA	✓				64.30%	49.18%
BHA	Behavioral Health Assessment: Behavioral Health Assessment completion within 30 days of enrollment ▼	MQD	✓				48.05%	—
CDC	Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	NCQA	✓	✓			68.61%	58.61%
CDC	Comprehensive Diabetes Care: HbA1c Control (<8%)	NCQA	✓	✓			51.25%	54.56%
CDC	Comprehensive Diabetes Care: HbA1c Poor Control (>9%)*	NCQA	✓	✓			37.21%	36.16%
CDC	Comprehensive Diabetes Care: HbA1c Testing	NCQA	✓	✓			91.73%	—
CDC	Comprehensive Diabetes Care: BP Control (<140/90 mm Hg)	NCQA	✓	✓			61.15%	60.15%
COB-AD	Concurrent Use of Opioids and Benzodiazepines*	PQA	✓	✓			14.30%	13.06%

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 2023 Target**	**RY 2023 Result**
			7	**8**	**9**	**10**		
FUA	Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence: 30-Day Follow-Up (Total)	NCQA	✓	✓			20.86%	42.44%
FUA	Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence: 7-Day Follow-Up (Total)	NCQA	✓	✓			12.98%	28.93%
FUH	Follow-Up After Hospitalization for Mental Illness: 30-Day Follow-Up	NCQA	✓	✓			55.43%	54.84%
FUH	Follow-Up After Hospitalization for Mental Illness: 7-Day Follow-Up	NCQA	✓	✓			35.70%	40.54%
FUM	Follow-Up After Emergency Department Visit for Mental Illness: 30-Day Follow-Up (Total)	NCQA	✓	✓			51.06%	51.79%
FUM	Follow-Up After Emergency Department Visit for Mental Illness: 7-Day Follow-Up (Total)	NCQA	✓	✓			33.60%	37.32%
FUP	Follow-Up With Assigned PCP Following Hospitalization for Mental Illness	MQD	✓	✓			NT	—
HPCMI-AD	Diabetes Care for People with SMI: HbA1c Poor Control (>9.0%)*	NCQA	✓	✓			49.70%	46.69%
IET	Initiation and Engagement of AOD Abuse or Dependence Treatment: Initiation of AOD Treatment (Total)	NCQA	✓	✓			36.65%	35.33%
IET	Initiation and Engagement of AOD Abuse or Dependence Treatment: Engagement of AOD Treatment (Total)	NCQA	✓	✓			12.16%	9.34%
LTSS-CCP	LTSS Comprehensive Care Plan and Update: Assessment of Core Elements	CMS	✓				10.02%	19.21%
LTSS-CCP	LTSS Comprehensive Care Plan and Update: Assessment of Supplemental Elements	CMS	✓				10.02%	18.97%
LTSS-PCP	LTSS Shared Care Plan with Primary Care Practitioner: LTSS Shared Care Plan with Primary Care Practitioner	CMS	✓	✓			18.58%	15.31%
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment after Inpatient Discharge	CMS	✓				10.74%	8.41%

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 2023 Target**	**RY 2023 Result**
			7	**8**	**9**	**10**		
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment and Care Plan after Inpatient Discharge	CMS	✓				1.32%	6.37%
PQI01-AD	PQI 01: Diabetes Short-Term Complications Admission Rate*	AHRQ	✓	✓			15.07	8.82
PQI05-AD	PQI 05: COPD or Asthma in Older Adults Admission Rate*	AHRQ	✓	✓			48.54	21.36
PQI08-AD	PQI 08: Heart Failure Admission Rate*	AHRQ	✓	✓			58.59	45.67
PQI15-AD	PQI 15: Asthma in Younger Adults Admission Rate*	AHRQ	✓	✓			2.51	2.66
PQI-92	PQI 92: Chronic Conditions Composite*	AHRQ	✓	✓			135.04	169.08
SAA	Adherence to Antipsychotic Medications for Individuals with Schizophrenia	NCQA	✓	✓			69.98%	67.15%
SSD	Diabetes Screening for People w/ Schizophrenia or Bipolar Dx using Antipsychotics	NCQA	✓	✓			76.08%	71.48%
CAHPS 5.0H	Composite Measure: How Well Doctors Communicate (Adults)	NCQA	✓	✓			98.07%	—
CAHPS 5.0H	Composite Measure: How Well Doctors Communicate (CHIP)	NCQA	✓	✓			99.63%	95.60%
CAHPS 5.0H	Composite Measure: Shared Decision Making: Composite Measure: Shared Decision Making (Adults)	NCQA	✓	✓			87.26%	—
CAHPS 5.0H	Composite Measure: Shared Decision Making (CHIP)	NCQA	✓	✓			78.94%	—
CAHPS 5.0H	Individual Measures: Coordination of Care (Adults)	NCQA	✓	✓			88.20%	—

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 2023 Target**	**RY 2023 Result**
			7	**8**	**9**	**10**		
CAHPS 5.0H	Individual Measures: Coordination of Care (CHIP)	NCQA	✓	✓			94.85%	87.00%
CAHPS Hospice	Rating of Hospice: % family caregivers rating the hospice agency a 9 or 10 on a scale of 0 (worst) to 10 (best)	CMS			✓		81.20%	82.00%
NA	Hospice and Palliative Care Composite Process Measure: Comprehensive Assessment at Admission	CMS			✓		96.60%	89.80%
NA	Hospice Visits when Death is Imminent: % patients receiving at least one visit from a provider in the last 3 days of life	CMS			✓		85.50%	85.80%

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**	**RY 2023 Target**	**RY 2023 Result**
			11		
LTSS-CA	LTSS Comprehensive Assessment and Update: Assessment of Core Elements	CMS	✓	18.92%	19.14%
LTSS-CA	LTSS Comprehensive Assessment and Update: Assessment of Supplemental Elements	CMS	✓	17.36%	18.41%
LTSS-CCP	LTSS Comprehensive Care Plan and Update: Assessment of Core Elements	CMS	✓	10.02%	19.21%
LTSS-CCP	LTSS Comprehensive Care Plan and Update: Assessment of Supplemental Elements	CMS	✓	10.02%	18.97%
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment after Inpatient Discharge	CMS	✓	10.74%	8.41%
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment and Care Plan after Inpatient Discharge	CMS	✓	1.32%	6.37%

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**	**RY 2023 Target**	**RY 2023 Result**
			11		
NA	Social Determinants of Health Collaborative: Design and implement a program to track the social determinants associated with patients	MQD	✓	Progress along continuum	Met

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 2023 Target**	**RY 2023 Result**
			12	**13**		
LTSS-AIF	LTSS Admission to an Institution from the Community: Short Term Stay	CMS	✓	✓	NT	90.89
LTSS-AIF	LTSS Admission to an Institution from the Community: Medium-Term Stay	CMS	✓	✓	NT	10.38
LTSS-AIF	LTSS Admission to an Institution from the Community: Long-Term Stay	CMS		✓	NT	8.70
LTSS-CA	LTSS Comprehensive Assessment and Update: Assessment of Core Elements	CMS	✓	✓	18.92%	19.14%
LTSS-CA	LTSS Comprehensive Assessment and Update: Assessment of Supplemental Elements	CMS	✓	✓	17.36%	18.41%
LTSS-CCP	LTSS Comprehensive Care Plan and Update: Assessment of Core Elements	CMS	✓	✓	10.02%	19.21%
LTSS-CCP	LTSS Comprehensive Care Plan and Update: Assessment of Supplemental Elements	CMS	✓	✓	10.02%	18.97%
LTSS-ILOS	LTSS Minimizing Institutional Length of Stay: Observed Rate	CMS	✓	✓	14.60%	13.31%

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 2023 Target**	**RY 2023 Result**
			12	**13**		
LTSS-ILOS	LTSS Minimizing Institutional Length of Stay: Risk-adjusted Ratio	CMS	✓	✓	0.4371	0.3785
LTSS-PCP	LTSS Shared Care Plan with Primary Care Practitioner: LTSS Shared Care Plan with Primary Care Practitioner	CMS	✓	✓	18.58%	15.31%
LTSS-TRAN	LTSS Successful Transition After Long-Term Institutional Stay: Observed Rate	CMS	✓	✓	81.57%	44.99%
LTSS-TRAN	LTSS Successful Transition After Long-Term Institutional Stay: Risk-adjusted Ratio	CMS	✓	✓	0.8764	0.8322
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment after Inpatient Discharge	CMS	✓	✓	10.74%	8.41%
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment and Care Plan after Inpatient Discharge	CMS	✓	✓	1.32%	6.37%
N024.01	Long Stay Urinary Tract Infections: Percentage of long-stay residents with a urinary tract infection*	CMS		✓	2.13%	2.59%
N031.02	Long Stay Antipsychotic Medications: Percent of Residents Who Received an Antipsychotic Medication (Long-Stay)*	CMS		✓	6.88%	9.71%
N015.01	Long Stay Pressure Ulcers: Percent of High-Risk Residents with Pressure Ulcers (Long Stay)*	CMS		✓	4.89%	4.99%
NA	PointRight Pro 30—Rehospitalizations: Risk adjusted rehospitalization rate*	AHCA		✓	8.75%	10.42%
NA	PointRight Pro Long Stay—Hospitalizations: Risk-adjusted rate of hospitalization of long-stay patients*	AHCA		✓	7.77%	8.01%
NA	BONUS: AHCA/NCAL National Quality Award: Number of facilities with an AHCA/NCAL Gold award for excellence in quality	AHCA		✓	NT	0

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 2023 Target**	**RY 2023 Result**
			14	**15**		
AAP	Adults' Access to Preventive/Ambulatory Health Services: Total	NCQA	✓		77.48%	67.50%
ACP	Advance Care Planning	NCQA	✓	✓	1.98%	8.31%
AMB	Ambulatory Care: Emergency Department (ED) Visits (per 1,000 member months)*	NCQA	✓	✓	41.98	35.99
AMB	Ambulatory Care: Outpatient Visits Including Telehealth (per 1,000 member months)	NCQA	✓	✓	360.27	293.75
AMR	Asthma Medication Ratio	NCQA		✓	52.74%	62.16%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing	NCQA		✓	40.39%	50.46%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing	NCQA		✓	17.80%	27.22%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing	NCQA		✓	20.88%	26.30%
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA		✓	64.30%	49.18%
BHA	Behavioral Health Assessment: Behavioral Health Assessment completion within 30 days of enrollment ▼	MQD		✓	48.05%	—
CDC	Comprehensive Diabetes Care: Eye Exam (Retinal) Performed	NCQA		✓	68.61%	58.61%
CDC	Comprehensive Diabetes Care: HbA1c Control (<8%)	NCQA		✓	51.25%	54.56%
CDC	Comprehensive Diabetes Care6: HbA1c Poor Control (>9%)	NCQA		✓	37.21%	36.16%
CDC	Comprehensive Diabetes Care: HbA1c Testing	NCQA		✓	91.73%	—
CDC	Comprehensive Diabetes Care: BP Control (<140/90 mm Hg)	NCQA		✓	61.15%	60.15%
COB-AD	Concurrent Use of Opioids and Benzodiazepines*	PQA		✓	14.30%	13.06%
ENPA	Enrollment by Product Line—Total Medicaid: Enrollment by Product Line—Total Medicaid member-months	NCQA	✓		NA	5,148,254
FUA	Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence: 30-Day Follow-Up (Total)	NCQA		✓	20.86%	42.44%

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 2023 Target**	**RY 2023 Result**
			14	**15**		
FUA	Follow-Up After ED Visit for Alcohol and Other Drug Abuse or Dependence: 7-Day Follow-Up (Total)	NCQA		✓	12.98%	28.93%
FUH	Follow-Up After Hospitalization for Mental Illness: 30-Day Follow-Up	NCQA		✓	55.43%	54.84%
FUH	Follow-Up After Hospitalization for Mental Illness: 7-Day Follow-Up	NCQA		✓	35.70%	40.54%
FUM	Follow-Up After Emergency Department Visit for Mental Illness: 30-Day Follow-Up (Total)	NCQA		✓	51.06%	51.79%
FUM	Follow-Up After Emergency Department Visit for Mental Illness: 7-Day Follow-Up (Total)	NCQA		✓	33.60%	37.32%
FUP	Follow-Up With Assigned PCP Following Hospitalization for Mental Illness	MQD		✓	NT	—
HPC	Hospitalization for Potentially Preventable Complications	NCQA	✓	✓	NT	—
HPCMI-AD	Diabetes Care for People with SMI: HbA1c Poor Control (>9.0%)*	NCQA		✓	49.70%	46.69%
IET	Initiation and Engagement of AOD Abuse or Dependence Treatment: Initiation of AOD Treatment (Total)	NCQA		✓	36.65%	35.33%
IET	Initiation and Engagement of AOD Abuse or Dependence Treatment: Engagement of AOD Treatment (Total)	NCQA		✓	12.16%	9.34%
IPU	Inpatient Utilization—General Hospital/Acute Care: Inpatient Utilization—General Hospital/Acute Care (Total, Days per 1000 member months)*	NCQA	✓		34.81	35.76
LTSS-PCP	LTSS Shared Care Plan with Primary Care Practitioner	CMS		✓	18.58%	15.31%
LTSS-TRAN	LTSS Successful Transition After Long-Term Institutional Stay: Observed Rate	CMS		✓	81.57%	44.99%
LTSS-TRAN	LTSS Successful Transition After Long-Term Institutional Stay: Risk-adjusted Ratio	CMS		✓	0.8764	0.8322
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment after Inpatient Discharge	CMS		✓	10.74%	8.41%

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 2023 Target**	**RY 2023 Result**
			14	**15**		
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment and Care Plan after Inpatient Discharge	CMS		✓	1.32%	6.37%
MPTA	Mental Health Utilization—Total Medicaid—telehealth/access: Mental Health Utilization—Total Medicaid (Any service)	NCQA		✓	10.78%	—
OHD-AD	Use of Opioids at High Dosage in Persons Without Cancer*	PQA		✓	10.98%	11.07%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Total (Rate 1)	CMS		✓	49.27%	56.24%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Buprenorphine (Rate 2)	CMS		✓	29.61%	31.83%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Oral Naltrexone (Rate 3)	CMS		✓	1.45%	0.97%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Long-Acting, Injectable Naltrexone (Rate 4)	CMS		✓	0.11%	0.24%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Methadone (Rate 5)	CMS		✓	20.27%	25.46%
PCR	Plan All-Cause Readmissions: Index Total Stays—Observed/Expected Ratio—Total*	NCQA		✓	0.6852	0.8577
PQI01-AD	PQI 01: Diabetes Short-Term Complications Admission Rate*	AHRQ		✓	15.07	8.82
PQI05-AD	PQI 05: COPD or Asthma in Older Adults Admission Rate*	AHRQ		✓	48.54	21.36
PQI08-AD	PQI 08: Heart Failure Admission Rate*	AHRQ		✓	58.59	45.67
PQI15-AD	PQI 15: Asthma in Younger Adults Admission Rate*	AHRQ		✓	2.51	2.66
THP	Telehealth Plan	MQD	✓		Progress along continuum	—

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 2023 Target**	**RY 2023 Result**
			14	**15**		
N024.01	Long Stay Urinary Tract Infections: Percentage of long-stay residents with a urinary tract infection*	CMS		✓	2.13%	2.59%
N031.02	Long Stay Antipsychotic Medications: Percent of Residents Who Received an Antipsychotic Medication (Long-Stay)*	CMS		✓	6.88%	9.71%
N015.01	Long Stay Pressure Ulcers: Percent of High-Risk Residents with Pressure Ulcers (Long Stay)*	CMS		✓	4.89%	4.99%
NA	PointRight Pro 30—Rehospitalizations: Risk adjusted rehospitalization rate*	AHCA		✓	8.75%	10.42%
NA	PointRight Pro Long Stay—Hospitalizations: Risk-adjusted rate of hospitalization of long-stay patients*	AHCA		✓	7.77%	8.01%
NA	30 Day All Cause Readmissions: Index Total Stays—Observed/Expected Ratio—Total*	NCQA		✓	1.0138	—
NA	Preventable ER Visits (NYU Algorithm): Total Visits—Number Preventable*	NYU		✓	45.54%	—
NA	Reducing ED Visits for Patients with 4 or more visits: ED treat and release visits for patients with 4+ visits to the same facility in a calendar year*	HAH		✓	15.00%	21.07%
OP-18	Time from ED Admit to Discharge: Average time patients spent in the emergency department before being sent home (Target and Rate are represented as # of minutes)*	CMS	✓	✓	67.62	78.00
CAHPS 5.0H	Composite Measure: Getting Needed Care: (CHIP)	NCQA	✓	✓	79.04%	78.90%
CAHPS 5.0H	Composite Measure: Getting Needed Care (Adults)	NCQA	✓	✓	87.57%	—
CAHPS 5.0H	Composite Measure: Getting Care Quickly (CHIP)	NCQA	✓	✓	88.71%	78.50%
CAHPS 5.0H	Composite Measure: Getting Care Quickly (Adults)	NCQA	✓	✓	85.89%	—
CAHPS 5.0H	Composite Measure: How Well Doctors Communicate (Adults)	NCQA		✓	98.07%	—

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 2023 Target**	**RY 2023 Result**
			14	**15**		
CAHPS 5.0H	Composite Measure: How Well Doctors Communicate (CHIP)	NCQA		✓	99.63%	95.60%
CAHPS 5.0H	Composite Measure: Customer Service (Adults)	NCQA	✓		93.77%	—
CAHPS 5.0H	Composite Measure: Shared Decision Making (Adults)	NCQA		✓	87.26%	—
CAHPS 5.0H	Composite Measure: Shared Decision Making (CHIP)	NCQA		✓	78.94%	—
CAHPS 5.0H	Individual Measures: Coordination of Care (Adults)	NCQA		✓	88.20%	—
CAHPS 5.0H	Individual Measures: Coordination of Care (CHIP)	NCQA		✓	94.85%	87.00%
CAHPS 5.0H	Individual Measures: Health Promotion and Education (Adults)	NCQA	✓		81.27%	—
CAHPS 5.0H	Individual Measures: Health Promotion and Education (CHIP)	NCQA	✓		78.31%	—
CAHPS 5.0H	Composite Measure: Rating of Health Plan (Adults)	NCQA	✓		66.26%	—
CAHPS 5.0H	Composite Measure: Rating of All Health Care (Adults)	NCQA	✓		59.33%	—
CAHPS 5.0H	Composite Measure: Rating of Health Plan (CHIP)	NCQA	✓		74.26%	75.40%
CAHPS 5.0H	Composite Measure: Rating of All Health Care (CHIP)	NCQA	✓		69.06%	65.50%
EPSDT	Screening Ratio: Observed: Expected ratio of number of screenings	CMS	✓		1.00	0.72
EPSDT	Participant Ratio: Observed: Expected ratio of eligibles receiving at least one initial or periodic screen	CMS	✓		89.61%	56.00%

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 2023 Target**	**RY 2023 Result**
			16	**17**		
AMB	Ambulatory Care: Outpatient Visits Including Telehealth (per 1,000 member months)	NCQA		✓	360.27	293.75
AWC	Adolescent Well-Care Visits	NCQA		✓	52.61%	—
CCS	Cervical Cancer Screening	NCQA		✓	61.95%	54.29%
CDC	Comprehensive Diabetes Care: HbA1c Control (<8%)	NCQA		✓	51.25%	54.56%
CDC	Comprehensive Diabetes Care: HbA1c Testing	NCQA		✓	91.73%	—
CIS	Childhood Immunization Status: Combination 3	NCQA		✓	71.33%	56.11%
FUH	Follow-Up After Hospitalization for Mental Illness: 7-Day Follow-Up	NCQA		✓	35.70%	40.54%
PCR	Plan All-Cause Readmissions: Index Total Stays—Observed/Expected Ratio—Total*	NCQA		✓	0.6852	0.8577
PPC	Prenatal and Postpartum Care: Timeliness of Prenatal Care	NCQA		✓	82.35%	78.00%
PPC	Prenatal and Postpartum Care: Postpartum Care	NCQA		✓	59.70%	71.38%
SBIRT	SBIRT Training	MQD		✓	NT	—
THP	Telehealth Plan	MQD		✓	Progress along continuum	—
W15	Well-Child Visits in the First 15 Months of Life: 6 or More Visits	NCQA		✓	74.13%	—
W30	Well-Child Visits in the First 30 Months of Life: 15 Months	NCQA		✓	64.42%	63.73%
W34	Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life: Well-Child Visits in the Third, Fourth, Fifth and Sixth Years of Life	NCQA		✓	74.85%	—
N024.01	Long Stay Urinary Tract Infections: Percentage of long-stay residents with a urinary tract infection*	CMS		✓	2.13%	2.59%
N031.02	Long Stay Antipsychotic Medications: Percent of Residents Who Received an Antipsychotic Medication (Long-Stay)*	CMS		✓	6.88%	9.71%
N015.01	Long Stay Pressure Ulcers: Percent of High-Risk Residents with Pressure Ulcers (Long Stay)*	CMS		✓	4.89%	4.99%
NA	PointRight Pro 30—Rehospitalizations: Risk adjusted rehospitalization rate*	AHCA		✓	8.75%	10.42%
NA	PointRight Pro Long Stay—Hospitalizations: Risk-adjusted rate of hospitalization of long-stay patients*	AHCA		✓	7.77%	8.01%

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 2023 Target**	**RY 2023 Result**
			16	**17**		
NA	BONUS: AHCA/NCAL National Quality Award: Number of facilities with an AHCA/NCAL Gold award for excellence in quality	AHCA		✓	NT	0
NA	SBIRT Screening: SBIRT screenings provided to a % of Medicaid beneficiaries over age 15 years	MQD		✓	5.72%	—
NA	Social Determinants of Health Collaborative: Design and implement a program to track the social determinants associated with patients	MQD	✓	✓	Progress along continuum	Met
NA	Perinatal Collaborative: Design and implement a program to improve the quality of care for mothers and babies	MQD		✓	Progress along continuum	Met
NA	30-Day All Cause Readmissions: Index Total Stays—Observed/Expected Ratio—Total*	NCQA		✓	1.0138	—
NA	Preventable ER Visits (NYU Algorithm): Total Visits—Number Preventable*	NYU		✓	45.54%	—
NA	Reducing ED Visits for Patients with 4 or more visits: ED treat and release visits for patients with 4+ visits to the same facility in a calendar year*	HAH		✓	15.00%	21.07%
OP-18	Time from ED Admit to Discharge: Average time patients spent in the emergency department before being sent home (Target and Rate are represented as # of minutes)*	CMS		✓	67.62	78.00
CAHPS 5.0H	Composite Measure: Getting Needed Care (CHIP)	NCQA		✓	79.04%	78.90%
CAHPS 5.0H	Composite Measure: Getting Needed Care (Adults)	NCQA		✓	87.57%	—
EPSDT	Participant Ratio: Observed: Expected ratio of eligibles receiving at least one initial or periodic screen	CMS		✓	89.61%	56.00%

* A lower rate indicates better performance for this measure.

▼ Indicates the measure was only reported by CCS.

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.

Indicates that the RY 2023 performance measure rate was at or above the RY 2023 target.