State of Hawaii

Department of Human Services

Med-QUEST Division

2025 External Quality Review Report of Results

for the

QUEST Integration Health Plans

and the

Community Care Services Program

April 2026

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Overview

The 2025 Hawaii External Quality Review Report of Results for the QUEST Integration (QI) Health Plans and the Community Care Services (CCS) program is presented to comply with the Code of Federal Regulations (CFR) at 42 CFR §438.364.[1] Health Services Advisory Group, Inc. (HSAG), is the external quality review organization (EQRO) for the Med-QUEST Division (MQD) of the State of Hawaii Department of Human Services (DHS), the single State agency responsible for the overall administration of Hawaii's Medicaid managed care program.

This report describes how data from activities conducted in accordance with 42 CFR §438.352 were aggregated and analyzed and how conclusions were drawn as to the quality and timeliness of, and access to, care furnished to Medicaid and Children's Health Insurance Program (CHIP) recipients in Hawaii. The QI health plans include five managed care organizations (MCOs) contracted with MQD to provide physical health and behavioral health services to Medicaid members. MQD also contracted with one prepaid inpatient health plan (PIHP), also known as Community Care Services (CCS), to provide behavioral health specialty services for individuals who have been determined by MQD to have a serious mental illness (SMI) or serious and persistent mental illness (SPMI), and who are enrolled in a QI health plan. The MCOs and PIHP that contracted with MQD during calendar year (CY) 2025 are displayed in Table 1-1. No health plans were exempt from external quality review (EQR) in CY 2025.

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] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 81, No. 88/Friday, May 6, 2016/Rules and Regulations. 42 CFR Parts 431, 433, and 438 with revisions released (or as amended) November 13, 2020.42 CFR Parts 430, 438, and 457 with revisions released (or as amended) May 10, 2024. Final Rule.

Purpose of the Report

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

- A description of the manner in which the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of, and access to the care furnished by the MCO, PIHP, or PAHP.
- For each EQR-related activity conducted in accordance with §438.358:
  - Objectives
  - Technical methods of data collection and analysis
  - The data and a description of data obtained, including validated performance measurement, any outcomes data and results from quantitative assessments, for each activity conducted with §438.358(b)(1)(i), (ii) and (iv).
  - Conclusions drawn from the data
- An assessment of each MCO's, PIHP's, or PAHP's strengths and weaknesses for the quality and timeliness of, and access to healthcare services furnished to Medicaid beneficiaries.
- Recommendations for improving the quality of healthcare services furnished by each MCO, PIHP, or PAHP, including how the State can target goals and objectives in the quality strategy, under §438.340, to better support improvement in the quality and timeliness of, and access to healthcare services furnished to Medicaid beneficiaries.
- Methodologically appropriate, comparative information about all MCOs, PIHPs, or PAHPs, consistent with guidance included in the EQR protocols issued in accordance with §438.352(e).
- An assessment of the degree to which each MCO, PIHP, or PAHP has effectively addressed the recommendations for quality improvement made by the EQRO during the previous year's EQR.
- The names of the MCOs exempt from EQR by the State, including the beginning date of the current exemption period, or that no MCOs are exempt, as appropriate.

Summary of Report Content

Encompassing a review period from January 1, 2025, through December 31, 2025, this report provides:

- A description of Hawaii's Medicaid delivery system and an overview of the QI and CCS programs.

[2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 81, No. 88/Friday, May 6, 2016/Rules and Regulations. 42 CFR Parts 431, 433 and 438 with revisions released (or as amended) November 13, 2020, 42 CFR Parts 430, 438, and 457 with revisions released (or as amended) May 10, 2024. Final Rule. Available at: https://www.federalregister.gov/agencies/centers-for-medicare-medicaid-services. Accessed on: Dec 31, 2025.

- A description of MQD's Quality Strategy and evaluation of Quality Strategy effectiveness.
- 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 description of the scope of EQR activities performed by HSAG and the manner in which the data from these activities were analyzed and aggregated, and conclusions were drawn.
- An assessment of each health plan's strengths and weaknesses for providing healthcare timeliness, access, and quality across CMS-required mandatory and optional activities for compliance with standards, network adequacy, performance measures, performance improvement projects (PIPs), and consumer satisfaction surveys.
- Recommendations for the health plans to improve member access to care, quality of care, and timeliness of care.
- 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.
- A description of the methodologies used to conduct EQR activities included as an appendix.

Scope of EQR Activities

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

Compliance Reviews

In accordance with 42 CFR §438.358, the state or its designee must conduct a review within the previous three-year period to determine the MCO's, PIHP's, or PAHP's compliance with federal standards set forth in 42 CFR 438 subpart D, the disenrollment requirements and limitations described in §438.56, the enrollee rights requirements described in §438.100, the emergency and post-stabilization services requirements described in §438.114, the quality assessment and performance improvement (QAPI) requirements described in §438.330, and associated state-specific requirements, when applicable.

MQD contracts with the EQRO to conduct a review of one-half of the full set of standards in year one and year two to complete the cycle within a three-year period. HSAG conducted on-site compliance reviews in June 2025. The health plans submitted documentation that was in effect from June 1, 2024, through May 31, 2025. HSAG provided detailed, final audit reports to the health plans and MQD in September 2025.

Performance Measure Validation

In accordance with 42 CFR §438.330(c), states must require that MCOs, PIHPs, and PAHPs, submit performance measurement data as part of the MCOs', PIHPs', and PAHPs' QAPI programs. Validating

performance measures is one of the mandatory EQR activities described in §438.358(b)(1). The EQR technical report must include information on the validation of MCO, PIHP, and PAHP performance measures (as required by the state) or MCO, PIHP, and PAHP performance measures calculated by the state during the preceding 12 months.

HSAG validated each health plan's performance measure results for a set of Healthcare Effectiveness Data and Information Set (HEDIS)® [3] and non-HEDIS performance measures selected by MQD to evaluate the accuracy and reliability of the health plans' data that contributed to the performance measure rate calculations. HSAG assessed the performance measure results and their impact on improving members' health outcomes. HSAG conducted validation of the performance measure rates following the National Committee for Quality Assurance (NCQA) HEDIS Compliance Audit™ [4] guidelines and timeline, which occurred from December 2024 through July 2025. The final audited performance measure validation results for each health plan reflected the measurement period of January 1, 2024, through December 31, 2024. HSAG provided final audit reports to the health plans and MQD in July 2025.

Network Adequacy Validation

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

MQD contracted with HSAG to conduct network adequacy validation (NAV) for the Hawaii managed care health plans. HSAG conducted NAV, validating the systems and processes, data sources, methods, and results, according to CMS EQR Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity, February 2023 (CMS EQR Protocol 4).[5] HSAG provided the final NAV aggregate report to MQD in December 2025.

Performance Improvement Project (PIP) Validation

Validating PIPs is one of the mandatory external quality review activities described at 42 CFR §438.358(b)(1). In accordance with §438.330(d), MCOs, PIHPs, and PAHPs are required to have a quality program that (1) includes ongoing PIPs designed to have a favorable effect on health outcomes and enrollee satisfaction and (2) focuses on both clinical and nonclinical areas that involve measuring performance using objective quality indicators, implementing interventions to achieve improvement in the access to and quality of care, evaluating effectiveness of the interventions, and planning and

[3] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
[4] NCQA HEDIS Compliance Audit™ is a trademark of the NCQA.
[5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols,* February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Dec 31, 2025.

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.

HSAG validated PIPs to ensure that the health plans designed, conducted, and reported the projects in a methodologically sound manner consistent with the CMS *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023.[6] In CY 2025, the QI health plans submitted three PIPs each, which were reviewed and validated by HSAG. 'Ohana CCS submitted two PIPs for HSAG's review and validation. HSAG also provided PIP trainings to the health plans prior to the PIP submissions, and additional technical assistance was provided to the health plans upon request throughout the year. HSAG provided final PIP validation reports to the health plans and MQD in December 2025.

Consumer or Provider Surveys

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

MQD contracted with HSAG to conduct CAHPS surveys of the child QI health plan members to learn more about parents'/caretakers' of child members experiences with care. The standardized survey instrument administered to parents/caretakers of child members enrolled in the five QI health plans was the CAHPS 5.1H Child Medicaid Health Plan Survey. All parents/caretakers of sampled child members completed the surveys from February to May 2025. HSAG aggregated and produced final reports in September 2025.

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 November 2025 to December 2025. At the time of this report, survey administration and data analysis were ongoing; therefore, results of the 2025 HCBS CAHPS survey will be presented in the 2026 Hawaii EQR Technical Report.

MQD contracted with HSAG to conduct a survey of healthcare providers who serve QI members through one or more QI health plans to learn more about providers' perceptions of the QI health plans. HSAG and MQD developed a survey instrument designed to acquire provider information and gain providers' insight into the QI health plans' performance and potential areas of performance improvement. Providers completed the surveys from July 2025 to September 2025. HSAG aggregated and produced a final report in January 2026.

[6] 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: Dec 31, 2025.

Technical Assistance

At the state's direction, the EQRO may provide technical guidance to groups of MCOs, PIHPs, or PAHPs to assist them in conducting activities related to the mandatory and optional activities described at 42 CFR §438.358 that provide information for the EQR and the resulting EQR technical report.

Overall Summary of Health Plan Performance

Compliance Monitoring Review

CY 2025 began a new three-year cycle of compliance reviews for the QI health plans and the CCS program. For the 2025 evaluation of health plan compliance, HSAG performed two types of activities. First, HSAG conducted a review of select standards for the QI and CCS programs using monitoring tools to assess and document compliance with a set of federal and State requirements. The standards selected for review were related to the health plan's State contract requirements and the federal Medicaid managed care regulations in the CFR for eight areas of review, or standards. Both a pre-on-site desk review and an on-site review with interview sessions, system and process demonstrations, and record reviews were conducted. The second compliance review activity in 2025 involved HSAG's and MQD's follow-up monitoring of the QI health plans' and CCS' corrective actions related to findings from the 2025 compliance review.

Findings, Conclusions, and Recommendations

Table 1-2 summarizes the results from the 2025 compliance monitoring reviews. This table contains high-level results used to compare the Hawaii Medicaid managed care health plans' performance on a set of requirements (federal Medicaid managed care regulations and State contract provisions) for each of the eight compliance standard areas selected for review this year. Scores have been calculated for each standard area statewide, and for each health plan for all standards.

Table 1-2—Standards and Compliance Scores

Standard Name	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI	'Ohana CCS	Statewide Score
I. Availability of Services	100%	100%	100%	100%	100%	100%	**100%**
II. Assurances of Adequate Capacity and Services	100%	100%	100%	100%	100%	100%	**100%**
III. Coordination and Continuity of Care	100%	100%	100%	100%	100%	100%	**100%**
IV. Confidentiality	100%	100%	100%	100%	100%	100%	**100%**
V. Coverage and Authorization of Services	100%	97% ↓	100%	100%	97% ↓	100%	**99%**
VI. Enrollee Information	95% ↓	100%	100%	100%	95% ↓	100%	**98%**
VII. Enrollee Rights and Protections	100%	100%	100%	100%	100%	100%	**100%**

Standard Name	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI	'Ohana CCS	Statewide Score
VIII. Grievance and Appeal System	97%	94%	97%	81% ↓	97%	94%	**93%**
Totals	**98%**	**98%**	**99%**	**95% ↓**	**98%**	**98%**	**98%**
***Totals*:** The percentages obtained by dividing the number of elements *Met* by the total number of applicable elements.							

and ↓ indicates health plan performance was below the statewide score.

In general, health plan performance demonstrates that all health plans had implemented robust systems, policies and procedures, and staff to ensure that their operational foundations support the core processes of providing quality 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—Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Confidentiality, and Enrollee Rights and Protections. The Grievance and Appeal System standard was identified as having the greatest opportunity for improvement, with a statewide compliance score 93 percent, and all plans having to implement corrective actions for this standard.

Individual health plan performance revealed the following:

- AlohaCare QI's performance across standards was above average, meeting or exceeding the statewide compliance score for seven of the eight standards.
  - AlohaCare QI had a total compliance score of 98 percent, with six of the eight standards scoring 100 percent: Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Confidentiality, Coverage and Authorization of Services, and Enrollee Rights and Protections.
  - 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 standards was above average, meeting or exceeding the statewide compliance score for seven of the eight standards.
  - HMSA QI had a total compliance score of 98 percent, with six of the eight standards scoring 100 percent: Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Confidentiality, Enrollee Information, and Enrollee Rights and Protection.
  - With two of the 31 elements found to be *Not Met* and a compliance score of 94 percent, HMSA QI has the greatest room for improvement in the Grievance and Appeal System standard.
  - 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 above average, meeting or exceeding the statewide compliance score for all eight standards.

  - KFHP QI had a total compliance score of 99 percent, with seven of the eight standards scoring 100 percent: Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Confidentiality, Coverage and Authorization of Services, Enrollee Information, and Enrollee Rights and Protection.
  - KFHP QI was required to develop a CAP to address and resolve one deficiency identified in the review. HSAG and MQD provided feedback on the proposed corrective action and KFHP QI was found to be in full compliance in September 2025.
- 'Ohana QI's performance across standards was above average, meeting or exceeding the statewide compliance score for seven of the eight standards.
  - 'Ohana QI had a total compliance score of 95 percent, with seven of the eight standards scoring 100 percent: Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Confidentiality, Coverage and Authorization of Services, Enrollee Information, and Enrollee Rights and Protection.
  - With six of the 31 elements found to be *Not Met* and a compliance score of 81 percent, 'Ohana QI has the greatest room for improvement in the Grievance and Appeal System standard.
  - 'Ohana QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and MQD provided feedback on the proposed corrective actions and 'Ohana QI was found to be in full compliance in December 2025.
- UHC CP QI's performance across standards was average, meeting or exceeding the statewide compliance score for six of the eight standards.
  - UHC CP QI had a total compliance score of 98 percent, with five of the eight standards scoring 100 percent: Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Confidentiality, and Enrollee Rights and Protection.
  - UHC CP QI had the greatest room for improvement in Coverage and Authorization of Services and Enrollee information, with both standards scoring below the statewide score.
  - UHC CP 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 UHC CP QI's CAP activities until the health plan is found to be in full compliance.
- 'Ohana CCS' performance across all standards was above average, meeting or exceeding the statewide compliance score for all eight standards.
  - 'Ohana CCS' had a total compliance score of 99 percent, with seven of the eight standards scoring 100 percent: Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Confidentiality, Coverage and Authorization of Services, Enrollee Information, and Enrollee Rights and Protection.
  - 'Ohana CCS' was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and MQD provided feedback on the proposed corrective actions and 'Ohana CCS was found to be in full compliance in December 2025.

With the completion of compliance monitoring reviews and initiation of the corrective action process, the health plans and CCS have demonstrated their structural and operational compliance and ability to support the provision of quality, timely, and accessible services. CY 2026 will be the second year in the

three-year cycle for compliance reviews. The reviews will target the remaining six standards: Provider Selection, Subcontractual Relationships and Delegation, Health Information Systems, Quality Assessment and Performance Improvement, Practice Guidelines, and Disenrollment: Requirements and Limitations.

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) 2024 Volume 5, HEDIS Compliance Audit: Standards, Policies and Procedures*.[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 2024.[8] The health plans that contracted with MQD during MY 2024 for the QI and CCS programs underwent separate NCQA HEDIS Compliance Audits for these programs. Each audit incorporated a detailed evaluation of the health plans' information system (IS) capabilities and their ability to process, store, analyze, and report medical, member, practitioner, and vendor data, which is essential for reporting accurate and reliable performance measure results. In addition, HSAG used NCQA's HEDIS Determination (HD) standards to assess the health plans' algorithmic compliance and oversight of outsourced or delegated reporting functions.

The NCQA HEDIS Compliance Audit for the CCS program evaluated compliance with IS and HD standards in reporting a set of HEDIS performance measures relevant to behavioral health. The measurement period was MY 2024 (January 1, 2024, through December 31, 2024), and the audit activities were conducted concurrently with the HEDIS MY 2024 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 2024 reporting, the State selected a set of performance measures from NCQA's *HEDIS Measurement Year 2024 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 2025 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 2025 Reporting; CMS' Measures for Medicaid Long Term Services and Supports Plans, Technical Specifications and Resource Manual, April 2024,* and NCQA's *HEDIS & Measurement Year 2024, 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 2024 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

[7] National Committee for Quality Assurance. *HEDIS Measurement Year 2024 Volume 5: HEDIS Compliance Audit™: Standards, Policies and Procedures.* Washington, DC: NCQA; 2024.
[8] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2024. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: December 30, 2025.

report on 31 measures for the QI population, yielding a total of 147 measure indicators. 'Ohana CCS was required to report on 10 measures, yielding 49 measure indicators, for the CCS program. The measures were organized into the following six categories, or domains, to evaluate the health plans' performance and the quality of, timeliness of, and access to Medicaid care and services.

- Access and Risk-Adjusted Utilization
- Children's Preventive Health
- Women's Health
- Care for Chronic Conditions
- Behavioral Health
- Long-Term Services and Supports (LTSS)

Findings, Conclusions, and Recommendations

NCQA HEDIS Compliance Audits

HSAG evaluated each QI and CCS health plan's measure data collection and reporting processes to determine compliance with NCQA's IS and HD standards during the MY 2024 NCQA HEDIS Compliance Audits. HSAG determined all five of the QI health plans and the CCS program to be *fully compliant* with all NCQA HEDIS IS and HD standards, which included NCQA's IS standard L for assessing case management data for LTSS measures. Overall, the health plans followed the measure specifications required by the State to calculate the required HEDIS and non-HEDIS performance measure rates, and all rates were determined to be *Reportable*.

Performance Measure Results

HSAG analyzed the HEDIS MY 2024 performance measure results for each health plan, and where applicable, HSAG compared the results to NCQA's 2024 Quality Compass®,[9] national Medicaid health maintenance organization (HMO) percentiles for HEDIS MY 2023 (referred to throughout this report as percentiles). For three measure indicators where a lower rate indicates better performance (i.e., *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status >9.0%—Total* and *Ambulatory Care—Emergency Department Visits/1,000 Member Years—Total)*, HSAG reversed the order of the benchmarks for performance level evaluation to be consistently applied.[10]

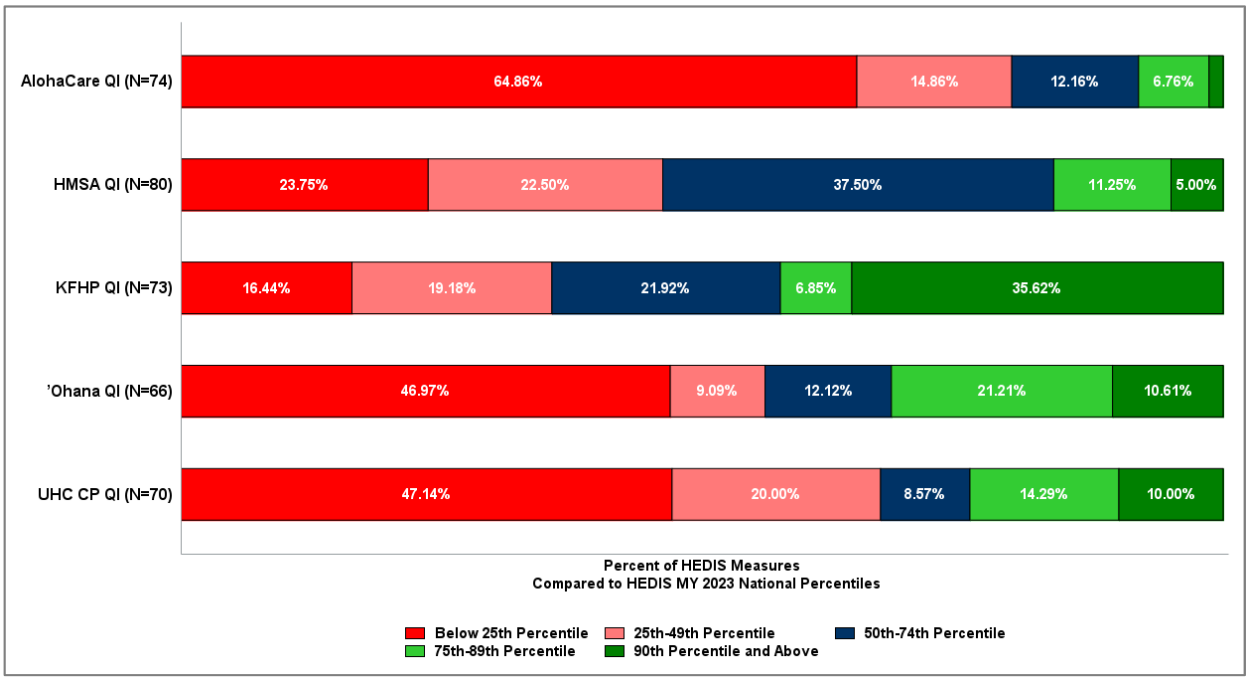
Additionally, HSAG analyzed the results for five CMS *Adult Core Set* measures, one CMS *Child Core Set* measure, two NCQA LTSS measures, and two CMS LTSS measure. Of note, these measures do not have applicable benchmarks for comparison.

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

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 2024 performance compared to benchmarks, where applicable. HSAG analyzed results from 31 performance measures for HEDIS MY 2024 (a total of 147 indicator rates), of which 84 indicators were comparable to benchmarks. Of note, all the health plans had at least one measure indicator or more receive a status of *NA* (i.e., small denominator).

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 2024, with 47 of 73 (64.38 percent) measure indicator rates ranking at or above the 50th percentile, including 31 indicator rates (42.47 percent) meeting or exceeding the 75th percentile and 26 rates (35.62 percent) meeting or exceeding the 90th percentile. Conversely, 26 of KFHP QI's measure indicator rates (35.62 percent) fell below the 50th percentile, 12 of which (16.44 percent) fell below the 25th percentile, suggesting that some opportunities for improvement exist.

HMSA QI was the second-highest performing health plan, with 43 of 80 (53.75 percent) measure indicator rates ranking at or above the 50th percentile, 13 of these rates (16.25 percent) ranking at or above the 75th percentile, and four of these rates (5 percent) ranking at or above the 90th percentile. Conversely, 37 of HMSA QI's measure indicator rates (46.25 percent) fell below the 50th percentile, with 19 of these rates (23.75 percent) falling below the 25th percentile.

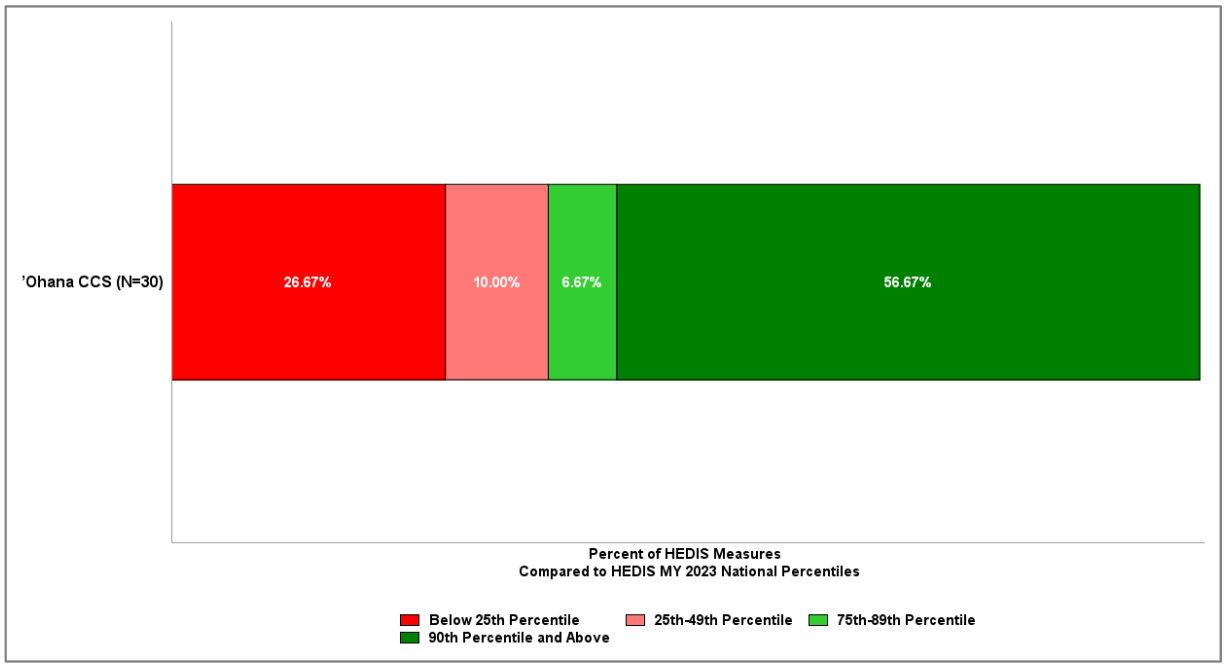
For ‘Ohana QI, 29 out of 66 (43.94 percent) measure indicator rates met or exceeded the 50th percentile, with 21 of these rates (31.82 percent) ranking at or above the 75th percentile, and seven of these rates (10.61 percent) ranking at or above the 90th percentile. Conversely, 37 of ‘Ohana QI’s measure indicator rates (56.06 percent) fell below the 50th percentile, with 31 of these rates (46.97 percent) falling below the 25th percentile.

For UHC CP QI, 47 of 70 (67.14 percent) measure indicator rates ranked below the 50th percentile, with 33 of these rates (47.14 percent) falling below the 25th percentile. Conversely, UHC CP QI met or exceed the 50th percentile for 23 measure indicator rates (32.86 percent), with 17 of these rates (24.29 percent) meeting or exceeding the 75th percentile, and seven of these rates (10 percent) meeting or exceeding the 90th percentile.

AlohaCare QI was the lowest-performing plan for HEDIS MY 2024, with 59 of 74 measure indicator rates (79.73 percent) falling below the 50th percentile, and 48 of these rates (64.86 percent) falling below the 25th percentile. Conversely, AlohaCare QI met or exceeded the 50th percentile for 15 measure indicator rates (20.27 percent), with six of these rates (8.11 percent) ranking at or above the 75th percentile.

Figure 1-2 displays ‘Ohana CCS’ HEDIS MY 2024 performance compared to benchmarks, where applicable. HSAG analyzed results from 10 performance measures for HEDIS MY 2024 (a total of 49 indicator rates), of which 30 indicators were comparable to benchmarks. Of note, ‘Ohana CCS had at least one measure indicator or more 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 19 of 30 (63.33 percent) measure indicator rates ranking at or above the 50th percentile, including 17 indicator rates (56.67 percent) that met or exceeded the 90th percentile. Additionally, 'Ohana CCS met six MQD Quality Strategy targets in HEDIS MY 2024. Conversely, 11 of 30 (36.67 percent) measure rates fell below the 50th percentile, including eight indicator rates (26.67 percent) that fell below the 25th percentile.

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

Validation of Network Adequacy

Based on the MQD-defined network adequacy standards, HSAG worked with MQD to define the network adequacy indicators, which HSAG then validated. The indicators are metrics used to assess adherence to the quantitative network adequacy standards required and set forth by the State. MQD identified network adequacy indicators to be validated for the reporting period of CY 2025.

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

Findings, Conclusions, and Recommendations

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

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

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

Performance Improvement Projects

In CY 2025, HSAG validated three PIPs for each of the five QUEST Integration health plans and two PIPs for one PIHP—'Ohana CCS. The PIP topics for the QI health plans were a nonclinical PIP: *Behavioral Health Coordination*, and two clinical PIPs: *Plan All-Cause Readmissions* and *Screening for Depression and Follow-Up Plan*. The PIP topics for 'Ohana CCS were a nonclinical PIP: *Behavioral Health Coordination*, and a clinical PIP: *7-Day Follow-Up After Emergency Department Visit for Mental Illness*. The PIPs addressed CMS' requirements related to quality outcomes—specifically, access to and timeliness of care and services.

Findings, Conclusions, and Recommendations

For the CY 2025 submission, the QI health plans progressed to the Implementation stage of the *Screening for Depression and Follow-Up Plan* PIP and the Outcomes stage for the *Behavioral Health Coordination* PIP and the *Plan All-Cause Readmissions* PIP. 'Ohana CCS progressed to the Outcomes stage for the *Behavioral Health Coordination* PIP and the *7-Day Follow-Up After Emergency Department Visit for Mental Illness* PIP. The health plans submitted Steps 1 through 8 in the PIP Submission Form. The PIPs were assessed for improvement in outcomes in Step 9.

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

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

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

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

Health Plan Name	Validation Rating 1			Validation Rating 2		
	Overall Confidence in Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence that the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Behavioral Health Coordination						
AlohaCare QI	100%	100%	*High Confidence*	100%	100%	*High Confidence*
HMSA QI	100%	100%	*High Confidence*	100%	100%	*High Confidence*
KFHP QI	94%	100%	*High Confidence*	33%	100%	*Low Confidence*
ʻOhana QI	100%	100%	*High Confidence*	100%	100%	*High Confidence*
UHC CP QI	100%	100%	*High Confidence*	50%	100%	*High Confidence*
Plan All-Cause Readmissions						
AlohaCare QI	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
HMSA QI	100%	100%	*High Confidence*	33%	100%	*No Confidence*
KFHP QI	100%	100%	*High Confidence*	33%	100%	*No Confidence*
ʻOhana QI	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
UHC CP QI	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
Screening for Depression and Follow-Up Plan						
AlohaCare QI	100%	100%	*High Confidence*	*Not Assessed*[4]		
HMSA QI	100%	100%	*High Confidence*	*Not Assessed*[4]		

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

[1] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[2] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Confidence Level**— Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

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

Behavioral Health Coordination

The third quarter of CY 2024 was the Remeasurement 3 period for the *Behavioral Health Coordination* PIP, which included two performance indicators. AlohaCare QI, HMSA QI, and ‘Ohana QI achieved statistically significant improvement over the baseline during Remeasurement 3 for both performance indicators. KFHP QI and UHC CP QI achieved statistically nonsignificant improvement in the Performance Indicator 1 rate; however, a decline from the baseline rate was noted in the Performance Indicator 2 rate.

Plan All-Cause Readmissions

CY 2024 was the Remeasurement 3 period for the *Plan All-Cause Readmissions* PIP, which included one performance indicator. AlohaCare QI, ‘Ohana QI, and UHC CP QI achieved statistically nonsignificant improvement in the Remeasurement 3 rate over the baseline. HMSA QI and KFHP QI demonstrated a decline in performance over the baseline, with an increase in the observed readmission rate.

Screening for Depression and Follow-Up Plan

The health plans had not progressed to the reporting of remeasurement outcomes during the CY 2025 validation.

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

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

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

[1] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[2] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

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

'Ohana CCS reported Remeasurement 3 data for the *7-Day Follow-Up After Emergency Department Visit for Mental Illness* PIP. The health plan achieved statistically nonsignificant decline in performance as compared to the baseline.

Based on the results of the CY 2025 PIP validation activities, HSAG had the following recommendations:

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

- In addition to working with other health plans on the implementation of data sharing per the memorandum of agreement (MOA) with the Department of Health (DOH) agencies, the health plans must also review internal plan-specific barriers affecting implementation of the MOA and initiate appropriate intervention for the *Behavioral Health Coordination* PIP.
- For the *Screening for Depression and Follow-Up Plan* PIP, the health plans must ensure that the interventions are implemented in a timely manner to impact outcomes during the remeasurement period.
- For the *Plan All-Cause Readmissions* PIP, the health plans should apply lessons learned and knowledge gained to future PIPs and other quality improvement efforts.
- The health plans must revisit the causal/barrier analysis at least annually to determine if previously identified barriers continue to be applicable and to determine if any new barriers exist that require the development of interventions.
- For the PIPs that did not demonstrate improvement, the health plans should consider the use of quality improvement science-based tools, such as process mapping with failure modes and effects analysis (FMEA), for causal/barrier analysis and consider additional interventions to drive improvement.
- The health plans must submit an intervention worksheet for each intervention listed in the Barriers/Interventions table in the PIP Submission Form.
- The intervention effectiveness measure in the intervention worksheet must not be the same as the performance indicator documented in Step 5. The effectiveness measure should be designed to measure the effectiveness of the intervention on addressing the barrier linked to that intervention.
- The health plans should collect the intervention effectiveness data more frequently (e.g., monthly, quarterly) unlike the annual performance indicator data. This would help health plans understand intervention effectiveness and make any updates to the interventions in a timely manner to impact remeasurement outcomes.
- Intervention effectiveness data must guide next steps for each individual intervention.
- The health plans should reference the PIP Completion Instructions to ensure that all requirements have been addressed when completing the PIP Submission Form and the intervention working sheet.
- 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

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. HSAG administered the CAHPS 5.1 Child Medicaid Health Plan Survey with the HEDIS supplemental item set to child Medicaid members enrolled in each of the QI health plans who met age and enrollment criteria. Results were provided at both plan-specific and statewide aggregate levels. A top-box score is defined by a positive or satisfied response.

Findings, Conclusions, and Recommendations

Comparison of the QI Program's (i.e., combination of the five QI health plans) 2025 scores to the 2024 NCQA child Medicaid national averages revealed the following summary results: [11,12]

- The QI Program's 2025 top-box score was statistically significantly higher than the 2024 NCQA child Medicaid national average for one measure, *Coordination of Care*.
- The QI Program's 2025 top-box score was statistically significantly lower than the 2024 NCQA child Medicaid national average for one measure, *Getting Care Quickly*.

Comparison of the QI Program's 2025 scores to the corresponding 2023 scores revealed the following summary results:

- The QI Program's 2025 top-box scores were not statistically significantly higher than the 2023 top-box scores for any measure; therefore, no substantial strengths or areas of improvement were identified.

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.

Provider Survey

HSAG conducted a provider survey during 2025 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 2025 Hawaii Provider Survey questions were presented by nine domains of satisfaction (General Positions, Prior Authorization Process Experience, Prior Authorization Process Impacts, Formulary, Non-Formulary, Substance Abuse, Health Coordinators, Specialists, and Mental Health Providers). Response options to each question (i.e., measure) within the nine domains were classified into 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.[13]

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

[12] The child population was last surveyed in 2023; therefore, the 2025 child CAHPS scores are compared to the corresponding 2023 scores.

[13] For this report, only the top-box scores are displayed. For more detailed results on the other response categories, please see the 2025 Hawaii Provider Survey full report.

Findings, Conclusions, and Recommendations

Comparison of the QI Program's 2025 scores to the corresponding 2023 scores revealed the following summary results[14]:

- The QI Program's 2025 top-box score was statistically significantly higher than the 2023 top-box score for one measure, *Compensation Satisfaction.*
- The QI Program's 2025 top-box scores were not statistically significantly lower than the 2023 top-box scores for any measure; therefore, no substantial areas of improvement were identified.

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 has provided general recommendations for improvement below. Additionally, recommendations for improvement are presented in the plan-specific results sections of this report.

- Overall, 'Ohana QI had the lowest experience scores for the measures *Disrupted Continuity of Care* and *Adequate Network of Specialists*. These findings suggest providers' dissatisfaction with the prior authorization process as well as dissatisfaction with the network of specialists currently offered to their patients. To address these low scores, HSAG recommends that MQD, in collaboration with 'Ohana QI:
  - Identify and define specific factors influencing providers' level of satisfaction with their prior authorization process to reduce any barriers to providers maintaining continuity of care for patients.
  - Implement a time-limited focus group to review provider concerns related to the lack of specialists within their network. The purpose of the workgroup is to identify and define underlying issues driving provider satisfaction levels.
- Overall, providers contracted with UHC CP QI had the lowest experience scores for the *Adequate Access to Non-Formulary Drugs*, *Helpfulness of Health Coordinators*, and *Access to Substance Abuse Treatment* measures within the Non-Formulary, Health Coordinators, and Substance Abuse domains, respectively. These findings suggest higher levels of provider dissatisfaction with the efficiency of UHC CP QI's access to non-formulary drugs for patients when needed, health coordinators providing patient help when needed, and access to substance abuse treatment for patients when needed. HSAG recommends that MQD, in collaboration with UHC CP QI:
  - Identify the factors driving provider dissatisfaction with providers' access to non-formulary drugs and substance abuse treatment to try to improve or expand providers' access.
  - Identify potential factors influencing provider satisfaction with the efficiency of the health coordinators associated with UHC CP QI to ensure adequate assistance is provided when needed.

[14] The Hawaii Provider Survey was not administered in 2024; therefore, 2023 was the last available year of results.

- HSAG recommends that MQD review the provider addresses included within MQD's Hawaii Online Kahu Utility (HOKU) system to reduce the number of returned surveys due to bad addresses (i.e., undeliverables).
- HSAG recommends that MQD collaborate with the QI health plans to implement a strategy to inform providers of the importance of the surveys and how essential their participation is to improve quality, access, and timeliness of care. In addition to the survey email reminders sent from HSAG, the EQRO recommends that MQD consider developing communication platforms to encourage providers to participate in the Hawaii Provider Survey, such as survey notifications, provider meetings, newsletters, and provider portal alerts.

2. Introduction

Overview of the Hawaii Medicaid Service Delivery System

The Hawaii Medicaid Program

Medicaid covers more than 400,000[15] 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."[16] 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.

[15] All Medicaid enrollment statistics cited in this section are as of December 2025, as cited in the Hawaii Medicaid Enrollment Report available at: https://medquest.hawaii.gov/en/resources/reports.html. Accessed on: Dec 31, 2025.
[16] Hawaii Department of Human Services, Med-QUEST Division. Mission Statement. Available at: https://medquest.hawaii.gov/en/about/mission-statement.html. Accessed on: Dec 31, 2025.

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:

- 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).
- 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, for all covered populations.
- Establish contractual accountability among the contracted health plans and healthcare providers.
- Continue the predictable and slower rate of expenditure growth associated with managed care.
- Expand and strengthen a sense of member responsibility and promote independence and choice among members that leads to a more appropriate utilization of the healthcare system.

MQD awarded contracts to five health plans, which became operational as QI program plans effective January 1, 2015:

- AlohaCare QI
- HMSA QI
- KFHP QI
- 'Ohana QI
- UHC CP QI

All QI health plans provide Medicaid services statewide (i.e., on all islands) except for KFHP QI, which chose to focus efforts on the islands of Oahu and Maui. In addition to the QI health plans, Hawaii's Medicaid program includes the Community Care Services (CCS) behavioral health carve-out, a program providing managed specialty behavioral health services for Medicaid individuals with SMI or SPMI. 'Ohana was awarded the CCS contract and has been operational statewide since March 1, 2013.

While each of the QI health plans also has at least one other line of health insurance business (e.g., Medicare, commercial), the focus of this report is on the health plans' and CCS' performance and quality outcomes for the Medicaid-eligible population.

The QUEST Integration Health Plans

AlohaCare QI

AlohaCare QI is a nonprofit health plan founded in 1994 by Hawaii's community health centers. As the second largest health plans in Hawaii, and administering both Medicaid and Medicare health plan products, AlohaCare QI serves more than 68,000 Medicaid members in its QI health plan and provides a dual special needs plan for dually eligible Medicare and Medicaid beneficiaries. AlohaCare QI contracts with a large network of providers statewide, emphasizing prevention and primary care. AlohaCare QI works very closely with 14 community health centers and the Queen Emma clinics to support the needs of the underserved, medically fragile members of Hawaii's communities on all the islands.

HMSA QI

HMSA QI, an independent licensee of the Blue Cross and Blue Shield Association, is a nonprofit health plan established in Hawaii in 1938. Administering Medicaid, Medicare Advantage, Health Insurance Marketplace, and commercial health plans, HMSA QI is the largest provider of healthcare coverage in the State and the largest QI plan, serving over 200,000 enrolled Medicaid members. The vast majority of Hawaii's doctors, hospitals, and other providers participate in HMSA QI's network. HMSA QI has been a Medicaid contracted health plan since 1994.

KFHP QI

Established by Henry J. Kaiser in Honolulu in 1958, KFHP QI's service delivery in Hawaii is based on a relationship between the Kaiser Foundation Health Plan and the Hawaii Permanente Medical Group of physicians and specialists. With its largely "staff-model" approach, KFHP QI operates clinics on several islands and a medical center on Oahu, with additional hospitals and specialists participating through contract arrangements. KFHP QI administers Medicaid, Medicare Advantage, Health Insurance Marketplace, and commercial health plans and provides care to over 46,000 enrolled Medicaid members on the islands of Maui and Oahu.

'Ohana QI

'Ohana QI is offered by Centene Corporation. Formerly a subsidiary of WellCare Health Plans, Inc., Centene Corporation completed its acquisition of WellCare in January 2020 and now provides healthcare in all 50 states. Centene Corporation offers government-sponsored and commercial healthcare programs, focusing on under-insured and uninsured individuals. 'Ohana QI began operating in Hawaii on February 1, 2009, initially as a QExA plan, then in July 2012 also as a QUEST plan. 'Ohana QI currently provides services to over 31,000 Medicaid members.

UHC CP QI

UHC CP QI is offered by UnitedHealthcare Inc. is one of the largest Medicaid health plan providers in the nation. Providing care to more than 55,000 Medicaid members in Hawaii, UHC CP also administers Medicare dual-eligible special needs plans and commercial health plans. UHC CP initially began

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

'Ohana CCS

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

The State's Quality Strategy [17]

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

- Serving as a technical document to conform to the CFR requirements.
- Serving as a blueprint to guide the development of innovations to meet MQDs goals.
- 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

[17] Hawai'i Quality Strategy 2023. State of Hawaii, Department of Human Services, Med-QUEST Division. Available at: https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/quality-strategy/MQD%20Quality%20Strategy%202023.FINAL.pdf. Accessed on: Dec 31, 2025.

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.

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

Goals	Objectives
 **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 (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 QAPI programs.

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

Community Integration Services (CIS)

The CIS program provides members who have physical and/or behavioral health needs and are homeless, or at risk of homelessness, with various housing services that are likely to ameliorate their physical or behavioral health needs. The benefits include pre-tenancy supports, tenancy sustaining services, housing quality and safety improvement services, legal assistance, and house payments, including a one-time payment for a security deposit and/or first month's rent. MQD will expand upon this program through its 1115 waiver renewal (2025–2029) to include medical respite benefits beginning

January 1, 2026. 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.* While the collaborative workgroups wrapped up in 2024, the health plans continued implementation of the PIP interventions and reporting of PIP outcomes.

Quality-Based Payment Programs

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

MQD's Hospital P4P and Nursing Facility P4P programs are administered in close partnership with the Healthcare Association of Hawaii (HAH). Measures are selected in partnership with the facilities to accelerate progress across various MQD quality objectives. During CY 2025, MQD, HAH, Milliman, and HSAG worked together on revamping the P4P program to ensure alignment with State quality goals.

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 2024 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

2024 EQRO Recommendations	2025 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.	The EQRO recommendation to consider a PIP focused on adult or pediatric preventive care services is under State's review. MQD continues to include preventive care measures such as *Well Child Visits*, *Child and Adolescent Well Care Visits*, and *Childhood Immunization Status* as focus areas within the MCO P4P and auto-assignment programs.

2024 EQRO Recommendations	2025 MQD Actions
Recommendation: While there was an increase in the number of Quality Strategy targets met from reporting year (RY) 2023 to RY 2024, adult and pediatric preventive care measures rates continue to show considerable room for improvement. To target improvement in Goal 1—Advance primary care, prevention, and health promotion, HSAG recommends that MQD consider requiring the health plans to conduct a PIP focusing on adult or pediatric preventive care services.	
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. **Recommendation:** All nine of the Prevention Quality Indicator (PQI) measure targets associated with Goal 3—Improve outcomes for high-need, high-cost individuals, showed an increase in the RY 2024 rates (PQI measures are inverse measures where lower rates indicate better performance). HSAG recommends that MQD consider requiring the health plans to conduct a root-cause analysis or other study to determine why avoidable hospital admissions increased. Timely and effective outpatient care, along with care coordination for members with special healthcare needs, will support continued improvement in this program area.	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. **Objective 15:** Increase coordination of care and decrease inappropriate care. **Recommendation:** As the Quality Strategy performance measures for Goal 6—Maintain access to appropriate care, span several care settings, Medicaid beneficiary populations, and include both physical and behavioral health services, HSAG recommends that MQD focus on one area for improvement that corresponds with the State's current managed care program priorities. Lower-performing	MQD continues the work on different initiatives related to SUD treatment: 1. Medication-assisted treatment (MAT) services—Prior to the MAT exemption expiration on 9/30/25, Hawaii submitted a new request to update MQD's MAT exemption on 9/2/25 as MQD still do not meet the provider requirements to have MAT services on every island, so MQD can be in compliance with this federal requirement. One option is to work with the Federally Qualified Health Centers to be MAT providers for MQD.

2024 EQRO Recommendations	2025 MQD Actions
measures that could benefit from quality improvement activities or initiatives include SUD treatment measures, potentially avoidable hospital admission measures, and LTSS rebalancing and utilization measures.	2. Contingency Management Program—Within the new 1115 Demonstration Waiver, a Contingency Management Program will be introduced to support individuals through evidence-based incentives that encourage positive health behaviors and sustained engagement in treatment. MQD is currently projecting that this program will be implemented in 2027, allowing time for program design, stakeholder collaboration, and the development of operational and compliance frameworks necessary for successful rollout. 3. Pre-Release Services—Under the 1115 Demonstration Waiver, there will be a process to assist those being released from incarceration to receive certain medical services and medication to assist in the prevention of recidivism. A component of the pre-release services will focus on releasing individuals who are identified as needing treatment services directly into appropriate treatment placements, ensuring timely access to care and reducing gaps that may contribute to recidivism. MQD is projecting that these Pre-Release services will be implemented in 2026, allowing for coordination with correctional facilities, providers, and community partners to support continuity of care.
Goal 7: Align payment structures to improve health outcomes. **Objective 16:** Align payment structures to support work on SDOH. **Objective 17:** Align payment structures to enhance quality and value of care. **Recommendation:** To target improvement in Goal 7—Align payment structures to improve health outcomes, HSAG recommends that MQD continue to evaluate its current incentive programs and make adjustments that support MQD priorities or implement other value-based	MQD recently updated its Hospital P4P Program to align payments with quality measures focused on care coordination and improving members' health outcomes.

2024 EQRO Recommendations	2025 MQD Actions
payment models that aim to increase care coordination, quality, and health outcomes.	

Evaluation of Quality Strategy Effectiveness

To track the progress of achieving goals and objectives outlined in the Quality Strategy, HSAG developed a Hawaii Medicaid Goals Tracking Table, as shown in Appendix B. The table comprises the metrics included in the Hawaii Quality Strategy 2023 Measures Appendix and is categorized by the State's associated goals and objectives, along with MY 2024 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. The statewide summary results in Table 2-4 and the performance measure results in Appendix B are limited to the QI Program. Not all performance measures included in Appendix B were audited by HSAG in CY 2025.

Table 2-4—MY 2024 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	50	28	48	6	14	63	14
Rates with an established target	48	23	43	6	14	55	13
Rates achieving the target	**28**	**10**	**20**	**5**	**8**	**21**	**7**
Percentage of rates achieving the target	**58.33%**	**43.48%**	**46.51%**	**83.33%**	**57.14%**	**38.18%**	**53.85%**

Table 2-5 summarizes QI health plan performance relative to MQD Quality Strategy targets for performance measures audited by HSAG in CY 2025. Detailed information can be found in Section 4. Comparative Analysis of Health Plan Performance.

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

	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Total MQD Targets Met	**13**	**23**	**35**	**23**	**20**
Percent MQD Targets Met	**26.53%**	**46.94%**	**71.43%**	**46.94%**	**40.82%**

Table 2-6 summarizes CCS' performance relative to MQD Quality Strategy targets for performance measures that were audited by HSAG in CY 2025.

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

	'Ohana CCS
Total MQD Targets Met	**4**
Percent MQD Targets Met	**57.14%**

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 EQR 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 continued to make progress toward achieving Goal 4—Support community initiatives to improve population health, as five of the six managed long-term services and supports (MLTSS) Quality Strategy statewide targets were achieved in RY 2025. Similarly, improvement was noted in Goal 1—Advance primary care, prevention, and health promotion; Goal 5—Enhance care in LTSS settings; and Goal 7—Align payment structures to improve health outcomes, with more than 50 percent of the statewide Quality Strategy targets met.

At the health plan level, KFHP QI and 'Ohana CCS met more than half of the RY 2025 Quality Strategy targets. AlohaCare QI has the greatest room for improvement, as it met the fewest Quality Strategy targets among the QI health plans.

Recommendations

Quality Strategy Goal 2, Goal 3, and Goal 6, have the greatest room for improvement, as statewide performance measure results revealed that less than 50 percent of targets were met. The EQRO has identified the following recommendations to target improvement:

- Ten Quality Strategy targets were met for Goal 2 in RY 2025, which is a decrease from 17 targets met in RY 2023 and RY 2024. To target improvement in Goal 2—Integrate behavioral health with physical health across the continuum of care, HSAG recommends that MQD 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. Additionally, HSAG recommends that the health plans identify barriers that inhibit members from seeking SUD treatment and implement solutions to increase engagement.
- Consistent with last year, eight of the nine Prevention Quality Indicator (PQI) measure targets associated with Goal 3—Improve outcomes for high-need, high-cost individuals, showed an increase

in the RY 2025 rates (PQI measures are inverse measures where lower rates indicate better performance). HSAG recommends that MQD consider requiring the health plans to conduct a root-cause analysis or other study to determine why avoidable hospital admissions continue to increase. Timely and effective outpatient care, along with care coordination for members with special healthcare needs, will support continued improvement in this program area.

- Given that the Quality Strategy performance measures tied to 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 continue to include SUD treatment measures, potentially avoidable hospital admission measures, and LTSS rebalancing measures.

In 2026, MQD will be reviewing and updating the Hawaii Quality Strategy. HSAG offers the following recommendations for MQD:

- HSAG recommends that MQD consider updating the Quality Strategy Measure Appendix annually. As performance measures are added or retired and benchmarks change, it is important that the health plans, hospitals, and nursing facilities have current information on measures and performance goals.
- HSAG recommends that MQD consider a change in metric benchmarks so that the health plans strive toward a consistent performance level. HSAG recommends that MQD establish benchmarks that align with nationally recognized quality measures (e.g., NCQA Quality Compass) and the State's performance published in the CMS Annual State Measure Trends Snapshot, Chart Packs for the Child Core Set and Adult Core Set, or the State Profile pages on medicaid.gov.

3. Assessment of Health Plan Performance

Introduction

This section of the report describes the results of HSAG's 2025 EQR activities and conclusions as to the strengths and weaknesses of each health plan about the quality of, timeliness of, and access to care furnished by the Hawaii Medicaid health plans serving QI members. Additionally, recommendations are offered to each health plan to facilitate continued quality improvement in the Medicaid program.

Methodology

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

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

  Quality, as it pertains to EQR, means the degree to which an MCO, PIHP, or PAHP increases the likelihood of desired outcomes of its enrollees through:
  - Its structural and operational characteristics.
  - The provision of services that are consistent with current professional, evidence-based knowledge.
  - Interventions for performance improvement.[18]
- **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).[19]
- **Timeliness**—NCQA defines "timeliness" relative to utilization decisions as follows:

[18] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 81, No. 88/Friday, May 6, 2016/Rules and Regulations. 42 CFR Parts 431, 433 and 438 with revisions released (or as amended) November 13, 2020, 42 CFR Parts 430, 438, and 457 with revisions released (or as amended) May 10, 2024, Final Rule. Available at: https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-C/part-438. Accessed on: Dec 31, 2025.
[19] Ibid.

"The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[20] NCQA further discusses the intent of this standard as being to minimize any disruption in the provision of healthcare. HSAG extends this definition of timeliness to include other managed care provisions that impact services to beneficiaries and that require timely response by the MCO—e.g., processing expedited appeals and providing timely follow-up care. The Agency for Healthcare Research and Quality (AHRQ) indicates that "timeliness is the health care system's capacity to provide health care quickly after a need is recognized."[21] Timeliness includes the interval between identifying a need for specific tests and treatments and receiving those services.[22]

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 2025 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 2025 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.

[20] National Committee for Quality Assurance. 2025 Standards and Guidelines for Accreditation of Health Plans.
[21] Agency for Healthcare Research and Quality. National Healthcare Quality and Disparities Reports. Elements of Access to Health Care: Timeliness. Available at: https://www.ahrq.gov/research/findings/nhqrdr/chartbooks/access/elements3.html. Accessed on: Dec 31, 2025.
[22] Ibid.

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

Standard #	Standard Name	Total # of Elements	Number of Elements		Total Compliance Score
			# Met	# Not Met	
I	Availability of Services	17	17	0	100%
II	Assurances of Adequate Capacity and Services	3	3	0	100%
III	Coordination and Continuity of Care	10	10	0	100%
IV	Confidentiality	10	10	0	100%
V	Coverage and Authorization of Services	31	31	0	100%
VI	Enrollee Information	19	18	1	95%
VII	Enrollee Rights and Protections	8	8	0	100%
VIII	Grievance and Appeal System	31	30	1	97%
	Totals	**129**	**127**	**2**	**98%**

Total Elements: The total number of applicable elements in each standard.
Total Compliance Score: The compliance scores were calculated by adding the ***Met*** elements and then dividing by the total number of applicable elements.

Strengths

AlohaCare QI achieved full compliance in six of the eight standards reviewed, demonstrating strengths and adherence to all requirements measured in the following areas:

- Availability of Services
- Assurances of Adequate Capacity and Services
- Coordination and Continuity of Care
- Confidentiality
- Coverage and Authorization of Services
- Enrollee Rights and Protections

These findings suggest that AlohaCare QI developed the necessary policies, procedures, and processes to operationalize the federal regulations and contractual requirements.

Areas for Improvement

AlohaCare QI did not receive performance scores under 95 percent for any standard.

Recommendations

Of the 129 elements, AlohaCare QI received *Not Met* scores for two elements. HSAG recommends that AlohaCare QI continue to work with HSAG and MQD on completing the CAPs for the one Enrollee Information element and one Grievance and Appeal System element that were scored as *Not Met.*

Validation of Performance Measures—NCQA HEDIS Compliance Audits

NCQA HEDIS Compliance Audit Findings

HSAG's review team assessed AlohaCare QI's IS capabilities and its ability to process data for reporting accurate performance measure rates. AlohaCare QI was found to be fully compliant with all HEDIS IS standards, including IS standard L for assessing case management data for LTSS measures. This demonstrated that AlohaCare QI had effective IS processes and control procedures in place for reporting the required performance measure rates. AlohaCare QI presented six supplemental data sources for consideration to use for supplementing its MY 2024 performance measure rates. HSAG determined one data source to be nonstandard supplemental data, and the remaining five were determined to be standard supplemental data. No concerns were identified, and all six supplemental data sources were approved for HEDIS MY 2024 reporting.

AlohaCare QI's medical record review processes did not change from the prior MY and passed all hybrid measures for medical record review validation (MRRV) in the prior MY; therefore, AlohaCare QI was not required to undergo convenience sample validation. The final statistical MRRV was conducted for *Blood Pressure Control for Patients With Diabetes*, *Cervical Cancer Screening, Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%—Total* and *Glycemic Status >9.0%—Total, Immunization for Adolescents—Combination 2,* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* as well as all medical record exclusions. All selected cases passed the final MRRV without any critical errors. The final statistical case management record review validation (CMRRV) was conducted for *Long-Term Services and Supports Comprehensive Assessment and Update—Assessment of Core Elements* and *Assessment of Supplemental Elements, Long-Term Services and Supports Comprehensive Care Plan and Update—Care Plan With Core Elements Documented* and *Assessment of Supplemental Elements* as well as all medical record exclusions. All selected cases passed the final MRRV and CMRRV without any critical errors.

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

Access and Risk-Adjusted Utilization Performance Measure Results

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

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

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	52.19%	52.48%	0.56%	★
45–64 Years	66.29%	67.51%	1.84%	★
65+ Years	73.73%	78.64%	6.66%	★★
Total	58.72%	60.09%	2.33%	★
Plan All-Cause Readmissions				
*Observed Readmissions—18–64 Years**	—	8.80%	—	NC
*Expected Readmissions—18–64 Years**	—	8.92%	—	NC
*Observed/Expected (O/E) Ratio—18–64 Years**	—	0.9859	—	NC
PQI 08: Heart Failure Admission Rate				
*18–64 Years**	41.39	53.55	29.38%	NC
*65+ Years**	117.25	195.66	66.87%	NC
*Total**	48.63	68.16	40.16%	NC
PQI 15: Asthma in Younger Adults Admission Rate				
*18–39 Years**	2.95	0.99 ✓	-66.44%	NC

** A lower rate indicates better performance.*
NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.
— Indicates that the health plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.
and ✓ indicates the health plan met or exceeded the target threshold established by MQD.
MY 2024 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

The *Adults' Access to Preventive/Ambulatory Health Services* measure indicator rates 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.

AlohaCare QI met the MQD-established Quality Strategy target for *Asthma in Younger Adults Admission Rate—18–39 Years*. No other MQD Quality Strategy targets were met in this domain.

Children's Preventive Health Performance Measure Results

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

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

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Child and Adolescent Well-Care Visits				
Total	42.51%	45.19%	6.30%	★
Childhood Immunization Status				
Combination 3	44.04%	39.17%	-11.06%	★
Combination 7	37.71%	32.85%	-12.89%	★
Combination 10	25.06%	22.87%	-8.74%	★★
Diphtheria, Tetanus, Pertussis (DTaP)	52.55%	45.74%	-12.96%	★
Hepatitis A	67.15%	59.61%	-11.23%	★
Hepatitis B	63.75%	52.31%	-17.95%	★
Haemophilus Influenzae Type B (HiB)	67.88%	55.47%	-18.28%	★
Influenza	38.20%	33.82%	-11.47%	★★
Inactivated Polio Vaccine (IPV)	69.34%	55.23%	-20.35%	★
Measles, Mumps, Rubella (MMR)	67.88%	59.85%	-11.83%	★
Pneumococcal Conjugate	51.34%	46.72%	-9.00%	★
Rotavirus	54.01%	45.01%	-16.66%	★
Varicella-Zoster Virus (VZV)	67.64%	59.37%	-12.23%	★
Immunizations for Adolescents				
Combination 1	59.85%	59.61%	-0.40%	★
Combination 2	32.12%	29.68%	-7.60%	★
Meningococcal	61.80%	60.34%	-2.36%	★
Tetanus, Diphtheria, Pertussis (Tdap)	61.56%	61.80%	0.39%	★
Human Papillomavirus (HPV)	33.33%	30.17%	-9.48%	★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
Body Mass Index (BMI) Percentile—3–11 Years	83.92%	84.29%	0.44%	★★★
BMI Percentile—12–17 Years	77.56%	81.75%	5.40%	★★★
BMI Percentile—Total	81.51%	83.23%	2.11%	★★★
Counseling for Nutrition—3–11 Years	75.69%	83.77%	10.68%	★★★★
Counseling for Nutrition—12–17 Years	73.08%	78.83%	7.87%	★★★★
Counseling for Nutrition—Total	74.70%	81.71% ✓	9.38%	★★★★
Counseling for Physical Activity—3–11 Years	73.33%	82.20%	12.10%	★★★★★
Counseling for Physical Activity—12–17 Years	73.72%	79.56%	7.92%	★★★★

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Counseling for Physical Activity—Total	73.48%	81.10% ✓	10.37%	★★★★
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	56.03%	61.95%	10.57%	★★★
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	57.47%	62.69%	9.08%	★

and ✓ indicates the health plan met or exceeded the target threshold established by MQD.
MY 2024 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

All *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* measure indicators met or exceeded the 50th percentile. In addition, *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* measure indicator met or exceeded the 50th percentile.

AlohaCare QI met the MQD-established Quality Strategy targets for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* and *Counseling for Physical Activity—Total* measure indicators.

Women's Health Performance Measure Results

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

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

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Cervical Cancer Screening				
Cervical Cancer Screening	47.69%	44.04%	-7.65%	★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	73.48%	69.21%	-5.81%	★
Postpartum Care	76.64%	69.82%	-8.90%	★
Timeliness of Prenatal Care—Under 21 Years	63.91%	68.84%	7.71%	NC
Postpartum Care—Under 21 Years	65.41%	69.57%	6.36%	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.
MY 2024 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

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

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

Care for Chronic Conditions Performance Measure Results

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

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

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Asthma Medication Ratio				
5–11 Years	75.00%	56.76%	-24.32%	★
12–18 Years	53.49%	NA	—	NC
19–50 Years	48.08%	33.91%	-29.47%	★
51–64 Years	58.89%	48.61%	-17.46%	★
Total	54.07%	41.99%	-22.34%	★
5–18 Years	63.86%	56.06%	-12.21%	NC
19–64 Years	51.34%	38.21%	-25.57%	NC
Blood Pressure Control for Patients With Diabetes				
Blood Pressure Control for Patients With Diabetes	54.74%	54.50%	-0.44%	★
Concurrent Use of Opioids and Benzodiazepines				
*18–64 Years**	10.84%	8.85%	-18.36%	NC
*65+ Years**	7.58%	9.57%	26.25%	NC
*Total**	10.35%	8.97% ✓	-13.33%	NC
Controlling High Blood Pressure				
18–64 Years	49.49%	47.00%	-5.03%	NC
65–85 Years	49.14%	55.86%	13.68%	NC
Total	49.39%	49.39%	0.00%	★

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Eye Exam for Patients With Diabetes				
Eye Exam for Patients With Diabetes	54.74%	50.85%	-7.11%	★★
Glycemic Status Assessment for Patients With Diabetes				
Glycemic Status <8.0%—18–64 Years	40.80%	45.67%	11.94%	NC
Glycemic Status <8.0%—65–75 Years	56.47%	63.16%	11.85%	NC
Glycemic Status <8.0%—Total	44.04%	48.91%	11.06%	★
*Glycemic Status >9.0%—18–64 Years**	50.31%	43.88%	-12.78%	NC
*Glycemic Status >9.0%—65–75 Years**	36.47%	30.26%	-17.03%	NC
*Glycemic Status >9.0%—Total**	47.45%	41.36%	-12.83%	★

** A lower rate indicates better performance.*
NA indicates that the QI health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.
— Indicates that the health plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.
and ✓ indicates the health plan met or exceeded the target threshold established by MQD.
MY 2024 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

No measure indicators in this domain met or exceeded the 50th percentile for MY 2024. Several measure indicators in this domain did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented.

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

Behavioral Health Performance Measure Results

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

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

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Antidepressant Medication Management				
Effective Acute Phase Treatment—18–64 Years	53.39%	59.68%	11.78%	NC
Effective Acute Phase Treatment—65+ Years	75.00%	NA	—	NC
Effective Acute Phase Treatment—Total	54.81%	60.44%	10.27%	★★
Effective Continuation Phase Treatment—18–64 Years	35.89%	38.27%	6.63%	NC
Effective Continuation Phase Treatment—65+ Years	56.25%	NA	—	NC
Effective Continuation Phase Treatment—Total	37.22%	38.90%	4.51%	★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	71.70%	73.58% ✓	2.62%	★
Follow-Up After Emergency Department Visit for Mental Illness				
7-Day Follow-Up—6–17 Years	22.50%	30.56%	35.82%	★
7-Day Follow-Up—18–64 Years	30.95%	20.45%	-33.93%	★
7-Day Follow-Up—65+ Years	NA	NA	—	NC
7-Day Follow-Up—Total	30.49%	21.32%	-30.08%	★
30-Day Follow-Up—6–17 Years	40.00%	44.44%	11.10%	★
30-Day Follow-Up—18–64 Years	45.83%	36.06%	-21.32%	★
30-Day Follow-Up—65+ Years	NA	NA	—	NC
30-Day Follow-Up—Total	45.74%	37.30%	-18.45%	★
Follow-Up After Emergency Department Visit for Substance Use				
7-Day Follow-Up—13–17 Years	NA	NA	—	NC
7-Day Follow-Up—18+ Years	27.10%	25.76%	-4.94%	★★★
7-Day Follow-Up—Total	26.98%	25.27%	-6.34%	★★★
7-Day Follow-Up—18–64 Years	27.22%	26.04%	-4.34%	NC
7-Day Follow-Up—65+ Years	NA	NA	—	NC
30-Day Follow-Up—13–17 Years	NA	NA	—	NC
30-Day Follow-Up—18+ Years	39.69%	39.39%	-0.76%	★★★
30-Day Follow-Up—Total	39.29%	38.55%	-1.88%	★★★

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
30-Day Follow-Up—18–64 Years	39.56%	39.36%	-0.51%	NC
30-Day Follow-Up—65+ Years	NA	NA	—	NC
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—6–17 Years	22.50%	26.42%	17.42%	★
7-Day Follow-Up—18–64 Years	26.98%	21.79%	-19.24%	★
7-Day Follow-Up—65+ Years	NA	NA	—	NC
7-Day Follow-Up—Total	25.96%	22.27%	-14.21%	★
30-Day Follow-Up—6–17 Years	45.00%	47.17%	4.82%	★
30-Day Follow-Up—18–64 Years	44.44%	36.87%	-17.03%	★
30-Day Follow-Up—65+ Years	NA	NA	—	NC
30-Day Follow-Up—Total	44.68%	38.66%	-13.47%	★
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication				
Initiation Phase	49.18%	37.10%	-24.56%	★
Continuation and Maintenance Phase	47.37%	NA	—	NC
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation of SUD Treatment—Total—13–17 Years	31.08%	43.37%	39.54%	★★★
Initiation of SUD Treatment—Total—18–64 Years	41.02%	38.84%	-5.31%	★
Initiation of SUD Treatment—Total—65+ Years	45.26%	38.99%	-13.85%	★★
Initiation of SUD Treatment—Total—Total	40.95%	39.01%	-4.74%	★
Engagement of SUD Treatment—Total—13–17 Years	5.41%	9.64%	78.19%	★★
Engagement of SUD Treatment—Total—18–64 Years	9.13%	10.15%	11.17%	★★
Engagement of SUD Treatment—Total—65+ Years	5.84%	4.59%	-21.40%	★★
Engagement of SUD Treatment—Total—Total	8.80%	9.63%	9.43%	★★
Screening for Depression and Follow-Up Plan				
12–17 Years	41.51%	41.97%	1.11%	NC
18–64 Years	29.09%	40.88%	40.53%	NC
65+ Years	28.92%	42.46%	46.82%	NC
Total	31.77%	41.27% ✓	29.90%	NC
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
1–11 Years	NA	NA	—	NC

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
12–17 Years	NA	NA	—	NC
Total	NA	NA	—	NC
Use of Pharmacotherapy for Opioid Use Disorder				
Rate 1: Total	55.15%	48.91%	-11.31%	NC
Rate 2: Buprenorphine	33.58%	31.72%	-5.54%	NC
Rate 3: Oral Naltrexone	0.98%	0.48%	-51.02%	NC
Rate 4: Long-Acting, Injectable Naltrexone	0.25%	0.24%	-4.00%	NC
Rate 5: Methadone	22.06%	17.92%	-18.77%	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 health plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.
and ✓ indicates the health plan met or exceeded the target threshold established by MQD.
MY 2024 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*

AlohaCare QI met or exceeded the 50th percentile for the following measure indicator rates:

- *Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—18+ Years, 7-Day Follow-Up—Total, 30-Day Follow-Up—18+ Years,* and *30-Day Follow-Up—Total*
- *Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment—Total—13–17 Years*

All other measure indicators in this domain either did not meet the 50th percentile or did not have national benchmarks to compare for MY 2024.

AlohaCare QI met the MQD-established Quality Strategy target for the following measure indicator rates:

- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Screening for Depression and Follow-Up Plan—Total*

No other MQD Quality Strategy targets were met for this domain.

Long-Term Services and Supports Performance Measure Results

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

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

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Long-Term Services and Supports Comprehensive Assessment and Update				
Assessment of Core Elements	47.92%	41.00% ✓	-14.44%	NC
Assessment of Supplemental Elements	47.92%	39.50% ✓	-17.57%	NC
Long-Term Services and Supports Comprehensive Care Plan and Update				
Care Plan With Core Elements Documented	66.67%	43.64% ✓	-34.54%	NC
Assessment of Supplemental Elements	66.67%	43.64% ✓	-34.54%	NC
Managed Long-Term Services and Supports Admission to a Facility from the Community				
Short-Term Stay—18–64 Years	701.15	624.49	-10.93%	NC
Short-Term Stay—65–74 Years	101.96	84.07	-17.55%	NC
Short-Term Stay—75–84 Years	54.78	30.28	-44.72%	NC
Short-Term Stay—85+ Years	44.94	29.01	-35.45%	NC
Short-Term Stay—Total	182.67	168.33 ✓	-7.85%	NC
Medium-Term Stay—18–64 Years	193.10	167.35	-13.34%	NC
Medium-Term Stay—65–74 Years	77.64	58.65	-24.46%	NC
Medium-Term Stay—75–84 Years	41.70	29.46	-29.35%	NC
Medium-Term Stay—85+ Years	24.45	14.50	-40.70%	NC
Medium-Stay—Total	72.51	60.82 ✓	-16.12%	NC
Long-Term Stay—18–64 Years	25.29	47.96	89.64%	NC
Long-Term Stay—65–74 Years	12.16	23.46	92.93%	NC
Long-Term Stay—75–84 Years	8.99	19.64	118.46%	NC
Long-Term Stay—85+ Years	11.24	18.85	67.70%	NC
Long-Term Stay—Total	13.48	26.28 ✓	94.96%	NC
Managed Long-Term Services and Supports Minimizing Facility Length of Stay				
Observed Discharge Rate	4.66%	8.99%	92.92%	NC
Expected Discharge Rate	31.36%	29.36%	-6.38%	NC
O/E Ratio	0.1486	0.3064	106.19%	NC
Managed Long-Term Services and Supports Successful Transition After Long-Term Facility Stay				
Observed Discharge Rate	NA	NA	—	NC
Expected Discharge Rate	NA	NA	—	NC
O/E 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 health plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.
[ ] *and* ✓ *indicates the health plan met or exceeded the target threshold established by MQD.*

AlohaCare QI met the MQD-established Quality Strategy target for the following measure indicator rates:

- *Long-Term Services and Supports Comprehensive Assessment and Update—Assessment of Core Elements*
- *Long-Term Services and Supports Comprehensive Assessment and Update—Assessment of Supplemental Elements*
- *Long-Term Services and Supports Comprehensive Care Plan and Update—Care Plan With Core Elements Documented*
- *Long-Term Services and Supports Comprehensive Care Plan and Update—Assessment of Supplemental Elements*
- *Managed Long-Term Services and Supports Admission to a Facility from the Community—Short-Term Stay—Total*
- *Managed Long-Term Services and Supports Admission to a Facility from the Community—Medium-Stay—Total*
- *Managed Long-Term Services and Supports Admission to a Facility from the Community—Long-Term Stay—Total*

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

Strengths

Based on HSAG's analyses of AlohaCare QI's 74 indicator rates comparable to benchmarks, 15 indicator rates (20.27 percent) ranked at or above the 50th percentile, with six of these rates (8.11 percent) ranking at or above the 75th percentile. Additionally, AlohaCare QI met 13 MQD Quality Strategy targets for MY 2024.

Areas for Improvement

Conversely, 59 of AlohaCare QI's measure rates comparable to benchmarks (79.73 percent) fell below the 50th percentile, with 48 rates (64.86 percent) falling below the 25th percentile, suggesting significant opportunities for improvement across most domains of care.

Recommendations

HSAG recommends that AlohaCare QI focus on improving performance related to the following measures with rates that fell below the 25th percentile for the QI population:

- Within the Access and Risk-Adjusted Utilization domain, the following recommendations were identified:
  - Regarding the *Adults' Access to Preventive/Ambulatory Health Services* measure, HSAG recommends that AlohaCare QI consider offering to schedule the appointment and addressing barriers as needed (e.g. transportation, SDOH). In addition, HSAG recommends that AlohaCare QI ensure provider availability is within required time frames and consider increasing appointment hours.
- Within the Children's Preventive Health domain, the following recommendations were identified:
  - Regarding the *Child and Adolescent Well-Care Visits* measure, HSAG recommends that AlohaCare QI incentivize providers, members, and parents to complete well-care visits. AlohaCare QI can conduct provider education to ensure providers practice teen-centered care during adolescent visits (e.g., privacy and confidentiality). AlohaCare QI can also promote well-care visits on social media, as well as via email or text outreach. Additionally, AlohaCare QI can develop partnerships with community stakeholders.[23]
  - Regarding the *Childhood Immunization Status* measure, HSAG recommends that AlohaCare QI continue to provide education to providers and members about the importance of vaccination for disease prevention and encourage vaccination at every opportunity, including mild illness visits.
  - Regarding the *Well-Child Visits in the First 30 Months of Life* measure, HSAG recommends that AlohaCare QI continue to identify performance improvement efforts to improve well-child visit rates. HSAG recommends that AlohaCare QI identify additional barriers to receiving care and conduct a focus group to identify strategies to address barriers.
- Within the Women's Health domain, the following recommendations were identified:
  - Regarding the *Cervical Cancer Screening* measure, HSAG recommends that AlohaCare QI consider utilizing community health workers (CHWs) or other one-on-one interactions with a healthcare professional, as they have been shown to improve cervical cancer screening.[24] In addition, HSAG recommends that AlohaCare QI provide education to members in need of screenings through health literacy campaigns, as well as focusing on barriers to completing screenings and addressing SDOH.
  - Regarding the *Prenatal and Postpartum Care* measure, HSAG recommends that AlohaCare QI consider further research and potential implementation of an incentive program focused on

[23] Centers for Medicare & Medicaid Services. Paving the Road to Good Health Strategies for Increasing Medicaid Adolescent Well-Care Visits. Available at: https://www.medicaid.gov/medicaid/benefits/downloads/paving-the-road-to-good-health.pdf. Accessed on: Jan 6, 2026.

[24] Popalis ML, Ramirez SI, Leach KM, et al. Improving cervical cancer screening rates: a scoping review of resources and interventions. *Cancer Causes Control*. 2022 Nov;33(11):1325–1333. Available at: https://pubmed.ncbi.nlm.nih.gov/35980511/. Accessed on Jan 6, 2026.

timely prenatal and postpartum care visits. Additionally, HSAG recommends that AlohaCare QI consider leveraging opportunities to host campaigns and/or conduct member outreach activities to engage members in the importance of timely prenatal and postpartum care. Further, HSAG recommends that AlohaCare QI consider exploring available programs and/or vendors that can provide additional services such as appointment and transportation scheduling, pregnancy and parenting education, and pregnancy monitoring.

- Within the Care for Chronic Conditions domain, the following recommendations were identified:
  - Regarding the *Asthma Medication Ratio* measure, HSAG recommends that AlohaCare QI provide education to providers about establishing an asthma action plan with members. HSAG also recommends that AlohaCare QI utilize pharmacy data to identify members outside the asthma medication ratio and prioritize case management services for these members. HSAG further recommends that AlohaCare QI provide member education about medication adherence.
  - Regarding the *Blood Pressure Control for Patients With Diabetes* and *Controlling High Blood Pressure* measures, HSAG recommends that AlohaCare QI continue to identify trends within the data to identify which demographic groups and regions report lower blood pressure. HSAG also recommends providing coverage for automated home blood pressure monitors for patients, while educating members about the benefits of this approach.[25] Further, HSAG recommends that AlohaCare QI provide incentives to members and providers to encourage blood pressure control.
- Within the Behavioral Health domain, the following recommendations were identified:
  - Regarding the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure, HSAG recommends that AlohaCare QI consider effective interventions to ensure annual screenings are conducted for people with schizophrenia, especially those taking antipsychotic medications. HSAG recommends that AlohaCare provide education to providers and members about the importance of diabetes screening tests and encourage timely follow-up for early detection and management.
  - Regarding the *Follow-Up After Hospitalization for Mental Illness* measure, HSAG recommends that AlohaCare QI continue to focus on coordination of care for members discharged from an inpatient setting. HSAG also recommends that AlohaCare QI consider effective interventions to reduce readmissions for members with mental illnesses.
  - Regarding the *Follow-Up After Emergency Department Visit for Mental Illness* measure, HSAG recommends that AlohaCare QI outreach to providers to ensure identification of members who have ED visits for mental illness to leverage discharge planning processes to facilitate scheduling member follow-up visits.
  - Regarding the *Initiation and Engagement of Substance Use Disorder Treatment* measure, HSAG recommends that AlohaCare QI review patient data for any patterns present by ZIP Code and other demographics for case management prioritization. For instance, one study suggests that members who are male and have a schizophrenia spectrum disorder diagnosis are less likely to initiate treatment, while current drug dependence and recent arrest were associated with lowered

[25] Centers for Disease Control and Prevention. The Surgeon General's Call to Action to Control Hypertension. Available at: https://www.cdc.gov/high-blood-pressure/php/cta/index.html. Accessed on: Jan 6, 2026.

odds of engaging in treatment. Current drug dependence is associated with factors that make scheduling and attending treatment appointments difficult, such as severe symptoms, chaotic living situations, and self-care and life functioning issues.[26]

Validation of Network Adequacy

HSAG evaluated and assessed the data methods that AlohaCare QI used to calculate results generated for each network adequacy indicator in the scope of the 2025 NAV activities. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that AlohaCare QI used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator.

Findings

Based on the results of the ISCA combined with the virtual audit and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the health plan's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each health plan according to the CMS EQR Protocol 4 and as defined in Table 3-8 of the Network Adequacy Indicator Validation Rating Determination section of this report. Table 3-9 presents a summary of the NAV validation ratings for AlohaCare QI by indicator.

Table 3-8—Indicator-Level Validation Rating Categories

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

Table 3-9—Summary of AlohaCare QI Validation Ratings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Time and Distance	100%	0%	0%	0%
Mandatory Provider Type	100%	0%	0%	0%
Provider Ratio	100%	0%	0%	0%

[26] Brown CH, Bennett ME, Li L, Bellack AS. Predictors of initiation and engagement in substance abuse treatment among individuals with co-occurring serious mental illness and substance use disorders. *Addictive Behaviors.* 2010;36(5):439-47.

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 122 indicators; 12 were unable to be validated for AlohaCare QI. Of these indicators, 100 percent received *High Confidence* ratings.

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

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

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

Provider Type	Ratio	Results	Compliance
Hospitals on Oahu	5	11	*Met*
Hospital on Kauai	1	4	*Met*
Hospital on Lanai	1	1	*Met*
Hospital on Maui	1	2	*Met*
Hospital on Molokai	1	1	*Met*
Hospitals in East Hawaii	1	3	*Met*
Hospitals in West Hawaii	1	4	*Met*
Primary Care Providers (PCPs)—Adult	1:300	1:11	*Met*
PCPs (Pediatric)	1:300	1:49	*Met*

HSAG determined that during the NAV review period, the Provider Ratios represented in Table 3-11 did not include members with SMI and SPMI diagnoses, as the guidance within the reporting template was not provided to the health plans until after the reporting period. This resulted in HSAG's Unable to Validate designation for each of the associated provider types.

Table 3-11—AlohaCare QI Network Adequacy Provider Ratios Unable to Validate

Provider Type
Behavioral Health Psychiatrists for members with an SMI or SPMI diagnosis. In geographic areas with a demonstrated shortage of qualified physicians, a psychiatric APRN-Rx may assume the role of psychiatrist.
Other Behavioral Health Providers to include Psychologists, Licensed Mental Health Counselors, Licensed Clinical Social Workers, and APRNs—Behavioral Health for members with an SMI or SPMI diagnosis.

HSAG determined that AlohaCare QI was compliant with network adequacy requirements for the Mandatory Provider Types standard for 42 of 46 indicators (91.3 percent). Compliance was determined based on the health plan meeting the State's Mandatory Provider Type indicators, which includes one

servicing provider within each provider type. All indicators were calculated by MQD. Compliant results are presented by provider type in Table 3-12, and noncompliant results are presented in Table 3-13.

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

Provider Type	Compliance
Audiologists	*Met*
Cardiologists	*Met*
Case Management Agencies	*Met*
Durable Medical Equipment (DME)	*Met*
Emergency Transportation Providers (both ground and air)	*Met*
Endocrinologists	*Met*
General Surgeons	*Met*
Geriatricians	*Met*
Hematologists	*Met*
Home Health Agencies and Hospices	*Met*
Infectious Disease Specialists	*Met*
LTSS: Adult Day Care Facilities	*Met*
LTSS: Adult Day Health Facilities	*Met*
LTSS: CCMA	*Met*
LTSS: CCFFH	*Met*
LTSS: E-ARCHs	*Met*
LTSS: Home-Delivered Meal Providers	*Met*
LTSS: Non-Medical Transportation Providers	*Met*
LTSS: NFs	*Met*
LTSS: Personal Care Assistance Providers	*Met*
LTSS: PERS Providers	*Met*
Laboratories which have either a Clinical Laboratory Improvement Amendments (CLIA) 1988 certificate or a waiver of a certificate of registration	*Met*
Non-Emergency Transportation (NET) Providers (both ground and air)	*Met*
Nephrologists	*Met*
Neurologists	*Met*
Obstetricians/Gynecologists (OB/GYNs)	*Met*
Occupational Therapists	*Met*
Oncologists	*Met*
Ophthalmologists	*Met*
Optometrists	*Met*

Provider Type	Compliance
Orthopedists	*Met*
Otolaryngologists	*Met*
Pediatric Specialists	*Met*
Pharmacies	*Met*
Physical Therapists	*Met*
Plastic Reconstructive Surgeons	*Met*
Providers of lodging and meals associated with obtaining necessary medical care	*Met*
Pulmonologists	*Met*
Radiologists	*Met*
Sign language interpreters and interpreters for languages other than English	*Met*
Speech-Language Pathologists	*Met*
Urologists	*Met*

Table 3-13—AlohaCare QI Network Adequacy Mandatory Provider Types Noncompliance

Provider Type	Compliance
Community Health Workers	*Not Met*
LTSS: Private Duty Nurses (PDN)	*Not Met*
LTSS: Respite Care Providers	*Not Met*
Licensed Dietitians	*Not Met*

HSAG determined that during the NAV review period, the mandatory provider types represented in Table 3-14 were not included in the provider network adequacy (PNA) reference tables and data submission format file used to report results; therefore, the health plan did not submit data allowing MQD to calculate compliance. This resulted in HSAG's Unable to Validate designation for each of the associated provider types.

Table 3-14—AlohaCare QI Network Adequacy Mandatory Provider Types Unable to Validate

Provider Type
Community Paramedics (CPs)
LTSS: Certified Substance Abuse Counselors
LTSS: State Licensed Special Treatment Facilities for the Provision of Substance Abuse Therapy/Treatment
Physician Assistants (PAs)

HSAG determined that AlohaCare QI was compliant with network adequacy requirements for a subset of the Time and Distance indicators. MQD required at least 85 percent of members to have access to the providers within the associated time or distance parameters. Compliance was determined based on the

health plan meeting the State's Time and Distance indicators for both Urban and Rural classifications. All indicators were calculated by MQD. Results are presented by provider type and urbanicity in Table 3-15, and noncompliant results are presented in Table 3-16.

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

Provider Type	Urbanicity	Compliance
24-Hour Pharmacies	Urban	86.2%
All Other Behavioral Health Providers	Urban	100.0%
	Rural	99.9%
Cardiologists	Urban	99.3%
	Rural	94.6%
Endocrinologists	Urban	86.3%
Hematologists	Urban	87.9%
	Rural	86.3%
Hospitals	Urban	96.6%
	Rural	95.7%
Infectious Disease Specialists	Urban	87.0%
Nephrologists	Urban	95.4%
Neurologists	Urban	95.5%
	Rural	93.8%
OB/GYNs	Urban	99.9%
	Rural	93.9%
Oncologists	Urban	95.8%
	Rural	86.0%
Ophthalmologists	Urban	97.1%
	Rural	87.7%
Optometrists	Urban	99.8%
	Rural	95.5%
Orthopedists	Urban	98.5%
	Rural	92.6%
Other Specialists	Urban	99.6%
	Rural	95.8%
Otolaryngologists	Urban	86.9%
PCPs (Adult)	Urban	100.0%
	Rural	99.9%

Provider Type	Urbanicity	Compliance
PCPs (Child)	Urban	100.0%
	Rural	99.7%
Pharmacies (All)	Urban	98.1%
	Rural	95.2%
Plastic and Reconstructive Surgeons	Urban	87.4%
Pulmonologists	Urban	94.9%
	Rural	91.7%
Radiologists	Urban	99.6%
	Rural	94.9%
Surgeons (All Other)	Urban	99.5%
	Rural	92.7%
Urologists	Urban	94.8%

Table 3-16—AlohaCare QI Network Adequacy Time and Distance < 85% Noncompliance by Urbanicity

Provider Type	Urbanicity	Compliance
LTSS: Adult Day Care/Adult Day Health	Urban	82.7%
	Rural	83.3%
LTSS: Respite Care Facilities	Urban	0%
	Rural	0%
Endocrinologists	Rural	36.9%
Geriatricians	Urban	66.4%
	Rural	30.2%
Otolaryngologists	Rural	64.8%
Infectious Disease	Rural	81.5%
Nephrologist	Rural	80.8%
Plastic and Reconstructive Surgeons	Rural	68.0%
Urologist	Rural	81.8%
Pediatric Specialists	Urban	70.9%
	Rural	79.8%

HSAG determined that during the NAV review period, the Time and Distance provider types represented in Table 3-17 were not included in the PNA reference tables and data submission format file used to report results; therefore, the health plan did not submit data allowing MQD to calculate

compliance. This resulted in HSAG's *Unable to Validate* designation for each of the associated provider types.

Table 3-17—AlohaCare QI Network Adequacy Time and Distance *Unable to Validate* Indicators

Provider Type
Emergency Services Facilities
LTSS: State Licensed Special Treatment Facilities for the Provision of Substance Abuse Therapy
LTSS: Certified Substance Abuse Counselors

Strengths

AlohaCare QI had established a robust process to maintain the accuracy and completeness of provider information through its quarterly newsletter reminders and on-site verification of provider data.

Areas for Improvement

- Of the 28 Urban provider types in scope of review, AlohaCare QI did not meet the 85 percent compliance threshold for the miles or minutes standard for four provider types. Of the 27 Rural provider types in scope of review, AlohaCare QI did not meet the 85 percent compliance threshold for the miles or minutes standard for 10 provider types.
- AlohaCare QI did not meet four of the 46 Minimum Required Provider Type indicators.

Recommendations

- HSAG recommends that AlohaCare QI continue its recruiting and contracting efforts for provider specialties that did not meet the Time and Distance threshold, with the goal of determining whether the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.
- HSAG recommends that AlohaCare QI continue its recruiting and contracting efforts for those provider types that did not meet the Minimum Required Provider Types standard, with the goal of determining whether the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

Validation of Performance Improvement Projects

In CY 2025, AlohaCare QI continued the two PIPs initiated in CY 2022—*Behavioral Health Coordination* and *Plan All-Cause Readmissions*. For the CY 2025 submission, the health plan progressed to the Design, Implementation, and Outcomes stages of the PIPs and submitted Steps 1 through 8 in the PIP Submission Form. The PIPs were assessed for improvement in outcomes in Step 9.

AlohaCare QI also submitted the *Screening for Depression and Follow-Up Plan* PIP that was initiated in CY 2024. For this PIP, AlohaCare QI progressed to the Design and Implementation stages of the PIP and submitted Steps 1 through 8 in the PIP submission form. The PIP will be assessed for improvement in outcomes in next year's validation when Remeasurement 1 data will be reported.

Table 3-18 displays the topics, progression status, and measurement periods reported for the PIPs.

Table 3-18—CY 2025 AlohaCare QI PIP Topics and Status

PIP Topic	PIP Progression Status	Baseline Measurement Period	Measurement Period Reported in CY 2025
Behavioral Health Coordination	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	07/01/2021 to 09/30/2021	07/01/2024 to 09/30/2024 (Remeasurement 3)
Plan All-Cause Readmissions	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	CY 2021	CY 2024 (Remeasurement 3)
Screening for Depression and Follow-Up Plan	PIP Design and Implementation Stages (Steps 1 through 8)	CY 2024	CY 2024 (Baseline)

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

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

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

Findings

Table 3-19 illustrates the validation results for the three PIPs submitted by AlohaCare QI for the CY 2025 validation.

Table 3-19—CY 2025 PIP Validation Results for AlohaCare QI

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

[1] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[2] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

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

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

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

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

Design (Steps 1-6)

Behavioral Health Coordination

The selected PIP topic was required by MQD. AlohaCare QI's Aim statement set the focus of the PIP, and the eligible population was clearly defined. The performance indicators were developed in consultation and discussion with MQD and HSAG. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process.

Plan All-Cause Readmissions

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

Screening for Depression and Follow-Up Plan

The selected PIP topic was required by MQD. AlohaCare QI's Aim statement set the focus of the PIP and the framework for data collection and analysis of results. AlohaCare QI clearly defined the eligible population and the performance indicator, which aligned with the CMS Child Core Set *Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH)* measure and the CMS Adult Core Set *Screening for Depression and Follow-Up Plan (CDF-AD)* measure. AlohaCare QI's data collection process was also found to be methodologically sound.

Implementation (Steps 7-8)

Behavioral Health Coordination

AlohaCare QI accurately reported and analyzed the Remeasurement 3 rate for the performance indicator. The health plan conducted accurate statistical testing between the measurement periods and provided narrative interpretations of the results. Appropriate quality improvement tools were utilized to conduct the causal/barrier analysis and to prioritize the identified barriers. Interventions were implemented in a timely manner, were reasonably linked to the identified barriers, and have the potential to impact the performance indicator outcomes. AlohaCare QI documented that the MOA for data sharing between the health plan and DOH Behavioral Health Services Administration divisions was signed and was effective January 1, 2025. At the time of the PIP reporting, the data sharing had not yet started. The health plan was working toward implementation of data sharing per the MOA in discussion with other health plans and DOH agencies.

Plan All-Cause Readmissions

AlohaCare QI accurately reported and analyzed the Remeasurement 3 rate for the performance indicator. The health plan conducted accurate statistical testing between the measurement periods and provided

narrative interpretations of the results. AlohaCare QI conducted appropriate quality improvement processes to identify barriers, and it deployed logical interventions linked to the identified barriers. The interventions appeared to positively impact performance indicator outcomes. AlohaCare QI included an evaluation of effectiveness for each intervention and appropriate next steps for the interventions.

Screening for Depression and Follow-Up Plan

AlohaCare QI accurately reported baseline rate for the performance indicators. Appropriate quality improvement tools were utilized to conduct causal/barrier analysis and the health plan initiated interventions that were reasonably linked to the identified barriers and had the potential to improve the performance indicator outcomes.

Outcomes (Step 9)

Behavioral Health Coordination

For the CY 2025 validation, AlohaCare QI progressed to reporting Remeasurement 3 results. During Remeasurement 3, both performance indicators sustained statistically significant improvement over the baseline.

Plan All-Cause Readmissions

For the CY 2025 validation, AlohaCare QI progressed to reporting Remeasurement 3 results. The performance indicator achieved statistically nonsignificant improvement in the Remeasurement 3 rate over the baseline.

Screening for Depression and Follow-Up Plan

AlohaCare QI has not progressed to reporting remeasurement outcomes. HSAG will assess and validate the first remeasurement period during the CY 2026 validation cycle.

Analysis of Results

Table 3-20 displays the data that the health plan reported for the *Behavioral Health Coordination* PIP.

Table 3-20—Outcomes for the *Behavioral Health Coordination* PIP

Performance Indicator	Baseline (07/01/2021–09/30/2021)		Remeasurement 1 (07/01/2022–09/30/2022)		Remeasurement 2 (07/01/2023–09/30/2023)		Remeasurement 3 (07/01/2024–09/30/2024)		Sustained Improvement
1. Percent of shared members with eligible trigger events who received a combined review in the past three months.	N: 9 D: 82	12.0%	N: 49 D: 148	33.1%*	N: 129 D: 309	41.7%*	N: 122 D: 261	46.7%*	*Yes*

Performance Indicator	Baseline (07/01/2021–09/30/2021)		Remeasurement 1 (07/01/2022–09/30/2022)		Remeasurement 2 (07/01/2023–09/30/2023)		Remeasurement 3 (07/01/2024–09/30/2024)		Sustained Improvement
2. 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%*	N: 48 D: 1,102	4.4%*	N: 53 D: 1,027	5.2%*	*Yes*

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

The percentage of shared members with eligible trigger events who received a combined review during the baseline measurement period (third quarter of 2021) was 12.0 percent. For Remeasurement 1, the Performance Indicator 1 rate increased to 33.0 percent. For Remeasurement 2, the rate was 41.7 percent, which represents a statistically significant increase of 29.7 percentage points over the baseline. For Remeasurement 3, the rate was 46.7 percent, which represents a statistically significant increase of 34.7 percentage points over the baseline.

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. For Remeasurement 1, the Performance Indicator 2 rate increased to 2.0 percent and for Remeasurement 2, the rate was 4.4 percent, which represents a statistically significant increase of 4.4 percentage points over the baseline. For Remeasurement 3, the rate was 5.2 percent, which represents a statistically significant improvement as compared to the baseline.

During Remeasurement 3, both performance indicators sustained statistically significant improvement in the performance. The improvement in the performance indicators is the result of increased data sharing with CCS. The health plan documented that an MOA was signed between DOH agencies and the health plans, effective January 1, 2025. However, implementation is in the planning stage with the other health plans to include data sharing with the DOH agencies in two phases, as outlined in the MOA.

Table 3-21 displays the data that the health plan reported for the *Plan All-Cause Readmissions* PIP.

Table 3-21—Outcomes for the *Plan All-Cause Readmissions* PIP

Performance Indicator	Baseline (01/01/2021–12/31/2021)		Remeasurement 1 (01/01/2022–12/31/2022)		Remeasurement 2 (01/01/2023–12/31/2023)		Remeasurement 3 (01/01/2024–12/31/2024)		Sustained Improvement
Percentage of eligible discharges for which members 18–64 years of age had at least one	N: 178	8.9%	N: 161	7.5%	N:169	7.4%	N: 197	8.8%	*Not Assessed*

Performance Indicator	Baseline (01/01/2021–12/31/2021)		Remeasurement 1 (01/01/2022–12/31/2022)		Remeasurement 2 (01/01/2023–12/31/2023)		Remeasurement 3 (01/01/2024–12/31/2024)		Sustained Improvement
acute readmission for any diagnosis within 30 days of the index discharge date.	D: 2,000		D: 2,154		D: 2,287		D: 2,239		

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

The baseline rate for the percentage of eligible discharges for which members 18–64 years of age had at least one acute readmission for any diagnosis within 30 days of the Index Discharge Date was 8.9 percent. For Remeasurement 1, the performance indicator rate decreased to 7.5 percent and for Remeasurement 2, the rate was 7.4 percent. For Remeasurement 3, the performance indicator rate was 8.8 percent, which was marginally below (0.1 percentage points) the baseline (favorable outcome).

The health plan has not achieved statistically significant improvement in the performance indicator rate at any remeasurement period and was therefore not assessed for sustained improvement.

Table 3-22 displays the data for the *Screening for Depression and Follow-Up Plan* PIP.

Table 3-22—Performance Indicator Results for the *Screening for Depression and Follow-Up Plan* PIP

Performance Indicator	Baseline (01/01/2024–12/31/2024)		Remeasurement 1 (01/01/2025–12/31/2025)		Sustained Improvement
1. Percentage of members ages 12 to 17 screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter.	N: 3,007 D: 7,164	42.0%			*Not Assessed*
2. Percentage of members aged 18 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and, if positive, a follow-up plan is documented on the date of the eligible encounter.	N: 11,942 D: 29,059	41.1%			*Not Assessed*

N–Numerator D–Denominator

HSAG rounded percentages to the first decimal place.

The baseline rate for Performance Indicator 1 was 42.0 percent and the baseline rate for Performance Indicator 2 was 41.1 percent.

Barriers/Interventions

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

Table 3-23 displays the barriers and interventions as documented by the health plan for each PIP.

Table 3-23—Interventions Implemented/Planned for AlohaCare QI PIPs

Barriers	Interventions
Behavioral Health Coordination (BH)	
1. Challenges with implementing data sharing process with DOH agencies as outlined in the MOA.	1. Discuss planning process for implementation of data sharing with DOH agencies as outlined in the MOA.
Plan All-Cause Readmissions (PCR)	
1. Unclear process or program to identify all discharges from acute facilities and member discharge needs. 2. Lack of knowledge on how to interpret and utilize the Predictive Analytics tool.	1. Continuation of an interdepartmental transition of care (TOC) workflow for referrals and outreach beginning at admission to follow up post-discharge. A TOC referral workflow includes notification of anticipated discharge date and supports if known. TOC team members document their activities in the GuidingCare Care Management system. 2. Interdepartmental clinical rounds and behavioral health rounds (daily) to discuss discharge dates, needs, risks, and community resources. The contractual arrangement with a BH provider to provide member contact and follow-up care within 7 days of discharge continues. 3. TOC team members continue attempts for face-to-face interactions with hospitalized members. This interaction allows the TOC staff to introduce the TOC Post-Discharge program to members. 4. Utilize Risk Scores obtained from the Predictive Analytics tool to determine if a higher risk score is an accurate indicator of readmission.

Barriers	Interventions
Screening for Depression and Follow-Up Plan	
1. Providers were billing codes that do not meet the value set of approved codes to meet the CMS Adult Core Set, the CMS Child Set, and the HEDIS Value Data Set when performing a depression screening and follow-up plan, if positive, to close the care gaps and receive credit for service provided.	1. Provider education on use of appropriate billing codes for depression screening and follow-up, if positive.

Strengths

- All of AlohaCare QI's PIPs received Met validation scores for 100 percent of all applicable evaluation elements validated for acceptable methodology for all phases of the PIP.
- For the *Behavioral Health Coordination* PIP, both performance indicators sustained statistically significant improvement over the baseline.

Areas for Improvement

- For the *Behavioral Health Coordination* PIP, the health plan had continued data sharing with 'Ohana CCS; however, the data sharing with the DOH Behavioral Health Services Administration divisions had not yet begun.
- For the *Plan All-Cause Readmissions* PIP, AlohaCare QI has an opportunity for improvement in achievement of statistically significant improvement in the performance indicator rate.

Recommendations

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

- AlohaCare QI must continually work on the PIPs throughout the year.
- For the *Behavioral Health Coordination* PIP, in addition to working with other health plans on the implementation of data sharing per the MOA with DOH agencies, the health plan must also review internal plan-specific barriers toward implementation of the MOA and initiate appropriate interventions.
- For the *PCR* PIP, AlohaCare QI should:
  - Build on the positive momentum gained and improvement achieved.
  - Apply lessons learned and knowledge gained to future PIPs and other quality improvement efforts.

- For the *Screening for Depression and Follow-Up Plan* PIP, AlohaCare QI must ensure that the interventions are implemented in a timely manner to impact outcomes during the remeasurement period.
- AlohaCare QI must revisit the causal/barrier analysis at least annually to determine if previously identified barriers continue to be applicable and to determine if any new barriers exist that require the development of interventions.
- AlohaCare QI must submit an intervention worksheet for each intervention listed in the Barriers/Interventions table in the PIP Submission Form.
- The intervention effectiveness measure in the intervention worksheet must not be the same as the performance indicator documented in Step 5. The effectiveness measure should be designed to measure the effectiveness of the specific intervention on addressing the barrier linked to that intervention.
- AlohaCare QI should collect the intervention effectiveness data more frequently (e.g., monthly, quarterly) unlike the annual performance indicator data. This would help the health plan understand intervention effectiveness and make any updates to the interventions in a timely manner to impact remeasurement outcomes.
- Intervention effectiveness data must guide next steps for each individual intervention.

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

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

Findings

Table 3-24 presents the 2025 scores for AlohaCare QI compared to the 2024 NCQA child Medicaid national averages, the corresponding 2023 scores, and the QI Program (i.e., combination of the five QI health plans).[27,28]

Table 3-24—Child CAHPS Results for AlohaCare QI

Measure	2023 AlohaCare QI Scores	2025 AlohaCare QI Scores	2025 QI Program Scores
Global Ratings			
Rating of Health Plan	81.21%	72.35% ▼	71.65%
Rating of All Health Care	70.06%	70.54%	68.95%
Rating of Personal Doctor	80.30%	71.34% ▼	76.22%

[27] The child population was last surveyed in 2023; therefore, the 2025 child CAHPS scores are compared to the corresponding 2023 scores.

[28] National Committee for Quality Assurance. *HEDIS® Measurement Year 2024, Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2024.

Measure	2023 AlohaCare QI Scores	2025 AlohaCare QI Scores	2025 QI Program Scores
Rating of Specialist Seen Most Often	70.00%+	75.00%+	77.78%
Composite Measures			
Getting Needed Care	74.93%+	77.32%+	80.76%
Getting Care Quickly	77.74%+	79.17%+ L	81.10%
How Well Doctors Communicate	91.81%	92.72%	94.25%
Customer Service	89.47%+	87.25%+	90.25%
Individual Item Measure			
Coordination of Care	81.82%+	83.02%+	87.77%

▲ *Indicates the 2025 score is statistically significantly higher than the 2023 score.*
▼ *Indicates the 2025 score is statistically significantly lower than the 2023 score.*
↑ *Indicates the 2025 score is statistically significantly higher than the QI Program.*
↓ *Indicates the 2025 score is statistically significantly lower than the QI Program.*
H *Indicates the 2025 score is statistically significantly higher than the NCQA national average.*
L *Indicates the 2025 score is statistically significantly lower than the NCQA national average.*
+ *Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.*

Strengths

- AlohaCare QI's 2025 top-box scores were not statistically significantly higher than the 2024 NCQA child Medicaid national averages, QI Program's 2025 top-box scores, or the 2023 top-box scores for any measure; therefore, no substantial strengths were identified.
- AlohaCare QI's 2025 top-box scores met or exceeded the RY 2025 target for one measure, *Rating of All Health Care*.

Areas for Improvement

- AlohaCare QI's 2025 top-box score was statistically significantly lower than the 2024 NCQA child Medicaid national average for one measure, *Getting Care Quickly*.
- AlohaCare QI's 2025 top-box scores were statistically significantly lower than the 2023 top-box scores for the following measures: *Rating of Health Plan* and *Rating of Personal Doctor*.

Recommendations

HSAG recommends that AlohaCare QI continue to explore the drivers of these lower experience scores and develop initiatives designed to improve quality and timeliness of care, develop initiatives designed to improve quality of care by focusing on improving parents/caretakers of child members' overall experiences with their child's healthcare and their child's personal doctor and determine a root cause for the lower performance.

Provider Survey

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

Findings

Table 3-25 presents the 2025 scores for AlohaCare QI compared to the QI Program and the corresponding 2023 scores, where applicable.[29]

Table 3-25—Provider Survey Results for AlohaCare QI: Measure Scores

	2023 AlohaCare QI Scores	2025 AlohaCare QI Scores	2025 QI Program Scores
General Positions			
Compensation Satisfaction	39.95%+	55.07%+	51.98%
Timeliness of Claims Payments	44.01%+	43.55%+	40.57%
Prior Authorization Process Experience*			
Approval or Authorization Delayed	NT	60.20%+ NT	67.02%
Inconsistent Requirements	NT	60.06%+ NT	64.73%
Difficult to Navigate	NT	59.33%+ NT	64.75%
Labor Intensive	NT	53.58%+ NT	55.53%
Prior Authorization Process Impacts*			
Delayed Ability to Provide Treatments	NT	48.71%+ NT	53.47%
Disrupted Continuity of Care	NT	52.60%+ NT	52.62%
Created Administrative Burden	NT	39.84%+ NT	44.32%
Led to Denial of Service	NT	59.01%+ NT	59.57%
Formulary			
Formulary Impact on Care	30.06%+	37.76%+	37.27%
Non-Formulary			
Adequate Access to Non-Formulary Drugs	43.57%+	44.38%+	42.75%
Health Coordinators			
Helpfulness of Health Coordinators	44.44%+	55.56%+	56.24%
Specialists			
Adequate Network of Specialists	29.76%+	35.22%+	37.96%

[29] For this report, only the top-box scores are displayed. For more detailed results on the other response categories, please see the 2025 Hawaii Provider Survey Report.

	2023 AlohaCare QI Scores	2025 AlohaCare QI Scores	2025 QI Program Scores
Substance Abuse			
Access to Substance Abuse Treatment	9.09%+	44.19%+	42.04%

▲ *Indicates the 2025 score is statistically significantly higher than the 2023 score.*
▼ *Indicates the 2025 score is statistically significantly lower than the 2023 score.*
↑ *Indicates the 2025 score is statistically significantly higher than the QI Program.*
↓ *Indicates the 2025 score is statistically significantly lower than the QI Program.*
NT *Indicates this measure was not included in 2023; therefore, a trend analysis was unable to be performed for this measure.*
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
**Providers who responded 'No' for the survey questions within the Prior Authorization Process Experience and Impact domains, indicating they did not have a negative experience with the prior authorization process, were classified into the 'Satisfied' response category.*

Strengths

While AlohaCare QI's 2025 top-box scores were not statistically significantly higher than the 2023 top-box scores or the QI Program for any measure, the top-box scores were higher in 2025 than in 2023 for the following measures:

- *Compensation Satisfaction*
- *Formulary Impact on Care*
- *Adequate Access to Non-Formulary Drugs*
- *Helpfulness of Health Coordinators*
- *Adequate Network of Specialists*
- *Access to Substance Abuse Treatment*

Areas for Improvement

AlohaCare QI 's 2025 top-box scores were not statistically significantly lower than the 2023 top-box scores or the QI Program for any measure; however, the top-box score was lower in 2025 than in 2023 for the following measure:

- *Timeliness of Claims Payments*

Recommendations

HSAG recommends that AlohaCare QI monitor the measures to ensure significant decreases in scores over time do not occur.

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

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 had systems, policies, and staff in place to ensure its structure and operations support core processes for providing care and services and promoting quality outcomes. AlohaCare QI's performance during the 2025 compliance review was above average, meeting or exceeding the statewide compliance score for seven of the eight standards. AlohaCare QI achieved 100 percent compliance in six standards. 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.

Conversely, more than three quarters (79.73 percent) of AlohaCare QI's performance measure indicator rates fell below the 50th percentile across all domains, with many (64.86 percent) falling below the 25th percentile. While some measures showed improvement from MY 2023, AlohaCare QI's performance suggests several areas in need of improvement, including the Access and Risk-Adjusted Utilization, Children's Preventive Health, Women's Health, Care for Chronic Conditions, and Behavioral Health domains. Only 13 of AlohaCare QI's measure rates met MQD Quality Strategy targets.

The results of the NAV activities revealed that AlohaCare QI had well-defined processes and procedures in place to ensure efficient and accurate collection of member and provider data to support network adequacy calculation and reporting. AlohaCare QI was compliant with the provider ratio requirements for all provider types that were able to be validated. While AlohaCare QI demonstrated high compliance with the Time and Distance standard for Urban provider types, more than one third of the Rural provider types showed noncompliance with the Time and Distance standard, indicating that the health plan should continue its recruiting and contracting efforts for those provider types.

AlohaCare QI progressed to the Outcomes stage of the two PIPs (*Behavioral Health Coordination* and *Plan All-Cause Readmissions*) that were initiated in CY 2022, and the Implementation stage for the *Screening for Depression and Follow-Up Plan* PIP initiated in CY 2024. The PIPs addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services.

The *Behavioral Health Coordination* PIP received a *High Confidence* level rating for both overall confidence of adherence to acceptable methodology for all phases of the PIP and overall confidence that the PIP achieved significant improvement. During Remeasurement 3, both performance indicators sustained statistically significant improvement over the baseline. The health plan continued data sharing

with CCS; however, the data sharing with DOH agencies had not yet started. The health plan was working toward implementation of data sharing per the MOA with DOH agencies.

The *Plan All-Cause Readmissions* PIP received a *High Confidence* level rating for overall confidence of adherence to acceptable methodology for all phases of the PIP and a *Moderate Confidence* rating for overall confidence that the PIP achieved significant improvement. The health plan conducted appropriate quality improvement processes and participated in the Readmissions Collaborative workgroup to identify barriers, and it deployed interventions that were logically linked to the identified barriers. For Remeasurement 3, the health plan had a decline in performance as compared to Remeasurement 2; however, the rate demonstrated marginal improvement over the baseline.

The *Screening for Depression and Follow-Up Plan* PIP received a *High Confidence* level rating for adherence to acceptable methodology for all phases of the PIP. This performance suggests a sound PIP design, accurate reporting of data, and implementation of interventions that were related to barriers identified through quality improvement processes and have the potential to drive improvement in desired outcomes. AlohaCare QI had not progressed to reporting remeasurement data and was therefore not assessed for achievement of improvement.

AlohaCare QI's CAHPS results illustrate opportunities for improvement in parent/caretaker of child members' satisfaction. While none of the 2025 top-box scores were statistically significantly lower than the QI Program for any measure, AlohaCare QI's 2025 top-box scores were statistically significantly lower than the 2023 top-box scores for the following measures: *Rating of Health Plan* and *Rating of Personal Doctor*. Additionally, AlohaCare QI's 2025 top-box scores were statistically significantly lower than the 2024 NCQA child Medicaid national average for one measure, *Getting Care Quickly*. These results indicate the need for AlohaCare QI to implement improvement strategies to ensure parents/caretakers of child members have high-quality care and timely access to care.

While one of the nine CAHPS measures MQD selected for monitoring within its Quality Strategy met or exceeded the RY 2025 target, AlohaCare QI should focus improvement efforts on the *Coordination of Care, Customer Service, Getting Care Quickly, Getting Needed Care, How Well Doctors Communicate, Rating of Health Plan, Rating of Personal Doctor,* and *Rating of Specialist Seen Most Often* measures, as these measures did not meet the RY 2025 target.

AlohaCare QI's Provider Survey results demonstrated mixed results. While no top-box scores were statistically significantly higher or lower than the 2023 top-box scores or QI Program aggregate, scores for six measures were higher in 2025 than in 2023. Conversely, the *Timeliness of Claims Payments* measure score was lower in 2025 than in 2023. AlohaCare QI should explore operational changes and improvement efforts to ensure provider claims are processed timely.

Hawaii Medical Service Association QUEST Integration (HMSA QI) Results

Compliance Monitoring Review

The 2025 compliance monitoring review activity included evaluation of the health plan's compliance with State and federal requirements for organizational and structural performance.

Findings

Table 3-26 presents the standards and compliance scores for HMSA QI.

Table 3-26—Standards and Compliance Review Scores—HMSA QI

Standard #	Standard Name	Total # of Elements	Number of Elements		Total Compliance Score
			# Met	# Not Met	
I	Availability of Services	17	17	0	100%
II	Assurances of Adequate Capacity and Services	3	3	0	100%
III	Coordination and Continuity of Care	10	10	0	100%
IV	Confidentiality	10	10	0	100%
V	Coverage and Authorization of Services	31	30	1	97%
VI	Enrollee Information	19	19	0	100%
VII	Enrollee Rights and Protections	8	8	0	100%
VIII	Grievance and Appeal System	31	29	2	94%
	Totals	**129**	**126**	**3**	**98%**

Total Elements: The total number of applicable elements in each standard.
Total Compliance Score: The compliance scores were calculated by adding the ***Met*** elements and then dividing by the total number of applicable elements.

Strengths

HMSA QI achieved full compliance in six of the eight standards reviewed, demonstrating strengths and adherence to all requirements measured in the following areas:

- Availability of Services
- Assurances of Adequate Capacity and Services
- Coordination and Continuity of Care
- Confidentiality
- Enrollee Information
- Enrollee Rights and Protections

These findings suggest that HMSA QI developed the necessary policies, procedures, and processes to operationalize the federal regulations and contractual requirements.

Areas for Improvement

The areas with the greatest opportunity for improvement were related to the following, as these areas received performance scores under 95 percent:

- Grievance and Appeal System

These findings suggest that HMSA QI did not always develop and implement the necessary policies, procedures, and processes required of the federal regulations and its health plan contract with MQD.

Recommendations

Of the 129 elements, HMSA QI received *Not Met* scores for three elements. HSAG recommends that HMSA QI continue to work with HSAG and MQD on completing the CAPs for the two Grievance and Appeal System elements and one Coverage and Authorization of Services element that were scored as *Not Met*.

Validation of Performance Measures—NCQA HEDIS Compliance Audits

NCQA HEDIS Compliance Audit Findings

HSAG's review team assessed HMSA QI's IS capabilities and its ability to process data for reporting accurate performance measure rates. HMSA QI was found to be fully compliant with all HEDIS IS standards, including IS standard L for assessing case management data for the LTSS measures. This demonstrated that HMSA QI had effective IS processes and control procedures in place for reporting the required performance measure rates. HMSA QI presented 10 supplemental data sources for consideration to use for supplementing its MY 2024 performance measure rates. HSAG determined three data sources to be nonstandard supplemental data; the remaining seven were considered standard supplemental data. HSAG reviewed all data sources and conducted primary source verification on the three nonstandard data sources. No concerns were identified, and all 10 supplemental data sources were approved for HEDIS MY 2024 reporting.

HMSA QI was required to undergo convenience sample validation for the *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%—Total* and *Eye Exam for Patients With Diabetes* measures. HMSA QI successfully passed the validation for all cases reviewed. The final MRRV was conducted for the *Immunizations for Adolescents—Combination 2*, *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%—Total*, *Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care*, and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* measures. All selected cases passed the final MRRV without any critical errors. The final statistical CMRRV was conducted for *Long-Term Services and Supports Comprehensive Assessment and Update—Assessment of Core Elements* and

Assessment of Supplemental Elements, Long-Term Services and Supports Comprehensive Care Plan and Update—Care Plan With Core Elements Documented and *Assessment of Supplemental Elements*. All selected cases passed the final MRRV and CMRRV without any critical errors.

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

Access and Risk-Adjusted Utilization Performance Measure Results

HMSA QI's Access and Risk-Adjusted Utilization performance measure results are shown in Table 3-27.

Table 3-27—HMSA QI's Results for QI Measures Under Access and Risk-Adjusted Utilization

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	63.48%	64.74%	1.98%	★
45–64 Years	76.15%	76.57%	0.55%	★★
65+ Years	76.29%	83.54%	9.50%	★★★
Total	68.54%	70.13%	2.32%	★★
Plan All-Cause Readmissions				
*Observed Readmissions—18–64 Years**	—	8.46%	—	NC
*Expected Readmissions—18–64 Years**	—	8.91%	—	NC
*O/E Ratio—18–64 Years**	—	0.9493	—	NC
PQI 08: Heart Failure Admission Rate				
*18–64 Years**	27.92	31.23	11.86%	NC
*65+ Years**	73.79	99.62	35.00%	NC
*Total**	31.40	36.85 ✓	17.36%	NC
PQI 15: Asthma in Younger Adults Admission Rate				
*18–39 Years**	2.53	1.76 ✓	-30.43%	NC

** A lower rate indicates better performance.*
NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.
— Indicates that the health plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.
and ✓ indicates the health plan met or exceeded the target threshold established by MQD.
MY 2024 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*

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

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

HMSA QI met the MQD-established Quality Strategy target for *PQI 08: Heart Failure Admission Rate—Total* and *PQI 15: Asthma in Younger Adults Admission Rate*. All other MQD Quality Strategy targets were not met for this domain.

Children's Preventive Health Performance Measure Results

HMSA QI's Children's Preventive Health performance measure results are shown in Table 3-28.

Table 3-28—HMSA QI's Results for QI Measures Under Children's Preventive Health

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Child and Adolescent Well-Care Visits				
Total	55.29%	58.37% ✓	5.57%	★★★★
Childhood Immunization Status				
Combination 3	63.75%	69.10% ✓	8.39%	★★★★
Combination 7	54.99%	58.15% ✓	5.75%	★★★
Combination 10	35.04%	30.90%	-11.82%	★★★
DTaP	67.40%	76.64%	13.71%	★★★★
Hepatitis A	79.08%	82.73%	4.62%	★★★
Hepatitis B	81.02%	81.75%	0.90%	★
HiB	82.00%	84.18%	2.66%	★★★
Influenza	46.96%	40.39%	-13.99%	★★★
IPV	81.51%	83.94%	2.98%	★★
MMR	80.78%	83.70%	3.61%	★★
Pneumococcal Conjugate	68.61%	75.18%	9.58%	★★★
Rotavirus	66.91%	68.37%	2.18%	★★
VZV	80.54%	82.24%	2.11%	★★
Immunizations for Adolescents				
Combination 1	69.10%	74.70% ✓	8.10%	★★
Combination 2	40.88%	50.61% ✓	23.80%	★★★★★
Meningococcal	71.53%	76.16%	6.47%	★★

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Tdap	71.78%	78.59%	9.49%	★
HPV	43.07%	52.31%	21.45%	★★★★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—3–11 Years	86.19%	84.27%	-2.23%	★★★
BMI Percentile—12–17 Years	90.91%	89.83%	-1.19%	★★★★
BMI Percentile—Total	88.01%	86.49% ✓	-1.73%	★★★
Counseling for Nutrition—3–11 Years	79.52%	78.65%	-1.09%	★★★
Counseling for Nutrition—12–17 Years	79.55%	76.27%	-4.12%	★★★
Counseling for Nutrition—Total	79.53%	77.70%	-2.30%	★★★
Counseling for Physical Activity—3–11 Years	77.14%	73.60%	-4.59%	★★★
Counseling for Physical Activity—12–17 Years	78.03%	76.27%	-2.26%	★★★
Counseling for Physical Activity—Total	77.49%	74.66%	-3.65%	★★★
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	68.53%	71.60% ✓	4.48%	★★★★★
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	73.72%	78.09% ✓	5.93%	★★★★

and ✓ indicates the health plan met or exceeded the target threshold established by MQD.

MY 2024 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*

HMSA QI met or exceeded the 90th percentile for the following measure indicator rates:

- *Immunization for Adolescents—Combination 2*
- *Immunization for Adolescents—HPV*
- *Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*

HMSA QI met the 75th to 89th percentile for the following measure indicator rates:

- *Child and Adolescent Well-Care Visits*
- *Childhood Immunization Status—Combination 3*

- *Childhood Immunization Status—DTaP*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—12–17 Years*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits*

HMSA QI met MQD's established Quality Strategy target for the following measure indicator rates:

- *Child and Adolescent Well-Care Visits*
- *Childhood Immunization Status—Combination 3* and *Combination 7*
- *Immunizations for Adolescents—Combination 1* and *Combination 2*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits*

All other MQD Quality Strategy targets were not met for this domain.

Women's Health Performance Measure Results

HMSA QI's Women's Health performance measure results are shown in Table 3-29.

Table 3-29—HMSA QI's Results for QI Measures Under Women's Health

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Cervical Cancer Screening				
Cervical Cancer Screening	59.55%	59.55% ✓	0.00%	★★★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	82.79%	79.17%	-4.37%	★
Postpartum Care	78.14%	82.64% ✓	5.76%	★★★
Timeliness of Prenatal Care—Under 21 Years	63.31%	67.49%	6.60%	NC
Postpartum Care—Under 21 Years	60.79%	64.66%	6.37%	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.

and ✓ indicates the health plan met or exceeded the target threshold established by MQD.

MY 2024 performance levels represent the following percentile comparisons:

★★★★★ *= 90th percentile and above*

★★★★ *= 75th to 89th percentile*

★★★ = *50th to 74th percentile*
★★ = *25th to 49th percentile*
★ = *Below 25th percentile*

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

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

Care for Chronic Conditions Performance Measure Results

HMSA QI's Care for Chronic Conditions performance measure results are shown in Table 3-30.

Table 3-30—HMSA QI's Results for QI Measures Under Care for Chronic Conditions

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Asthma Medication Ratio				
5–11 Years	55.28%	37.43%	-32.29%	★
12–18 Years	50.86%	41.58%	-18.25%	★
19–50 Years	42.04%	32.27%	-23.24%	★
51–64 Years	49.41%	39.11%	-20.85%	★
Total	46.97%	35.70%	-23.99%	★
5–18 Years	53.43%	38.97%	-27.06%	NC
19–64 Years	44.56%	34.25%	-23.14%	NC
Blood Pressure Control for Patients With Diabetes				
Blood Pressure Control for Patients With Diabetes	64.06%	63.14% ✓	-1.44%	★★
Concurrent Use of Opioids and Benzodiazepines				
*18–64 Years**	13.65%	12.22%	-10.48%	NC
*65+ Years**	9.29%	11.63%	25.19%	NC
*Total**	13.32%	12.18% ✓	-8.56%	NC
Controlling High Blood Pressure				
18–64 Years	58.64%	54.23%	-7.52%	NC
65–85 Years	62.96%	55.70%	-11.53%	NC
Total	59.51%	54.52%	-8.39%	★
Eye Exam for Patients With Diabetes				
Eye Exam for Patients With Diabetes	59.41%	55.77%	-6.13%	★★★

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Glycemic Status Assessment for Patients With Diabetes				
Glycemic Status <8.0%—18–64 Years	53.58%	53.67%	0.17%	NC
Glycemic Status <8.0%—65–75 Years	66.67%	72.73%	9.09%	NC
Glycemic Status <8.0%—Total	55.50%	56.76% ✓	2.27%	★★
*Glycemic Status >9.0%—18–64 Years**	38.40%	36.66%	-4.53%	NC
*Glycemic Status >9.0%—65–75 Years**	25.00%	15.15%	-39.40%	NC
*Glycemic Status >9.0%—Total**	36.43%	33.17% ✓	-8.95%	★★★

** 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.
and ✓ indicates the health plan met or exceeded the target threshold established by MQD.
MY 2024 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

The *Eye Exam for Patients With Diabetes* and *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status >9.0%—Total* measure indicators met or exceeded the 50th percentile. All other measure indicators in this domain did not meet or exceed the 50th percentile or did not have national benchmarks to compare for MY 2024.

HMSA QI met the MQD-established Quality Strategy target for *Blood Pressure Control for Patients With Diabetes, Concurrent Use of Opioids and Benzodiazepines—Total,* and *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%—Total* and *Glycemic Status >9.0%—Total*. All other MQD Quality Strategy targets were not met for this domain.

Behavioral Health Performance Measure Results

HMSA QI's Behavioral Health performance measure results are shown in Table 3-31.

Table 3-31—HMSA QI's Results for QI Measures Under Behavioral Health

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Antidepressant Medication Management				
Effective Acute Phase Treatment—18–64 Years	65.94%	68.30%	3.58%	NC

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Effective Acute Phase Treatment—65+ Years	67.92%	70.21%	3.37%	NC
Effective Acute Phase Treatment—Total	66.00%	68.35% ✓	3.56%	★★★★
Effective Continuation Phase Treatment—18–64 Years	46.97%	49.75%	5.92%	NC
Effective Continuation Phase Treatment—65+ Years	50.94%	40.43%	-20.63%	NC
Effective Continuation Phase Treatment—Total	47.08%	49.51% ✓	5.16%	★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	70.08%	74.79% ✓	6.72%	★
Follow-Up After Emergency Department Visit for Mental Illness				
7-Day Follow-Up—6–17 Years	34.00%	34.93%	2.74%	★
7-Day Follow-Up—18–64 Years	25.37%	27.10%	6.82%	★★
7-Day Follow-Up—65+ Years	NA	NA	—	NC
7-Day Follow-Up—Total	26.21%	27.91%	6.49%	★
30-Day Follow-Up—6–17 Years	46.67%	52.74%	13.01%	★
30-Day Follow-Up—18–64 Years	42.78%	44.87%	4.89%	★★
30-Day Follow-Up—65+ Years	NA	NA	—	NC
30-Day Follow-Up—Total	42.67%	45.52%	6.68%	★
Follow-Up After Emergency Department Visit for Substance Use				
7-Day Follow-Up—13–17 Years	21.05%	14.89%	-29.26%	★★
7-Day Follow-Up—18+ Years	26.87%	27.35%	1.79%	★★★
7-Day Follow-Up—Total	26.64%	26.89%	0.94%	★★★
7-Day Follow-Up—18–64 Years	27.37%	27.69%	1.17%	NC
7-Day Follow-Up—65+ Years	14.81%	15.15%	2.30%	NC
30-Day Follow-Up—13–17 Years	38.60%	34.04%	-11.81%	★★★
30-Day Follow-Up—18+ Years	42.36%	41.20%	-2.74%	★★★
30-Day Follow-Up—Total	42.21%	40.93%	-3.03%	★★★
30-Day Follow-Up—18–64 Years	42.89%	41.84%	-2.45%	NC
30-Day Follow-Up—65+ Years	29.63%	18.18%	-38.64%	NC

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—6–17 Years	62.11%	58.33%	-6.09%	★★★★
7-Day Follow-Up—18–64 Years	42.91%	44.41%	3.50%	★★★★
7-Day Follow-Up—65+ Years	NA	NA	—	NC
7-Day Follow-Up—Total	47.31%	47.12% ✓	-0.40%	★★★★
30-Day Follow-Up—6–17 Years	68.42%	73.44%	7.34%	★★★
30-Day Follow-Up—18–64 Years	56.73%	58.06%	2.34%	★★★
30-Day Follow-Up—65+ Years	NA	NA	—	NC
30-Day Follow-Up—Total	59.13%	61.32%	3.70%	★★★
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	47.18%	40.27%	-14.65%	★
Continuation and Maintenance Phase	59.15%	58.06%	-1.84%	★★★
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation of SUD Treatment—Total—13–17 Years	41.97%	41.98%	0.02%	★★★
Initiation of SUD Treatment—Total—18–64 Years	33.73%	34.69%	2.85%	★
Initiation of SUD Treatment—Total—65+ Years	30.82%	33.41%	8.40%	★
Initiation of SUD Treatment—Total—Total	33.96%	34.86%	2.65%	★
Engagement of SUD Treatment—Total—13–17 Years	23.36%	24.06%	3.00%	★★★★★
Engagement of SUD Treatment—Total—18–64 Years	11.24%	10.50%	-6.58%	★★
Engagement of SUD Treatment—Total—65+ Years	3.93%	4.09%	4.07%	★★
Engagement of SUD Treatment—Total—Total	11.39%	10.51%	-7.73%	★★
Screening for Depression and Follow-Up Plan				
12–17 Years	47.16%	50.75%	7.61%	NC
18–64 Years	25.29%	30.26%	19.65%	NC
65+ Years	24.23%	32.66%	34.79%	NC
Total	29.79%	34.35% ✓	15.31%	NC
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
1–11 Years	NA	NA	—	NC
12–17 Years	43.33%	58.18%	34.27%	★★

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Total	45.71%	58.57%	28.13%	★★
Use of Pharmacotherapy for Opioid Use Disorder				
Rate 1: Total	57.90%	49.56%	-14.40%	NC
Rate 2: Buprenorphine	38.13%	32.25%	-15.42%	NC
Rate 3: Oral Naltrexone	1.41%	1.12% ✓	-20.57%	NC
Rate 4: Long-Acting, Injectable Naltrexone	0.27%	0.19%	-29.63%	NC
Rate 5: Methadone	19.91%	18.12%	-8.99%	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 health plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.
and ✓ indicates the health plan met or exceeded the target threshold established by MQD.
MY 2024 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*

HMSA QI met or exceeded the 90th percentile for the following measure indicator rates:

- *Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment—Total—13–17 Years*

HMSA QI met the 75th to 89th percentile for the following measure indicator rates:

- *Antidepressant Medication Management—Effective Acute Phase Treatment—Total*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—6–17 Years*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—18–64 Years*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total*

HMSA QI met the 50th to 74th percentile for the following measure indicator rates:

- *Antidepressant Medication Management—Effective Continuation Phase Treatment—Total*
- *Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—18+ Years*
- *Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Total*
- *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—13–17 Years*
- *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—18+ Years*
- *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total*

- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—6–17 Years*
- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—18–64 Years*
- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total*
- *Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase*
- *Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment—Total—13–17 Years*

All other measure indicators in this domain either did not meet the 50th percentile or did not have national benchmarks to compare for MY 2024.

HMSA QI met the MQD-established Quality Strategy target for the following measure indicator rates:

- *Antidepressant Medication Management—Effective Acute Phase Treatment—Total*
- *Antidepressant Medication Management—Effective Continuation Phase Treatment—Total*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total*
- *Screening for Depression and Follow-Up Plan—Total*
- *Use of Pharmacotherapy for Opioid Use Disorder—Rate 3: Oral Naltrexone*

All other MQD Quality Strategy targets were not met for this domain.

Long-Term Services and Supports Performance Measure Results

HMSA QI's Long-Term Services and Supports performance measure results are shown in Table 3-32.

Table 3-32—HMSA QI's Results for QI Measures Under Long-Term Services and Supports

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Long-Term Services and Supports Comprehensive Assessment and Update				
Assessment of Core Elements	26.04%	6.81%	-73.85%	NC
Assessment of Supplemental Elements	18.75%	6.81%	-63.68%	NC
Long-Term Services and Supports Comprehensive Care Plan and Update				
Care Plan With Core Elements Documented	2.08%	2.92%	40.38%	NC
Assessment of Supplemental Elements	2.08%	2.92%	40.38%	NC
Managed Long-Term Services and Supports Admission to a Facility from the Community				
Short-Term Stay—18–64 Years	0.55	1.07	94.55%	NC
Short-Term Stay—65–74 Years	0.00	0.47	—	NC
Short-Term Stay—75–84 Years	1.44	0.00	-100.00%	NC

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Short-Term Stay—85+ Years	0.00	0.00	—	NC
Short-Term Stay—Total	0.44	0.32	-27.27%	NC
Medium-Term Stay—18–64 Years	0.00	0.53	—	NC
Medium-Term Stay—65–74 Years	0.48	0.00	-100.00%	NC
Medium-Term Stay—75–84 Years	1.92	0.45	-76.56%	NC
Medium-Term Stay—85+ Years	0.64	0.32	-50.00%	NC
Medium-Stay—Total	0.77	0.32	-58.44%	NC
Long-Term Stay—18–64 Years	10.92	11.22	2.75%	NC
Long-Term Stay—65–74 Years	15.03	14.48	-3.66%	NC
Long-Term Stay—75–84 Years	11.52	10.74	-6.77%	NC
Long-Term Stay—85+ Years	8.99	4.14	-53.95%	NC
Long-Term Stay—Total	11.33	9.48 ✓	-16.33%	NC
Managed Long-Term Services and Supports Minimizing Facility Length of Stay				
Observed Discharge Rate	NA	NA	—	NC
Expected Discharge Rate	NA	NA	—	NC
O/E Ratio	NA	NA	—	NC
Managed Long-Term Services and Supports Successful Transition After Long-Term Facility Stay				
Observed Discharge Rate	NA	NA	—	NC
Expected Discharge Rate	NA	NA	—	NC
O/E 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 health plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.
and ✓ indicates the health plan met or exceeded the target threshold established by MQD.

For the *Managed Long-Term Services and Supports Minimizing Institutional Length of Stay* and *Managed Long-Term Services and Supports Successful Transition After Long-Term Facility Stay* measures, HMSA QI did not have enough members in its eligible population to report valid rates; therefore, a status of NA (i.e., small denominator) was assigned. The measures in this domain did not have applicable benchmarks; therefore, no comparison to national benchmarks is presented.

HMSA QI met the MQD-established Quality Strategy targets for the *Managed Long-Term Services and Supports Admission to a Facility from the Community—Long-Term Stay—Total*.

Strengths

Based on HSAG's analyses of HMSA QI's 80 measure indicator rates comparable to benchmarks, 43 measure rates (53.75 percent) ranked at or above the 50th percentile, with 13 of these rates (16.25

percent) ranking at or above the 75th percentile and four rates (5 percent) ranking at or above the 90th percentile. Additionally, HMSA QI met 23 MQD Quality Strategy targets for MY 2024.

Areas for Improvement

Conversely, 37 of HMSA QI's measure indicator rates (46.25 percent) comparable to benchmarks fell below the 50th percentile, with 19 rates (23.75 percent) falling below the 25th percentile, suggesting significant opportunities for improvement.

Recommendations

HSAG recommends that HMSA QI focus on improving performance related to the following measures with rates that fell below the 25th percentile for the QI population:

- Within the Women's Health domain, the following measure indicator recommendations were identified:
  - Regarding the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator, HSAG recommends that HMSA QI consider further research and potential implementation of an incentive program focused on timely prenatal care visits. Additionally, HSAG recommends that HMSA QI consider leveraging opportunities to host campaigns and/or conduct member outreach activities to engage members in the importance of timely prenatal care. Further, HSAG recommends that HMSA QI consider exploring available programs and/or vendors that can provide additional services, such as appointment and transportation scheduling, pregnancy and parenting education, and pregnancy monitoring.
- Within the Care for Chronic Conditions domain, the following recommendations were identified:
  - Regarding the *Asthma Medication Ratio* measure, HSAG recommends that HMSA QI provide education to providers about establishing an asthma action plan with members. HSAG also recommends that HMSA QI utilize pharmacy data to identify members outside the asthma medication ratio and prioritize case management services for these members. HSAG further recommends that HMSA QI provide member education about medication adherence.
  - Regarding the *Controlling High Blood Pressure* measure, HSAG recommends that HMSA QI continue to identify trends within the data to identify which demographic groups and regions report lower blood pressure. HSAG recommends providing coverage for automated home blood pressure monitors for patients, while educating members about the benefits of this approach.[30] Further, HSAG recommends providing incentives to members and providers to encourage blood pressure control.
- Within the Behavioral Health domain, the following recommendations were identified:
  - Regarding the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure, HSAG recommends that HMSA QI consider

[30] Centers for Disease Control and Prevention. The Surgeon General's Call to Action to Control Hypertension. Available at: https://www.cdc.gov/high-blood-pressure/php/cta/index.html. Accessed on: Jan 6, 2026.

effective interventions to ensure annual screenings are conducted for people with schizophrenia, especially those taking antipsychotic medications. HSAG recommends that HMSA QI provide education to providers and members about the importance of diabetes screening tests and encourage timely follow-up for early detection and management.

– Regarding the *Follow-Up After Hospitalization for Mental Illness* measure, HSAG recommends that HMSA QI continue to focus on coordination of care for members discharged from an inpatient setting. HSAG recommends that HMSA QI consider effective interventions to reduce readmissions for members with mental illnesses.

Validation of Network Adequacy

HSAG evaluated and assessed the data methods that HMSA QI used to calculate results generated for each network adequacy indicator in the scope of the 2025 NAV activities. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that HMSA QI used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator.

Findings

Based on the results of the ISCA combined with the virtual audit and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the health plan's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each health plan according to the CMS EQR Protocol 4 and as defined in Table 3-33 of the Network Adequacy Indicator Validation Rating Determinations section of this report. Table 3-34 presents a summary of the NAV validation ratings for HMSA QI by indicator.

Table 3-33—Indicator-Level Validation Rating Categories

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

Table 3-34—Summary of HMSA QI Validation Ratings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Time and Distance	100%	0%	0%	0%

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Mandatory Provider Type	100%	0%	0%	0%
Provider Ratio	100%	0%	0%	0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 122 indicators; 12 were unable to be validated for HMSA QI. Of these indicators, 100 percent received *High Confidence* ratings.

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

HSAG determined that HMSA QI was compliant with network adequacy requirements for the Provider Ratios standard for all provider types. Compliance was determined based on the health plan meeting the State's Provider Ratio indicators. All indicators were calculated by MQD. Results are presented by provider type in Table 3-35.

Table 3-35—HMSA QI Network Adequacy Provider Ratios Compliance

Provider Type	Ratio	Results	Compliance
Hospitals on Oahu	5	17	*Met*
Hospitals on Kauai	1	3	*Met*
Hospitals on Lanai	1	1	*Met*
Hospitals on Maui	1	2	*Met*
Hospitals on Molokai	1	3	*Met*
Hospitals in East Hawaii	1	4	*Met*
Hospitals in West Hawaii	1	3	*Met*
PCPs (Adult)	1:300	1:92	*Met*
PCPs (Pediatric)	1:300	1:48	*Met*

HSAG determined that during the NAV review period, the Provider Ratios represented in Table 3-36 did not include members with SMI and SPMI diagnoses, as the guidance within the reporting template was not provided to the health plans until after the reporting period. This resulted in HSAG's *Unable to Validate* designation for each of the associated provider types.

Table 3-36—HMSA QI Network Adequacy Provider Ratios Unable to Validate

Provider Type
Behavioral Health Psychiatrists for members with an SMI or SPMI diagnosis. In geographic areas with a demonstrated shortage of qualified physicians, a psychiatric APRN-Rx may assume the role of psychiatrist.

Provider Type
Other Behavioral Health Providers to include Psychologists, Licensed Mental Health Counselors, Licensed Clinical Social Workers, and APRNs—Behavioral Health for members with an SMI or SPMI diagnosis.

HSAG determined that HMSA QI was compliant with network adequacy requirements for the Mandatory Provider Types standard for 42 of 46 indicators (91.3 percent). Compliance was determined based on the health plan meeting the State's Mandatory Provider Type indicators, which includes one servicing provider within each provider type. All indicators were calculated by MQD. Compliant results are presented by provider type in Table 3-37, and noncompliant results are presented in Table 3-38.

Table 3-37—HMSA QI Network Adequacy Mandatory Provider Types Compliance

Provider Type	Compliance
Audiologists	*Met*
Cardiologists	*Met*
Case Management Agencies	*Met*
DME	*Met*
Emergency Transportation Providers (both ground and air)	*Met**
Endocrinologists	*Met*
General Surgeons	*Met*
Geriatricians	*Met*
Hematologists	*Met*
Home Health Agencies and Hospices	*Met*
Infectious Disease Specialists	*Met*
LTSS: CCMA	*Met*
LTSS: Adult Day Care Facilities	*Met*
LTSS: Adult Day Health Facilities	*Met*
LTSS: E-ARCHs	*Met*
LTSS: CCFFH	*Met*
LTSS: Home-delivered meal providers	*Met*
LTSS: Non-Medical Transportation Providers	*Met*
LTSS: NFs	*Met*
LTSS: Personal Care Assistance Providers	*Met*
LTSS: PERS Providers	*Met*
LTSS: PDN	*Met*

Provider Type	Compliance
Laboratories which have either a CLIA 1988 certificate or a waiver of a certificate of registration	*Met*
Nephrologists	*Met*
Neurologists	*Met*
NET Providers (both ground and air)	*Met*
OB/GYNs	*Met*
Occupational Therapists	*Met*
Oncologists	*Met*
Ophthalmologists	*Met*
Optometrists	*Met*
Orthopedists	*Met*
Otolaryngologists	*Met*
Pediatric Specialists	*Met*
Pharmacies	*Met*
Physical Therapists	*Met*
Plastic Reconstructive Surgeons	*Met*
Providers of lodging and meals associated with obtaining necessary medical care	*Met*
Pulmonologists	*Met*
Radiologists	*Met*
Sign language interpreters and interpreters for languages other than English	*Met*
Urologists	*Met*

**Met* for a subset of provider types.

Table 3-38—HMSA QI Network Adequacy Mandatory Provider Types Noncompliance

Provider Type	Compliance
Community Health Workers	*Not Met*
LTSS: Respite Care Providers	*Not Met*
Licensed Dietitians	*Not Met*
Speech-Language Pathologists	*Not Met*

HSAG determined that during the NAV review period, the mandatory provider types represented in Table 3-39 were not included in the PNA reference tables and data submission format file used to report results; therefore, the health plan did not submit data allowing MQD to calculate compliance. This resulted in HSAG's *Unable to Validate* designation for each of the associated provider types.

Table 3-39—HMSA QI Network Adequacy Mandatory Provider Types *Unable to Validate Indicators*

Provider Type
CPs
LTSS: Certified Substance Abuse Counselors
LTSS: State Licensed Special Treatment Facilities for the Provision of Substance Abuse Therapy/Treatment
PAs

HSAG determined that HMSA QI was compliant with network adequacy requirements for a subset of the Time and Distance indicators. MQD required at least 85 percent of members to have access to the providers within the associated time or distance parameters. Compliance was determined based on the health plan meeting the State's Time and Distance indicators for both Urban and Rural classifications. All indicators were calculated by MQD. Results are presented by provider type and urbanicity in Table 3-40, and noncompliant results are presented in Table 3-41.

Table 3-40—HMSA QI Network Adequacy Time and Distance ≥85% Compliance by Urbanicity

Provider Type	Urbanicity	Compliance
24-Hour Pharmacies	Urban	100.0%
LTSS: Adult Day Care/Adult Day Health	Urban	97.3%
All Other Behavioral Health Providers	Urban	100.0%
	Rural	100.0%
Cardiologists	Urban	99.6%
	Rural	96.7%
Endocrinologists	Urban	90.9%
	Rural	93.4%
Hospitals	Urban	96.9%
	Rural	96.3%
Infectious Disease Specialists	Urban	96.6%
	Rural	85.2%
Nephrologists	Urban	98.6%
	Rural	89.6%
Neurologists	Urban	97.3%
	Rural	93.4%
OB/GYNs	Urban	99.9%
	Rural	96.4%

Provider Type	Urbanicity	Compliance
Oncologists	Urban	97.5%
	Rural	94.2%
Ophthalmologists	Urban	99.8%
	Rural	89.3%
Optometrists	Urban	99.9%
	Rural	96.1%
Orthopedists	Urban	98.5%
	Rural	93.5%
Other Specialists	Urban	100.0%
	Rural	99.3%
Otolaryngologists	Urban	96.6%
PCPs (Adult)	Urban	100.0%
	Rural	99.9%
PCPs (Child)	Urban	100.0%
	Rural	99.9%
Pharmacies (All)	Urban	98.7%
	Rural	97.6%
Pulmonologists	Urban	96.8%
Radiologists	Urban	99.9%
	Rural	97.1%
LTSS: Respite Care Facilities	Urban	100.0%
	Rural	100.0%
Surgeons (All Other)	Urban	99.2%
	Rural	95.7%
Urologists	Urban	96.8%
	Rural	89.2%

Table 3-41—HMSA QI Network Adequacy Time and Distance < 85% Noncompliance by Urbanicity

Provider Type	Urbanicity	Compliance
LTSS: Adult Day Care/Adult Day Health	Rural	78.7%
Hematologists	Urban	75.6%
	Rural	3.4%
Otolaryngologists	Rural	71.30%

Provider Type	Urbanicity	Compliance
Pediatric Specialists	Rural	61.9%
	Urban	80.9%
Plastic and Reconstructive Surgeons	Urban	75.8%
	Rural	63.9%
Pulmonologists	Rural	78.9%
Geriatricians	Urban	77.2%
	Rural	3.8%

HSAG determined that during the NAV review period, the Time and Distance provider types represented in Table 3-42 were not included in the PNA reference tables and data submission format file used to report results; therefore, the health plan did not submit data allowing MQD to calculate compliance. This resulted in HSAG's *Unable to Validate* designation for each of the associated provider types.

Table 3-42—HMSA QI Network Adequacy Time and Distance *Unable to Validate* Indicators

Provider Type
Emergency Services Facilities
LTSS: State Licensed Special Treatment Facilities for the Provision of Substance Abuse Therapy
LTSS: Certified Substance Abuse Counselors

Strengths

HMSA QI continues to demonstrate the ability to maintain current provider data through regular outreach to providers and processes implemented to validate the accuracy of its demographic information.

Areas for Improvement

- Of the 28 Urban provider types in scope of review, HMSA QI did not meet the 85 percent compliance threshold for the miles or minutes standard for four provider types. Of the 27 Rural provider types in scope of review, HMSA QI did not meet the 85 percent compliance threshold for the miles or minutes standard for seven provider types.
- HMSA QI did not meet four of the 46 Minimum Required Provider Type indicators.

Recommendations

- HSAG recommends that HMSA QI continue its recruiting and contracting efforts for provider specialties that did not meet the Time and Distance threshold. HSAG also recommends that HMSA

QI continue its recruiting and contracting efforts for (list all provider types) that did not meet the mandatory provider type standard.

- HSAG recommends that HMSA QI continue its recruiting and contracting efforts for those provider types that did not meet the Minimum Required Provider Types standard, with the goal of determining whether the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

Validation of Performance Improvement Projects

In CY 2025, HMSA QI continued the two PIPs initiated in CY 2022—*Behavioral Health Coordination* and *Plan All-Cause Readmissions*. For the CY 2025 submission, the health plan progressed to the Design, Implementation, and Outcomes stages of the PIPs and submitted Steps 1 through 8 in the PIP Submission Form. The PIPs were assessed for improvement in outcomes in Step 9.

HMSA QI also submitted the *Screening for Depression and Follow-Up Plan* PIP that was initiated in CY 2024. For this PIP, HMSA QI progressed to the Design and Implementation stages of the PIP and submitted Steps 1 through 8 in the PIP submission form. The PIP will be assessed for improvement in outcomes in next year's validation when Remeasurement 1 data will be reported.

Table 3-43 displays the topics, progression status, and measurement periods reported for the PIPs.

Table 3-43—CY 2025 HMSA QI PIP Topics and Status

PIP Topic	PIP Progression Status	Baseline Measurement Period	Measurement Period Reported in CY 2025
Behavioral Health Coordination	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	07/01/2021 to 09/30/2021	07/01/2024 to 09/30/2024 (Remeasurement 3)
Plan All-Cause Readmissions	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	CY 2021	CY 2024 (Remeasurement 3)
Screening for Depression and Follow-Up Plan	PIP Design and Implementation Stages (Steps 1 through 8)	CY 2024	CY 2024 (Baseline)

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

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

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

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

Findings

Table 3-44 illustrates the validation results for the three PIPs submitted by HMSA QI for CY 2025 validation.

Table 3-44—CY 2025 PIP Validation Results for HMSA QI

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

[1] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[2] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

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

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

methodology. For Validation Rating 2, HSAG assigned a *High Confidence* level rating that the PIP achieved significant improvement.

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

The *Screening for Depression and Follow-Up Plan* PIP was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. HMSA QI had not progressed to reporting remeasurement data and therefore the PIP was not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement.)

Design (Steps 1-6)

Behavioral Health Coordination

The selected PIP topic was required by MQD. HMSA QI's Aim statement set the focus of the PIP, and the eligible population was clearly defined. The performance indicators were developed in consultation and discussion with MQD and HSAG. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process.

Plan All-Cause Readmissions

The selected PIP topic was required by MQD, and the plan-specific historical and baseline data showed an opportunity for improvement. HMSA QI's Aim statement set the focus of the PIP and the eligible population was clearly defined. The performance indicator and data collection process were aligned with the HEDIS specifications.

Screening for Depression and Follow-Up Plan

The selected PIP topic was required by MQD. HMSA QI's Aim statement set the focus of the PIP and the eligible population was clearly defined. The performance indicators and data collection process were aligned with the CMS Child Core Set Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH) measure and CMS Adult Core Set Screening for Depression and Follow-Up Plan (CDF-AD) measure.

Implementation (Steps 7-8)

Behavioral Health Coordination

HMSA QI accurately reported and analyzed the Remeasurement 3 rate for the performance indicator. The health plan conducted accurate statistical testing between the measurement periods and provided narrative interpretations of the results. Appropriate quality improvement tools were utilized to conduct

its causal/barrier analysis and to prioritize the identified barriers. Interventions were implemented in a timely manner, were reasonably linked to the identified barriers, and have the potential to impact the performance indicator outcomes. HMSA QI documented that the MOA for data sharing between the health plan and DOH Behavioral Health Services Administration divisions was signed and was effective January 1, 2025. At the time of the PIP reporting, the data sharing had not yet started. The health plan was working toward implementation of data sharing per the MOA in discussion with other health plans and DOH agencies.

Plan All-Cause Readmissions

HMSA QI accurately reported and analyzed the Remeasurement 3 rate for the performance indicator. The health plan conducted accurate statistical testing between the measurement periods and provided narrative interpretations of the results. As part of the Readmissions Collaborative workgroup, the health plan identified barriers and deployed logical interventions linked to the barriers. HMSA QI included an evaluation of effectiveness for each intervention and appropriate next steps for the interventions.

Screening for Depression and Follow-Up Plan

HMSA QI accurately reported baseline rate for the performance indicators. Appropriate quality improvement tools were utilized to conduct causal/barrier analysis and the health plan initiated interventions that were reasonably linked to the identified barriers and have the potential to improve the performance indicator outcomes.

Outcomes (Step 9)

Behavioral Health Coordination

During Remeasurement 3, both performance indicators demonstrated statistically significant improvement over the baseline. The health plan documented sustained improvement in Performance Indicator 1 rate.

Plan All-Cause Readmissions

During Remeasurement 3, there was a decline in the performance indicator rate as compared to the baseline with an increase in the observed readmission rate.

Screening for Depression and Follow-Up Plan

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

Analysis of Results

Table 3-45 displays the data that the health plan reported for the *Behavioral Health Coordination* PIP.

Table 3-45—Outcomes for the *Behavioral Health Coordination* PIP

Performance Indicator	Baseline (07/01/2021–09/30/2021)		Remeasurement 1 (07/01/2022–09/30/2022)		Remeasurement 2 (07/01/2023–09/30/2023)		Remeasurement 3 (07/01/2024–09/30/2024)		Sustained Improvement
1. Percent of shared members with eligible trigger events who received a combined review in the past three months.	N: 7 D: 330	2.1%	N: 21 D: 165	12.7%*	N: 67 D:171	39.2%*	N: 48 D: 231	20.8%*	*Yes*
2. Percent of shared members whose data are actively shared at a regular frequency with partner agencies.	N: 98 D: 1,071	9.2%	N: 100 D: 1,190	8.4%	N: 114 D: 1,309	8.7%	N: 219 D: 1,354	16.2%*	*Not Assessed*

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

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. For Remeasurement 1, the Performance Indicator 1 rate increased to 12.7 percent and for Remeasurement 2, the rate was 39.2 percent. For Remeasurement 3, the rate was 20.8 percent, which represents a statistically significant increase of 18.7 percentage points over the baseline. HMSA QI documented that only formal combined reviews were counted in the numerator of the baseline rate; however, during the remeasurement periods, with system enhancements made to the health plan's care management platform Coreo Care, the health plan's care coordination team is now able to document interactions with partner agencies by selecting appropriate options from the drop-down menu. Therefore, both formal and informal combined reviews were captured.

The percentage of shared members whose data were actively shared with the partner agencies during the baseline measurement period was 9.2 percent. For Remeasurement 1, the Performance Indicator 2 rate decreased to 8.4 percent and for Remeasurement 2, the rate was 8.7 percent. For Remeasurement 3, the rate was 16.2 percent, which represents a statistically significant increase of 7 percentage points over the baseline. For the Performance Indicator 2 denominator, the health plan had information for shared members' with the Child & Adolescent Mental Health Division (CAMHD) and CCS only. The health plan indicated that it was unable to accurately identify all shared members with the Adult Mental Health Division (AMHD), Alcohol and Drug Abuse Division (ADAD), or Developmental Disabilities Division (DDD) until the time when MOA and member identification mechanisms are in place.

The health plan documented sustained improvement in Performance Indicator 1. Performance Indicator 2 did not achieve statistically significant improvement during previous remeasurement periods and therefore was not assessed for sustained improvement during Remeasurement 3.

Table 3-46 displays the data that the health plan reported for the *Plan All-Cause Readmissions* PIP.

Table 3-46—Outcomes for the *Plan All-Cause Readmissions* PIP

Performance Indicator	Baseline (01/01/2021–12/31/2021)		Remeasurement 1 (01/01/2022–12/31/2022)		Remeasurement 2 (01/01/2023–12/31/2023)		Remeasurement 3 (01/01/2024–12/31/2024)		Sustained Improvement
For members 18–64 years of age, the percent of acute inpatient and observed stays during the measurement year that were followed up by an unplanned acute readmission for any diagnosis within 30 days.	N: 332 D: 4,298	7.7%	N: 390 D: 4,702	8.3%	N: 396 D: 5,006	7.9%	N: 394 D: 4,657	8.5%	*Not Assessed*

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

The baseline (CY 2021) rate for the percentage of eligible discharges for which members 18–64 years of age had at least one acute readmission for any diagnosis within 30 days of the Index Discharge Date was 7.7 percent. For Remeasurement 1, the performance indicator rate increased to 8.3 percent and for Remeasurement 2, the rate was 7.9 percent. For Remeasurement 3, the rate was 8.5 percent, which represents a statistically nonsignificant increase (decline in performance) of 0.8 percentage points from the baseline.

The health plan was not assessed for sustained improvement because it had not achieved statistically significant improvement during previous remeasurement periods.

Table 3-47 displays the data that the health plan reported for the *Screening for Depression and Follow-Up Plan* PIP.

Table 3-47—Performance Indicator Results for the *Screening for Depression and Follow-Up Plan* PIP

Performance Indicator	Baseline (01/01/2024–12/31/2024)		Remeasurement 1 (01/01/2025–12/31/2025)		Sustained Improvement
1. Percentage of members ages 12 to 17 screened for depression on the date of the encounter or 14 days prior to the date of the	N: 12,242	50.8%			

Performance Indicator	Baseline (01/01/2024–12/31/2024)		Remeasurement 1 (01/01/2025–12/31/2025)		Sustained Improvement
encounter using an age-appropriate standardized depression screening tool and, if positive, a follow-up plan is documented on the date of the eligible encounter.	D: 24,121				
2. Percentage of members aged 18 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and, if positive, a follow-up plan is documented on the date of the eligible encounter.	N: 31,218 D: 102,387	30.5%			

The baseline rate for Performance Indicator 1 was 50.8 percent, and the baseline rate for Performance Indicator 2 was 30.5 percent.

Barriers/Interventions

Table 3-48 displays the barriers and interventions as documented by the health plan for each PIP.

Table 3-48—Interventions Implemented/Planned for HMSA QI PIPs

Barriers	Interventions
Behavioral Health Coordination (BH)	
1. No formal data sharing agreements between health plans and the DOH agencies that would allow bi-directional exchange of data pertaining to shared member population. 2. No established group of stakeholders with regularly scheduled meetings to discuss collaboration strategies. 3. Lack of a workflow to facilitate regular and effective communication among QUEST Integration Health Plans and partnering agencies. 4. Limited capability for data capture and reporting. Reliance on information entered in	1. Established a workgroup with partnering agencies that meets at least quarterly. 2. Developed a workflow for ongoing communication between health plan and partnering agencies. 3. Completion of MOA between other health plans and DOH agencies (AMHD, CAMHD, DDD, and ADAD). 4. Transition to new single platform that will combine pharmacy utilization, service authorization, member eligibility, and health coordination functions. 5. Weekly recurring schedule created for Inter-disciplinary Team (IDT) meetings between health plan and CCS. In addition, the IDT meeting template was expanded so that collaboration discussions become

Barriers	Interventions
text format and challenge with extracting that information for reporting. 5. Challenge in scheduling interdisciplinary team (IDT) meetings among multiple partnering agencies.	more effective by accessing members' behavioral and physical health information presented in the template.
Plan All-Cause Readmissions	
1. Members returning to the emergency room instead of accessing appropriate medical services. 2. Member not regularly seeking care for chronic conditions. 3. Members' lack of understanding of post-discharge planning. Care transition staff may not be effectively communicating with members to ensure they understood discharge instructions, medications, treatment plan, and action plan.	1. Members will be enrolled in HMSA's Event Driven Care (EDC) program and receive education from nurses via phone on the importance of managing chronic conditions, including regular visits to primary care providers, and the importance of accessing appropriate medical services. 2. Ensure member's attributed primary care provider (PCP) is correct. Members might be unaware if auto assigned and do not have a designated PCP. Educate members on the importance of managing chronic conditions provide appointment reminders to members. (Discontinued) 3. Develop and train EDC staff on the teach-back method. Teach back is a method to improve communication skills and has been associated with improved comprehension of discharge instructions. Using this method, the EDC nurse will communicate the member's discharge instructions, medications, treatment plan, and action plan. Then, the EDC nurse will ask the member to explain back in their own words, thereby validating that the EDC nurse communicated the information to the member and checked their understanding. Staff training on the method includes an overview and sample questionnaire; a tip sheet on how to incorporate teach-back into visits with members; a training video with links to additional online resources; an observation tool, 10 elements of competence, and coaching tips from Always Use Teach-Back.
Screening for Depression and Follow-Up Plan	
1. Lack of Documentation: While screenings are often completed, they are not consistently documented in the medical record, leading to gaps in data capture and reporting. 2. Incomplete Follow-Up: Positive screening results frequently lack documented follow-up	1. P4Q Incentive Program (Federally Qualified Health Centers [FQHCs]/Rural Health Centers [RHCs]): Providers will be rewarded with bonus payment annually for closure of gaps in care.

Barriers	Interventions
plans, which limits the ability to ensure appropriate care and track outcomes. 3. Limited Provider Incentives: Currently, there is one incentive program in place to encourage providers to complete and document depression screenings. However, only providers who are affiliated with Provider Organization (PO) groups are eligible to participate. 4. Low Clinical Priority: Depression screening is often deprioritized during patient visits due to competing demands and time constraints, resulting in missed opportunities for early identification and intervention.	

Strengths

- For all three PIPs, HMSA QI received an overall *High Confidence* level rating for overall confidence in adherence to acceptable methodology for all phases of the PIP for Steps 1 through 8.
- For the *Behavioral Health Coordination* PIP, during Remeasurement 3, both performance indicators achieved statistically significant improvement over the baseline.

Areas for Improvement

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

Recommendations

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

- HMSA QI must continually work on the PIPs throughout the year.
- For the *Behavioral Health Coordination* PIP, in addition to working with other health plans on the implementation of data sharing per the MOA with DOH agencies, the health plan must also review internal health plan-specific barriers toward implementation of the MOA and initiate appropriate interventions.
- For the *Plan All-Cause Readmissions* PIP:
  - HMSA QI should apply lessons learned and knowledge gained while conducting the PIP to future PIPs and other quality improvement efforts.
  - HMSA QI must continue with its efforts to decrease the observed readmission rate.

- For the *Screening for Depression and Follow-Up Plan* PIP, HMSA QI must ensure that the interventions are implemented in a timely manner to impact outcomes during the remeasurement period.
- HMSA QI must revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers and to see if any new barriers exist that require the development of interventions to drive improvement.
- HMSA QI must submit an intervention worksheet for each intervention listed in the Barriers/Interventions table in the PIP Submission Form.
- The intervention effectiveness measure in the intervention worksheet must not be the same as the performance indicator documented in Step 5. The effectiveness measure should be designed to measure the effectiveness of the specific intervention on addressing the barrier linked to that intervention.
- HMSA QI should collect the intervention effectiveness data more frequently (e.g., monthly, quarterly) unlike the annual performance indicator data. This would help HMSA QI understand intervention effectiveness and make any updates to the interventions in a timely manner to impact remeasurement outcomes.
- Intervention effectiveness data must guide next steps for each individual intervention.

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

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

Findings

Table 3-49 presents the 2025 scores for HMSA QI compared to the 2024 NCQA child Medicaid national averages, the corresponding 2023 scores, and the QI Program.

Table 3-49—Child CAHPS Results for HMSA QI

Measure	2023 HMSA QI Scores	2025 HMSA QI Scores	2025 QI Program Scores
Global Ratings			
Rating of Health Plan	72.07%	72.34%	71.65%
Rating of All Health Care	68.63%	68.97%	68.95%
Rating of Personal Doctor	80.60%	76.38%	76.22%
Rating of Specialist Seen Most Often	78.57%+	73.53%+	77.78%
Composite Measures			
Getting Needed Care	72.66%	72.27%+ L	80.76%
Getting Care Quickly	78.16%	83.37%+	81.10%

Measure	2023 HMSA QI Scores	2025 HMSA QI Scores	2025 QI Program Scores
How Well Doctors Communicate	93.99%	95.96%	94.25%
Customer Service	84.31%+	84.44%+	90.25%
Individual Item Measure			
Coordination of Care	84.71%+	80.00%+	87.77%

▲ *Indicates the 2025 score is statistically significantly higher than the 2023 score.*
▼ *Indicates the 2025 score is statistically significantly lower than the 2023 score.*
↑ *Indicates the 2025 score is statistically significantly higher than the QI Program.*
↓ *Indicates the 2025 score is statistically significantly lower than the QI Program.*
H *Indicates the 2025 score is statistically significantly higher than the NCQA national average.*
L *Indicates the 2025 score is statistically significantly lower than the NCQA national average.*
+ *Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.*

Strengths

- HMSA QI's 2025 top-box scores were not statistically significantly higher than the 2024 child Medicaid national averages, QI Program's 2025 top-box scores, or the 2023 top-box scores for any measure; therefore, no substantial strengths were identified.
- HMSA QI's 2025 top-box scores met or exceeded the RY 2025 target for the following measures: *Getting Care Quickly* and *How Well Doctors Communicate*.

Areas for Improvement

- HMSA QI's 2025 top-box score was statistically significantly lower than the 2024 NCQA child Medicaid national average for one measure, *Getting Needed Care*.

Recommendations

- HSAG recommends that HMSA QI continue to explore what may be the drivers of this lower experience score and develop initiatives designed to improve quality of care. In addition, HMSA QI should identify any barriers to accessing healthcare (e.g., transportation, geography) and work toward removing these barriers, so parents/caretakers of child members have better access to care.

Provider Survey

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

Findings

Table 3-50 presents the 2025 scores for HMSA QI compared to the QI Program and the corresponding 2023 scores, where applicable.

Table 3-50—Provider Survey Results for HMSA QI: Measure Scores

	2023 HMSA QI Scores	2025 HMSA QI Scores	2025 QI Program Scores
General Positions			
Compensation Satisfaction	41.20%	47.91%+	51.98%
Timeliness of Claims Payments	54.96%	40.18%+	40.57%
Prior Authorization Process Experience*			
Approval or Authorization Delayed	NT	73.84%+ NT	67.02%
Inconsistent Requirements	NT	73.25%+ NT↑	64.73%
Difficult to Navigate	NT	70.31%+ NT↑	64.75%
Labor Intensive	NT	61.50%+ NT	55.53%
Prior Authorization Process Impacts*			
Delayed Ability to Provide Treatments	NT	61.58%+ NT↑	53.47%
Disrupted Continuity of Care	NT	62.55%+ NT↑	52.62%
Created Administrative Burden	NT	50.11%+ NT	44.32%
Led to Denial of Service	NT	61.64%+ NT	59.57%
Formulary			
Formulary Impact on Care	31.81%	39.35%+	37.27%
Non-Formulary			
Adequate Access to Non-Formulary Drugs	40.08%	50.53%+ ↑	42.75%
Health Coordinators			
Helpfulness of Health Coordinators	43.37%	54.36%+	56.24%
Specialists			
Adequate Network of Specialists	49.38%	48.72%+ ↑	37.96%
Substance Abuse			
Access to Substance Abuse Treatment	28.53%+	41.70%+	42.04%

▲ *Indicates the 2025 score is statistically significantly higher than the 2023 score.*
▼ *Indicates the 2025 score is statistically significantly lower than the 2023 score.*
↑ *Indicates the 2025 score is statistically significantly higher than the QI Program.*
↓ *Indicates the 2025 score is statistically significantly lower than the QI Program.*
NT *Indicates this measure was not included in 2023; therefore, a trend analysis was unable to be performed for this measure.*
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
**Providers who responded 'No' for the survey questions within the Prior Authorization Process Experience and Impact domains, indicating they did not have a negative experience with the prior authorization process, were classified into the 'Satisfied' response category.*

Strengths

For HMSA QI, the 2025 top-box scores were statistically significantly higher than the QI Program's 2025 top-box scores for the following measures:

- *Inconsistent Requirements*
- *Difficult to Navigate*
- *Delayed Ability to Provide Treatments*
- *Disrupted Continuity of Care*
- *Adequate Access to Non-Formulary Drugs*
- *Adequate Network of Specialists*

The top-box scores for the following measures were higher in 2025 than in 2023, although no measure's top-box score was statistically significantly higher:

- *Compensation Satisfaction*
- *Formulary Impact on Care*
- *Adequate Access to Non-Formulary Drugs*
- *Helpfulness of Health Coordinators*
- *Access to Substance Abuse Treatment*

Areas for Improvement

HMSA QI's 2025 top-box scores were not statistically significantly lower than the 2023 top-box scores or the QI Program for any measure; however, the top-box score was lower in 2025 than in 2023 for the following measures:

- *Timeliness of Claims Payments*
- *Adequate Network of Specialists*

Recommendations

HSAG recommends that HMSA QI monitor the measures to ensure significant decreases in scores over time do not occur.

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

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 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 2025 compliance review was above average, meeting or exceeding the statewide compliance score for seven of the eight standards. HMSA QI achieved 100 percent compliance in six standards. 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.

Conversely, nearly half (46.25 percent) of HMSA QI's performance measures fell below the 50th percentile across all domains. While 23 MQD Quality Strategy targets were met in HEDIS MY 2024, HMSA QI should focus improvement efforts on Care for Chronic Conditions, Behavioral Health, and Women's Health measures that fell below the 25th percentile.

The results of the NAV activities revealed that HMSA QI had well-defined processes and procedures in place to ensure efficient and accurate collection of member and provider data to support network adequacy calculation and reporting. HMSA QI was compliant with the provider ratio requirements for all seven provider types that were able to be validated. While HMSA QI demonstrated high compliance with the Time and Distance standard for Urban provider types, one fourth of the Rural provider types showed noncompliance with the Time and Distance standard, indicating that the health plan should continue its recruiting and contracting efforts for those provider types.

HMSA QI progressed to the Outcomes stage of the two PIPs (*Behavioral Health Coordination* and *Plan All-Cause Readmissions*) that were initiated in CY 2022 and the Implementation stage for the *Screening for Depression and Follow-Up Plan* PIP initiated in CY 2024. The PIPs addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services.

The *Behavioral Health Coordination* PIP received a *High Confidence* level rating for overall confidence of adherence to acceptable methodology for all phases of the PIP and a *High Confidence* rating for overall confidence that the PIP achieved significant improvement. During Remeasurement 3, both performance indicators sustained statistically significant improvement over the baseline. Besides CCS and CAMHD, the health plan could not identify shared members with the remaining DOH partnering agencies. At the time of the PIP submission, the health plan was working toward implementation of data sharing per the MOA with DOH agencies.

The *Plan All-Cause Readmissions* PIP received a *High Confidence* level rating for overall confidence of adherence to acceptable methodology for all phases of the PIP and a *No Confidence* rating for overall confidence that the PIP achieved significant improvement. The documented PIP design and data were accurate. The health plan conducted appropriate quality improvement processes and participated in the

Readmissions Collaborative workgroup to identify barriers, and it deployed interventions that were logically linked to the identified barriers. However, for Remeasurement 3, the health plan had a decline in performance as compared to the baseline.

The *Screening for Depression and Follow-Up Plan* PIP received a *High Confidence* rating for adherence to acceptable methodology for all phases of the PIP. This performance suggests a sound PIP design, accurate reporting of data, and implementation of interventions that were related to barriers identified through quality improvement processes and have the potential to drive improvement in desired outcomes. HMSA QI had not progressed to reporting remeasurement data and was therefore not assessed for achievement of improvement.

HMSA QI's CAHPS results illustrate opportunities for improvement in parents/caretakers of child members' satisfaction. While none of the 2025 top-box scores were statistically significantly lower than the QI Program or 2023 scores, HMSA QI's 2025 top-box score was statistically significantly lower than the 2024 NCQA child Medicaid national average for one measure, *Getting Needed Care*. These results indicate the need for HMSA QI to implement improvement strategies to ensure parents/caretakers of child members have access to high-quality care.

While two of the nine CAHPS measures MQD selected for monitoring within its Quality Strategy met or exceeded the RY 2025 target, HMSA QI should focus improvement efforts on the *Coordination of Care, Customer Service, Getting Needed Care, Rating of All Health Care, Rating of Health Plan, Rating of Personal Doctor,* and *Rating of Specialist Seen Most Often* measures, as these measures did not meet the RY 2025 target.

HMSA QI's Provider Survey results demonstrated mixed results. Top-box scores for six measures were statistically significantly higher than the QI Program aggregate rates. While none of the top-box scores were statistically significantly higher or lower than the 2023 top-box scores, five measures scored higher in 2025 than in 2023. Conversely, the *Timeliness of Claims Payments* and *Adequate Network of Specialists* measures scored lower in 2025 than in 2023, indicating a need for HMSA QI to continue implementing strategies to ensure members have high-quality care and access to care.

Kaiser Foundation Health Plan QUEST Integration (KFHP QI) Results

Compliance Monitoring Review

The 2025 compliance monitoring review activity included evaluation of the health plan's compliance with State and federal requirements for organizational and structural performance.

Findings

Table 3-51 presents the standards and compliance scores for KFHP QI.

Table 3-51—Standards and Compliance Review Scores—KFHP QI

Standard #	Standard Name	Total # of Elements	Number of Elements		Total Compliance Score
			# Met	# Not Met	
I	Availability of Services	17	17	0	100%
II	Assurances of Adequate Capacity and Services	3	3	0	100%
III	Coordination and Continuity of Care	10	10	0	100%
IV	Confidentiality	10	10	0	100%
V	Coverage and Authorization of Services	31	31	0	100%
VI	Enrollee Information	19	19	0	100%
VII	Enrollee Rights and Protections	8	8	0	100%
VIII	Grievance and Appeal System	31	30	1	97%
	Totals	**129**	**128**	**1**	**99%**

Total Elements: The total number of applicable elements in each standard.
Total Compliance Score: The compliance scores were calculated by adding the ***Met*** elements and then dividing by the total number of applicable elements.

Strengths

KFHP QI achieved full compliance in seven of the eight standards reviewed, demonstrating strengths and adherence to all requirements measured in the following areas:

- Availability of Services
- Assurances of Adequate Capacity and Services
- Coordination and Continuity of Care
- Confidentiality
- Coverage and Authorizations of Services
- Enrollee Information
- Enrollee Rights and Protections

These findings suggest that KFHP QI developed the necessary policies, procedures, and processes to operationalize the federal regulations and contractual requirements.

Areas for Improvement

KFHP QI did not receive performance scores under 95 percent for any standard.

Recommendations

KFHP QI was required to develop a CAP to address and resolve one deficiency identified in the review. HSAG and MQD provided feedback on the proposed corrective action and KFHP QI was found to be in full compliance in September 2025.

Validation of Performance Measures—NCQA HEDIS Compliance Audits

NCQA HEDIS Compliance Audit Findings

HSAG's review team assessed KFHP QI's IS capabilities and its ability to process data for reporting accurate performance measure rates. KFHP QI was found to be fully compliant with all HEDIS IS standards, as well as IS standard L for assessing case management data for LTSS measures. This demonstrated that KFHP QI had effective IS processes and control procedures in place for reporting the required performance measure rates. KFHP QI presented eight supplemental data sources for consideration to use for supplementing its MY 2024 performance measure rates. HSAG determined six data sources to be nonstandard supplemental data, and the remaining two were considered standard supplemental data. No concerns were identified, and all eight supplemental data sources were approved for HEDIS MY 2024 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 MRRV was conducted for the *Blood Pressure Control for Patients With Diabetes; Controlling High Blood Pressure; Eye Exam for Patients With Diabetes; Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%—Total* and *Glycemic Status >9.0%—Total l; Prenatal and Postpartum Care—Timeliness of Prenatal Care* and *Postpartum Care;* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total, Counseling for Nutrition—Total,* and *Counseling for Physical Activity—Total* measure indicators, as well as all medical record exclusions. The final statistical CMRRV was conducted for *Long-Term Services and Supports Comprehensive Assessment and Update—Assessment of Core Elements* and *Assessment of Supplemental Elements, Long-Term Services and Supports Comprehensive Care Plan and Update—Care Plan With Core Elements Documented* and *Assessment of Supplemental Elements* as well as all medical record exclusions. All selected cases passed the final MRRV and CMRRV 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 3-52.

Table 3-52—KFHP QI's Results for QI Measures Under Access and Risk-Adjusted Utilization

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	58.57%	61.44%	4.90%	★
45–64 Years	73.25%	75.03%	2.43%	★
65+ Years	83.76%	84.24%	0.57%	★★★
Total	65.75%	68.15%	3.65%	★
Plan All-Cause Readmissions				
*Observed Readmissions—18–64 Years**	—	8.58%	—	NC
*Expected Readmissions—18–64 Years**	—	8.51%	—	NC
*O/E Ratio—18–64 Years**	—	1.0089	—	NC
PQI 08: Heart Failure Admission Rate				
*18–64 Years**	29.19	36.20	24.02%	NC
*65+ Years**	116.61	93.98	-19.41%	NC
*Total**	37.26	41.91 ✓	12.48%	NC
PQI 15: Asthma in Younger Adults Admission Rate				
*18–39 Years**	2.75	1.72 ✓	-37.45%	NC

** A lower rate indicates better performance.*
NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.
— Indicates that the health plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.
and ✓ indicates the health plan met or exceeded the target threshold established by MQD.
MY 2024 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

The *Adults' Access to Preventive/Ambulatory Health Services—65+ Years* indicator rate met or exceeded the 50th percentile. All other measure indicators in this domain did not meet or exceed the

50th percentile or did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented.

KFHP QI met the MQD-established Quality Strategy target for *PQI 08: Heart Failure Admission Rate—Total* and *PQI 15: Asthma in Younger Adults Admission Rate—18–39 Years*. All other MQD Quality Strategy targets were not met for this domain.

Children's Preventive Health Performance Measure Results

KFHP QI's Children's Preventive Health performance measure results are shown in Table 3-53.

Table 3-53—KFHP QI's Results for QI Measures Under Children's Preventive Health

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Child and Adolescent Well-Care Visits				
Total	42.94%	46.86%	9.13%	★★
Childhood Immunization Status				
Combination 3	68.65%	69.47% ✓	1.19%	★★★★
Combination 7	65.73%	66.55% ✓	1.25%	★★★★★
Combination 10	52.46%	51.18% ✓	-2.44%	★★★★★
DTaP	72.41%	73.06%	0.90%	★★★
Hepatitis A	82.34%	83.28%	1.14%	★★★
Hepatitis B	86.83%	86.53%	-0.35%	★★★
HiB	82.13%	84.40%	2.76%	★★★
Influenza	60.40%	59.82%	-0.96%	★★★★★
IPV	82.86%	84.62%	2.12%	★★
MMR	83.80%	83.61%	-0.23%	★★
Pneumococcal Conjugate	69.59%	71.16%	2.26%	★★
Rotavirus	77.95%	78.56%	0.78%	★★★★★
VZV	83.39%	82.94%	-0.54%	★★
Immunizations for Adolescents				
Combination 1	73.48%	73.70% ✓	0.30%	★
Combination 2	52.93%	51.90% ✓	-1.95%	★★★★★
Meningococcal	74.25%	74.28%	0.04%	★
Tdap	75.47%	75.89%	0.56%	★
HPV	54.25%	53.06%	-2.19%	★★★★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—3–11 Years	97.34%	96.38%	-0.99%	★★★★★

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
BMI Percentile—12–17 Years	95.71%	97.48%	1.85%	★★★★★
BMI Percentile—Total	96.77%	96.84% ✓	0.07%	★★★★★
Counseling for Nutrition—3–11 Years	97.72%	97.74%	0.02%	★★★★★
Counseling for Nutrition—12–17 Years	97.86%	98.74%	0.90%	★★★★★
Counseling for Nutrition—Total	97.77%	98.16% ✓	0.40%	★★★★★
Counseling for Physical Activity—3–11 Years	97.72%	97.29%	-0.44%	★★★★★
Counseling for Physical Activity—12–17 Years	97.86%	98.74%	0.90%	★★★★★
Counseling for Physical Activity—Total	97.77%	97.89% ✓	0.12%	★★★★★
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	72.10%	74.69% ✓	3.59%	★★★★★
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	80.11%	83.39% ✓	4.09%	★★★★★

and ✓indicates the health plan met or exceeded the target threshold established by MQD.

MY 2024 performance levels represent the following percentile comparisons:

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

Twenty-two of 30 measure rates that could be compared to national benchmarks met or exceeded the 50th percentile, including 17 rates that ranked at or above the 90th percentile. All indicators for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* and *Well-Child Visits in the First 30 Months of Life* measures met or exceeded the 90th percentile. For *Childhood Immunization Status,* nine indicators met or exceeded the 50th percentile and four met or exceeded the 90th percentile.

KFHP QI met MQD's established Quality Strategy targets for the following measure indicators:

- *Childhood Immunization Status—Combination 3*, *Combination 7*, and *Combination 10*
- *Immunizations for Adolescents—Combination 1* and *Combination* 2
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*
- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total*

- *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits*
- *Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits*

All other MQD Quality Strategy targets were not met for this domain.

Women's Health Performance Measure Results

KFHP QI's Women's Health performance measure results are shown in Table 3-54.

Table 3-54—KFHP QI's Results for QI Measures Under Women's Health

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Cervical Cancer Screening				
Cervical Cancer Screening	61.12%	61.22% ✓	0.16%	★★★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	90.63%	90.00% ✓	-0.70%	★★★★
Postpartum Care	85.07%	82.40% ✓	-3.14%	★★★
Timeliness of Prenatal Care—Under 21 Years	81.03%	84.09%	3.78%	NC
Postpartum Care—Under 21 Years	77.59%	88.64%	14.24%	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.
and ✓ indicates the health plan met or exceeded the target threshold established by MQD.
MY 2024 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

All three indicator rates in this domain that could be compared to benchmarks performed at or above the 50th percentile. Additionally, the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* indicator benchmarked at or above the 75th percentile. The *Prenatal and Postpartum Care—Timeliness of Prenatal Care—Under 21 Years* and *Postpartum Care—Under 21 Years* measure indicators in this domain did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented.

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

Care for Chronic Conditions Performance Measure Results

KFHP QI's Care for Chronic Conditions performance measure results are shown in Table 3-55.

Table 3-55—KFHP QI's Results for QI Measures Under Care for Chronic Conditions

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Asthma Medication Ratio				
5–11 Years	97.04%	97.86%	0.85%	★★★★★
12–18 Years	100.00%	93.75%	-6.25%	★★★★★
19–50 Years	81.31%	82.78%	1.81%	★★★★★
51–64 Years	90.91%	89.26%	-1.81%	★★★★★
Total	89.67%	89.38% ✓	-0.32%	★★★★★
5–18 Years	97.95%	96.81%	-1.16%	NC
19–64 Years	85.15%	85.15%	0.00%	NC
Blood Pressure Control for Patients With Diabetes				
Blood Pressure Control for Patients With Diabetes	76.32%	73.10% ✓	-4.22%	★★★
Concurrent Use of Opioids and Benzodiazepines				
*18–64 Years**	6.45%	6.48%	0.47%	NC
*65+ Years**	7.92%	7.32%	-7.58%	NC
*Total**	6.77%	6.67% ✓	-1.48%	NC
Controlling High Blood Pressure				
18–64 Years	71.43%	74.71%	4.59%	NC
65–85 Years	78.13%	78.21%	0.10%	NC
Total	73.68%	75.52% ✓	2.50%	★★★★★
Eye Exam for Patients With Diabetes				
Eye Exam for Patients With Diabetes	71.16%	70.83% ✓	-0.46%	★★★★★
Glycemic Status Assessment for Patients With Diabetes				
Glycemic Status <8.0%—18–64 Years	55.21%	57.10%	3.42%	NC
Glycemic Status <8.0%—65–75 Years	70.07%	66.23%	-5.48%	NC
Glycemic Status <8.0%—Total	58.02%	58.85% ✓	1.43%	★★★
*Glycemic Status >9.0%—18–64 Years**	33.35%	32.72%	-1.89%	NC
*Glycemic Status >9.0%—65–75 Years**	20.62%	23.38%	13.39%	NC
*Glycemic Status >9.0%—Total**	30.94%	30.92% ✓	-0.06%	★★★

** 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.

and ✓indicates the health plan met or exceeded the target threshold established by MQD.
MY 2024 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

All *Asthma Medication Ratio*, *Controlling High Blood Pressure—Total*, and *Eye Exam for Patients With Diabetes* indicators met or exceeded the 90th percentile. Additionally, the *Blood Pressure Control for Patients With Diabetes* and *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%—Total* and *Glycemic Status >9.0%—Total* met or exceeded the 50th percentile. All other indicators in this domain could not be compared to benchmarks or did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented.

KFHP QI met the established Quality Strategy target for *Asthma Medication Ratio—Total*, *Blood Pressure Control for Patients With Diabetes, Concurrent Use of Opioids and Benzodiazepines—Total*, *Controlling High Blood Pressure—Total*, *Eye Exam for Patients With Diabetes*, and *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%—Total* and *Glycemic Status >9.0%—Total*.

Behavioral Health Performance Measure Results

KFHP QI's Behavioral Health performance measure results are shown in Table 3-56.

Table 3-56—KFHP QI's Results for QI Measures Under Behavioral Health

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Antidepressant Medication Management				
Effective Acute Phase Treatment—18–64 Years	72.73%	77.53%	6.60%	NC
Effective Acute Phase Treatment—65+ Years	83.87%	NA	—	NC
Effective Acute Phase Treatment—Total	73.52%	77.96% ✓	6.04%	★★★★★
Effective Continuation Phase Treatment—18–64 Years	51.35%	52.84%	2.90%	NC
Effective Continuation Phase Treatment—65+ Years	48.39%	NA	—	NC
Effective Continuation Phase Treatment—Total	51.14%	53.32% ✓	4.26%	★★★★

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	86.61%	82.93% ✓	-4.25%	★★★
Follow-Up After Emergency Department Visit for Mental Illness				
7-Day Follow-Up—6–17 Years	NA	NA	—	NC
7-Day Follow-Up—18–64 Years	23.53%	27.34%	16.19%	★★
7-Day Follow-Up—65+ Years	NA	NA	—	NC
7-Day Follow-Up—Total	29.89%	28.57%	-4.42%	★
30-Day Follow-Up—6–17 Years	NA	NA	—	NC
30-Day Follow-Up—18–64 Years	46.32%	42.97%	-7.23%	★★
30-Day Follow-Up—65+ Years	NA	NA	—	NC
30-Day Follow-Up—Total	49.43%	45.96%	-7.02%	★
Follow-Up After Emergency Department Visit for Substance Use				
7-Day Follow-Up—13–17 Years	NA	NA	—	NC
7-Day Follow-Up—18+ Years	20.49%	20.63%	0.68%	★★
7 -Day Follow-Up—Total	20.00%	19.66%	-1.70%	★★
7-Day Follow-Up—18–64 Years	20.50%	20.37%	-0.63%	NC
7-Day Follow-Up—65+ Years	NA	NA	—	NC
30-Day Follow-Up—13–17 Years	NA	NA	—	NC
30-Day Follow-Up—18+ Years	39.02%	34.53%	-11.51%	★★
30-Day Follow-Up—Total	38.14%	33.76%	-11.48%	★★
30-Day Follow-Up—18–64 Years	39.50%	34.26%	-13.27%	NC
30-Day Follow-Up—65+ Years	NA	NA	—	NC
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—6–17 Years	78.95%	57.45%	-27.23%	★★★★
7-Day Follow-Up—18–64 Years	40.00%	41.60%	4.00%	★★★
7-Day Follow-Up—65+ Years	NA	NA	—	NC
7-Day Follow-Up—Total	48.24%	46.55% ✓	-3.50%	★★★
30-Day Follow-Up—6–17 Years	94.74%	72.34%	-23.64%	★★★
30-Day Follow-Up—18–64 Years	61.54%	60.80%	-1.20%	★★★
30-Day Follow-Up—65+ Years	NA	NA	—	NC
30-Day Follow-Up—Total	68.82%	64.37% ✓	-6.47%	★★★

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	66.67%	64.62% ✓	-3.07%	★★★★★
Continuation and Maintenance Phase	NA	NA	—	NC
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation of SUD Treatment—Total—13–17 Years	40.43%	34.69%	-14.20%	★
Initiation of SUD Treatment—Total—18–64 Years	28.21%	29.96%	6.20%	★
Initiation of SUD Treatment—Total—65+ Years	46.15%	48.15%	4.33%	★★★★
Initiation of SUD Treatment—Total—Total	29.92%	31.33%	4.71%	★
Engagement of SUD Treatment—Total—13–17 Years	21.28%	4.08%	-80.83%	★
Engagement of SUD Treatment—Total—18–64 Years	6.75%	9.60%	42.22%	★★
Engagement of SUD Treatment—Total—65+ Years	1.54%	3.70%	140.26%	★★
Engagement of SUD Treatment—Total—Total	7.09%	8.94%	26.09%	★★
Screening for Depression and Follow-Up Plan				
12–17 Years	1.56%	1.55%	-0.64%	NC
18–64 Years	6.08%	6.27%	3.13%	NC
65+ Years	8.60%	6.79%	-21.05%	NC
Total	5.47%	5.49%	0.37%	NC
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
1–11 Years	NA	NA	—	NC
12–17 Years	NA	NA	—	NC
Total	NA	NA	—	NC
Use of Pharmacotherapy for Opioid Use Disorder				
Rate 1: Total	57.38%	54.55% ✓	-4.93%	NC
Rate 2: Buprenorphine	45.90%	40.15% ✓	-12.53%	NC
Rate 3: Oral Naltrexone	0.00%	0.76%	—	NC
Rate 4: Long-Acting, Injectable Naltrexone	0.00%	0.00%	—	NC
Rate 5: Methadone	14.75%	15.15%	2.71%	NC

NA indicates that the health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.

— Indicates that the health plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.
and ✓indicates the health plan met or exceeded the target threshold established by MQD.
MY 2024 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*

KFHP QI met or exceeded the 90th percentile for the following measure indicator rates:

- *Antidepressant Medication Management— Effective Acute Phase Treatment—Total*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*

KFHP QI met the 75th to 89th percentile for the following measure indicator rates:

- *Antidepressant Medication Management—Effective Continuation Phase Treatment—Total*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—6–17 Years*
- *Initiation and Engagement of Substance Use Disorder Treatment—Initiation of SUD Treatment—Total—65+ Years*

KFHP QI met the 50th to 74th percentile for the following measure indicator rates:

- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—18–64 Years*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—6–17 Years*
- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—18–64 Years*
- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total*

All other measure indicators in this domain either did not meet the 50th percentile or did not have national benchmarks to compare for MY 2024.

KFHP QI met the MQD-established Quality Strategy Target for the following measure indicator rates:

- *Antidepressant Medication Management—Effective Acute Phase Treatment—Total* and *Effective Continuation Phase Treatment—Total*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* and *30-Day Follow-Up—Total*
- *Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase*

- *Use of Pharmacotherapy for Opioid Use Disorder—Rate 1:Total* and *Rate 2: Buprenorphine*

All other MQD Quality Strategy targets were not met for this domain.

Long-Term Services and Supports Performance Measure Results

KFHP QI's Long-Term Services and Supports performance measure results are shown in Table 3-57.

Table 3-57—KFHP QI's Results for QI Measures Under Long-Term Services and Supports

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Long-Term Services and Supports Comprehensive Assessment and Update				
Assessment of Core Elements	44.79%	22.87% ✓	-48.94%	NC
Assessment of Supplemental Elements	42.71%	18.00% ✓	-57.86%	NC
Long-Term Services and Supports Comprehensive Care Plan and Update				
Care Plan With Core Elements Documented	35.42%	15.09% ✓	-57.40%	NC
Assessment of Supplemental Elements	35.42%	15.09% ✓	-57.40%	NC
Managed Long-Term Services and Supports Admission to a Facility from the Community				
Short-Term Stay—18–64 Years	3.73	3.47	-6.97%	NC
Short-Term Stay—65–74 Years	11.02	4.82	-56.26%	NC
Short-Term Stay—75–84 Years	11.52	6.09	-47.14%	NC
Short-Term Stay—85+ Years	4.12	1.39	-66.26%	NC
Short-Term Stay—Total	5.84	3.71	-36.47%	NC
Medium-Term Stay—18–64 Years	1.16	3.87	233.62%	NC
Medium-Term Stay—65–74 Years	9.02	2.41	-73.28%	NC
Medium-Term Stay—75–84 Years	5.32	5.33	0.19%	NC
Medium-Term Stay—85+ Years	1.37	3.47	153.28%	NC
Medium-Stay—Total	2.79	3.82	36.92%	NC
Long-Term Stay—18–64 Years	21.20	11.62	-45.19%	NC
Long-Term Stay—65–74 Years	25.05	17.68	-29.42%	NC
Long-Term Stay—75–84 Years	50.53	27.42	-45.74%	NC
Long-Term Stay—85+ Years	43.24	21.54	-50.19%	NC
Long-Term Stay—Total	29.96	16.40 ✓	-45.26%	NC
Managed Long-Term Services and Supports Minimizing Facility Length of Stay				
Observed Discharge Rate	28.51%	NA	—	NC
Expected Discharge Rate	35.92%	NA	—	NC
O/E Ratio	0.7937	NA	—	NC
Managed Long-Term Services and Supports Successful Transition After Long-Term Facility Stay				
Observed Discharge Rate	1.33%	NA	—	NC

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Expected Discharge Rate	70.00%	NA	—	NC
O/E Ratio	0.0190	NA	—	NC

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

The measures in this domain did not have applicable benchmarks; therefore, no comparison to national benchmarks is presented. For the *Managed Long-Term Services and Supports Minimizing Institutional Length of Stay* and *Managed Long-Term Services and Supports Successful Transition After Long-Term Facility Stay* measures, KFHP QI did not have enough members in its eligible population to report valid rates; therefore, a status of NA (i.e., small denominator) was assigned.

KFHP QI met the MQD-established Quality Strategy target for the following measure indicator rates:

- *Long-Term Services and Supports Comprehensive Assessment and Update—Assessment of Core Elements*
- *Long-Term Services and Supports Comprehensive Assessment and Update—Assessment of Supplemental Elements*
- *Long-Term Services and Supports Comprehensive Care Plan and Update—Care Plan With Core Elements Documented*
- *Long-Term Services and Supports Comprehensive Care Plan and Update—Assessment of Supplemental Elements*
- *Managed Long-Term Services and Supports Admission to a Facility from the Community—Long-Term Stay—Total*

All other MQD Quality Strategy targets were not met for this domain.

Strengths

Based on HSAG's analyses of KFHP QI's 73 measure indicator rates comparable to benchmarks, 47 measure rates (64.38 percent) ranked at or above the 50th percentile, with 31 indicator rates (42.47 percent) meeting or exceeding the 75th percentile and 26 rates (35.62 percent) meeting or exceeding the 90th percentile, indicating strong performance across all domains. Additionally, KFHP QI met 35 MQD Quality Strategy targets for MY 2024.

Areas for Improvement

Conversely, 26 of KFHP QI's measure rates comparable to benchmarks (35.62 percent) fell below the 50th percentile, 12 of which (16.44 percent) fell below the 25th percentile, suggesting that some opportunities for improvement exist.

Recommendations

HSAG recommends that KFHP QI focus on improving performance related to the following measures with rates that fell below the 25th percentile for the QI population:

- Within the Behavioral Health domain, the following recommendations were identified:
  - Regarding the *Follow-Up After Emergency Department Visit for Mental Illness* measure, HSAG recommends that KFHP QI outreach to providers to ensure identification of members who have ED visits for mental illness to leverage discharge planning processes to facilitate scheduling member follow-up visits.
  - Regarding the *Initiation and Engagement of Substance Use Disorder Treatment* measure, HSAG recommends that KFHP QI review patient data for any patterns present by ZIP Code and other demographics for case management prioritization. For instance, one study suggests that members who are male and have a schizophrenia spectrum disorder diagnosis are less likely to initiate treatment, while current drug dependence and recent arrest were associated with lowered odds of engaging in treatment. Current drug dependence is associated with factors that make scheduling and attending treatment appointments difficult, such as severe symptoms, chaotic living situations, and self-care and life functioning issues.[31]

Validation of Network Adequacy

HSAG evaluated and assessed the data methods that KFHP QI used to calculate results generated for each network adequacy indicator in the scope of the 2025 NAV activities. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that KFHP QI used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator.

Findings

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

[31] Brown CH, Bennett ME, Li L, Bellack AS. Predictors of initiation and engagement in substance abuse treatment among individuals with co-occurring serious mental illness and substance use disorders. *Addictive Behaviors.* 2010;36(5):439-47.

and determined the final indicator-specific validation ratings for each health plan according to the CMS EQR Protocol 4 and as defined in Table 3-58 of the Network Adequacy Indicator Validation Rating Determinations section of this report. Table 3-59 presents a summary of the NAV validation ratings for KFHP by indicator.

Table 3-58—Indicator-Level Validation Rating Categories

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

Table 3-59—Summary of KFHP QI Validation Ratings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Time and Distance	100%	0%	0%	0%
Mandatory Provider Type	100%	0%	0%	0%
Provider Ratio	100%	0%	0%	0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 122 indicators; 12 were unable to be validated for KFHP QI. Of these indicators, 100 percent received *High Confidence* ratings.

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

HSAG determined that KFHP QI was compliant with network adequacy requirements for the Provider Ratios standard for four of nine indicators (44.44 percent). Compliance was determined based on the health plan meeting the State's Provider Ratio indicators. All indicators were calculated by MQD. Results are presented by provider type in Table 3-60.

Table 3-60—KFHP QI Network Adequacy Provider Ratios Compliance

Provider Type	Ratio	Results	Compliance
Hospitals on Oahu	5	12	*Met*
Hospitals on Kauai	1	0	*Not Met*
Hospitals on Lanai	1	0	*Not Met*
Hospitals on Maui	1	1	*Met*
Hospitals on Molokai	1	0	*Not Met*
Hospitals in East Hawaii	1	0	*Not Met*

Provider Type	Ratio	Results	Compliance
Hospitals in West Hawaii	1	0	*Not Met*
PCPs (Adult)	1:300	1:151	*Met*
PCPs (Pediatric)	1:300	1:292	*Met*

HSAG determined that during the NAV review period, the Provider Ratios represented in Table 3-61 did not include members with SMI and SPMI diagnoses, as the guidance within the reporting template was not provided to the health plan until after the reporting period. This resulted in HSAG's *Unable to Validate* designation for each of the associated provider types.

Table 3-61—KFHP QI Network Adequacy Provider Ratios Unable to Validate

Provider Type
Behavioral Health Psychiatrists for members with an SMI or SPMI diagnosis. In geographic areas with a demonstrated shortage of qualified physicians, a psychiatric APRN-Rx may assume the role of psychiatrist.
Other Behavioral Health Providers to include Psychologists, Licensed Mental Health Counselors, Licensed Clinical Social Workers, and APRNs—Behavioral Health for members with an SMI or SPMI diagnosis.

HSAG determined that KFHP QI was compliant with network adequacy requirements for the Mandatory Provider Types standard for 37 of 46 (80.4 percent) indicators. Compliance was determined based on the health plan meeting the State's Mandatory Provider Type indicators, which includes one servicing provider within each provider type. All indicators were calculated by MQD. Compliant results are presented by provider type in Table 3-62, and noncompliant results are presented in Table 3-63.

Table 3-62—KFHP QI Network Adequacy Mandatory Provider Types Compliance

Provider Type	Compliance
Audiologists	*Met*
Cardiologists	*Met*
Case Management Agencies	*Met*
DME	*Met*
Endocrinologists	*Met*
General Surgeons	*Met*
Geriatricians	*Met*
Hematologists	*Met*
Home Health Agencies and Hospices	*Met*
Infectious Disease Specialists	*Met*

Provider Type	Compliance
LTSS: CCMA	*Met*
LTSS: CCFFH	*Met*
LTSS: E-ARCHs	*Met*
LTSS: Home-Delivered Meal Providers	*Met*
LTSS: Non-Medical Transportation Providers	*Met*
LTSS: NFs	*Met*
LTSS: Personal Care Assistance Providers	*Met*
LTSS: PDN	*Met*
LTSS: Respite Care Providers	*Met*
Laboratories which have either a CLIA 1988 certificate or a waiver of a certificate of registration	*Met*
Nephrologists	*Met*
Neurologists	*Met*
NET Providers (both ground and air)	*Met*
OB/GYNs	*Met*
Occupational Therapists	*Met*
Oncologists	*Met*
Ophthalmologists	*Met*
Orthopedists	*Met*
Otolaryngologists	*Met*
Pediatric Specialists	*Met*
Pharmacies	*Met*
Physical Therapists	*Met*
Plastic Reconstructive Surgeons	*Met*
Pulmonologists	*Met*
Radiologists	*Met*
Speech-Language Pathologists	*Met*
Urologists	*Met*

Table 3-63—KFHP QI Network Adequacy Mandatory Provider Types Noncompliance

Provider Type	Compliance
Community Health Workers	*Not Met*
Emergency Transportation Providers (both ground and air)	*Not Met*
LTSS: PERS Providers	*Not Met*

Provider Type	Compliance
Licensed Dietitians	*Not Met*
Optometrists	*Not Met*
Providers of lodging and meals associated with obtaining necessary medical care	*Not Met*
Sign language interpreters and interpreters for languages other than English	*Not Met*
LTSS: Adult Day Care Facilities	*Not Met*
LTSS: Adult Day Health Facilities	*Not Met*

HSAG determined that during the NAV review period, the mandatory provider types represented in Table 3-64 were not included in the PNA reference tables and data submission format file used to report results; therefore, the health plan did not submit data allowing MQD to calculate compliance. This resulted in HSAG's *Unable to Validate* designation for each of the associated provider types.

Table 3-64—KFHP QI Network Adequacy Mandatory Provider Types *Unable to Validate* Indicators

Provider Type
CPs
LTSS: State Licensed Special Treatment Facilities for the Provision of Substance Abuse Therapy
LTSS: Certified Substance Abuse Counselors
PAs

HSAG determined that KFHP QI was compliant with network adequacy requirements for a subset of the Time and Distance indicators. MQD required at least 85 percent of members to have access to the providers within the associated time or distance parameters. Compliance was determined based on the health plan meeting the State's Time and Distance indicators for both Urban and Rural classifications. All indicators were calculated by MQD. Results are presented by provider type and urbanicity in Table 3-65, and noncompliant results are presented in Table 3-66.

Table 3-65—KFHP QI Network Adequacy Time and Distance ≥85% Compliance by Urbanicity

Provider Type	Urbanicity	Compliance
All Other Behavioral Health Providers	Urban	99.9%
	Rural	99.1%
Cardiologists	Rural	95.4%
Endocrinologists	Rural	91.4%
Geriatricians	Urban	88.0%
	Rural	96.7%
Infectious Disease Specialists	Rural	95.5%

Provider Type	Urbanicity	Compliance
Nephrologists	Urban	91.6%
	Rural	95.5%
Neurologists	Rural	95.5%
OB/GYNs	Urban	95.3%
	Rural	98.9%
Oncologists	Urban	85.0%
	Rural	95.4%
Ophthalmologists	Urban	88.0%
	Rural	96.7%
Orthopedists	Urban	91.8%
	Rural	97.1%
Other Specialists	Urban	94.7%
	Rural	97.3%
Otolaryngologists	Rural	95.4%
PCPs (Adult)	Urban	95.0%
	Rural	100.0%
PCPs (Child)	Urban	95.3%
	Rural	100.0%
Pediatric Specialists	Rural	92.5%
Pharmacies (All)	Rural	98.8%
Plastic and Reconstructive Surgeons	Rural	95.5%
Pulmonologists	Urban	88.7%
	Rural	99.0%
Radiologists	Rural	95.4%
LTSS: Respite Care Facilities	Urban	96.4%
	Rural	85.7%
Surgeons (All Other)	Urban	92.7%
	Rural	97.1%
Urologists	Rural	95.4%

Table 3-66—KFHP QI Network Adequacy Time and Distance < 85% Noncompliance by Urbanicity

Provider Type	Urbanicity	Compliance
Cardiologists	Urban	83.4%
Endocrinologists	Urban	68.9%

Provider Type	Urbanicity	Compliance
Hospitals	Urban	76.2%
	Rural	58.2%
Infectious Disease Specialists	Urban	82.8%
Neurologists	Urban	83.5%
Otolaryngologists	Urban	83.4%
Pediatric Specialists	Urban	81.9%
Pharmacies (All)	Urban	72.9%
Plastic and Reconstructive Surgeons	Urban	83.5%
Radiologists	Urban	83.4%
Urologists	Urban	83.4%
24-Hour Pharmacies	Urban	72.1%
Optometrists	Urban	0%
	Rural	0%
Hematologists	Urban	61.5%
	Rural	10.6%
LTSS: Adult Day Care/Adult Day Health	Urban	0%
	Rural	0%

HSAG determined that during the NAV review period, the Time and Distance provider types represented in Table 3-67 were not included in the PNA reference tables and data submission format file used to report results; therefore, the health plan did not submit data allowing MQD to calculate compliance. This resulted in HSAG's *Unable to Validate* designation for each of the associated provider types.

Table 3-67—KFHP QI Network Adequacy Time and Distance *Unable to Validate* Indicators

Provider Type
Emergency Services Facilities
LTSS: State Licensed Special Treatment Facilities for the Provision of Substance Abuse Therapy
LTSS: Certified Substance Abuse Counselors

Strengths

- KFHP QI continued to demonstrate the ability to maintain accurate and complete member data through its automated process to scan for 834 files every 30 minutes during business hours, use of electronic data file matches to identify existing members within the system, automated reports to

identify missing and incomplete data, and the weekly 1179 file process to report updates identified by the health plan to MQD.

- KFHP QI maintained detailed process documentation and validation for the creation of the data submission to MQD, ensuring consistent, timely, and accurate data reports.

Areas for Improvement

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

- Although KFHP QI continued to conduct outreach to providers via email every 90 days, KFHP QI did not have specific time frames during which providers were required to respond to the provider directory validation.
- KFHP QI labeled Optometrists under the incorrect Provider Group in its submission to MQD, resulting in a miscalculation.
- Of the 28 Urban provider types in scope of review, KFHP QI did not meet the 85 percent compliance threshold for the miles or minutes standard for 15 provider types. Of the 27 Rural provider types in scope of review, KFHP QI did not meet the 85 percent compliance threshold for the miles or minutes standard for four provider types.
- KFHP QI did not meet nine of the 46 Minimum Required Provider Type indicators.
- KFHP QI did not meet five of the nine Provider Ratio indicators.
- KFHP QI did not have specific time frame requirements for providers to notify KFHP QI of any provider data updates.

Recommendations

- HSAG recommends that KFHP QI establish time frames during which provider demographic changes are required to be reported to ensure that processes are in place for ongoing management and collection of updated demographic data.
- HSAG recommends KFHP QI conduct additional validation of provider data included on the provider-level data file to ensure providers are assigned to the correct provider group.
- HSAG recommends that KFHP QI continue its recruiting and contracting efforts for provider specialties that did not meet the Time and Distance threshold, with the goal of determining whether the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area. HSAG recommends that KFHP QI continue its recruiting and contracting efforts for those provider types that did not meet the Minimum Required Provider Types standard, with the goal of determining whether the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.
- HSAG recommends that KFHP QI continue its recruiting and contracting efforts for those provider types that did not meet the Provider Ratios standard, with the goal of determining whether the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area

- HSAG recommends that KFHP QI establish a time frame requiring providers to notify KFHP QI of any updates within a set number of days (e.g., one week, 30 days) and communicate the requirements to all providers to ensure accurate reporting of network adequacy data.

Validation of Performance Improvement Projects

In CY 2025, KFHP QI continued the two PIPs initiated in CY 2022—*Behavioral Health Coordination* and *Plan All-Cause Readmissions*. For the CY 2025 submission, the health plan progressed to the Design, Implementation, and Outcomes stages of the PIPs and submitted Steps 1 through 8 in the PIP Submission Form. The PIPs were assessed for improvement in outcomes in Step 9.

KFHP QI also submitted the *Screening for Depression and Follow-Up Plan* PIP that was initiated in CY 2024. For this PIP, KFHP QI progressed to the Design and Implementation stages of the PIP and submitted Steps 1 through 8 in the PIP submission form. The PIP will be assessed for improvement in outcomes in next year's validation when Remeasurement 1 data will be reported.

Table 3-68 displays the topics, progression status, and measurement periods reported for the PIPs.

Table 3-68—CY 2025 KFHP QI PIP Topics and Status

PIP Topic	PIP Progression Status	Baseline Measurement Period	Measurement Period Reported in CY 2024
Behavioral Health Coordination	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	07/01/2021 to 09/30/2021	07/01/2024 to 09/30/2024 (Remeasurement 3)
Plan All-Cause Readmissions	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	CY 2021	CY 2024 (Remeasurement 3)
Screening for Depression and Follow-Up Plan	PIP Design and Implementation Stages (Steps 1 through 8)	CY 2024	CY 2024 (Baseline)

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

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

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

Findings

Table 3-69 illustrates the validation results for the three PIPs submitted by KFHP QI for CY 2025 validation.

Table 3-69—CY 2025 PIP Validation Results for KFHP QI

PIP Topic	Validation Rating 1			Validation Rating 2		
	Overall Confidence in Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Behavioral Health Coordination	94%	100%	*High Confidence*	33%	100%	*Low Confidence*
Plan All-Cause Readmissions	100%	100%	*High Confidence*	33%	100%	*No Confidence*
Screening for Depression and Follow-Up Plan	100%	100%	*High Confidence*	*Not Assessed*[4]		

[1] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[2] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Confidence Level**— Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

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

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

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

methodology. For Validation Rating 2, HSAG assigned a *No Confidence* level rating that the PIP achieved significant improvement.

The *Screening for Depression and Follow-Up Plan* PIP was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. KFHP QI had not progressed to reporting remeasurement data and therefore the PIP was not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement.)

Design (Steps 1-6)

Behavioral Health Coordination

The selected PIP topic was required by MQD. KFHP QI's Aim statement set the focus of the PIP, and the eligible population was clearly defined. The performance indicators were developed in consultation and discussion with MQD and HSAG. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process.

Plan All-Cause Readmissions

The selected PIP topic was required by MQD, and the plan-specific historical and baseline data showed an opportunity for improvement. KFHP QI's Aim statement set the focus of the PIP and the eligible population was clearly defined. The performance indicator and data collection process were aligned with the HEDIS specifications.

Screening for Depression and Follow-Up Plan

The selected PIP topic was required by MQD. KFHP QI's Aim statement set the focus of the PIP and the eligible population was clearly defined. The performance indicators and data collection process were aligned with the CMS Child Core Set Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH) measure and CMS Adult Core Set Screening for Depression and Follow-Up Plan (CDF-AD) measure.

Implementation (Steps 7-8)

Behavioral Health Coordination

KFHP QI accurately reported and analyzed the Remeasurement 3 rate for the performance indicators. The health plan conducted accurate statistical testing between the measurement periods; however, there was opportunity for improvement in the narrative interpretations of the results. Appropriate quality improvement tools were utilized to conduct its causal/barrier analysis and to prioritize the identified barriers. Interventions were implemented in a timely manner, were reasonably linked to the identified barriers, and have the potential to impact the performance indicator outcomes. KFHP QI documented that the MOA for data sharing between the health plan and DOH Behavioral Health Services Administration divisions was signed and was effective January 1, 2025. At the time of the PIP reporting,

the data sharing had not yet started. The health plan was working toward implementation of data sharing per the MOA with the DOH agencies.

Plan All-Cause Readmissions

KFHP QI accurately reported and analyzed the Remeasurement 3 rate for the performance indicator. KFHP QI conducted appropriate quality improvement processes. As part of the Readmissions Collaborative workgroup, the health plan identified barriers, and it deployed logical interventions linked to the identified barriers. KFHP QI included an evaluation of effectiveness for each intervention and appropriate next steps for the interventions.

Screening for Depression and Follow-Up Plan

KFHP QI accurately reported baseline rate for the performance indicators. Appropriate quality improvement tools were utilized to conduct causal/barrier analysis and the health plan initiated interventions that were reasonably linked to the identified barriers and have the potential to impact the performance indicator outcomes

Outcomes (Step 9)

Behavioral Health Coordination

For this year's validation, KFHP QI progressed to reporting Remeasurement 3 results. For Remeasurement 3, Performance Indicator 1 demonstrated statistically nonsignificant improvement over the baseline; however, the Performance Indicator 2 rate was below the baseline rate.

Plan All-Cause Readmissions

For this year's validation, KFHP QI progressed to reporting Remeasurement 3 results. During Remeasurement 3, there was a statistically significant decline in performance as compared to the baseline.

Screening for Depression and Follow-Up Plan

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

Analysis of Results

Table 3-70 displays the data that the health plan reported for the *Behavioral Health Coordination* PIP.

Table 3-70—Outcomes for the *Behavioral Health Coordination* PIP

Performance Indicator	Baseline (07/01/2021–09/30/2021)		Remeasurement 1 (07/01/2022–09/30/2022)		Remeasurement 2 (07/01/2023–09/30/2023)		Remeasurement 3 (07/01/2024–09/30/2024)		Sustained Improvement
1. Percent of shared members with eligible trigger events who received a combined review in the past three months.	N: 3 D: 38	7.9%	N: 18 D: 48	37.5%*	N: 2 D: 40	5.0%	N: 7 D: 49	14.3%	*Not Assessed*
2. 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	N: 78 D: 477	16.4%	N: 68 D: 502	13.5%	*Not Assessed*

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

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. For Remeasurement 1, the Performance Indicator 1 rate increased to 37.5 percent and for Remeasurement 2, the rate decreased to 5.0 percent. For Remeasurement 3, the rate was 14.3 percent, which represents a decrease of 6.4 percentage points from 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 37.7 percent. For Remeasurement 1, the Performance Indicator 2 rate decreased to 20.9 percent and for Remeasurement 2, the rate was 16.4 percent. For Remeasurement 3, the rate was 13.5 percent, which represents a decrease of 24.2 percentage points from the baseline.

Both performance indicators did not achieve statistically significant improvement during previous remeasurement periods and therefore were not assessed for sustained improvement during Remeasurement 3.

Table 3-71 displays the data that the health plan reported for the *Plan All-Cause Readmissions* PIP.

Table 3-71—Outcomes for the *Plan All-Cause Readmissions* PIP

Performance Indicator	Baseline (01/01/2021–12/31/2021)		Remeasurement 1 (01/01/2022–12/31/2022)		Remeasurement 2 (01/01/2023–12/31/2023)		Remeasurement 3 (01/01/2024–12/31/2024)		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: 70 D: 939	7.5%	N: 77 D: 897	8.6%	*Not Assessed*

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

The baseline (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 and for Remeasurement 1, the performance indicator rate increased to 8.8 percent. For Remeasurement 2, the rate was 7.5 percent, which represents a statistically nonsignificant decrease (improvement in performance) of 0.1 percentage points from the baseline. For Remeasurement 3, the rate was 8.6 percent, which represents a statistically nonsignificant increase of 1.0 percentage point from the baseline.

The health plan has not achieved statistically significant improvement in the performance indicator rate at any remeasurement period and therefore was not assessed for sustained improvement.

Table 3-72 displays the data that the health plan reported for the *Screening for Depression and Follow-Up Plan* PIP.

Table 3-72—Performance Indicator Results for the *Screening for Depression and Follow-Up Plan* PIP

Performance Indicator	Baseline (01/01/2023–12/31/2023)		Remeasurement 1 (01/01/2024–12/31/2024)		Sustained Improvement
1. Percentage of members ages 12 to 17 screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter.	N: 1,786 D: 4,610	38.7%			
2. Percentage of members aged 18 and older screened for depression on the date of the encounter or 14 days prior to the date of the	N: 1,962	9.2%			

Performance Indicator	Baseline (01/01/2023–12/31/2023)		Remeasurement 1 (01/01/2024–12/31/2024)		Sustained Improvement
encounter using an age-appropriate standardized depression screening tool, and, if positive, a follow-up plan is documented on the date of the eligible encounter.	D: 21,240				

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

The baseline rate for Performance Indicator 1 was 38.7 percent, and the baseline rate for Performance Indicator 2 was 9.2 percent.

Barriers/Interventions

Table 3-73 displays the barriers and interventions as documented by the health plan for each PIP.

Table 3-73—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. Having a workgroup with partnering agencies that meets at least on a quarterly basis. 2. Develop a workflow for ongoing communication between health plan and partnering agencies. 3. MOA is fully executed. Work toward establishing the method of data transfer/sharing.
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 members discharged with readmission risk score of ≥19.
Screening for Depression and Follow-Up Plan	
1. Do not capture interventions for positive screening without the use of G-codes. 2. The Patient Health Questionnaire (PHQ) screening tool uses different names.	1. Accurate data collection for same-day intervention. 2. Capturing PHQ screening due to tool name variations. 3. Ensuring consistent follow-up for members who screen positive for depression.

Barriers	Interventions
3. Inconsistency in follow-up for individuals who screen positive for depression.	

Strengths

All of KFHP QI's PIPs received Met validation scores for 100 percent of all applicable evaluation elements validated for acceptable methodology for all phases of the PIP.

Areas for Improvement

For the *Behavioral Health Coordination* and *Plan All-Cause Readmissions* PIPs, KFHP QI has an opportunity for improvement in achievement of statistically significant improvement in the performance indicator rates.

Recommendations

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

- KFHP QI must continually work on the PIPs throughout the year.
- For the *BH* PIP,
  - In addition to working with other health plans on the implementation of data sharing per the MOA with DOH agencies, the health plan must also review internal health plan-specific barriers toward implementation of the MOA and initiate appropriate interventions.
  - There was a significant decrease in data sharing with CCS as compared to the baseline. The health plan must revisit and identify additional barriers toward ongoing data sharing and combined reviews with CCS and consider interventions to address those barriers.
- For the *PCR* PIP:
  - KFHP QI should apply lessons learned and knowledge gained while conducting the PIP to future PIPs and other quality improvement efforts.
- For the *Screening for Depression and Follow-Up Plan* PIP, KFHP QI must ensure that the interventions are implemented in a timely manner to impact outcomes during the remeasurement period.
- KFHP QI must revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers and to see if any new barriers exist that require the development of interventions to drive improvement.
- KFHP QI must submit an intervention worksheet for each intervention listed in the Barriers/Interventions table in the PIP Submission Form.
- The intervention effectiveness measure in the intervention worksheet must not be the same as the performance indicator documented in Step 5. The effectiveness measure should be designed to

measure the effectiveness of the specific intervention on addressing the barrier linked to that intervention.

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

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

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

Findings

Table 3-74 presents the 2025 scores for KFHP QI compared to the 2024 NCQA child Medicaid national averages, the corresponding 2023 scores, and the QI Program.

Table 3-74—Child CAHPS Results for KFHP QI

Measure	2023 KFHP QI Scores	2025 KFHP QI Scores	2025 QI Program Scores
Global Ratings			
Rating of Health Plan	74.87%	74.77%	71.65%
Rating of All Health Care	68.14%	70.39%	68.95%
Rating of Personal Doctor	77.56%	79.47%	76.22%
Rating of Specialist Seen Most Often	76.00%+	80.00%+	77.78%
Composite Measures			
Getting Needed Care	78.58%	88.18% ↑ ▲	80.76%
Getting Care Quickly	81.92%	84.47%	81.10%
How Well Doctors Communicate	94.55%	94.84%	94.25%
Customer Service	90.63%+	96.21%+ ↑ H	90.25%
Individual Item Measure			
Coordination of Care	91.51%	93.00% ↑ H	87.77%

▲ *Indicates the 2025 score is statistically significantly higher than the 2023 score.*
▼ *Indicates the 2025 score is statistically significantly lower than the 2023 score.*
↑ *Indicates the 2025 score is statistically significantly higher than the QI Program.*
↓ *Indicates the 2025 score is statistically significantly lower than the QI Program.*
H *Indicates the 2025 score is statistically significantly higher than the NCQA national average.*
L *Indicates the 2025 score is statistically significantly lower than the NCQA national average.*
+ *Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.*

Strengths

- KFHP QI's 2025 top-box scores were statistically significantly higher than the 2024 NCQA child Medicaid national averages for the following measures: *Customer Service* and *Coordination of Care*.
- KFHP QI's 2025 top-box scores were statistically significantly higher than the QI Program's 2025 top-box scores for the following measures: *Getting Needed Care*, *Customer Service*, and *Coordination of Care*.
- KFHP QI's 2025 top-box score was statistically significantly higher than the 2023 top-box score for one measure, *Getting Needed Care*.
- KFHP QI's 2025 top-box scores met or exceeded the RY 2025 target for the following measures: *Coordination of Care, Customer Service, Getting Care Quickly, Getting Needed Care, Rating of All Health Care,* and *Rating of Specialist Seen Most Often*.

Areas for Improvement

- KFHP QI's 2025 top-box scores were not statistically significantly lower than the 2024 NCQA child Medicaid national averages, QI Program's 2025 top-box scores, or 2023 top-box scores for any measure; therefore, no areas for improvement were identified.

Recommendations

- HSAG recommends that KFHP QI monitor the measures to ensure significant decreases in scores over time do not occur.

Provider Survey

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

Findings

Table 3-75 presents the 2025 scores for KFHP QI compared to the QI Program and the corresponding 2023 scores, where applicable.

Table 3-75—Provider Survey Results for KFHP QI: Measure Scores

	2023 KFHP QI Scores	2025 KFHP QI Scores	2025 QI Program Scores
General Positions			
Compensation Satisfaction	62.20%$^{+}$	79.41%$^{+}$ ↑	51.98%
Timeliness of Claims Payments	52.94%$^{+}$	NA	40.57%
Prior Authorization Process Experience*			

	2023 KFHP QI Scores	2025 KFHP QI Scores	2025 QI Program Scores
Approval or Authorization Delayed	NT	100.00%+ NT↑	67.02%
Inconsistent Requirements	NT	85.71%+ NT↑	64.73%
Difficult to Navigate	NT	84.62%+ NT	64.75%
Labor Intensive	NT	84.62%+ NT↑	55.53%
Prior Authorization Process Impacts*			
Delayed Ability to Provide Treatments	NT	92.31%+ NT↑	53.47%
Disrupted Continuity of Care	NT	92.31%+ NT↑	52.62%
Created Administrative Burden	NT	76.92%+ NT↑	44.32%
Led to Denial of Service	NT	92.31%+ NT↑	59.57%
Formulary			
Formulary Impact on Care	48.89%+	60.53%+ ↑	37.27%
Non-Formulary			
Adequate Access to Non-Formulary Drugs	82.42%+	76.32%+ ↑	42.75%
Health Coordinators			
Helpfulness of Health Coordinators	82.42%+	94.59%+ ▲↑	56.24%
Specialists			
Adequate Network of Specialists	73.96%+	64.10%+ ↑	37.96%
Substance Abuse			
Access to Substance Abuse Treatment	52.33%+	72.73%+ ▲↑	42.04%

▲ *Indicates the 2025 score is statistically significantly higher than the 2023 score.*
▼ *Indicates the 2025 score is statistically significantly lower than the 2023 score.*
↑ *Indicates the 2025 score is statistically significantly higher than the QI Program.*
↓ *Indicates the 2025 score is statistically significantly lower than the QI Program.*
Results based on fewer than 11 respondents were suppressed and noted as "NA".
NT *Indicates this measure was not included in 2023; therefore, a trend analysis was unable to be performed for this measure.*
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
**Providers who responded 'No' for the survey questions within the Prior Authorization Process Experience and Impact domains, indicating they did not have a negative experience with the prior authorization process, were classified into the 'Satisfied' response category.*

Strengths

KFHP QI's 2025 top-box scores were statistically significantly higher than the QI Program's 2025 top-box scores for the following measures:

- *Compensation Satisfaction*

- *Approval or Authorization Delayed*
- *Inconsistent Requirements*
- *Labor Intensive*
- *Delayed Ability to Provide Treatments*
- *Disrupted Continuity of Care*
- *Created Administrative Burden*
- *Led to Denial of Service*
- *Formulary Impact on Care*
- *Adequate Access to Non-Formulary Drugs*
- *Helpfulness of Health Coordinators*
- *Adequate Network of Specialists*
- *Access to Substance Abuse Treatment*

KFHP QI's 2025 top-box scores were statistically significantly higher than the 2023 top-box scores for the following measures:

- *Helpfulness of Health Coordinators*
- *Access to Substance Abuse Treatment*

Areas for Improvement

KFHP QI's 2025 top-box scores were not statistically significantly lower than the 2023 top-box scores or the QI Program for any measure; however, the top-box score was lower in 2025 than in 2023 for the following measures:

- *Adequate Access to Non-Formulary Drugs*
- *Adequate Network of Specialists*

Recommendations

HSAG recommends that KFHP QI monitor the measures to ensure significant decreases in scores over time do not occur.

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

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 its structure and operations support core processes for providing care and services and promoting quality outcomes. KFHP QI's performance during the 2025 compliance review was above average, meeting or exceeding the statewide compliance score for all eight standards. KFHP QI achieved 100 percent compliance in seven standards. KFHP QI was required to develop a CAP to address and resolve the deficiency identified in the review. HSAG and MQD provided feedback on the proposed corrective action and KFHP QI was found to be in full compliance in September 2025.

KFHP QI continued to show strong performance in quality, timeliness, and access to care measures. Overall, more than half (64.38 percent) of KFHP QI's measure rates ranked at or above the 50th percentile across all domains, with less than half (42.47 percent) of the measure rates ranking at or above the 75th percentile. Conversely, 26 of KFHP QI's measure rates (35.62 percent) fell below the 50th percentile. KFHP QI's performance demonstrated a few areas for improvement, including the Behavioral Health domain. KFHP QI's measure rates met 35 MQD Quality Strategy targets.

The results of the NAV activities revealed that KFHP QI demonstrated the ability to maintain accurate and complete member data through various automated processes and reports. While KFHP QI demonstrated high compliance with the Time and Distance standard for Rural provider types, more than 50 percent of the Urban provider types showed noncompliance with the Time and Distance standard, indicating that the health plan should continue its recruiting and contracting efforts for those provider types.

KFHP QI progressed to the Outcomes stage of the two PIPs (*Behavioral Health Coordination* and *Plan All-Cause Readmissions*) that were initiated in CY 2022 and the Implementation stage for the *Screening for Depression and Follow-Up Plan* PIP initiated in CY 2024. The PIPs addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services.

The *Behavioral Health Coordination* PIP received a *High Confidence* level rating for overall confidence of adherence to acceptable methodology for all phases of the PIP and a *Low Confidence* level rating for overall confidence that the PIP achieved significant improvement. For Remeasurement 3, Performance Indicator 1 demonstrated statistically nonsignificant improvement over the baseline; however, the Performance Indicator 2 rate was below the baseline rate. At the time of the PIP submission, the health plan was working toward implementation of data sharing per the MOA with DOH agencies.

The *Plan All-Cause Readmissions* PIP received a *High Confidence* level rating for overall confidence of adherence to acceptable methodology for all phases of the PIP and a *No Confidence* rating for overall confidence that the PIP achieved significant improvement. The documented PIP design and data were accurate. The health plan conducted appropriate quality improvement processes and participated in the Readmissions Collaborative workgroup to identify barriers, and it deployed interventions that were logically linked to the identified barriers. However, for Remeasurement 3, the health plan had a decline in performance as compared to baseline.

The *Screening for Depression and Follow-Up Plan* PIP received a *High Confidence* level rating for adherence to acceptable methodology for all phases of the PIP. This performance suggests a sound PIP design, accurate reporting of data, and implementation of interventions that were related to barriers identified through quality improvement processes and have the potential to drive improvement in desired outcomes. KFHP QI had not progressed to reporting remeasurement data and was therefore not assessed for achievement of improvement.

KFHP QI's CAHPS survey results showed that the 2025 top-box scores were not statistically significantly lower than the QI Program, 2024 NCQA child Medicaid national averages, or 2023 top-box scores for any measure; therefore, no substantial opportunities for improvement were identified. These results indicate that KFHP QI should continue to monitor the measures to ensure significant decreases in scores over time do not occur.

While six of the nine CAHPS measures MQD selected for monitoring within its Quality Strategy met or exceeded the RY 2025 target, KFHP QI should focus improvement efforts on the *How Well Doctors Communicate, Rating of Health Plan,* and *Rating of Personal Doctor* measures, as these measures did not meet the RY 2025 target.

KFHP QI's Provider Survey results demonstrated high levels of satisfaction among providers. Top-box scores for 13 measure results were statistically significantly higher than the QI Program aggregate rates. While KFHP QI's 2025 top-box scores were not statistically significantly lower than the 2023 top-box scores or the QI Program for any measure; the top-box score was lower in 2025 than in 2023 for *Adequate Access to Non-Formulary Drugs* and *Adequate Network of Specialists*. KFHP QI should continue implementing strategies to ensure members have high-quality care and access to care.

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

Compliance Monitoring Review

The 2025 compliance monitoring review activity included evaluation of the health plan’s compliance with State and federal requirements for organizational and structural performance.

Findings

Table 3-76 presents the standards and compliance scores for ‘Ohana QI.

Table 3-76—Standards and Compliance Review Scores—‘Ohana QI

Standard #	Standard Name	Total # of Elements	Number of Elements		Total Compliance Score
			# Met	# Not Met	
I	Availability of Services	17	17	0	100%
II	Assurances of Adequate Capacity and Services	3	3	0	100%
III	Coordination and Continuity of Care	10	10	0	100%
IV	Confidentiality	10	10	0	100%
V	Coverage and Authorization of Services	31	31	0	100%
VI	Enrollee Information	19	19	0	100%
VII	Enrollee Rights and Protections	8	8	0	100%
VIII	Grievance and Appeal System	31	25	6	81%
	Totals	**129**	**123**	**6**	**95%**

Total Elements: The total number of applicable elements in each standard.
Total Compliance Score: The compliance scores were calculated by adding the ***Met*** elements and then dividing by the total number of applicable elements.

Strengths

‘Ohana QI achieved full compliance in seven of the eight standards reviewed, demonstrating strengths and adherence to all requirements measured in the following areas:

- Availability of Services
- Assurances of Adequate Capacity and Services
- Coordination and Continuity of Care
- Confidentiality
- Coverage and Authorization of Services
- Enrollee Information
- Enrollee Rights and Protections

These findings suggest that ‘Ohana QI developed the necessary policies, procedures, and processes to operationalize the federal regulations and contractual requirements.

Areas for Improvement

The areas with the greatest opportunity for improvement were related to the following, as these areas received performance scores under 95 percent:

- Grievance and Appeal System

These findings suggest that ‘Ohana QI did not always develop and implement the necessary policies, procedures, and processes required of the federal regulations and its health plan contract with MQD.

Recommendations

Of the 129 elements, ‘Ohana QI received *Not Met* scores for six elements. ‘Ohana QI was required to develop a CAP to address and resolve deficiencies identified in the review. HSAG and MQD provided feedback on the proposed corrective actions and ‘Ohana QI was found to be in full compliance in December 2025.

Validation of Performance Measures—NCQA HEDIS Compliance Audits

NCQA HEDIS Compliance Audit Findings

HSAG’s review team assessed ‘Ohana QI’s IS capabilities and its ability to process data for reporting accurate performance measure rates. ‘Ohana QI was found to be fully compliant with all HEDIS IS standards, as well as IS standard L for assessing case management data for LTSS measures. This demonstrated that ‘Ohana QI had effective IS processes and control procedures for reporting the required performance measure rates. ‘Ohana QI presented 33 supplemental data sources for consideration to use for supplementing its MY 2024 performance measure rates. HSAG determined seven data sources to be standard supplemental data, and the remaining 11 were considered nonstandard supplemental data. ‘Ohana QI withdrew 14 supplemental data sources, leaving 15 standard data sources and four nonstandard data sources. No concerns were identified, and the 15 standard and four nonstandard data sources were approved for HEDIS MY 2024 reporting.

‘Ohana 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, ‘Ohana QI was not required to undergo convenience sample validation. The final statistical MRRV was conducted for the *Childhood Immunization Status—Combination 10, Controlling High Blood Pressure, Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%—Total,* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total* measure indicators, as well as all medical record exclusions. The final statistical CMRRV was conducted for *Long-Term Services and Supports Comprehensive Assessment and Update—Assessment of Core Elements* and *Assessment of Supplemental Elements, Long-Term Services and Supports Comprehensive Care Plan and*

Update—Care Plan With Core Elements Documented and *Assessment of Supplemental Elements* as well as all medical record exclusions. All selected cases passed the final MRRV and CMRRV without any critical errors.

All measures under the scope of the audit were determined to be *Reportable*. 'Ohana QI was determined to be fully compliant with all IS standards, including IS standard L for assessing case management data; therefore, HSAG did not have any recommendations for 'Ohana QI.

Access and Risk-Adjusted Utilization Performance Measure Results

'Ohana QI's Access and Risk-Adjusted Utilization performance measure results are shown in Table 3-77.

Table 3-77—'Ohana QI's Results for QI Measures Under Access and Risk-Adjusted Utilization

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	48.95%	50.41%	2.98%	★
45–64 Years	68.40%	70.02%	2.37%	★
65+ Years	80.72%	81.49%	0.95%	★★★
Total	60.70%	62.45%	2.88%	★
Plan All-Cause Readmissions				
*Observed Readmissions—18–64 Years**	—	9.37%	—	NC
*Expected Readmissions—18–64 Years**	—	9.93%	—	NC
*O/E Ratio—18–64 Years**	—	0.9434	—	NC
PQI 08: Heart Failure Admission Rate				
*18–64 Years**	72.61	85.38	17.59%	NC
*65+ Years**	196.03	177.24	-9.59%	NC
*Total**	91.17	98.78	8.35%	NC
PQI 15: Asthma in Younger Adults Admission Rate				
*18–39 Years**	2.71	1.99 ✓	-26.57%	NC

** A lower rate indicates better performance.*
NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.
— Indicates that the health plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.
and ✓ indicates the health plan met or exceeded the target threshold established by MQD.
MY 2023 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

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

'Ohana QI met the MQD-established Quality Strategy target for *PQI 15: Asthma in Younger Adults Admission Rate—18–39 Years*. All other MQD Quality Strategy targets were not met for this domain.

Children's Preventive Health Performance Measure Results

'Ohana QI's Children's Preventive Health performance measure results are shown in Table 3-78.

Table 3-78—'Ohana QI's Results for QI Measures Under Children's Preventive Health

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Child and Adolescent Well-Care Visits				
Total	36.67%	43.93%	19.80%	★
Childhood Immunization Status				
Combination 3	36.72%	48.99%	33.42%	★
Combination 7	29.25%	43.77%	49.64%	★
Combination 10	19.70%	30.72%	55.94%	★★★
DTaP	46.87%	56.52%	20.59%	★
Hepatitis A	66.57%	70.14%	5.36%	★
Hepatitis B	60.00%	70.43%	17.38%	★
HiB	62.69%	70.72%	12.81%	★
Influenza	38.81%	42.61%	9.79%	★★★
IPV	63.58%	69.86%	9.88%	★
MMR	67.46%	71.59%	6.12%	★
Pneumococcal Conjugate	47.46%	55.65%	17.26%	★
Rotavirus	47.16%	56.52%	19.85%	★
VZV	65.97%	70.14%	6.32%	★
Immunizations for Adolescents				
Combination 1	50.15%	52.77%	5.22%	★
Combination 2	23.72%	28.86%	21.67%	★
Meningococcal	54.05%	53.06%	-1.83%	★
Tdap	51.95%	55.39%	6.62%	★
HPV	25.23%	29.45%	16.73%	★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
BMI Percentile—3–11 Years	84.62%	92.48%	9.29%	★★★★★
BMI Percentile—12–17 Years	78.40%	93.79%	19.63%	★★★★★
BMI Percentile—Total	82.73%	92.94% ✓	12.34%	★★★★★
Counseling for Nutrition—3–11 Years	72.73%	82.33%	13.20%	★★★★
Counseling for Nutrition—12–17 Years	67.20%	84.83%	26.24%	★★★★
Counseling for Nutrition—Total	71.05%	83.21% ✓	17.11%	★★★★
Counseling for Physical Activity—3–11 Years	70.98%	80.83%	13.88%	★★★★
Counseling for Physical Activity—12–17 Years	67.20%	84.83%	26.24%	★★★★★
Counseling for Physical Activity—Total	69.83%	82.24% ✓	17.77%	★★★★★
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	58.24%	53.82%	-7.59%	★
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	58.16%	63.21%	8.68%	★

and ✓indicates the health plan met or exceeded the target threshold established by MQD.

MY 2024 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

All the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* indicators met or exceeded the 75th percentile, and five of the indicators met or exceeded the 90th percentile. In addition, the *Childhood Immunization Status—Combination 10* and *Influenza* indicators met or exceeded the 50th percentile. All other measure indicators in this domain did not meet or exceed the 50th percentile.

'Ohana QI met MQD's established Quality Strategy targets for the *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*, *Counseling for Nutrition—Total*, and *Counseling for Physical Activity—Total* measure indicators.

Women's Health Performance Measure Results

Ohana QI's Women's Health performance measure results are shown in Table 3-79.

Table 3-79—'Ohana QI's Results for QI Measures Under Women's Health

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Cervical Cancer Screening				
Cervical Cancer Screening	40.63%	44.77%	10.19%	★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	66.99%	69.74%	4.11%	★
Postpartum Care	69.28%	76.38%	10.25%	★★
Timeliness of Prenatal Care—Under 21 Years	NA	NA	—	NC
Postpartum Care—Under 21 Years	NA	NA	—	NC

NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.
NA indicates that the health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
— Indicates that the health plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.
MY 2024 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

None of the measure indicators rates in this domain met or exceeded the 50th percentile. The *Prenatal and Postpartum Care—Timeliness of Prenatal Care—Under 21 Years* and *Postpartum Care—Under 21 Years* measure indicators in this domain did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented.

'Ohana QI did not meet the MQD-established Quality Strategy targets for this domain.

Care for Chronic Conditions Performance Measure Results

'Ohana QI's Care for Chronic Conditions performance measure results are shown in Table 3-80.

Table 3-80—'Ohana QI's Results for QI Measures Under Care for Chronic Conditions

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Asthma Medication Ratio				
5–11 Years	NA	NA	—	NC

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
12–18 Years	NA	NA	—	NC
19–50 Years	50.77%	58.00%	14.24%	★★
51–64 Years	41.82%	44.44%	6.26%	★
Total	44.36%	52.00%	17.22%	★
5–18 Years	23.08%	NA	—	NC
19–64 Years	46.67%	52.33%	12.13%	NC
Blood Pressure Control for Patients With Diabetes				
Blood Pressure Control for Patients With Diabetes	57.91%	68.37% ✓	18.06%	★★
Concurrent Use of Opioids and Benzodiazepines				
*18–64 Years**	16.51%	17.33%	4.97%	NC
*65+ Years**	21.30%	15.53%	-27.09%	NC
*Total**	17.66%	16.84%	-4.64%	NC
Controlling High Blood Pressure				
18–64 Years	56.72%	65.13%	14.83%	NC
65–85 Years	56.64%	67.33%	18.87%	NC
Total	56.69%	65.94% ✓	16.32%	★★★
Eye Exam for Patients With Diabetes				
Eye Exam for Patients With Diabetes	57.18%	63.26% ✓	10.63%	★★★★
Glycemic Status Assessment for Patients With Diabetes				
Glycemic Status <8.0%—18–64 Years	54.41%	57.06%	4.87%	NC
Glycemic Status <8.0%—65–75 Years	59.76%	73.24%	22.56%	NC
Glycemic Status <8.0%—Total	55.47%	59.85% ✓	7.90%	★★★
*Glycemic Status >9.0%—18–64 Years**	35.26%	31.47%	-10.75%	NC
*Glycemic Status >9.0%—65–75 Years**	34.15%	19.72%	-42.25%	NC
*Glycemic Status >9.0%—Total**	35.04%	29.44% ✓	-15.98%	★★★★

** 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.
NA indicates that the health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
— Indicates that the health plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.
and ✓ indicates the health plan met or exceeded the target threshold established by MQD.
MY 2024 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

The *Controlling High Blood Pressure—Total, Eye Exam for Patients With Diabetes,* and *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%—Total* and *Glycemic Status >9.0%—Total* measure indicators met or exceeded the 50th percentile. All other measure indicators in this domain either did not meet the 50th percentile or did not have national benchmarks to compare for MY 2024.

'Ohana QI met the MQD-established Quality Strategy target for *Blood Pressure Control for Patients With Diabetes, Controlling High Blood Pressure—Total*, *Eye Exam for Patients With Diabetes*, and *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%—Total* and *Glycemic Status >9.0%—Total.* All other MQD Quality Strategy targets were not met for this domain.

Behavioral Health Performance Measure Results

'Ohana QI's Behavioral Health performance measure results are shown in Table 3-81.

Table 3-81—'Ohana QI's Results for QI Measures Under Behavioral Health

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Antidepressant Medication Management				
Effective Acute Phase Treatment—18–64 Years	64.76%	50.00%	-22.79%	NC
Effective Acute Phase Treatment—65+ Years	88.57%	73.47%	-17.05%	NC
Effective Acute Phase Treatment—Total	67.94%	54.15%	-20.30%	★
Effective Continuation Phase Treatment—18–64 Years	46.26%	36.84%	-20.36%	NC
Effective Continuation Phase Treatment—65+ Years	65.71%	57.14%	-13.04%	NC
Effective Continuation Phase Treatment—Total	48.85%	40.43%	-17.24%	★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	68.81%	71.79% ✓	4.33%	★
Follow-Up After Emergency Department Visit for Mental Illness				
7-Day Follow-Up—6–17 Years	NA	NA	—	NC
7-Day Follow-Up—18–64 Years	37.50%	45.00%	20.00%	★★★★
7-Day Follow-Up—65+ Years	NA	NA	—	NC
7-Day Follow-Up—Total	37.76%	42.65% ✓	12.95%	★★★

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
30-Day Follow-Up—6–17 Years	NA	NA	—	NC
30-Day Follow-Up—18–64 Years	55.88%	62.50%	11.85%	★★★★
30-Day Follow-Up—65+ Years	NA	NA	—	NC
30-Day Follow-Up—Total	56.12%	60.66% ✓	8.09%	★★★
Follow-Up After Emergency Department Visit for Substance Use				
7-Day Follow-Up—13–17 Years	NA	NA	—	NC
7-Day Follow-Up—18+ Years	29.67%	37.41%	26.09%	★★★★
7-Day Follow-Up—Total	29.08%	36.62%	25.93%	★★★★
7-Day Follow-Up—18–64 Years	28.82%	35.61%	23.56%	NC
7-Day Follow-Up—65+ Years	NA	NA	—	NC
30-Day Follow-Up—13–17 Years	NA	NA	—	NC
30-Day Follow-Up—18+ Years	46.33%	54.68%	18.02%	★★★★★
30-Day Follow-Up—Total	45.42%	53.52%	17.83%	★★★★★
30-Day Follow-Up—18–64 Years	45.49%	53.41%	17.41%	NC
30-Day Follow-Up—65+ Years	NA	NA	—	NC
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—6–17 Years	NA	NA	—	NC
7-Day Follow-Up—18–64 Years	59.06%	48.08%	-18.59%	★★★★
7-Day Follow-Up—65+ Years	NA	NA	—	NC
7-Day Follow-Up—Total	58.68%	47.75% ✓	-18.63%	★★★★
30-Day Follow-Up—6–17 Years	NA	NA	—	NC
30-Day Follow-Up—18–64 Years	74.50%	71.15%	-4.50%	★★★★
30-Day Follow-Up—65+ Years	NA	NA	—	NC
30-Day Follow-Up—Total	72.46%	70.79% ✓	-2.30%	★★★★
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	NA	NA	—	NC
Continuation and Maintenance Phase	NA	NA	—	NC
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation of SUD Treatment—Total—13–17 Years	NA	NA	—	NC
Initiation of SUD Treatment—Total—18–64 Years	34.13%	34.05%	-0.23%	★
Initiation of SUD Treatment—Total—65+ Years	40.22%	33.01%	-17.93%	★
Initiation of SUD Treatment—Total—Total	34.33%	33.74%	-1.72%	★

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Engagement of SUD Treatment—Total—13–17 Years	NA	NA	—	NC
Engagement of SUD Treatment—Total—18–64 Years	8.59%	9.27%	7.92%	★★
Engagement of SUD Treatment—Total—65+ Years	11.96%	7.77%	-35.03%	★★★
Engagement of SUD Treatment—Total—Total	8.80%	9.11%	3.52%	★★
Screening for Depression and Follow-Up Plan				
12–17 Years	17.82%	21.99%	23.40%	NC
18–64 Years	11.57%	18.08%	56.27%	NC
65+ Years	24.06%	31.78%	32.09%	NC
Total	14.71%	21.03% ✓	42.96%	NC
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
1–11 Years	NA	NA	—	NC
12–17 Years	NA	NA	—	NC
Total	NA	NA	—	NC
Use of Pharmacotherapy for Opioid Use Disorder				
Rate 1: Total	59.18%	51.50%	-12.98%	NC
Rate 2: Buprenorphine	21.72%	21.56%	-0.74%	NC
Rate 3: Oral Naltrexone	0.75%	0.60%	-20.00%	NC
Rate 4: Long-Acting, Injectable Naltrexone	0.00%	0.00%	—	NC
Rate 5: Methadone	38.95%	30.84% ✓	-20.82%	NC

NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.
NA indicates that the health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
— Indicates that the health plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.
and ✓ indicates the health plan met or exceeded the target threshold established by MQD.
MY 2024 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

'Ohana QI met or exceeded the 90th percentile for the following measure indicator rates:

- *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—18+ Years*
- *Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Total*

'Ohana QI met the 75th to 89th percentile for the following measure indicator rates:

- *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—18–64 Years*
- *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—18–64 Years*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—18–64 Years*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—18–64 Years*
- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total*

'Ohana QI met the 50th to 74th percentile for the following measure indicator rates:

- *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*
- *Initiation and Engagement of Substance Use Disorder Treatment— Engagement of SUD Treatment—Total—65+ Years*

All other measure indicators in this domain either did not meet the 50th percentile or did not have national benchmarks to compare for MY 2024.

'Ohana QI met the MQD-established Quality Strategy Target for the following measure indicator rates:

- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total*
- *Screening for Depression and Follow-Up Plan—Total*
- *Use of Pharmacotherapy for Opioid Use Disorder—Rate 5: Methadone*

All other MQD Quality Strategy targets were not met for this domain.

Long-Term Services and Supports Performance Measure Results

'Ohana QI's Long-Term Services and Supports performance measure results are shown in Table 3-82.

Table 3-82—'Ohana QI's Results for QI Measures Under Long-Term Services and Supports

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Long-Term Services and Supports Comprehensive Assessment and Update				
Assessment of Core Elements	50.00%	46.23% ✓	-7.54%	NC
Assessment of Supplemental Elements	47.92%	45.50% ✓	-5.05%	NC
Long-Term Services and Supports Comprehensive Care Plan and Update				
Care Plan With Core Elements Documented	50.00%	37.96% ✓	-24.08%	NC
Assessment of Supplemental Elements	42.71%	37.47% ✓	-12.27%	NC
Managed Long-Term Services and Supports Admission to a Facility from the Community				
Short-Term Stay—18–64 Years	714.15	836.65	17.15%	NC
Short-Term Stay—65–74 Years	389.25	558.06	43.37%	NC
Short-Term Stay—75–84 Years	412.95	389.45	-5.69%	NC
Short-Term Stay—85+ Years	248.41	406.53	63.65%	NC
Short-Term Stay—Total	476.18	593.90 ✓	24.72%	NC
Medium-Term Stay—18–64 Years	19.18	39.77	107.35%	NC
Medium-Term Stay—65–74 Years	26.52	38.71	45.97%	NC
Medium-Term Stay—75–84 Years	12.95	34.79	168.65%	NC
Medium-Term Stay—85+ Years	18.25	37.09	103.23%	NC
Medium-Stay—Total	19.25	37.92 ✓	96.99%	NC
Long-Term Stay—18–64 Years	11.51	5.68	-50.65%	NC
Long-Term Stay—65–74 Years	5.73	8.60	50.09%	NC
Long-Term Stay—75–84 Years	5.04	8.98	78.17%	NC
Long-Term Stay—85+ Years	4.76	5.93	24.58%	NC
Long-Term Stay—Total	7.34	7.17 ✓	-2.32%	NC
Managed Long-Term Services and Supports Minimizing Facility Length of Stay				
Observed Discharge Rate	1.40%	2.62%	87.14%	NC
Expected Discharge Rate	37.87%	36.94%	-2.46%	NC
O/E Ratio	0.0371	NA	—	NC
Managed Long-Term Services and Supports Successful Transition After Long-Term Facility Stay				
Observed Discharge Rate	NA	NA	—	NC
Expected Discharge Rate	NA	NA	—	NC
O/E Ratio	NA	NA	—	NC

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

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

'Ohana QI met the MQD-established Quality Strategy target for the following measure indicator rates:

- *Long-Term Services and Supports Comprehensive Assessment and Update—Assessment of Core Elements*
- *Long-Term Services and Supports Comprehensive Assessment and Update—Assessment of Supplemental Elements*
- *Long-Term Services and Supports Comprehensive Care Plan and Update—Care Plan With Core Elements Documented*
- *Long-Term Services and Supports Comprehensive Care Plan and Update—Assessment of Supplemental Elements*
- *Managed Long-Term Services and Supports Admission to a Facility from the Community—Short-Term Stay—Total*
- *Managed Long-Term Services and Supports Admission to a Facility from the Community—Medium-Stay—Total*
- *Managed Long-Term Services and Supports Admission to a Facility from the Community—Long-Term Stay—Total*

All other MQD Quality Strategy targets were not met for this domain.

Strengths

Based on HSAG's analyses of 'Ohana QI's 66 measure indicator rates comparable to benchmarks, 29 indicators (73.94 percent) met or exceeded the 50th percentile, 21 indicators (31.82 percent) ranked at or above the 75th percentile, and seven indicators (10.61 percent) met or exceeded the 90th percentile. Additionally, 'Ohana QI met 23 MQD Quality Strategy targets for MY 2024.

Areas for Improvement

Conversely, 37 measure indicator rates comparable to benchmarks (56.06 percent) ranked below the 50th percentile, with 31 measure rates (46.97 percent) falling below the 25th percentile, suggesting considerable opportunities for improvement across all domains.

Recommendations

HSAG recommends that 'Ohana QI focus on improving performance related to the following measures with rates that fell below the 25th percentile for the QI population:

- Within the Children's Preventive Health domain, the following recommendations were identified:

  - Regarding the *Child and Adolescent Well-Care Visits* measure, HSAG recommends that 'Ohana QI conduct provider education about encouraging preventive care when members are seen for sickness, sports physicals, and other reasons. Additionally, HSAG recommends that 'Ohana QI promote well-visits on social media or other outreach and develop partnerships with community stakeholders.[32]
  - Regarding the *Childhood Immunization Status* measure, HSAG recommends that 'Ohana QI continue to provide education to providers and members about the importance of vaccination for disease prevention and encourage vaccination at every opportunity, including mild illness visits.[33]
  - Regarding the *Well-Child Visits in the First 30 Months of Life* measure, HSAG recommends that 'Ohana QI identify performance improvement efforts to improve well-child visits. HSAG recommends that 'Ohana QI identify other barriers to care and conduct a focus group on identifying strategies to address barriers.
- Within the Women's Health domain, the following recommendations were identified:
  - Regarding the *Cervical Cancer Screening* measure, HSAG recommends that 'Ohana QI consider utilizing CHWs or other one-on-one interactions with a healthcare professional, as they have been shown to improve cervical cancer screening.[34] In addition, HSAG recommends that 'Ohana QI provide education to members in need of screenings through health literacy campaigns, as well as focusing on barriers to completing screenings and addressing SDOH.
  - Regarding the *Prenatal and Postpartum Care—Timeliness of Prenatal Care* measure indicator, HSAG recommends that 'Ohana QI consider further research and potential implementation of an incentive program focused on timely prenatal care visits. Additionally, HSAG recommends that 'Ohana QI consider leveraging opportunities to host campaigns and/or conduct member outreach activities to engage members in the importance of timely prenatal care. Further, HSAG recommends that 'Ohana QI consider exploring available programs and/or vendors that can provide additional services such as appointment and transportation scheduling, pregnancy and parenting education, and pregnancy monitoring.
- Within the Chronic Conditions domain, the following recommendations were identified:
  - Regarding the *Asthma Medication Ratio* measure, HSAG recommends that 'Ohana QI provide education to providers about establishing an asthma action plan with members. HSAG also recommends that 'Ohana QI utilize pharmacy data to identify members outside the asthma medication ratio and prioritize case management services for these members. HSAG further recommends that 'Ohana QI provide member education about medication adherence.

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

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

[34] Popalis ML, Ramirez SI, Leach KM, et al. Improving cervical cancer screening rates: a scoping review of resources and interventions. *Cancer Causes Control*. 2022 Nov;33(11):1325–1333. Available at: https://pubmed.ncbi.nlm.nih.gov/35980511/. Accessed on Jan 6, 2026.

- Within the Behavioral Health domain, the following recommendations were identified:
  - Regarding the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure, HSAG recommends that ‘Ohana QI consider effective interventions to ensure annual screenings are conducted for people with schizophrenia, especially those taking antipsychotic medications. HSAG recommends that ‘Ohana QI provide education to providers and members about the importance of diabetes screening tests and encourage timely follow-up for early detection and management.
  - Regarding the *Initiation and Engagement of Substance Use Disorder Treatment* measure, HSAG recommends that ‘Ohana QI review patient data for any patterns present by ZIP Code and other demographics for case management prioritization. For instance, one study suggests that members who are male and have a schizophrenia spectrum disorder diagnosis are less likely to initiate treatment, while current drug dependence and recent arrest were associated with lowered odds of engaging in treatment. Current drug dependence is associated with factors that make scheduling and attending treatment appointments difficult, such as severe symptoms, chaotic living situations, and self-care and life functioning issues.[35]

Validation of Network Adequacy

HSAG evaluated and assessed the data methods that ‘Ohana QI used to calculate results generated for each network adequacy indicator in the scope of the 2025 NAV activities. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG’s overall confidence that ‘Ohana QI used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator.

Findings

Based on the results of the ISCA combined with the virtual audit and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the health plan’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each health plan according to the CMS EQR Protocol 4 and as defined in Table 3-83 of the Network Adequacy Indicator Validation Rating Determinations section of this report. Table 3-84 presents a summary of the NAV validation ratings for ‘Ohana QI by indicator.

Table 3-83—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*

[35] Brown CH, Bennett ME, Li L, Bellack AS. Predictors of initiation and engagement in substance abuse treatment among individuals with co-occurring serious mental illness and substance use disorders. *Addictive Behaviors.* 2010;36(5):439-47.

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

Table 3-84—Summary of 'Ohana QI Validation Ratings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Time and Distance	100%	0%	0%	0%
Mandatory Provider Type	100%	0%	0%	0%
Provider Ratio	100%	0%	0%	0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 122 indicators; 12 were unable to be validated for ‘Ohana QI. Of these indicators, 100 percent received *High Confidence* ratings.

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

HSAG determined that ‘Ohana QI was compliant with network adequacy requirements for the Provider Ratios standard for all provider types. Compliance was determined based on the health plan meeting the State’s Provider Ratio indicators. All indicators were calculated by MQD. Results are presented by provider type in Table 3-85.

Table 3-85—‘Ohana QI Network Adequacy Provider Ratios Compliance

Provider Type	Ratio	Results	Compliance
Hospitals on Oahu	5	14	*Met*
Hospitals on Kauai	1	3	*Met*
Hospitals on Lanai	1	1	*Met*
Hospitals on Maui	1	2	*Met*
Hospitals on Molokai	1	1	*Met*
Hospitals in East Hawaii	1	4	*Met*
Hospitals in West Hawaii	1	3	*Met*
PCPs (Adult)	1:300	1:31	*Met*
PCPs (Pediatric)	1:300	1:95	*Met*

HSAG determined that during the NAV review period, the Provider Ratios represented in Table 3-86 did not include members with SMI and SPMI diagnoses, as the guidance within the reporting template was

not provided to the health plan until after the reporting period. This resulted in HSAG's *Unable to Validate* designation for each of the associated provider types.

Table 3-86—'Ohana QI Network Adequacy Provider Ratios Unable to Validate

Provider Type
Behavioral Health Psychiatrists for members with an SMI or SPMI diagnosis. In geographic areas with a demonstrated shortage of qualified physicians, a psychiatric APRN-Rx may assume the role of psychiatrist.
Other Behavioral Health Providers to include Psychologists, Licensed Mental Health Counselors, Licensed Clinical Social Workers, and APRNs—Behavioral Health for members with an SMI or SPMI diagnosis.

HSAG determined that 'Ohana QI was compliant with network adequacy requirements for the Mandatory Provider Types standard for 40 of 46 (86.95 percent) indicators. Compliance was determined based on the health plan meeting the State's Mandatory Provider Type indicators, which includes one servicing provider within each provider type. All indicators were calculated by MQD. Compliant results are presented by provider type in Table 3-87, and noncompliant results are presented in Table 3-88.

Table 3-87—'Ohana QI Network Adequacy Mandatory Provider Types Compliance

Provider Type	Compliance
Audiologists	*Met*
Cardiologists	*Met*
Case Management Agencies	*Met*
DME	*Met*
Endocrinologists	*Met*
Emergency Transportation Providers (both ground and air)	*Met**
General Surgeons	*Met*
Geriatricians	*Met*
Hematologists	*Met*
Home Health Agencies and Hospices	*Met*
Infectious Disease Specialists	*Met*
LTSS: Adult Day Care Facilities	*Met*
LTSS: Adult Day Health Facilities	*Met*
LTSS: E-ARCHs	*Met*
LTSS: CCMA	*Met*
LTSS: CCFFH	*Met*

Provider Type	Compliance
LTSS: Home-Delivered Meal Providers	*Met*
LTSS: NFs	*Met*
LTSS: Personal Care Assistance Providers	*Met*
LTSS: PERS Providers	*Met*
LTSS: PDN	*Met*
Laboratories which have either a CLIA 1988 certificate or a waiver of a certificate of registration	*Met*
Licensed Dietitians	*Met*
Nephrologists	*Met*
Neurologists	*Met*
OB/GYNs	*Met*
Occupational Therapists	*Met*
Oncologists	*Met*
Optometrists	*Met*
Ophthalmologists	*Met*
Orthopedists	*Met*
Otolaryngologists	*Met*
Pediatric Specialists	*Met*
Pharmacies	*Met*
Physical Therapists	*Met*
Plastic Reconstructive Surgeons	*Met*
Pulmonologists	*Met*
Radiologists	*Met*
Speech-Language Pathologists	*Met*
Urologists	*Met*

**Met* for a subset of provider types.

Table 3-88—'Ohana QI Network Adequacy Mandatory Provider Types Noncompliance

Provider Type	Compliance
Community Health Workers	*Not Met*
Providers of lodging and meals associated with obtaining necessary medical care	*Not Met*
Sign language interpreters and interpreters for languages other than English	*Not Met*
LTSS: Non-Medical Transportation Providers	*Not Met*

Provider Type	Compliance
LTSS: Respite Care Providers	*Not Met*
NET Providers (both ground and air)	*Not Met*

HSAG determined that during the NAV review period, the mandatory provider types represented in Table 3-89 were not included in the PNA reference tables and data submission format file used to report results; therefore, the health plan did not submit data allowing MQD to calculate compliance. This resulted in HSAG's *Unable to Validate* designation for each of the associated provider types.

Table 3-89 'Ohana QI Network Adequacy Mandatory Provider Types *Unable to Validate* Indicators

Provider Type
CPs
PAs
LTSS: State Licensed Special Treatment Facilities for the Provision of Substance Abuse Therapy
LTSS: Certified Substance Abuse Counselors

HSAG determined that 'Ohana QI was compliant with network adequacy requirements for a subset of the Time and Distance indicators. MQD required at least 85 percent of members to have access to the providers within the associated time or distance parameters. Compliance was determined based on the health plan meeting the State's Time and Distance indicators for both Urban and Rural classifications. All indicators were calculated by MQD. Results are presented by provider type and urbanicity in Table 3-90, and noncompliant results are presented in Table 3-91.

Table 3-90—'Ohana QI Network Adequacy Time and Distance ≥85% Compliance by Urbanicity

Provider Type	Urbanicity	Compliance
24-Hour Pharmacies	Urban	88.7%
LTSS: Adult Day Care/Adult Day Health	Urban	100.0%
	Rural	100.0%
All Other Behavioral Health Providers	Urban	100.0%
	Rural	100.0%
Cardiologists	Urban	100.0%
	Rural	100.0%
Endocrinologists	Urban	100.0%
	Rural	90.8%
Geriatricians	Urban	88.7%
Hematologists	Urban	100.0%
	Rural	100.0%

Provider Type	Urbanicity	Compliance
Hospitals	Urban	100.0%
	Rural	100.0%
Infectious Disease Specialists	Urban	95.3%
	Rural	100.0%
Nephrologists	Urban	100.0%
	Rural	100.0%
Neurologists	Urban	100.0%
	Rural	90.8%
OB/GYNs	Urban	100.0%
	Rural	100.0%
Oncologists	Urban	100.0%
	Rural	97.7%
Ophthalmologists	Urban	100.0%
	Rural	100.0%
Optometrists	Urban	100.0%
	Rural	100.0%
Orthopedists	Urban	100.0%
	Rural	100.0%
Other Specialists	Urban	100.0%
	Rural	100.0%
Otolaryngologists	Urban	100.0%
	Rural	90.8%
PCPs (Adult)	Urban	100.0%
	Rural	100.0%
PCPs (Child)	Urban	100.0%
	Rural	97.9%
Pediatric Specialists	Urban	100.0%
Pharmacies (All)	Urban	100.0%
	Rural	100.0%
Plastic and Reconstructive Surgeons	Urban	100.0%
Pulmonologists	Urban	100.0%
	Rural	100.0%
Radiologists	Urban	100.0%
	Rural	100.0%

Provider Type	Urbanicity	Compliance
Surgeons (All Other)	Urban	100.0%
	Rural	100.0%
Urologists	Urban	100.0%
	Rural	100.0%

Table 3-91—'Ohana QI Network Adequacy Time and Distance < 85% Noncompliance by Urbanicity

Provider Type	Urbanicity	Compliance
Geriatricians	Rural	81.9%
Pediatric Specialists	Rural	80.2%
Plastic and Reconstructive Surgeons	Rural	84.8%
LTSS: Respite Care Facilities	Urban	0%
	Rural	0%

HSAG determined that during the NAV review period, the Time and Distance provider types represented in Table 3-92 were not included in the PNA reference tables and data submission format file used to report results; therefore, the health plan did not submit data allowing MQD to calculate compliance. This resulted in HSAG's *Unable to Validate* designation for each of the associated provider types.

Table 3-92—'Ohana QI Network Adequacy Time and Distance *Unable to Validate* Indicators

Provider Type
Emergency Services Facilities
LTSS: Certified Substance Abuse Counselors
LTSS: State Licensed Special Treatment Facilities for the Provision of Substance Abuse Therapy

Strengths

HSAG identified the following strengths related to NAV for 'Ohana QI:

- 'Ohana QI continued to maintain detailed process documentation for creation of the network adequacy report by extracting robust data and cleaning processes to ensure business continuity of the network adequacy reporting process.

Areas for Improvement

- Of the 28 Urban provider types in scope of review, ‘Ohana QI did not meet the 85 percent compliance threshold for the miles or minutes standard for one provider type. Of the 27 Rural provider types in scope of review, ‘Ohana QI did not meet the 85 percent compliance threshold for the miles or minutes standard for four provider types.
- ‘Ohana QI did not meet six of the 46 Minimum Required Provider Type indicators.

Recommendations

- HSAG recommends that ‘Ohana QI continue its recruiting and contracting efforts for provider specialties that did not meet the Time and Distance threshold, with the goal of determining whether the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.
- HSAG recommends that ‘Ohana QI continue its recruiting and contracting efforts for provider specialties that did not meet the Minimum Required Provider Types standard, with the goal of determining whether the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

Validation of Performance Improvement Projects

In CY 2025, ‘Ohana QI continued the two PIPs initiated in CY 2022—*Behavioral Health Coordination* and *Plan All-Cause Readmissions*. For the CY 2025 submission, the health plan progressed to the Design, Implementation, and Outcomes stages of the PIPs and submitted Steps 1 through 8 in the PIP Submission Form. The PIPs were assessed for improvement in outcomes in Step 9.

‘Ohana QI also submitted the *Screening for Depression and Follow-Up Plan* PIP that was initiated in CY 2024. For this PIP, ‘Ohana QI progressed to the Design and Implementation stages of the PIP and submitted Steps 1 through 8 in the PIP submission form. The PIP will be assessed for improvement in outcomes in next year’s validation when Remeasurement 1 data will be reported.

Table 3-93 displays the topics, progression status, and measurement periods reported for the PIPs.

Table 3-93—CY 2025 ‘Ohana QI PIP Topics and Status

PIP Topic	PIP Progression Status	Baseline Measurement Period	Measurement Period Reported in CY 2024
Behavioral Health Coordination	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	07/01/2021 to 09/30/2021	07/01/2024 to 09/30/2024 (Remeasurement 3)
Plan All-Cause Readmissions	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	CY 2021	CY 2024 (Remeasurement 3)

PIP Topic	PIP Progression Status	Baseline Measurement Period	Measurement Period Reported in CY 2024
Screening for Depression and Follow-Up Plan	PIP Design and Implementation Stages (Steps 1 through 8)	CY 2024	CY 2024 (Baseline)

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

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

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

Findings

Table 3-94 illustrates the validation results for the three PIPs submitted by ‘Ohana QI for CY 2025 validation.

Table 3-94—CY 2025 PIP Validation Results for ‘Ohana QI

PIP Topic	Validation Rating 1			Validation Rating 2		
	Overall Confidence in Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Behavioral Health Coordination	100%	100%	*High Confidence*	100%	100%	*High Confidence*
Plan All-Cause Readmissions	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*

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

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

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

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

The *Screening for Depression and Follow-Up Plan* PIP was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. 'Ohana QI had not progressed to reporting remeasurement data and therefore the PIP was not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement.)

Design (Steps 1-6)

Behavioral Health Coordination

The selected PIP topic was required by MQD. 'Ohana QI's Aim statement set the focus of the PIP, and the eligible population was clearly defined. The performance indicators were developed in consultation and discussion with MQD and HSAG. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process.

Plan All-Cause Readmissions

The selected PIP topic was required by MQD, and the plan-specific historical and baseline data showed an opportunity for improvement. ‘Ohana QI’s Aim statement set the focus of the PIP and the eligible population was clearly defined. The performance indicator and data collection process were aligned with the HEDIS specifications.

Screening for Depression and Follow-Up Plan

The selected PIP topic was required by MQD. ‘Ohana QI’s Aim statement set the focus of the PIP and the eligible population was clearly defined. The performance indicators and data collection process were aligned with the CMS Child Core Set Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH) measure and CMS Adult Core Set Screening for Depression and Follow-Up Plan (CDF-AD) measure.

Implementation (Steps 7-8)

Behavioral Health Coordination

‘Ohana QI accurately reported and analyzed the Remeasurement 3 rate for the performance indicator. The health plan conducted accurate statistical testing between the measurement periods and provided narrative interpretations of the results. Appropriate quality improvement tools were utilized to conduct its causal/barrier analysis and to prioritize the identified barriers. Interventions were implemented in a timely manner, were reasonably linked to the identified barriers, and have the potential to impact the performance indicator outcomes. ‘Ohana QI documented that the MOA for data sharing between the health plan and DOH Behavioral Health Services Administration divisions was signed and was effective January 1, 2025. At the time of the PIP reporting, the data sharing had not yet started. The health plan was working toward implementation of data sharing per the MOA in discussion with other health plans and DOH agencies.

Plan All-Cause Readmissions

‘Ohana QI accurately reported and analyzed the Remeasurement 3 rate for the performance indicator. The health plan conducted accurate statistical testing between the measurement periods and provided narrative interpretations of the results As part of the Readmissions Collaborative workgroup, the health plan deployed logical interventions linked to the identified barriers. ‘Ohana QI included an evaluation of effectiveness for each intervention and appropriate next steps for the interventions.

Screening for Depression and Follow-Up Plan

‘Ohana QI accurately reported baseline rate for the performance indicators. Appropriate quality improvement tools were utilized to conduct causal/barrier analysis and the health plan initiated interventions that were reasonably linked to the identified barriers and have the potential to improve the performance indicator outcomes.

The health plan has not progressed to reporting and analyzing data or conducting QI activities.

Outcomes (Step 9)

Behavioral Health Coordination

During Remeasurement3, both performance indicators sustained statistically significant improvement over the baseline.

Plan All-Cause Readmissions

During Remeasurement 3, the health plan had a statistically nonsignificant decline (favorable outcome) in performance indicator rate compared to the baseline.

Screening for Depression and Follow-Up Plan

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

Analysis of Results

Table 3-95 displays the data that the health plan reported for the *Behavioral Health Coordination* PIP.

Table 3-95—Outcomes for the *Behavioral Health Coordination* PIP

Performance Indicator	Baseline (07/01/2021–09/30/2021)		Remeasurement 1 (07/01/2022–09/30/2022)		Remeasurement 2 (07/01/2023–09/30/2023)		Remeasurement 3 (07/01/2024–09/30/2024)		Sustained Improvement
1. Percent of shared members with eligible trigger events who received a combined review in the past three months.	N: 2 D: 113	1.7%	N: 40 D: 108	37.0%*	N: 59 D: 191	30.9%*	N: 31 D: 155	20.0%*	*Yes*
2. 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%*	N: 277 D: 2,589	10.7%*	N: 141 D: 2,491	5.7%*	*Yes*

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

The baseline rate for the percentage of shared members with eligible trigger events who received a combined review during the baseline measurement period was 1.7 percent. For Remeasurement 1, the Performance Indicator 1 rate increased to 37.0 percent and for Remeasurement 2, the rate was 30.9 percent. For Remeasurement 3, the rate decreased to 20.0 percent; however, it represents a statistically significant increase of 18.3 percentage points 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 and for Remeasurement 2, the rate was 10.7 percent. For Remeasurement 3, the rate decreased to 5.7 percent; however, it represents a statistically significant increase of 3.3 percentage points over the baseline.

During Remeasurement 3, both performance indicators sustained statistically significant improvement over the baseline.

Table 3-96 displays the data that the health plan reported for the *Plan All-Cause Readmissions* PIP.

Table 3-96—Outcomes for the *Plan All-Cause Readmissions* PIP

Performance Indicator	Baseline (01/01/2021–12/31/2021)		Remeasurement 1 (01/01/2022–12/31/2022)		Remeasurement 2 (01/01/2023–12/31/2023)		Remeasurement 3 (01/01/2024–12/31/2024)		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: 105 D: 994	10.6%	N: 93 D: 993	9.4%	*Not Assessed*

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

The baseline (CY 2021) rate for the percentage of eligible discharges for which members 18–64 years of age had at least one unplanned acute readmission for any diagnosis within 30 days of the Index Discharge Date was 9.6 percent. For Remeasurement 1, there was a decline in performance and the readmission rate increased to 9.9 percent and for Remeasurement 2, the performance indicator rate was 10.6 percent. For Remeasurement 3, the performance indicator rate was 9.4 percent, which represents a statistically nonsignificant decrease (improvement in performance) of 0.2 percentage points from the baseline.

Table 3-97 displays the data that the health plan reported for the *Screening for Depression and Follow-Up Plan* PIP.

Table 3-97—Performance Indicator Results for the *Screening for Depression and Follow-Up Plan* PIP

Performance Indicator	Baseline (01/01/2024–12/31/2024)		Remeasurement 1 (01/01/2025–12/31/2025)		Sustained Improvement
1. Percentage of members ages 12 to 17 screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter.	N: 300 D: 1,364	22.0%			
2. Percentage of members aged 18 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and, if positive, a follow-up plan is documented on the date of the eligible encounter.	N: 2,412 D: 11,534	20.9%			

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

The baseline rate for Performance Indicator 1 was 22.0 percent, and the baseline rate for Performance Indicator 2 was 20.9 percent.

Barriers/Interventions

Table 3-98 displays the barriers and interventions as documented by the health plan for each PIP.

Table 3-98—Interventions Implemented/Planned for 'Ohana QI PIPs

Barriers	Interventions
Behavioral Health Coordination	
1. Minimal data sharing and lack of standardization of data exchange requirements. 2. Lack of ongoing communication between partnering agencies. 3. Identifying gaps in data and workflow among health plans and CCS.	1. Having a workgroup with partnering agencies that meets at least on a quarterly basis. The health plans and CCS have a workgroup that meets as needed or scheduled for every three weeks on the calendar.

Barriers	Interventions
4. Lack of staff's knowledge regarding the MOA with DOH agencies and that we started the combined reviews and exchanging shared member's data.	2. Develop a workflow for ongoing communication between health plan and partnering agencies.* 3. Standardize data sharing between health plans and CCS. 4. Educate staff internally and meet DOH agencies Point of Contact (POC) prior to sending data in accordance with MOA.
Plan All-Cause Readmissions	
1. High utilizers with readmissions within 30 days or difficult discharges with no viable discharge plan. 2. Members readmitting due to avoidable reasons. 3. Members readmitting due to Congestive Heart Failure (CHF). 4. Members readmitting due to social challenges and lack of community services.	1. Multidisciplinary rounds within health plan to discuss high utilizers. 2. Contact with all members post-discharge via transition of care process. 3. Added CHF on Disease Management Program, and member outreach will be conducted post discharge. 4. Developed focused discharge planning process.
Screening for Depression and Follow-Up Plan	
1. The MCO receives supplemental data that describes the providers are likely addressing the CDF care gaps; however, the supplemental data do not contain the correct codes to close the gaps. 2. Lack of provider knowledge/awareness of measure specifications and documentation issues.	1. Aligning Supplemental Data with Measure Specifications. 2. Provider Education—Behavioral Health Month. 3. Provider Education—CDF Flyer.

Strengths

- All of 'Ohana QI's PIPs received *Met* validation scores for 100 percent of all applicable evaluation elements validated for acceptable methodology for all phases of the PIP.
- For the *Behavioral Health Coordination* PIP, both performance indicators sustained statistically significant improvement over the baseline.

Areas for Improvement

- For the Plan All-Cause Readmissions PIP, 'Ohana QI has an opportunity for improvement in achievement of statistically significant improvement in the performance indicator rate

Recommendations

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

- 'Ohana QI must continually work on the PIPs throughout the year.

- For the *BH* PIP, in addition to working with other health plans on the implementation of data sharing per the MOA with DOH agencies, the health plan must also review internal health plan-specific barriers toward implementation of the MOA and initiate appropriate interventions.
- For the *PCR* PIP:
  - ‘Ohana QI should build on the positive momentum gained and improvement achieved.
  - ‘Ohana QI should apply lessons learned and knowledge gained while conducting the PIP to future PIPs and other quality improvement efforts.
- For the *Screening for Depression and Follow-Up Plan* PIP, ‘Ohana QI must ensure that the interventions are implemented in a timely manner to impact outcomes during the remeasurement period.
- ‘Ohana QI must revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers and to see if any new barriers exist that require the development of interventions to drive improvement.
- ‘Ohana QI must submit an intervention worksheet for each intervention listed in the Barriers/Interventions table in the PIP Submission Form.
- The intervention effectiveness measure in the intervention worksheet must not be the same as the performance indicator documented in Step 5. The effectiveness measure should be designed to measure the effectiveness of the intervention on addressing the barrier linked to that intervention.
- ‘Ohana QI should collect the intervention effectiveness data more frequently (e.g., monthly, quarterly) unlike the annual performance indicator data. This would help ‘Ohana QI understand intervention effectiveness and make any updates to the interventions in a timely manner to impact remeasurement outcomes.
- Intervention effectiveness data must guide next steps for each individual intervention.

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

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

Findings

Table 3-99 presents the 2025 scores for ‘Ohana QI compared to the 2024 NCQA child Medicaid national averages, the corresponding 2023 scores, and the QI Program.

Table 3-99—Child CAHPS Results for ‘Ohana QI

Measure	2023 ‘Ohana QI Scores	2025 ‘Ohana QI Scores	2025 QI Program Scores
Global Ratings			
Rating of Health Plan	67.59%	70.13%	71.65%
Rating of All Health Care	69.40%	66.91%	68.95%

Measure	2023 'Ohana QI Scores	2025 'Ohana QI Scores	2025 QI Program Scores
Rating of Personal Doctor	74.70%	76.00%	76.22%
Rating of Specialist Seen Most Often	78.95%+	77.78%+	77.78%
Composite Measures			
Getting Needed Care	77.94%+	82.39%+	80.76%
Getting Care Quickly	80.11%+	81.21%+	81.10%
How Well Doctors Communicate	90.58%	92.10%	94.25%
Customer Service	81.69%+	92.32%+ ▲	90.25%
Individual Item Measure			
Coordination of Care	77.42%+	85.94%+	87.77%

▲ *Indicates the 2025 score is statistically significantly higher than the 2023 score.*
▼ *Indicates the 2025 score is statistically significantly lower than the 2023 score.*
↑ *Indicates the 2025 score is statistically significantly higher than the QI Program.*
↓ *Indicates the 2025 score is statistically significantly lower than the QI Program.*
H *Indicates the 2025 score is statistically significantly higher than the NCQA national average.*
L *Indicates the 2025 score is statistically significantly lower than the NCQA national average.*
+ *Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.*

Strengths

- 'Ohana QI's 2025 top-box score was statistically significantly higher than the 2023 top-box score for one measure, *Customer Service*.
- 'Ohana QI's 2025 top-box scores met or exceeded the RY 2025 target for the following measures: *Customer Service, Getting Needed Care,* and *Rating of Specialist Seen Most Often*.

Areas for Improvement

- 'Ohana QI's 2025 top-box scores were not statistically significantly lower than the 2024 NCQA child Medicaid national averages, QI Program's 2025 top-box scores, or 2023 top-box scores for any measure; therefore, no areas for improvement were identified.

Recommendations

- HSAG recommends that 'Ohana QI monitor the measures to ensure significant decreases in scores over time do not occur.

Provider Survey

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

Findings

Table 3-100 presents the 2025 scores for ‘Ohana QI compared to the QI Program and the corresponding 2023 scores, where applicable.

Table 3-100—Provider Survey Results for ‘Ohana QI: Measure Scores

	2023 ‘Ohana QI Scores	2025 ‘Ohana QI Scores	2025 QI Program Scores
General Positions			
Compensation Satisfaction	24.00%+	50.74%+ ▲	51.98%
Timeliness of Claims Payments	31.65%+	38.13%+	40.57%
Prior Authorization Process Experience*			
Approval or Authorization Delayed	NT	68.40%+ NT	67.02%
Inconsistent Requirements	NT	66.04%+ NT	64.73%
Difficult to Navigate	NT	65.44%+ NT	64.75%
Labor Intensive	NT	53.45%+ NT	55.53%
Prior Authorization Process Impacts*			
Delayed Ability to Provide Treatments	NT	51.67%+ NT	53.47%
Disrupted Continuity of Care	NT	43.52%+ NT↓	52.62%
Created Administrative Burden	NT	45.39%+ NT	44.32%
Led to Denial of Service	NT	61.91%+ NT	59.57%
Formulary			
Formulary Impact on Care	24.85%+	34.68%+	37.27%
Non-Formulary			
Adequate Access to Non-Formulary Drugs	34.64%+	41.97%+	42.75%
Health Coordinators			
Helpfulness of Health Coordinators	34.14%+	57.94%+	56.24%
Specialists			
Adequate Network of Specialists	15.11%+	23.92%+ ↓	37.96%
Substance Abuse			
Access to Substance Abuse Treatment	29.63%+	38.71%+	42.04%

▲ *Indicates the 2025 score is statistically significantly higher than the 2023 score.*
▼ *Indicates the 2025 score is statistically significantly lower than the 2023 score.*
↑ *Indicates the 2025 score is statistically significantly higher than the QI Program.*
↓ *Indicates the 2025 score is statistically significantly lower than the QI Program.*
NT *Indicates this measure was not included in 2023; therefore, a trend analysis was unable to be performed for this measure.*

	2023 'Ohana QI Scores	2025 'Ohana QI Scores	2025 QI Program Scores
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.			
**Providers who responded 'No' for the survey questions within the Prior Authorization Process Experience and Impact domains, indicating they did not have a negative experience with the prior authorization process, were classified into the 'Satisfied' response category.*			

Strengths

'Ohana QI's 2025 top-box score was statistically significantly higher than the 2023 top-box score for the following measure:

- *Compensation Satisfaction*

The top-box scores for the following measures were higher in 2025 than in 2023, although not statistically significantly higher:

- *Timeliness of Claims Payments*
- *Formulary Impact on Care*
- *Adequate Access to Non-Formulary Drugs*
- *Helpfulness of Health Coordinators*
- *Adequate Network of Specialists*
- *Access to Substance Abuse Treatment*

Areas for Improvement

'Ohana QI's 2025 top-box scores were statistically significantly lower than QI Program's 2025 top-box scores for the following measures:

- *Disrupted Continuity of Care*
- *Adequate Network of Specialists*

Recommendations

'Ohana QI had the lowest experience scores for the *Disrupted Continuity of Care* and *Adequate Network of Specialists* measures in the Prior Authorization Process Impacts and Specialists domains, respectively. These findings suggest providers' dissatisfaction with the prior authorization process impacting continuity of care as well as dissatisfaction with the network of specialists currently offered to their patients. To address these low scores, HSAG recommends that MQD, in collaboration with 'Ohana QI:

- Identify and define specific factors influencing providers' level of satisfaction with their prior authorization process to reduce any barriers to providers maintaining continuity of care for patients.

- Implement a time-limited focus group to review provider concerns related to the lack of specialists within their network. The purpose of the workgroup is to identify and define underlying issues driving provider satisfaction levels.

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

‘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 room for improvement.

‘Ohana QI met or exceeded the statewide compliance score for seven of the eight standards. While ‘Ohana QI achieved 100 percent compliance in seven standards, the health plan scored below the statewide compliance score for one standard. ‘Ohana QI achieved 100 percent compliance in six standards. ‘Ohana QI was required to develop a CAP to address and resolve the deficiencies identified in the review. HSAG and MQD provided feedback on the proposed corrective actions and ‘Ohana QI was found to be in full compliance in December 2025.

Overall, almost half (43.94 percent) of ‘Ohana QI’s performance measures fell below the 50th percentile across all domains, with (31.82 percent) of the measure rates falling below the 25th percentile. While some measures showed improvement from MY 2023, ‘Ohana QI’s performance demonstrated the need to improve process and outcome measures across all domains. In particular, ‘Ohana QI should address performance in the Children’s Preventive Health, Behavioral Health, Women’s Health, and Chronic Conditions domains. ‘Ohana QI’s measure indicator rates met 23 MQD Quality Strategy targets.

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

‘Ohana QI progressed to the Outcomes stage of the two PIPs (*Behavioral Health Coordination* and *Plan All-Cause Readmissions*) that were initiated in CY 2022 and the Implementation stage for the *Screening for Depression and Follow-Up Plan* PIP initiated in CY 2024. The PIPs addressed CMS’ requirements related to quality outcomes—specifically, the timeliness of and access to care and services.

The *Behavioral Health Coordination* PIP received a *High Confidence* level rating for overall confidence of adherence to acceptable methodology for all phases of the PIP and a *High Confidence* level rating for

overall confidence that the PIP achieved significant improvement. During Remeasurement 3, the health plan documented statistically significant improvement in both performance indicator rates over the baseline. 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. The health plan was working toward implementation of data sharing per the MOA with DOH agencies.

The *Plan All-Cause Readmissions* PIP received a *High Confidence* level rating for overall confidence of adherence to acceptable methodology for all phases of the PIP and a *Moderate Confidence* level rating for overall confidence that the PIP achieved significant improvement. The documented PIP design and data were accurate. The health plan conducted appropriate quality improvement processes to identify barriers, and it deployed interventions that were logically linked to the identified barriers. During Remeasurement 3, the health plan achieved statistically nonsignificant improvement in the observed readmission rate over the baseline.

The *Screening for Depression and Follow-Up Plan* PIP received a *High Confidence* rating for adherence to acceptable methodology for all phases of the PIP. This performance suggests a sound PIP design, accurate reporting of data, and implementation of interventions that were related to barriers identified through quality improvement processes and have the potential to drive improvement in desired outcomes. ‘Ohana QI had not progressed to reporting remeasurement data and was therefore not assessed for achievement of improvement.

‘Ohana QI’s 2025 top-box CAHPS survey scores were not statistically significantly lower than the QI Program, 2024 NCQA child Medicaid national averages, or 2023 top-box scores for any measure; therefore no substantial opportunities for improvement were identified. These results indicate that ‘Ohana QI should continue to monitor the measures to ensure significant decreases in scores over time do not occur.

While three of the nine measures MQD selected for monitoring within its Quality Strategy met or exceeded the RY 2025 target, ‘Ohana QI should focus improvement efforts on the *Coordination of Care, Getting Care Quickly, How Well Doctors Communicate, Rating of All Health Care, Rating of Health Plan,* and *Rating of Personal Doctor measures*, as these measures did not meet the RY 2025 target.

‘Ohana QI’s Provider Survey results demonstrated mixed results. The 2025 top-box score for *Compensation Satisfaction* was statistically significantly higher than the 2023 top-box score. Although not statistically significantly higher, six measures had higher top-box scores in 2025 than in 2023. Conversely, ‘Ohana QI’s providers expressed dissatisfaction with *Disrupted Continuity of Care* and *Adequate Network of Specialists*, as the 2025 scores for these measures were statistically significantly lower than the QI Program, indicating a need for ‘Ohana QI to implement strategies to ensure members have access to care.

UnitedHealthcare Community Plan QUEST Integration (UHC CP QI) Results

Compliance Monitoring Review

The 2025 compliance monitoring review activity included evaluation of the health plan's compliance with State and federal requirements for organizational and structural performance.

Findings

Table 3-101 presents the standards and compliance scores for UHC CP QI.

Table 3-101—Standards and Compliance Review Scores—UHC CP QI

Standard #	Standard Name	Total # of Elements	Number of Elements		Total Compliance Score
			# Met	# Not Met	
I	Availability of Services	17	17	0	100%
II	Assurances of Adequate Capacity and Services	3	3	0	100%
III	Coordination and Continuity of Care	10	10	0	100%
IV	Confidentiality	10	10	0	100%
V	Coverage and Authorization of Services	31	30	1	97%
VI	Enrollee Information	19	18	1	95%
VII	Enrollee Rights and Protections	8	8	0	100%
VIII	Grievance and Appeal System	31	30	1	97%
	Totals	**129**	**126**	**3**	**98%**

Total Elements: The total number of applicable elements in each standard.
Total Compliance Score: The compliance scores were calculated by adding the ***Met*** elements and then dividing by the total number of applicable elements.

Strengths

UHC CP QI achieved full compliance in five of the eight standards reviewed, demonstrating strengths and adherence to all requirements measured in the following areas:

- Availability of Services
- Assurances of Adequate Capacity and Services
- Coordination and Continuity of Care
- Confidentiality
- Enrollee Rights and Protections

These findings suggest that UHC CP QI developed the necessary policies, procedures, and processes to operationalize the federal regulations and contractual requirements.

Areas for Improvement

UHC CP QI did not receive performance scores under 95 percent for any standard.

Recommendations

Of the 129 elements, UHC CP QI received *Not Met* scores for three elements. HSAG recommends that UHC CP QI continue to work with HSAG and MQD on completing the CAPs for the Coverage and Authorization, Enrollee Information, and Grievance and Appeal System elements that were scored as *Not Met.*

Validation of Performance Measures—NCQA HEDIS Compliance Audits

NCQA HEDIS Compliance Audit Findings

HSAG's review team assessed UHC CP QI's IS capabilities and its ability to process data for reporting accurate performance measure rates. UHC CP QI was found to be fully compliant with all HEDIS IS standards, as well as IS standard L for assessing case management data for LTSS measures. This demonstrated that UHC CP QI had effective IS processes and control procedures for reporting the required performance measure rates. UHC CP QI presented 22 supplemental data sources for consideration to use for supplementing its MY 2024 performance measure rates. HSAG determined 10 data sources to be nonstandard supplemental data, and the remaining 12 were considered standard supplemental data. UHC CP QI withdrew two of the nonstandard data sources from reporting. HSAG reviewed the remaining 20 data sources, and no concerns were identified. All 20 supplemental data sources were approved for HEDIS MY 2024 reporting.

UHC CP 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, UHC CP QI was not required to undergo convenience sample validation. The final statistical MRRV was conducted for the *Controlling High Blood Pressure, Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%—Total, Immunizations for Adolescents—Combination 2*, and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total* measure indicators, as well as all medical record exclusions. All selected cases passed the final MRRV without any critical errors. The final statistical CMRRV was conducted for *Long-Term Services and Supports Comprehensive Assessment and Update—Assessment of Core Elements* and *Assessment of Supplemental Elements, Long-Term Services and Supports Comprehensive Care Plan and Update—Care Plan With Core Elements Documented* and *Assessment of Supplemental Elements* as well as all medical record exclusions. All selected cases passed the final MRRV and CMRRV 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 3-102.

Table 3-102—UHC CP QI's Results for QI Measures Under Access and Risk-Adjusted Utilization

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Adults' Access to Preventive/Ambulatory Health Services				
20–44 Years	47.57%	50.42%	5.99%	★
45–64 Years	70.31%	71.35%	1.48%	★
65+ Years	90.84%	92.15%	1.44%	★★★★
Total	69.40%	73.03%	5.23%	★★
Plan All-Cause Readmissions				
*Observed Readmissions—18–64 Years**	—	11.71%	—	NC
*Expected Readmissions—18–64 Years**	—	9.77%	—	NC
*O/E Ratio—18–64 Years**	—	1.1983	—	NC
PQI 08: Heart Failure Admission Rate				
*18–64 Years**	52.86	63.56	20.24%	NC
*65+ Years**	123.13	173.65	41.03%	NC
*Total**	76.08	102.54	34.78%	NC
PQI 15: Asthma in Younger Adults Admission Rate				
*18–39 Years**	3.12	4.19	34.29%	NC

** A lower rate indicates better performance.*
NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.
— Indicates that the health plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.
MY 2024 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

The *Adults' Access to Preventive/Ambulatory Health Services—65+ Years* indicator met or exceeded the 75th percentile. All other measure indicators in this domain did not meet or exceed the 50th percentile or did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented.

UHC CP QI did not meet the MQD-established Quality Strategy targets for any of the measure indicators in this domain.

Children's Preventive Health Performance Measure Results

UHC CP QI's Children's Preventive Health performance measure results are shown in Table 3-103.

Table 3-103—UHC CP QI's Results for QI Measures Under Children's Preventive Health

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Child and Adolescent Well-Care Visits				
Total	41.80%	45.04%	7.75%	★
Childhood Immunization Status				
Combination 3	48.91%	54.99%	12.43%	★
Combination 7	42.09%	50.36% ✓	19.65%	★
Combination 10	29.44%	33.58%	14.06%	★★★
DTaP	52.80%	59.12%	11.97%	★
Hepatitis A	66.18%	72.75%	9.93%	★
Hepatitis B	72.51%	78.35%	8.05%	★
HiB	70.07%	74.21%	5.91%	★
Influenza	40.15%	43.07%	7.27%	★★★
IPV	70.56%	74.21%	5.17%	★
MMR	67.40%	73.48%	9.02%	★
Pneumococcal Conjugate	52.55%	59.37%	12.98%	★
Rotavirus	55.47%	61.80%	11.41%	★
VZV	66.67%	72.99%	9.48%	★
Immunizations for Adolescents				
Combination 1	51.82%	56.20%	8.45%	★
Combination 2	28.47%	34.06%	19.63%	★★
Meningococcal	54.74%	56.93%	4.00%	★
Tdap	54.74%	59.61%	8.90%	★
HPV	30.90%	35.28%	14.17%	★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile—3–11 Years	90.07%	89.40%	-0.74%	★★★★
BMI Percentile—12–17 Years	91.47%	92.97%	1.64%	★★★★★
BMI Percentile—Total	90.51%	90.51% ✓	0.00%	★★★★
Counseling for Nutrition—3–11 Years	62.77%	78.80%	25.54%	★★★

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Counseling for Nutrition—12–17 Years	55.81%	85.94%	53.99%	★★★★★
Counseling for Nutrition—Total	60.58%	81.02% ✓	33.74%	★★★★
Counseling for Physical Activity—3–11 Years	59.93%	77.03%	28.53%	★★★★
Counseling for Physical Activity—12–17 Years	61.24%	89.06%	45.43%	★★★★★
Counseling for Physical Activity—Total	60.34%	80.78% ✓	33.87%	★★★★
Well-Child Visits in the First 30 Months of Life				
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	53.94%	58.33%	8.14%	★★
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	54.01%	58.70%	8.68%	★

and ✓indicates the health plan met or exceeded the target threshold established by MQD.

MY 2024 performance levels represent the following percentile comparisons:

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

The *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* indicators all ranked at or above the 50th percentile, and three of the indicators met or exceeded the 90th percentile. In addition, the *Childhood Immunization Status—Combination 10* and *Influenza* indicators met or exceeded the 50th percentile. All other measure indicators in this domain did not meet or exceed the 50th percentile.

UHC CP QI met MQD's established Quality Strategy targets for *Childhood Immunization Status—Combination 7* and *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total, Counseling for Nutrition—Total,* and *Counseling for Physical Activity—Total.* All other MQD Quality Strategy targets were not met for this domain.

Women's Health Performance Measure Results

UHC CP QI's Women's Health performance measure results are shown in Table 3-104.

Table 3-104—UHC CP QI's Results for QI Measures Under Women's Health

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Cervical Cancer Screening				
Cervical Cancer Screening	48.42%	41.61%	-14.06%	★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	74.21%	73.71%	-0.67%	★
Postpartum Care	76.89%	74.69%	-2.86%	★
Timeliness of Prenatal Care—Under 21 Years	44.12%	NA	—	NC
Postpartum Care—Under 21 Years	67.65%	NA	—	NC

NA indicates that the health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.
— Indicates that the health plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.
MY 2024 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

The indicator rates that could be compared to benchmarks in this domain did not meet or exceed the 50th percentile. The *Prenatal and Postpartum Care—Timeliness of Prenatal Care—Under 21 Years* and *Postpartum Care—Under 21 Years* measure indicators in this domain did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented.

UHC CP QI did not meet the MQD-established Quality Strategy targets for this domain.

Care for Chronic Conditions Performance Measure Results

UHC CP QI's Care for Chronic Conditions performance measure results are shown in Table 3-105.

Table 3-105—UHC CP QI's Results for QI Measures Under Care for Chronic Conditions

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Asthma Medication Ratio				
5–11 Years	NA	NA	—	NC
12–18 Years	NA	NA	—	NC
19–50 Years	52.71%	52.17%	-1.02%	★
51–64 Years	57.89%	55.47%	-4.18%	★

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Total	54.46%	53.21%	-2.30%	★
5–18 Years	40.91%	48.65%	18.92%	NC
19–64 Years	55.52%	53.91%	-2.90%	NC
Blood Pressure Control for Patients With Diabetes				
Blood Pressure Control for Patients With Diabetes	69.59%	66.67% ✓	-4.20%	★★
Concurrent Use of Opioids and Benzodiazepines				
*18–64 Years**	13.99%	12.26%	-12.37%	NC
*65+ Years**	13.59%	12.59%	-7.36%	NC
*Total**	13.80%	12.43% ✓	-9.93%	NC
Controlling High Blood Pressure				
18–64 Years	60.87%	62.96%	3.43%	NC
65–85 Years	71.06%	73.27%	3.11%	NC
Total	67.64%	70.56% ✓	4.32%	★★★★
Eye Exam for Patients With Diabetes				
Eye Exam for Patients With Diabetes	63.99%	66.91% ✓	4.56%	★★★★★
Glycemic Status Assessment for Patients With Diabetes				
Glycemic Status <8.0%—18–64 Years	59.01%	57.85%	-1.97%	NC
Glycemic Status <8.0%—65–75 Years	74.07%	77.66%	4.85%	NC
Glycemic Status <8.0%—Total	65.94%	66.91% ✓	1.47%	★★★★★
*Glycemic Status >9.0%—18–64 Years**	29.73%	32.74%	10.12%	NC
*Glycemic Status >9.0%—65–75 Years**	15.87%	13.30%	-16.19%	NC
*Glycemic Status >9.0%—Total**	23.36%	23.84% ✓	2.05%	★★★★★

** A lower rate indicates better performance.*
NA indicates that the health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.
— Indicates that the health plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.
and ✓ indicates the health plan met or exceeded the target threshold established by MQD.
MY 2024 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*

Controlling High Blood Pressure—Total met or exceeded the 75th percentile. In addition, *Eye Exam for Patients With Diabetes* as well as *Glycemic Status Assessment for Patients With Diabetes—Glycemic*

Status <8.0%—Total and *Glycemic Status >9.0%—Total* met or exceeded the 90th percentile. All other measure indicators in this domain did not meet the 50th percentile or did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented.

UHC CP QI met the established Quality Strategy target for *Blood Pressure Control for Patients With Diabetes, Concurrent Use of Opioids and Benzodiazepines—Total, Controlling High Blood Pressure—Total*, *Eye Exam for Patients With Diabetes*, and *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%—Total* and *Glycemic Status >9.0%—Total.* All other MQD Quality Strategy targets were not met for this domain.

Behavioral Health Performance Measure Results

UHC CP QI's Behavioral Health performance measure results are shown in Table 3-106.

Table 3-106—UHC CP QI's Results for QI Measures Under Behavioral Health

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Antidepressant Medication Management				
Effective Acute Phase Treatment—18–64 Years	65.64%	68.58%	4.48%	NC
Effective Acute Phase Treatment—65+ Years	81.11%	83.53%	2.98%	NC
Effective Acute Phase Treatment—Total	71.15%	74.03% ✓	4.05%	★★★★
Effective Continuation Phase Treatment—18–64 Years	47.55%	50.34%	5.87%	NC
Effective Continuation Phase Treatment—65+ Years	66.11%	61.76%	-6.58%	NC
Effective Continuation Phase Treatment—Total	54.15%	54.51% ✓	0.66%	★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	76.92%	78.34% ✓	1.85%	★★
Follow-Up After Emergency Department Visit for Mental Illness				
7-Day Follow-Up—6–17 Years	NA	NA	—	NC
7-Day Follow-Up—18–64 Years	35.41%	28.87%	-18.47%	★★
7-Day Follow-Up—65+ Years	30.95%	17.78%	-42.55%	★
7-Day Follow-Up—Total	35.10%	27.73%	-21.00%	★
30-Day Follow-Up—6–17 Years	NA	NA	—	NC

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
30-Day Follow-Up—18–64 Years	53.77%	46.83%	-12.91%	★★
30-Day Follow-Up—65+ Years	40.48%	35.56%	-12.15%	★
30-Day Follow-Up—Total	52.37%	45.43%	-13.25%	★
Follow-Up After Emergency Department Visit for Substance Use				
7-Day Follow-Up—13–17 Years	NA	NA	—	NC
7-Day Follow-Up—18+ Years	27.66%	21.18%	-23.43%	★★
7 -Day Follow-Up—Total	27.70%	21.20%	-23.47%	★★
7-Day Follow-Up—18–64 Years	28.06%	21.45%	-23.56%	NC
7-Day Follow-Up—65+ Years	NA	19.05%	—	NC
30-Day Follow-Up—13–17 Years	NA	NA	—	NC
30-Day Follow-Up—18+ Years	41.04%	35.39%	-13.77%	★★
30-Day Follow-Up—Total	40.99%	35.08%	-14.42%	★★
30-Day Follow-Up—18–64 Years	41.49%	35.05%	-15.52%	NC
30-Day Follow-Up—65+ Years	NA	38.10%	—	NC
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—6–17 Years	NA	NA	—	NC
7-Day Follow-Up—18–64 Years	53.21%	38.46%	-27.72%	★★★
7-Day Follow-Up—65+ Years	NA	40.00%	—	★★★★
7-Day Follow-Up—Total	52.08%	38.79%	-25.52%	★★★
30-Day Follow-Up—6–17 Years	NA	NA	—	NC
30-Day Follow-Up—18–64 Years	65.38%	53.85%	-17.64%	★★★
30-Day Follow-Up—65+ Years	NA	66.67%	—	★★★★★
30-Day Follow-Up—Total	63.54%	55.61%	-12.48%	★★
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	NA	NA	—	NC
Continuation and Maintenance Phase	NA	NA	—	NC
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation of SUD Treatment—Total—13–17 Years	NA	NA	—	NC
Initiation of SUD Treatment—Total—18–64 Years	37.18%	39.92%	7.37%	★
Initiation of SUD Treatment—Total—65+ Years	36.25%	35.87%	-1.05%	★
Initiation of SUD Treatment—Total—Total	37.12%	38.87%	4.71%	★
Engagement of SUD Treatment—Total—13–17 Years	NA	NA	—	NC

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Engagement of SUD Treatment—Total—18–64 Years	8.60%	8.44%	-1.86%	★
Engagement of SUD Treatment—Total—65+ Years	5.18%	3.69%	-28.76%	★★
Engagement of SUD Treatment—Total—Total	7.99%	7.33%	-8.26%	★
Screening for Depression and Follow-Up Plan				
12–17 Years	20.28%	24.33%	19.97%	NC
18–64 Years	14.04%	22.21%	58.19%	NC
65+ Years	35.45%	41.34%	16.61%	NC
Total	23.06%	30.27% ✓	31.27%	NC
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
1–11 Years	NA	NA	—	NC
12–17 Years	NA	NA	—	NC
Total	NA	NA	—	NC
Use of Pharmacotherapy for Opioid Use Disorder				
Rate 1: Total	50.93%	38.62%	-24.17%	NC
Rate 2: Buprenorphine	24.38%	20.88%	-14.36%	NC
Rate 3: Oral Naltrexone	1.54%	0.63%	-59.09%	NC
Rate 4: Long-Acting, Injectable Naltrexone	0.00%	0.42% ✓	—	NC
Rate 5: Methadone	26.85%	18.37%	-31.58%	NC

NA indicates that the health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.
— Indicates that the health plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.
and ✓ indicates the health plan met or exceeded the target threshold established by MQD.
MY 2024 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*

UHC CP QI met or exceeded the 90th percentile for the following measure indicator rate:

- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—65+ Years*

UHC CP QI met the 75th to 89th percentile for the following measure indicator rates:

- *Antidepressant Medication Management—Effective Acute Phase Treatment—Total*

- *Antidepressant Medication Management—Effective Continuation Phase Treatment—Total*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—65+ Years*

UHC CP QI met the 50th to 74th percentile for the following measure indicator rates:

- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—18–64 Years*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—18–64 Years*

All other measure indicators in this domain either did not meet the 50th percentile or did not have national benchmarks to compare for MY 2024.

UHC CP QI met the MQD-established Quality Strategy Target for the following measure indicator rates:

- *Antidepressant Medication Management—Effective Acute Phase Treatment—Total*
- *Antidepressant Medication Management—Effective Continuation Phase Treatment—Total*
- *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*
- *Screening for Depression and Follow-Up Plan—Total*
- *Use of Pharmacotherapy for Opioid Use Disorder—Rate 4: Long-Acting, Injectable Naltrexone*

All other MQD Quality Strategy targets were not met for this domain.

Long-Term Services and Supports Performance Measure Results

UHC CP QI's Long-Term Services and Supports performance measure results are shown in Table 3-107.

Table 3-107—UHC CP QI's Results for QI Measures Under Long-Term Services and Supports

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Long-Term Services and Supports Comprehensive Assessment and Update				
Assessment of Core Elements	8.33%	41.61% ✓	399.52%	NC
Assessment of Supplemental Elements	8.33%	39.66% ✓	376.11%	NC
Long-Term Services and Supports Comprehensive Care Plan and Update				
Care Plan With Core Elements Documented	10.42%	18.00% ✓	72.74%	NC
Assessment of Supplemental Elements	10.42%	18.00% ✓	72.74%	NC
Managed Long-Term Services and Supports Admission to a Facility from the Community				
Short-Term Stay—18–64 Years	15.73	35.78	127.46%	NC

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Short-Term Stay—65–74 Years	42.30	20.50	-51.54%	NC
Short-Term Stay—75–84 Years	29.28	19.97	-31.80%	NC
Short-Term Stay—85+ Years	24.86	7.92	-68.14%	NC
Short-Term Stay—Total	24.92	18.93	-24.04%	NC
Medium-Term Stay—18–64 Years	1.70	4.35	155.88%	NC
Medium-Term Stay—65–74 Years	8.13	5.07	-37.64%	NC
Medium-Term Stay—75–84 Years	7.88	4.74	-39.85%	NC
Medium-Term Stay—85+ Years	5.22	4.43	-15.13%	NC
Medium-Stay—Total	4.73	4.63	-2.11%	NC
Long-Term Stay—18–64 Years	0.71	7.25	921.13%	NC
Long-Term Stay—65–74 Years	2.49	7.71	209.64%	NC
Long-Term Stay—75–84 Years	2.74	13.84	405.11%	NC
Long-Term Stay—85+ Years	2.24	9.39	319.20%	NC
Long-Term Stay—Total	1.73	9.68 ✓	459.54%	NC
Managed Long-Term Services and Supports Minimizing Facility Length of Stay				
Observed Discharge Rate	32.60%	12.74%	-60.92%	NC
Expected Discharge Rate	37.29%	39.78%	6.68%	NC
O/E Ratio	0.8743	0.3203	-63.36%	NC
Managed Long-Term Services and Supports Successful Transition After Long-Term Facility Stay				
Observed Discharge Rate	87.13%	NA	—	NC
Expected Discharge Rate	65.90%	NA	—	NC
O/E Ratio	1.3221	NA	—	NC

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

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

UHC CP QI met the MQD-established Quality Strategy target for the following measure indicator rates:

- *Long-Term Services and Supports Comprehensive Assessment and Update—Assessment of Core Elements*
- *Long-Term Services and Supports Comprehensive Assessment and Update—Assessment of Supplemental Elements*
- *Long-Term Services and Supports Comprehensive Care Plan and Update—Care Plan With Core Elements Documented*

- *Long-Term Services and Supports Comprehensive Care Plan and Update—Assessment of Supplemental Elements*
- *Managed Long-Term Services and Supports Admission to a Facility from the Community—Long-Term Stay—Total*

All other MQD Quality Strategy targets were not met for this domain.

Strengths

Based on HSAG's analyses of UHC CP QI's 70 indicator rates comparable to benchmarks, 23 rates (32.86 percent) ranked at or above the 50th percentile, with 17 of these rates (24.29 percent) ranking at or above the 75th percentile and seven rates (10 percent) ranking at or above the 90th percentile. Additionally, UHC CP QI met 20 MQD Quality Strategy targets for MY 2024.

Areas for Improvement

Conversely, 47 of UHC CP QI's 70 indicator rates comparable to benchmarks (67.14 percent) fell below the 50th percentile, with 33 of these rates (47.14 percent) falling below the 25th percentile, suggesting considerable opportunities for improvement across all domains.

Recommendations

HSAG recommends that UHC CP QI focus on improving performance related to the following measures with rates that fell below the 25th percentile for the QI population:

- Within the Children's Preventive Health domain, the following recommendations were identified:
  - Regarding the *Child and Adolescent Well-Care Visits* measure, HSAG recommends that UHC CP QI conduct provider education about encouraging preventive care when members are seen for sickness, sports physicals, and other reasons. Additionally, HSAG recommends that UHC CP QI promote well-visits on social media or other outreach and develop partnerships with community stakeholders.[36]
  - Regarding the *Childhood Immunization Status* measure, HSAG recommends that UHC CP QI provide education to providers and members about the importance of vaccination for disease prevention and encourage vaccination at every opportunity, including mild illness visits.
- Within the Women's Health domain, the following recommendations were identified:
  - Regarding the *Cervical Cancer Screening* measure, HSAG recommends that UHC CP QI consider utilizing CHWs or other one-on-one interactions with a healthcare professional, as they

[36] Centers for Medicare & Medicaid Services. Paving the Road to Good Health Strategies for Increasing Medicaid Adolescent Well-Care Visits. Available at: https://www.medicaid.gov/medicaid/benefits/downloads/paving-the-road-to-good-health.pdf. Accessed on: Jan 6, 2026.

have been shown to improve cervical cancer screening.[37] In addition, HSAG recommends that UHC CP QI provide education to members in need of screenings through health literacy campaigns, as well as focusing on barriers to completing screenings and addressing SDOH.

  - Regarding the *Prenatal and Postpartum Care* measure, HSAG recommends that UHC CP QI consider further research and potential implementation of an incentive program focused on timely prenatal and postpartum care visits. Additionally, HSAG recommends that UHC CP QI consider leveraging opportunities to host campaigns and/or conduct member outreach activities to engage members in the importance of timely prenatal and postpartum care. Further, HSAG recommends that UHC CP QI consider exploring available programs and/or vendors that can provide additional services such as appointment and transportation scheduling, pregnancy and parenting education, and pregnancy monitoring.

- Within the Care for Chronic Conditions domain, the following recommendations were identified:
  - Regarding the *Asthma Medication Ratio* measure, HSAG recommends that UHC CP QI provide education to providers about establishing an asthma action plan with members. HSAG also recommends that UHC CP QI utilize pharmacy data to identify members outside the asthma medication ratio and prioritize case management services for these members. HSAG further recommends that UHC CP QI provide member education about medication adherence.
- Within the Behavioral Health domain, the following recommendations were identified:
  - Regarding the *Follow-Up After Emergency Department Visit for Mental Illness* measure, HSAG recommends that UHC CP QI outreach to providers to ensure identification of members who have ED visits for mental illness to leverage discharge planning processes to facilitate scheduling member follow-up visits.
  - Regarding the *Initiation and Engagement of Substance Use Disorder Treatment* measure, HSAG recommends that UHC CP QI review patient data for any patterns present by ZIP Code and other demographics for case management prioritization. For instance, one study suggests that members who are male and have a schizophrenia spectrum disorder diagnosis are less likely to initiate treatment, while current drug dependence and recent arrest were associated with lowered odds of engaging in treatment. Current drug dependence is associated with factors that make scheduling and attending treatment appointments difficult, such as severe symptoms, chaotic living situations, and self-care and life functioning issues.[38]

Validation of Network Adequacy

HSAG evaluated and assessed the data methods that UHC CP QI used to calculate results generated for each network adequacy indicator in the scope of the 2025 NAV activities. HSAG used indicator-specific

[37] Popalis ML, Ramirez SI, Leach KM, et al. Improving cervical cancer screening rates: a scoping review of resources and interventions. *Cancer Causes Control*. 2022 Nov;33(11):1325–1333. Available at: https://pubmed.ncbi.nlm.nih.gov/35980511/. Accessed on Jan 6, 2026.

[38] Brown CH, Bennett ME, Li L, Bellack AS. Predictors of initiation and engagement in substance abuse treatment among individuals with co-occurring serious mental illness and substance use disorders. *Addictive Behaviors.* 2010;36(5):439-47.

worksheets to generate a validation rating that reflects HSAG's overall confidence that UHC CP QI used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator.

Findings

Based on the results of the ISCA combined with the virtual audit and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the health plan's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each health plan according to the CMS EQR Protocol 4 and as defined in Table 3-108 of the Network Adequacy Indicator Validation Rating Determinations section of this report. Table 3-109 presents a summary of the NAV validation ratings for UHC CP QI by indicator.

Table 3-108—Indicator-Level Validation Rating Categories

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

Table 3-109—Summary of UHC CP QI Validation Ratings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Time and Distance	79.4%	0%	0%	0%
Mandatory Provider Type	90%	0%	0%	0%
Provider Ratio	77%	0%	0%	0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 122 indicators; 12 were unable to be validated for UHC CP QI. Of these indicators, 100 percent received *High Confidence* ratings.

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

HSAG determined that UHC CP QI was compliant with network adequacy requirements for the Provider Ratios indicators. Compliance was determined based on the health plan meeting the State's Provider Ratio indicators. All indicators were calculated by MQD. Results are presented by provider type in Table 3-110.

Table 3-110—UHC CP QI Network Adequacy Provider Ratios Compliance

Provider Type	Ratio	Results	Compliance
Hospitals on Oahu	5	21	*Met*
Hospitals on Kauai	1	3	*Met*
Hospitals on Lanai	1	1	*Met*
Hospitals on Maui	1	2	*Met*
Hospitals on Molokai	1	1	*Met*
Hospitals in East Hawaii	1	7	*Met*
Hospitals in West Hawaii	1	5	*Met*
PCPs (Adult)	1:300	1:30	*Met*
PCPs (Pediatric)	1:300	1:65	*Met*

HSAG determined that during the NAV review period, the Provider Ratios represented in Table 3-111 did not include members with SMI and SPMI diagnoses, as the guidance within the reporting template was not provided to the health plan until after the reporting period. This resulted in HSAG's *Unable to Validate* designation for each of the associated provider types.

Table 3-111—UHC CP QI Network Adequacy Provider Ratios Unable to Validate

Provider Type
Behavioral Health Psychiatrists for members with an SMI or SPMI diagnosis. In geographic areas with a demonstrated shortage of qualified physicians, a psychiatric APRN-Rx may assume the role of psychiatrist.
Other Behavioral Health Providers to include Psychologists, Licensed Mental Health Counselors, Licensed Clinical Social Workers, and APRNs—Behavioral Health for members with an SMI or SPMI diagnosis.

HSAG determined that UHC CP QI was compliant with network adequacy requirements for the Mandatory Provider Types standard for 42 of 46 (91.3 percent) indicators. Compliance was determined based on the health plan meeting the State's Mandatory Provider Type indicators, which includes one servicing provider within each provider type. All indicators were calculated by MQD. Results are presented by provider type in Table 3-112, and noncompliant results are presented in Table 3-113.

Table 3-112—UHC CP QI Network Adequacy Mandatory Provider Types Compliance

Provider Type	Compliance
Audiologists	*Met*
Cardiologists	*Met*
Case Management Agencies	*Met*

Provider Type	Compliance
DME	*Met*
Emergency Transportation Providers (both ground and air)	*Met**
Endocrinologists	*Met*
General Surgeons	*Met*
Geriatricians	*Met*
Hematologists	*Met*
Home Health Agencies and Hospices	*Met*
Infectious Disease Specialists	*Met*
LTSS: Adult Day Care Facilities	*Met*
LTSS: Adult Day Health Facilities	*Met*
LTSS: CCMA	*Met*
LTSS: CCFFH	*Met*
LTSS: E-ARCHs	*Met*
LTSS: Home-Delivered Meal Providers	*Met*
LTSS: Non-Medical Transportation Providers	*Met*
LTSS: NFs	*Met*
LTSS: Personal Care Assistance Providers	*Met*
LTSS: PERS Providers	*Met*
LTSS: PDN	*Met*
LTSS: Respite Care Providers	*Met*
Laboratories which have either a CLIA 1988 certificate or a waiver of a certificate of registration	*Met*
Nephrologists	*Met*
Neurologists	*Met*
NET Providers (both ground and air)	*Met*
OB/GYNs	*Met*
Occupational Therapists	*Met*
Oncologists	*Met*
Ophthalmologists	*Met*
Optometrists	*Met*
Orthopedists	*Met*
Otolaryngologists	*Met*
Pediatric Specialists	*Met*
Pharmacies	*Met*
Physical Therapists	*Met*

Provider Type	Compliance
Plastic Reconstructive Surgeons	*Met*
Pulmonologists	*Met*
Radiologists	*Met*
Speech-Language Pathologists	*Met*
Urologists	*Met*

**Met* for a subset of provider types.

Table 3-113—UHC CP QI Network Adequacy Mandatory Provider Types Noncompliance

Provider Type	Compliance
Community Health Workers	*Not Met*
Licensed Dietitians	*Not Met*
Providers of lodging and meals associated with obtaining necessary medical care	*Not Met*
Sign language interpreters and interpreters for languages other than English	*Not Met*

HSAG determined that during the NAV review period, the mandatory provider types represented in Table 3-114 were not included in the PNA reference tables and data submission format file used to report results; therefore, the health plan did not submit data allowing MQD to calculate compliance. This resulted in HSAG's *Unable to Validate* designation for each of the associated provider types.

Table 3-114—UHC CP QI Network Adequacy Mandatory Provider Types *Unable to Validate* Indicators

Provider Type
LTSS: State Licensed Special Treatment Facilities for the Provision of Substance Abuse Therapy/Treatment
LTSS: Certified Substance Abuse Counselors
PAs
CPs

HSAG determined that UHC CP QI was compliant with a subset of network adequacy requirements for the Time and Distance indicators. MQD required at least 85 percent of members to have access to the providers within the associated time or distance parameters. Compliance was determined based on the health plan meeting the State's Time and Distance indicators for both Urban and Rural classifications. All indicators were calculated by MQD. Results are presented by provider type and urbanicity in Table 3-115 and noncompliant results are presented in Table 3-116.

Table 3-115—UHC CP QI Network Adequacy Time and Distance ≥85% Compliance by Urbanicity

Provider Type	Urbanicity	Compliance
24-Hour Pharmacies	Urban	91.8%

Provider Type	Urbanicity	Compliance
LTSS: Adult Day Care/Adult Day Health	Urban	100.0%
	Rural	90.7%
All Other Behavioral Health Providers	Urban	100.0%
	Rural	99.9%
Cardiologists	Urban	99.9%
	Rural	95.1%
Endocrinologists	Urban	98.4%
	Rural	86.9%
Geriatricians	Urban	98.3%
	Rural	88.7%
Hematologists	Urban	97.8%
	Rural	93.4%
Hospitals	Urban	98.2%
	Rural	96.8%
Infectious Disease Specialists	Urban	98.5%
Nephrologists	Urban	99.2%
	Rural	91.2%
Neurologists	Urban	97.9%
	Rural	96.2%
OB/GYNs	Urban	99.8%
	Rural	98.2%
Oncologists	Urban	98.2%
	Rural	93.3%
Ophthalmologists	Urban	99.9%
	Rural	94.1%
Optometrists	Urban	99.9%
	Rural	99.2%
Orthopedists	Urban	99.9%
	Rural	93.3%
Other Specialists	Urban	100.0%
	Rural	100.0%
Otolaryngologists	Urban	98.1%
PCPs (Adult)	Urban	100.0%
	Rural	100.0%

Provider Type	Urbanicity	Compliance
PCPs (Child)	Urban	99.9%
	Rural	99.6%
Pediatric Specialists	Urban	99.8%
	Rural	99.6%
Pharmacies (All)	Urban	99.5%
	Rural	96.2%
Plastic and Reconstructive Surgeons	Urban	97.1%
Pulmonologists	Urban	97.1%
	Rural	93.9%
Radiologists	Urban	99.9%
	Rural	96.3%
LTSS: Respite Care Facilities	Urban	99.7%
Surgeons (All Other)	Urban	99.9%
	Rural	95.2%
Urologists	Urban	98.2%
	Rural	94.4%

Table 3-116—UHC CP QI Network Adequacy Time and Distance < 85% Noncompliance by Urbanicity

Provider Type	Urbanicity	Compliance
Otolaryngologists	Rural	80.2%
LTSS: Respite Care Facilities	Rural	70.4%
Infectious Disease	Rural	76.5%
Plastic and Reconstructive Surgeons	Rural	73.3%

HSAG determined that during the NAV review period, the Time and Distance provider types represented in Table 3-117 were not included in the PNA reference tables and data submission format file used to report results; therefore, the health plan did not submit data allowing MQD to calculate compliance. This resulted in HSAG's *Unable to Validate* designation for each of the associated provider types.

Table 3-117—UHC CP QI Network Adequacy Time and Distance *Unable to Validate* Indicators

Provider Type	Urbanicity
Emergency Services Facilities	Rural
	Urban

Provider Type	Urbanicity
LTSS: Certified Substance Abuse Counselors	Rural
	Urban
LTSS: State Licensed Special Treatment Facilities for the Provision of Substance Abuse Therapy	Rural
	Urban

Strengths

HSAG identified the following strengths related to NAV for UHC CP QI:

- UHC CP QI continued to efficiently maintain the accuracy and completeness of provider information through its monthly directory audit process. An automated process was in place that pulled provider database records for a statistically valid sample size of providers. UHC CP QI conducted outreach to providers, and data collected were compared to the on-file records to confirm accuracy, ensure completeness, and identify errors.
- UHC CP QI continued to maintain detailed process documentation for creation of the network adequacy reports, ensuring business continuity of the network adequacy reporting process.

Areas for Improvement

- Of the 27 Rural provider types in scope of review, UHC CP QI did not meet the 85 percent compliance threshold for the miles or minutes standard for four provider types. Of the 46 mandatory provider types in scope of review, UHC CP QI did not meet four provider types.

Recommendations

- HSAG recommends that UHC CP QI continue its recruiting and contracting efforts for provider specialties that did not meet the Time and Distance threshold or the mandatory provider type standard.

Validation of Performance Improvement Projects

In CY 2025, UHC CP QI continued the two PIPs initiated in CY 2022—*Behavioral Health Coordination* and *Plan All-Cause Readmissions*. For the CY 2025 submission, the health plan progressed to the Design, Implementation, and Outcomes stages of the PIPs and submitted Steps 1 through 8 in the PIP Submission Form. The PIPs were assessed for improvement in outcomes in Step 9.

UHC CP QI also submitted the *Screening for Depression and Follow-Up Plan* PIP that was initiated in CY 2024. For this PIP, UHC CP QI progressed to the Design and Implementation stages of the PIP and submitted Steps 1 through 8 in the PIP submission form. The PIP will be assessed for improvement in outcomes in next year's validation when Remeasurement 1 data will be reported.

Table 3-118 displays the topics, progression status, and measurement periods reported for the PIPs.

Table 3-118—CY 2025 UHC CP QI PIP Topics and Status

PIP Topic	PIP Progression Status	Baseline Measurement Period	Measurement Period Reported in CY 2023
Behavioral Health Coordination	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	07/01/2021 to 09/30/2021	07/01/2024 to 09/30/2024 (Remeasurement 3)
Plan All-Cause Readmissions	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	CY 2021	CY 2024 (Remeasurement 3)
Screening for Depression and Follow-Up Plan	PIP Design and Implementation Stages (Steps 1 through 8)	CY 2024	CY 2024 (Baseline)

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

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

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

Findings

Table 3-119 illustrates the validation results for the three PIPs submitted by UHC CP QI for CY 2025 validation.

Table 3-119—CY 2025 PIP Validation Results for UHC CP QI

PIP Topic	Validation Rating 1			Validation Rating 2		
	Overall Confidence in Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Behavioral Health Coordination	100%	100%	*High Confidence*	50%	100%	*High Confidence*
Plan All-Cause Readmissions	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
Screening for Depression Screening and Follow-Up Plan	100%	100%	*High Confidence*	*Not Assessed*[4]		

[1] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[2] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[3] **Confidence Level**— Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

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

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

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

The *Screening for Depression and Follow-Up Plan* PIP was validated through the first eight steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. UHC CP QI had not progressed to reporting remeasurement data and the PIP was therefore not assessed for Validation Rating 2 (i.e., Overall Confidence That the PIP Achieved Significant Improvement).

Design (Steps 1-6)

Behavioral Health Coordination

The selected PIP topic was required by MQD. UHC CP QI's Aim statement set the focus of the PIP, and the eligible population was clearly defined. The performance indicators were developed in consultation and discussion with MQD and HSAG. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process.

Plan All-Cause Readmissions

The selected PIP topic was required by MQD, and the plan-specific historical and baseline data showed an opportunity for improvement. UHC CP QI's Aim statement set the focus of the PIP and the eligible population was clearly defined. The performance indicator and data collection process were aligned with the HEDIS specifications.

Screening for Depression and Follow-Up Plan

The selected PIP topic was required by MQD. UHC CP QI's Aim statement set the focus of the PIP and the eligible population was clearly defined. The performance indicators and data collection process were aligned with the CMS Child Core Set Screening for Depression and Follow-Up Plan: Ages 12 to 17 (CDF-CH) measure and CMS Adult Core Set Screening for Depression and Follow-Up Plan (CDF-AD) measure.

Implementation (Steps 7-8)

Behavioral Health Coordination

UHC CP QI accurately reported and analyzed the Remeasurement 3 rate for the performance indicators. The health plan conducted accurate statistical testing between the measurement periods and provided narrative interpretations of the results. Appropriate quality improvement tools were utilized to conduct its causal/barrier analysis and to prioritize the identified barriers. Interventions were implemented in a timely manner, were reasonably linked to the identified barriers, and have the potential to impact the performance indicator outcomes. UHC CP QI documented that the MOA for data sharing between the health plan and DOH Behavioral Health Services Administration divisions was signed and was effective January 1, 2025. At the time of the PIP reporting, the data sharing had not yet started. The health plan was working toward implementation of data sharing per the MOA in discussion with other health plans and DOH agencies.

Plan All-Cause Readmissions

UHC CP QI accurately reported and analyzed the Remeasurement 3 rate for the performance indicator. The health plan conducted accurate statistical testing between the measurement periods and provided narrative interpretations of the results. As part of the Readmissions Collaborative workgroup, the health

plan deployed logical interventions linked to the identified barriers. UHC CP QI included an evaluation of effectiveness for each intervention and appropriate next steps for the interventions.

Screening for Depression and Follow-Up Plan

UHC CP QI accurately reported the baseline rate for the performance indicators. Appropriate quality improvement tools were utilized to conduct causal/barrier analysis and the health plan initiated interventions that were reasonably linked to the identified barriers and have the potential to impact the performance indicator outcomes.

Outcomes (Step 9)

Behavioral Health Coordination

For this year's validation, UHC CP QI progressed to reporting Remeasurement 3 results. Performance Indicator 1 had statistically nonsignificant improvement over the baseline. Performance Indicator 2 was below the baseline. The health plan did not sustain statistically significant improvement for both performance indicators.

Plan All-Cause Readmissions

For this year's validation, UHC CP QI progressed to reporting Remeasurement 3 results. The health plan achieved marginal improvement in the Remeasurement 3 performance indicator rate over the baseline.

Screening for Depression and Follow-Up Plan

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

Analysis of Results

Table 3-120 displays the data that the health plan reported for the *Behavioral Health Coordination* PIP.

Table 3-120—Outcomes for the *Behavioral Health Coordination* PIP

Performance Indicator	Baseline (07/01/2021–09/30/2021)		Remeasurement 1 (07/01/2022–09/30/2022)		Remeasurement 2 (07/01/2023–09/30/2023)		Remeasurement 3 (07/01/2024–09/30/2024)		Sustained Improvement
1. Percent of shared members with eligible trigger events who received a combined review in the past three months.	N: 21 D: 102	20.6%	N: 90 D: 236	38.1%*	N: 63 D: 192	32.8%*	N: 48 D: 177	27.1%	*Not Met*

Performance Indicator	Baseline (07/01/2021–09/30/2021)		Remeasurement 1 (07/01/2022–09/30/2022)		Remeasurement 2 (07/01/2023–09/30/2023)		Remeasurement 3 (07/01/2024–09/30/2024)		Sustained Improvement
2. Percent of shared members whose data are actively shared at a regular frequency with partner agencies.	N: 849 D: 2,634	32.2%	N: 854 D: 2,764	30.9%	N: 1,092 D: 2,982	36.6%*	N: 869 D: 4,097	21.2%	*Not Met*

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

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. For Remeasurement 1, the Performance Indicator 1 rate increased to 38.1 percent and for Remeasurement 2, the rate was 32.8 percent. For Remeasurement 3, the rate was 27.1 percent, which represents statistically nonsignificant increase of 6.5 percentage points over the baseline.

The percentage of shared members whose data were actively shared with the partner agencies during the measurement period was 32.2 percent. For Remeasurement 1, Performance Indicator 2 rate decreased to 30.9 percent and for Remeasurement 2, the rate was 36.6 percent. For Remeasurement 3, the rate was 21.2 percent, which represents a statistically significant decrease of 11.0 percentage points over the baseline.

During Remeasurement 3, the health plan did not sustain statistically significant improvement for both performance indicators.

Table 3-121 displays the data that the health plan reported for the *Plan All-Cause Readmissions* PIP.

Table 3-121—Outcomes for the *Plan All-Cause Readmissions* PIP

Performance Indicator	Baseline (01/01/2021–12/31/2021)		Remeasurement 1 (01/01/2022–12/31/2022)		Remeasurement 2 (01/01/2023–12/31/2023)		Remeasurement 3 (01/01/2024–12/31/2024)		Sustained Improvement
For members 18–64 years of age, the percentage 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: 116 D: 1,121	10.4%	N: 129 D: 1,102	11.7%	*Not Assessed*

*Rate demonstrates statistically significant improvement over the baseline rate.
N–Numerator D–Denominator
HSAG rounded percentages to the first decimal place. The reported Remeasurement 3 rate was 11.71 percent and baseline rate was 11.73 percent.

The baseline rate for the percentage of eligible discharges for which members 18–64 years of age had at least one unplanned acute readmission for any diagnosis within 30 days of the Index Discharge Date was 11.7 percent. For Remeasurement 1, the rate decreased to 11.4 percent and for Remeasurement 2, the rate was 10.4 percent. For Remeasurement 3, the rate was 11.7 percent, which represents no change from the baseline when the data are reported up to one decimal place. In the PIP Submission Form, the health plan reported data up to two decimal places, which represents a marginal decrease (favorable outcome) of 0.02 percentage points from the baseline.

Table 3-122 displays the data that the health plan reported for the *Screening for Depression and Follow-Up Plan* PIP.

Table 3-122—Performance Indicator Results for the *Screening for Depression and Follow-Up Plan* PIP

Performance Indicator	Baseline (01/01/2024–12/31/2024)		Remeasurement 1 (01/01/2025–12/31/2025)		Sustained Improvement
1. Percentage of members ages 12 to 17 screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the eligible encounter.	N: 488 D: 2,006	24.3%			
2. Percentage of members aged 18 and older screened for depression on the date of the encounter or 14 days prior to the date of the encounter using an age-appropriate standardized depression screening tool, and, if positive, a follow-up plan is documented on the date of the eligible encounter.	N: 8,564 D: 27,899	30.7%			

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

The baseline rate for Performance Indicator 1 was 24.3 percent, and the baseline rate for Performance Indicator 2 was 30.7 percent.

Barriers/Interventions

Table 3-123 displays the barriers and interventions as documented by the health plan for each PIP.

Table 3-123—Interventions Implemented/Planned for UHC CP QI PIPs

Barriers	Interventions
Behavioral Health Coordination (BH)	
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 resources for unknown funding needed for system integration and data sharing. 5. Uncertain points of contact with partnering agencies and within health plan to streamline communication. 6. Inconsistent collaboration with DOH entities; limited systems view of coordination of services between MCO and partnering agencies. 7. 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. Develop a workflow for ongoing communication between health plan and partnering agencies. 6. Having a workgroup with partnering agencies that meets at least on a quarterly basis. 7. Explore funding needs for system integration and data sharing. 8. Executing MOAs.
Plan All-Cause Readmissions (PCR)	
1. Member not adhering to discharge instructions or medication plan. 2. Lack of member understanding of the importance of following up after discharge. 3. Member not established with their assigned primary care provider (PCP). 4. Social determinants of health (SDOH) challenges (transportation, housing, etc.). 5. Members with an underlying, untreated BH condition. 6. Untimely notification of discharges/discharge summary to the PCP and health plan (from the hospital). 7. Limited/inadequate resources to conduct follow-up (e.g., staffing shortages). 8. Lack of appropriate coordination of care before discharge and post-discharge.	1. Post discharge 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. 2. 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. 3. 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. 4. Collaborate with providers (e.g., Accountable Care Organizations [ACOs]) to conduct follow-up after discharge such as appointment reminders and scheduling. 5. Provider education for hospitals on timely notification of discharges.

Barriers	Interventions
9. Lack of staff directly involved in discharge planning and coordination at the hospital.	6. UHCCP initiated a review of functional areas that have internal care coordination roles to ensure efficient transitions of care and reduce duplication of efforts. This included clearly defining the responsibilities of Health Coordinators (HCs), Discharge Case Managers (DCMs), and Inpatient Care Managers (ICMs). The goal is to ensure seamless communication, real-time tracking of discharges, and consistent follow-up care. 7. UHCCP has expanded its clinical staffing model to focus on clinical discharge planning, care transitions, and member education. Clinical staff in expanded roles will work closely with hospital case managers to support high-risk members and reduce readmissions.
Screening for Depression and Follow-Up Plan	
1. Confusion: Provider believes screenings are being done. 2. Provider Claims and Documentation: Providers are not using appropriate codes and there is lack of proper documentation. 3. Lack of standardized screening protocols. 4. Lack of resources: Lack of training, referral resources, and support staff. 5. Lack of standardized screening protocols. 6. Claim Denials: Denying claims that capture CDF and administrative burden when claims get denied. 7. Lack of resources for provider resolution for claims. 8. Data Capture: Not an extractable measure, incomplete documentation from providers.	1. Educate PCPs via online news article and email distribution of existing interactive tool available on the provider portal (uhcprovider.com). 2. Face-to-face provider education conducted by Clinical Practice Consultants (CPCs) related to coding guidelines and updated workflows. 3. Collaborate with ACOs on updated workflows and coding practices.

Strengths

- For all three PIPs, UHC CP QI received an overall *High Confidence* validation rating for overall confidence in adherence to acceptable methodology for all phases of the PIP for Steps 1 through 8.

Areas for Improvement

- For the *Behavioral Health Coordination* and *Plan All-Cause Readmissions* PIPs, UHC CP QI has an opportunity for improvement in achievement of statistically significant improvement in the performance indicator rates.

Recommendations

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

- UHC CP QI must continually work on the PIPs throughout the year.
- For the *Behavioral Health Coordination* PIP, in addition to working with other health plans on the implementation of data sharing per the MOA with DOH agencies, the health plan must also review internal health plan-specific barriers toward implementation of the MOA and initiate appropriate interventions.
- For the *Plan All-Cause Readmissions* PIP:
  - UHC CP QI should build on the positive momentum gained and improvement achieved.
  - UHC CP QI should apply lessons learned and knowledge gained while conducting the PIP to future PIPs and other quality improvement efforts.
- For the *Screening for Depression and Follow-Up Plan* PIP, UHC CP QI must ensure that the interventions are implemented in a timely manner to impact outcomes during the remeasurement period.
- UHC CP QI must revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers and to see if any new barriers exist that require the development of interventions to drive improvement.
- UHC CP QI must submit an intervention worksheet for each intervention listed in the Barriers/Interventions table in the PIP Submission Form.
- The intervention effectiveness measure in the intervention worksheet must not be the same as the performance indicator documented in Step 5. The effectiveness measure should be designed to measure the effectiveness of the specific intervention on addressing the barrier linked to that intervention.
- UHC CP QI should collect the intervention effectiveness data more frequently (e.g., monthly, quarterly) unlike the annual performance indicator data. This would help UHC CP QI understand intervention effectiveness and make any updates to the interventions in a timely manner to impact remeasurement outcomes.
- Intervention effectiveness data must guide next steps for each individual intervention.

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

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

Findings

Table 3-124 presents the 2025 scores for UHC CP QI compared to the 2024 NCQA child Medicaid national averages, the corresponding 2023 scores, and the QI Program.

Table 3-124—Child CAHPS Results for UHC CP QI

Measure	2023 UHC CP QI Scores	2025 UHC CP QI Scores	2025 QI Program Scores
Global Ratings			
Rating of Health Plan	66.23%	65.66%	71.65%
Rating of All Health Care	67.82%+	66.67%+	68.95%
Rating of Personal Doctor	78.45%	75.81%	76.22%
Rating of Specialist Seen Most Often	66.67%+	81.82%+	77.78%
Composite Measures			
Getting Needed Care	79.03%+	78.22%+	80.76%
Getting Care Quickly	80.00%+	75.04%+ L	81.10%
How Well Doctors Communicate	95.97%+	95.63%+	94.25%
Customer Service	90.57%+	87.55%+	90.25%
Individual Item Measure			
Coordination of Care	88.24%+	95.24%+ ↑ H	87.77%

▲ *Indicates the 2025 score is statistically significantly higher than the 2023 score.*
▼ *Indicates the 2025 score is statistically significantly lower than the 2023 score.*
↑ *Indicates the 2025 score is statistically significantly higher than the QI Program.*
↓ *Indicates the 2025 score is statistically significantly lower than the QI Program.*
H *Indicates the 2025 score is statistically significantly higher than the NCQA national average.*
L *Indicates the 2025 score is statistically significantly lower than the NCQA national average.*
+ *Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.*

Strengths

- UHC CP QI's 2025 top-box score was statistically significantly higher than the 2024 NCQA child Medicaid national average for one measure, *Coordination of Care*.
- UHC CP QI's 2025 top-box score was statistically significantly higher than the QI Program's 2025 top-box score for one measure, *Coordination of Care*.
- UHC CP QI's 2025 top-box scores met or exceeded the RY 2025 target for the following measures: *Coordination of Care, Getting Needed Care, How Well Doctors Communicate,* and *Rating of Specialist Seen Most Often*.

Areas for Improvement

- UHC CP QI's 2025 top-box score was statistically significantly lower than the 2024 NCQA child Medicaid national average for one measure, *Getting Care Quickly*.

Recommendations

- HSAG recommends that UHC CP QI conduct root cause analyses or focus studies to determine why parents/caretakers of child members did not have timely access to care. UHC CP QI could consider if there are disparities within its populations that contribute to the lower performance in a particular race or ethnicity, age group, ZIP Code, etc. Upon identification of a root cause, UHC CP QI should implement appropriate interventions to improve the performance related to the care child members need.

Provider Survey

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

Findings

Table 3-125 presents the 2025 scores for UHC CP QI compared to the QI Program and the corresponding 2023 scores, where applicable.

Table 3-125—Provider Survey Results for UHC CP QI: Measure Scores

	2023 UHC CP QI Scores	2025 UHC CP QI Scores	2025 QI Program Scores
General Positions			
Compensation Satisfaction	39.84%	49.21%+	51.98%
Timeliness of Claims Payments	40.16%	39.94%+	40.57%
Prior Authorization Process Experience*			
Approval or Authorization Delayed	NT	62.90%+ NT	67.02%
Inconsistent Requirements	NT	58.05%+ NT	64.73%
Difficult to Navigate	NT	62.57%+ NT	64.75%
Labor Intensive	NT	51.13%+ NT	55.53%
Prior Authorization Process Impacts*			
Delayed Ability to Provide Treatments	NT	48.85%+ NT	53.47%
Disrupted Continuity of Care	NT	47.16%+ NT	52.62%
Created Administrative Burden	NT	39.55%+ NT	44.32%
Led to Denial of Service	NT	53.11%+ NT	59.57%
Formulary			
Formulary Impact on Care	28.53%+	33.46%+	37.27%

	2023 UHC CP QI Scores	2025 UHC CP QI Scores	2025 QI Program Scores
Non-Formulary			
Adequate Access to Non-Formulary Drugs	31.87%+	25.20%+ ↓	42.75%
Health Coordinators			
Helpfulness of Health Coordinators	35.10%+	47.66%+ ↓	56.24%
Specialists			
Adequate Network of Specialists	22.50%	35.16%+	37.96%
Substance Abuse			
Access to Substance Abuse Treatment	29.63%+	38.63%+ ↓	42.04%

▲ *Indicates the 2025 score is statistically significantly higher than the 2023 score.*
▼ *Indicates the 2025 score is statistically significantly lower than the 2023 score.*
↑ *Indicates the 2025 score is statistically significantly higher than the QI Program.*
↓ *Indicates the 2025 score is statistically significantly lower than the QI Program.*
NT *Indicates this measure was not included in 2023; therefore, a trend analysis was unable to be performed for this measure.*
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.
**Providers who responded 'No' for the survey questions within the Prior Authorization Process Experience and Impact domains, indicating they did not have a negative experience with the prior authorization process, were classified into the 'Satisfied' response category.*

Strengths

While UHC CP QI's 2025 top-box scores were not statistically significantly higher than the 2023 top-box scores or the QI Program for any measure, the top-box scores were higher in 2025 than in 2023 for the following measures:

- *Compensation Satisfaction*
- *Formulary Impact on Care*
- *Helpfulness of Health Coordinators*
- *Adequate Network of Specialists*
- *Access to Substance Abuse Treatment*

Areas for Improvement

- UHC CP QI's 2025 top-box scores were statistically significantly lower than the QI Program's 2025 top-box scores for the following measures: *Adequate Access to Non-Formulary Drugs*, *Helpfulness of Health Coordinators*, and *Access to Substance Abuse Treatment*.

Recommendations

UHC CP QI had the lowest experience scores for the *Adequate Access to Non-Formulary Drugs*, *Helpfulness of Health Coordinators*, and *Access to Substance Abuse Treatment* measures within the Non-Formulary, Health Coordinators, and Substance Abuse domains, respectively. The findings suggest higher levels of provider dissatisfaction with the efficiency of UHC CP QI's access to non-formulary drugs for patients when needed, health coordinators providing patient help when needed, and access to substance abuse treatment for patients when needed. HSAG recommends that MQD, in collaboration with UHC CP QI:

- Identify the factors driving provider dissatisfaction with providers' access to non-formulary drugs and substance abuse treatment to try to improve or expand providers' access.
- Identify potential factors influencing provider satisfaction with the efficiency of the health coordinators associated with UHC CP QI to ensure adequate assistance is provided when needed.

Overall Assessment of Quality, Accessibility, and Timeliness of Care

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

Conclusions

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 room for improvement.

UHC CP QI showed that it has systems, policies, and staff in place to ensure its structure and operations support core processes for providing care and services and promoting quality outcomes. UHC CP QI's performance during the 2025 compliance review was average, meeting or exceeding the statewide compliance score for six of the eight standards. UHC CP QI achieved 100 percent compliance in five of the eight standards. UHC CP 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 UHC CP QI's CAP activities until the health plan is found to be in full compliance.

Over two-thirds (67.14 percent) of UHC CP QI's performance measure rates fell below the 50th percentile, with almost half (47.14 percent) of the measure rates falling below the 25th percentile. While some measures showed improvement from MY 2023, UHC CP QI's performance demonstrated the need to improve process and outcome measures across most domains. UHC CP QI should address performance in the Children's Preventive Health, Care for Chronic Conditions, Behavioral Health, and Women's Health domains. Overall, 20 MQD Quality Strategy targets were met in MY 2024.

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

UHC CP QI progressed to the Outcomes stage of the two PIPs (*Behavioral Health Coordination* and *Plan All-Cause Readmissions*) that were initiated in CY 2022 and the Implementation stage for the *Screening for Depression and Follow-Up Plan* PIP initiated in CY 2024. The PIPs addressed CMS' requirements related to quality outcomes—specifically, the timeliness of and access to care and services.

The *Behavioral Health Coordination* PIP received a *High Confidence* level rating for overall confidence of adherence to acceptable methodology for all phases of the PIP and a *High Confidence* level rating for overall confidence that the PIP achieved significant improvement. The health plan achieved statistically significant improvement for both performance indicators during Remeasurement 2. During Remeasurement 3, Performance Indicator 1 had statistically nonsignificant improvement over the baseline. Performance Indicator 2 was below the baseline. The health plan did not sustain statistically significant improvement for both performance indicators.

The *Plan All-Cause Readmissions* PIP received a *High Confidence* level rating for overall confidence of adherence to acceptable methodology for all phases of the PIP and a *Moderate Confidence* rating for overall confidence that the PIP achieved significant improvement. The documented PIP design and data were accurate. The health plan conducted appropriate quality improvement processes to identify barriers, and it deployed interventions that were logically linked to the identified barriers. During Remeasurement 3, the health plan demonstrated a marginal improvement in the observed readmission rate.

The *Screening for Depression and Follow-Up Plan* PIP received a *High Confidence* level rating for adherence to acceptable methodology for all phases of the PIP. This performance suggests a sound PIP design, accurate reporting of data, and implementation of interventions that were related to barriers identified through quality improvement processes and have the potential to drive improvement in desired outcomes. UHC CP QI had not progressed to reporting remeasurement data and was therefore not assessed for achievement of improvement.

UHC CP QI's CAHPS results illustrate opportunities for improvement in parents/caretakers of child members' satisfaction. While none of the 2025 top-box scores were statistically significantly lower than the QI Program or 2023 top-box scores, UHC CP QI's 2025 top-box score was statistically significantly lower than the 2024 NCQA child Medicaid national average for one measure, *Getting Care Quickly*. These results indicate the need for UHC CP QI to implement improvement strategies to ensure parents/caretakers of child members have high-quality care and timely access to care.

While four of the nine measures MQD selected for monitoring within its Quality Strategy met or exceeded the RY 2025 target, UHC CP QI should focus improvement efforts on the *Customer Service, Getting Care Quickly, Rating of All Health Care, Rating of Health Plan,* and *Rating of Personal Doctor* measures, as these measures did not meet the RY 2025 target.

Although five measures had non-statistically significant increases in top-box scores from 2023 to 2025, UHC CP QI's Provider Survey results demonstrated areas for improvement. UHC CP QI's providers expressed dissatisfaction with the *Adequate Access to Non-Formulary Drugs*, *Helpfulness of Health Coordinators,* and *Access to Substance Abuse Treatment*, as the 2025 scores for these measures were statistically significantly lower than the QI Program, indicating a need for UHC CP QI to implement strategies to ensure members have access to care.

‘Ohana Community Care Services (‘Ohana CCS) Results

Compliance Monitoring Review

The 2025 compliance monitoring review activity included evaluation of the health plan’s compliance with State and federal requirements for organizational and structural performance.

Findings

Table 3-126 presents the standards and compliance scores for ‘Ohana CCS.

Table 3-126—Standards and Compliance Review Scores—‘Ohana CCS

Standard #	Standard Name	Total # of Elements	Number of Elements		Total Compliance Score
			# Met	# Not Met	
I	Availability of Services	14	14	0	100%
II	Assurances of Adequate Capacity and Services	3	3	0	100%
III	Coordination and Continuity of Care	9	9	0	100%
IV	Confidentiality	10	10	0	100%
V	Coverage and Authorization of Services	33	33	0	100%
VI	Enrollee Information	18	18	0	100%
VII	Enrollee Rights and Protections	7	7	0	100%
VIII	Grievance and Appeal System	31	29	2	94%
	Totals	**125**	**123**	**2**	**98%**

Total Elements: The total number of applicable elements in each standard.
Total Compliance Score: The compliance scores were calculated by adding the ***Met*** elements and then dividing by the total number of applicable elements.

Strengths

‘Ohana CCS achieved full compliance in seven of the eight standards reviewed, demonstrating strengths and adherence to all requirements measured in the following areas:

- Availability of Services
- Assurances of Adequate Capacity and Services
- Coordination and Continuity of Care
- Confidentiality
- Coverage and Authorization of Services
- Enrollee Information
- Enrollee Rights and Protections

These findings suggest that ‘Ohana CCS developed the necessary policies, procedures, and processes to operationalize the federal regulations and contractual requirements.

Areas for Improvement

The areas with the greatest opportunity for improvement were related to the following, as these areas received performance scores under 95 percent:

- Grievance and Appeal System

These findings suggest that ‘Ohana CCS did not always develop and implement the necessary policies, procedures, and processes required of the federal regulations and its health plan contract with MQD.

Recommendations

Of the 129 elements, ‘Ohana CCS received *Not Met* scores for two elements. HSAG recommends that ‘Ohana CCS continue to work with MQD on completing the CAPs for the two Grievance and Appeal System elements that scored as *Not Met*.

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 33 supplemental data sources for consideration to use for supplementing its MY 2024 performance measure rates. HSAG determined seven data sources to be standard supplemental data, and the remaining 11 were considered nonstandard supplemental data. ‘Ohana CCS withdrew 14 supplemental data sources, leaving 15 standard data sources and four nonstandard data sources. No concerns were identified, and the 15 standard and four nonstandard data sources were approved for HEDIS MY 2024 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 3-127.

Table 3-127—'Ohana CCS' Results for QI Measures Under Access and Risk-Adjusted Utilization

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Ambulatory Care				
*Emergency Department Visits/1,000 Member Years—Total**	528.14	468.09	-11.37%	★★★★
Outpatient Visits/1,000 Member Years—Total	2,130.75	2,425.49	13.83%	★

** A lower rate indicates better performance.*
MY 2024 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

The *Ambulatory Care—Emergency Department Visits/1,000 Member Years—Total* rate ranked at or above the 75th percentile when compared to the national benchmark.

Behavioral Health Performance Measure Results

'Ohana CCS' Behavioral Health performance measure results are shown in Table 3-128.

Table 3-128—'Ohana CCS' Results for QI Measures Under Behavioral Health

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	65.64%	71.93%	9.58%	★★★★
Antidepressant Medication Management				
Effective Acute Phase Treatment—18–64 Years	—	57.87%	—	NC
Effective Acute Phase Treatment—65+ Years	—	56.67%	—	NC
Effective Acute Phase Treatment—Total	57.03%	57.74%	1.24%	★★
Effective Continuation Phase Treatment—18–64 Years	—	36.60%	—	NC
Effective Continuation Phase Treatment—65+ Years	—	43.33%	—	NC
Effective Continuation Phase Treatment—Total	36.95%	37.36%	1.11%	★

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
Diabetes Monitoring for People With Diabetes and Schizophrenia				
Diabetes Monitoring for People With Diabetes and Schizophrenia	—	59.29%	—	★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	—	37.51%	—	★
Diagnosed Mental Health Disorders				
1–17 Years	NA	NA	—	NC
18–64 Years	99.20%	98.43%	-0.78%	★★★★★
65+ Years	98.51%	96.22%	-2.32%	★★★★★
Total	99.06%	97.96%	-1.11%	★★★★★
Follow-Up After Emergency Department Visit for Mental Illness				
7-Day Follow-Up—6–17 Years	NA	NA	—	NC
7-Day Follow-Up—18–64 Years	65.86%	62.91%	-4.48%	★★★★★
7-Day Follow-Up—65+ Years	NA	NA	—	NC
7-Day Follow-Up—Total	65.13%	62.77% ✓	-3.62%	★★★★★
30-Day Follow-Up—6–17 Years	NA	NA	—	NC
30-Day Follow-Up—18–64 Years	83.54%	84.34%	0.96%	★★★★★
30-Day Follow-Up—65+ Years	NA	NA	—	NC
30-Day Follow-Up—Total	83.14%	84.04% ✓	1.08%	★★★★★
Follow-Up After Emergency Department Visit for Substance Use				
7-Day Follow-Up—13–17 Years	NA	NA	—	NC
7-Day Follow-Up—18+ Years	54.29%	56.52%	4.11%	★★★★★
7 -Day Follow-Up—Total	54.29%	56.52%	4.11%	★★★★★
7-Day Follow-Up—18–64 Years	—	55.91%	—	NC
7-Day Follow-Up—65+ Years	—	NA	—	NC
30-Day Follow-Up—13–17 Years	NA	NA	—	NC
30-Day Follow-Up—18+ Years	77.86%	78.26%	0.51%	★★★★★
30-Day Follow-Up—Total	77.86%	78.26%	0.51%	★★★★★
30-Day Follow-Up—18–64 Years	—	77.95%	—	NC
30-Day Follow-Up—65+ Years	—	NA	—	NC
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—6–17 Years	NA	NA	—	NC
7-Day Follow-Up—18–64 Years	67.15%	59.95%	-10.72%	★★★★★

Measure	HEDIS MY 2023 Rate	HEDIS MY 2024 Rate	Relative Difference	MY 2024 Performance Level
7-Day Follow-Up—65+ Years	NA	57.14%	—	★★★★★
7-Day Follow-Up—Total	66.48%	59.73% ✓	-10.15%	★★★★★
30-Day Follow-Up—6–17 Years	NA	NA	—	NC
30-Day Follow-Up—18–64 Years	82.42%	79.85%	-3.12%	★★★★★
30-Day Follow-Up—65+ Years	NA	71.43%	—	★★★★★
30-Day Follow-Up—Total	82.40%	79.18% ✓	-3.91%	★★★★★
Initiation and Engagement of Substance Use Disorder Treatment				
Initiation of SUD Treatment—Total—13–17 Years	NA	NA	—	NC
Initiation of SUD Treatment—Total—18–64 Years	32.10%	32.02%	-0.25%	★
Initiation of SUD Treatment—Total—65+ Years	25.00%	13.89%	-44.44%	★
Initiation of SUD Treatment—Total—Total	31.35%	29.68%	-5.33%	★
Engagement of SUD Treatment—Total—13–17 Years	NA	NA	—	NC
Engagement of SUD Treatment—Total—18–64 Years	11.60%	9.50%	-18.10%	★★
Engagement of SUD Treatment—Total—65+ Years	12.50%	2.78%	-77.76%	★
Engagement of SUD Treatment—Total—Total	11.70%	8.63%	-26.24%	★★

NC indicates that the rate was not compared to national benchmarks, either because the measure did not have a benchmark, or it was not appropriate to compare due to NCQA's recommendation for a break in trending.
NA indicates that the health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
— Indicates that the health plan was not previously required to report this measure or that the relative difference could not be calculated because one of the rates was not reported.
and ✓ indicates the health plan met or exceeded the target threshold established by MQD.
MY 2024 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*

Eighteen of the measure indicator rates ranked at or above the 75th percentile. Conversely, 11 measure indicator rates ranked below the 90th percentile.

'Ohana CCS met the MQD-established Quality Strategy target for the following measure indicator rates:

- *Follow-Up After Emergency Department for Mental Illness—7-Day Follow-Up—Total*

- *Follow-Up After Emergency Department for Mental Illness—30-Day Follow-Up—Total*
- *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total*
- *Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total*

All other MQD Quality Strategy targets were not met for this domain.

Strengths

Based on HSAG's analyses of the 30 'Ohana CCS measure indicator rates with comparable benchmarks, 19 of these measure rates (63.33 percent) ranked at or above the 50th percentile, and 17 of the 30 measure rates (56.67 percent) met or exceeded the 90th percentile. In addition, 'Ohana CCS met four MQD Quality Strategy targets for MY 2024.

Areas for Improvement

Conversely, 11 measure indicator rates (36.67 percent) fell below the 50th percentile, suggesting opportunities for improvement.

Recommendations

HSAG recommends that 'Ohana CCS focus on improving performance related to the following measures:

- Within the Behavioral Health domain, the following recommendations were identified:
  - Regarding the *Antidepressant Medication Management* measure, HSAG recommends that 'Ohana CCS continue to consider clinical recommendations shown to improve adherence to antidepressants, such as assessing depressive symptoms at baseline and each follow-up, as well as providing psychoeducation to members and their families.[39] In addition, HSAG recommends that 'Ohana CCS provide education to providers and members about the importance of medication management.
  - Regarding the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* and *Diabetes Monitoring for People With Diabetes and Schizophrenia* measures, HSAG recommends that 'Ohana CCS consider effective interventions to ensure annual screenings are conducted for people with schizophrenia, especially those taking antipsychotic medications. HSAG recommends that 'Ohana CCS provide education to providers and members about the importance of diabetes screening tests and encourage timely follow-up for early detection, monitoring, and management.
  - Regarding the *Initiation and Engagement of Substance Use Disorder Treatment* measure, HSAG recommends that 'Ohana CCS continue to review patient data for any patterns present by ZIP Code and other demographics for case management prioritization. For instance, one study

[39] Solmi M, Miola A, Croatto G, et al. How can we improve antidepressant adherence in the management of depression? A targeted review and 10 clinical recommendations. *Brazilian Journal of Psychiatry*. 2021;43(2):189–202.

suggests that members who are male and have a schizophrenia spectrum disorder diagnosis are less likely to initiate treatment, while current drug dependence and recent arrest were associated with lowered odds of engaging in treatment. Current drug dependence is associated with factors that make scheduling and attending treatment appointments difficult, such as severe symptoms, chaotic living situations, and self-care and life functioning issues.[40]

Validation of Network Adequacy

HSAG evaluated and assessed the data methods that ‘Ohana CCS used to calculate results generated for each network adequacy indicator in the scope of the 2025 NAV activities. HSAG used indicator-specific worksheets to generate a validation rating that reflects HSAG’s overall confidence that `Ohana CCS used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicator.

Findings

Based on the results of the ISCA combined with the virtual audit and detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the health plan’s interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator. HSAG calculated the validation score for each indicator and determined the final indicator-specific validation ratings for each health plan according to the CMS EQR Protocol 4 and as defined in Table 3-129 of the Network Adequacy Indicator Validation Rating Determinations section of this report. Table 3-130 presents a summary of the NAV validation ratings for ‘Ohana CCS by indicator.

Table 3-129—Indicator-Level Validation Rating Categories

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

Table 3-130—Summary of 'Ohana CCS Validation Ratings

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Time and Distance	77.78%	0%	0%	0%

[40] Brown CH, Bennett ME, Li L, Bellack AS. Predictors of initiation and engagement in substance abuse treatment among individuals with co-occurring serious mental illness and substance use disorders. *Addictive Behaviors.* 2010;36(5):439-47.

Network Adequacy Indicator Type	High Confidence	Moderate Confidence	Low Confidence	No Confidence/ Significant Bias
Mandatory Provider Type	82.35%	0%	0%	0%

Between unique minimum network requirement standards and urbanicity designations, HSAG assessed a total of 26 indicators; five were unable to be validated for ‘Ohana CCS. Of these indicators, 100 percent received *High Confidence* ratings.

No indicators were designated as *Low Confidence* or *No Confidence* for ‘Ohana CCS.

HSAG determined that ‘Ohana CCS was compliant with a subset of network adequacy requirements for the Mandatory Provider Types indicators. Compliance was determined based on the health plan meeting the State’s Mandatory Provider Type indicators, which includes one servicing provider within each provider type. All indicators were calculated by MQD. Results are presented by provider type in Table 3-131, and noncompliant results are presented in Table 3-132.

Table 3-131—'Ohana CCS Network Adequacy Mandatory Provider Types Compliance

Provider Type	Compliance
Behavioral Healthcare Specialist services as provided by Psychiatrists, Psychologists, Social Workers, Certified Substance Abuse Counselors (CSACs), and Advanced Practice Nurses trained in Psychology	*Met*
Case Management	*Met*
Crisis Services: Mobile Crisis Response, Crisis Residential Services	*Met*
Laboratory Services	*Met*
Mental Health Rehabilitation Services	*Met*
Peer Specialists	*Met*
Pharmacies	*Met*
Representative Payee	*Met*
Substance use disorder (SUD) Services	*Met*
Supported Employment	*Met*

Table 3-132—'Ohana CCS Network Adequacy Mandatory Provider Types Noncompliance

Provider Type	Compliance
Day Treatment Programs	*Not Met*
Interpretation Services	*Not Met*
Psychosocial Rehabilitation (PSR)/Clubhouse	*Not Met*
Supportive Housing	*Not Met*

HSAG determined that during the NAV review period, the mandatory provider types represented in Table 3-133 were not included in the PNA reference tables and data submission format file used to report results; therefore, the health plan did not submit data allowing MQD to calculate compliance. This resulted in HSAG's *Unable to Validate* designation for each of the associated provider types.

Table 3-133—'Ohana CCS Network Adequacy Mandatory Provider Types *Unable to Validate* Indicators

Provider Type
Inpatient Behavioral Health Hospital Services
Outpatient Behavioral Health Hospital Services
Community Integration Services (CIS)

HSAG determined that 'Ohana CCS was compliant with network adequacy requirements for the Time and Distance standard for six of seven (85.71 percent) indicators. MQD required at least 85 percent of members to have access to the providers within the associated time or distance parameters. Compliance was determined based on the health plan meeting the State's Time and Distance indicators for both Urban and Rural classifications. All indicators were calculated by MQD. Results are presented by provider type and urbanicity in Table 3-134.

Table 3-134—'Ohana CCS Network Adequacy Time and Distance ≥85% Compliance by Urbanicity

Provider Type	Urbanicity	Compliance
24-Hour Pharmacies	Urban	87.8%
Any Mental Health Provider	Urban	100.0%
	Rural	100.0%
Certified Substance Use Counselors	Urban	94.0%
	Rural	94.1%
Hospitals	Urban	100.0%
	Rural	100.0%
Mental Health Nurse Practitioners	Urban	100.0%
	Rural	100.0%
Other Mental Health Counselors	Urban	94.0%
	Rural	94.1%
Pharmacies	Urban	100.0%
	Rural	100.0%
Psychiatrists	Urban	100.0%
	Rural	100.0%
Psychologists	Urban	100.0%
	Rural	100.0%

Provider Type	Urbanicity	Compliance
Social Workers	Urban	100.0%
	Rural	100.0%

HSAG determined that during the NAV review period, the Time and Distance provider types represented in Table 3-135 were not included in the PNA reference tables and data submission format file used to report results; therefore, the health plan did not submit data allowing MQD to calculate compliance. This resulted in HSAG's *Unable to Validate* designation for each of the associated provider types.

Table 3-135—'Ohana CCS Network Adequacy Time and Distance *Unable to Validate* Indicators

Provider Type	Urbanicity
Emergency Services Facilities	Urban
	Rural

Strengths

HSAG identified the following strengths related to NAV for 'Ohana CCS:

- 'Ohana CCS continued to maintain detailed process documentation for creation of the network adequacy report by extracting robust data and cleaning processes to ensure business continuity of the network adequacy reporting process.

Areas for Improvement

- 'Ohana CCS did not meet four of the 14 Minimum Required Provider Type indicators.

Recommendations

- HSAG recommends that 'Ohana CCS continue its recruiting and contracting efforts for provider specialties that did not meet the Provider Ratios standard, with the goal of determining whether the failure to meet the contract standards was the result of a lack of providers or an inability to contract providers in the geographic area.

Validation of Performance Improvement Projects

In CY 2025, 'Ohana CCS continued two PIPs—*Behavioral Health Coordination* and *7-Day Follow-Up After Emergency Department Visit for Mental Illness*. For the CY 2025 submission, the health plan reported Outcomes stage of the PIPs and submitted Steps 1 through 8 in the PIP Submission Form. The PIPs were assessed for improvement in outcomes in Step 9.

Table 3-136 displays the topics, progression status, and measurement periods reported for the PIPs.

Table 3-136—CY 2025 'Ohana CCS PIP Topics and Status

PIP Topic	PIP Progression Status	Baseline Measurement Period	Measurement Period Reported in CY 2025
Behavioral Health Coordination	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	07/01/2021 to 09/30/2021	07/01/2024 to 09/30/2024 (Remeasurement 3)
7-Day Follow-Up After Emergency Department Visit for Mental Illness	PIP Design, Implementation, and Outcomes Stages (Steps 1 through 9)	CY 2021	CY 2024 (Remeasurement 3)

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

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

Findings

Table 3-137 illustrates the validation results for the two PIPs submitted by 'Ohana CCS for CY 2025 validation.

Table 3-137—CY 2025 PIP Validation Results for 'Ohana CCS

PIP Topic	Validation Rating 1			Validation Rating 2		
	Overall Confidence in Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Behavioral Health Coordination	100%	100%	*High Confidence*	100%	100%	*High Confidence*

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

[1] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.
[2] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
[3] **Confidence Level**— Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

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

The *7-Day Follow-Up After Emergency Department Visit for Mental Illness* PIP was validated through all nine steps in the PIP Validation Tool. For Validation Rating 1, HSAG assigned a *High Confidence* level rating for adhering to acceptable PIP methodology. For Validation Rating 2, HSAG assigned a *No Confidence* level rating that the PIP achieved significant improvement.

Design (Steps 1-6)

Behavioral Health Coordination

The selected PIP topic was required by MQD. 'Ohana CCS' Aim statement set the focus of the PIP, and the eligible population was clearly defined. The performance indicators were developed in consultation and discussion with MQD and HSAG. The technical design of the PIP was sufficient to measure outcomes, allowing for successful progression to the next stage of the PIP process.

7-Day Follow-Up After Emergency Department Visit for Mental Illness

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.

Implementation (Steps 7-8)

Behavioral Health Coordination

'Ohana CCS accurately reported and analyzed the Remeasurement 3 rates for the two performance indicators. 'Ohana CCS documented its quality improvement efforts, which included participating in workgroup meetings with partnering agencies to discuss data sharing and identify the gaps in information needed by the health plans and DOH agencies. 'Ohana CCS documented that the MOA for data sharing between the health plan and DOH Behavioral Health Services Administration divisions was signed and was effective January 1, 2025. At the time of the PIP reporting, the data sharing had not yet started. The health plan was working toward implementation of data sharing per the MOA in discussion with other health plans and DOH agencies.

7-Day Follow-Up After Emergency Department Visit for Mental Illness

'Ohana CCS accurately reported and analyzed the Remeasurement 3 rate for the performance indicator. 'Ohana CCS conducted appropriate quality improvement processes to identify barriers, and it deployed interventions that were logically linked to the identified barriers. The interventions could reasonably be expected to positively impact performance indicator outcomes. 'Ohana CCS included an evaluation of effectiveness for each intervention and appropriate next steps for the interventions.

Outcomes (Step 9)

Behavioral Health Coordination

During Remeasurement 3, the health plan sustained statistically significant improvement over the baseline in the Performance Indicator 1 rate and documented a rate of 100 percent for Performance Indicator 2.

7-Day Follow-Up After Emergency Department Visit for Mental Illness

During Remeasurement 3, the health plan did not achieve any improvement and had a statistically nonsignificant decline in the performance indicator rate as compared to the baseline.

Analysis of Results

Table 3-138 displays the data that the health plan reported for the *Behavioral Health Coordination* PIP.

Table 3-138—Outcomes for the *Behavioral Health Coordination* PIP

Performance Indicator	Baseline (07/01/2021–09/30/2021)		Remeasurement 1 (07/01/2022–09/30/2022)		Remeasurement 2 (07/01/2023–09/30/2023)		Remeasurement 3 (07/01/2024–09/30/2024)		Sustained Improvement
1. Percent of shared members with eligible trigger events who received a combined review in the past three months.	N: 4 D: 132	3.0%	N: 17 D: 144	11.8%*	N: 82 D: 326	25.2%*	N: 53 D: 284	18.7%*	*Yes*
2. 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%	N: 5,560 D: 5,560	100%	N: 5,408 D: 5,408	100%	*Not Applicable*

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

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. For Remeasurement 1, the Performance Indicator 1 rate increased to 11.8 percent and for Remeasurement 2, the rate was 25.2 percent. For Remeasurement 3, the rate was 18.7 percent, which represents a statistically significant increase of 15.7 percentage points over the baseline. Only formal reviews were included in the baseline data. Due to enhanced data capturing capability to capture informal combined reviews during the remeasurement periods as compared to the baseline, the improvement in Performance Indicator 1 rate must be interpreted with caution.

The percentage of shared members whose data were actively shared with the partner agencies during the baseline measurement period was 100 percent. The health plan documented that it sends enrollment files of all shared members to all health plans on a regular basis. The enrollment files include information useful for 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 'Ohana CCS and the DOH agencies, and data regarding a member were exchanged at the time of the meeting from both parties. For Remeasurement 1, Remeasurement 2, and Remeasurement 3, the Performance Indicator 2 rate remained at 100 percent, and the data sharing process was the same as during the baseline. Routine data sharing between the health plan and the DOH Behavioral Health Services Administration divisions had not yet started.

Table 3-139 displays the data that the health plan reported for the *7-Day Follow-Up After Emergency Department Visit for Mental Illness* PIP.

Table 3-139—Outcomes for the *7-Day Follow-Up After Emergency Department Visit for Mental Illness*

Performance Indicator	Baseline (01/01/2021–12/31/2021)		Remeasurement 1 (01/01/2022–12/31/2022)		Remeasurement 2 (01/01/2023–12/31/2023)		Remeasurement 3 (01/01/2024–12/31/2024)		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: 282 D: 433	65.1%	N: 236 D: 376	62.8%	*Not Assessed*

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

The baseline (CY 2021) rate for the percentage of ED visits for members (18+ years of age) with a principal diagnosis of mental illness or intentional self-harm who had a follow-up visit within seven days of the ED visit was 69.9 percent. For Remeasurement 1, the rate increased to 72.1 percent and for Remeasurement 2, the rate was 65.1 percent. For Remeasurement 3, the rate was 62.8 percent, which represents a statistically nonsignificant decline of 7.1 percentage points as compared to the baseline rate.

Barriers/Interventions

Table 3-140 displays the barriers and interventions as documented by the health plan for both PIPs.

Table 3-140—Interventions Implemented/Planned for 'Ohana CCS PIPs

Barriers	Interventions
Behavioral Health Coordination (BH)	
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. 3. Lack of ongoing communication between partnering agencies. 4. Lack of health plan staff's knowledge about MOA with the DOH agencies and starting the	1. Having a workgroup with partnering agencies that meets at least on a quarterly basis. 2. Developed a workflow for ongoing communication with the health plans. 3. Educate staff internally and meet DOH agencies prior to sending data per the MOA.

Barriers	Interventions
combined reviews and exchange of shared member's data.	
7-Day Follow-Up After Emergency Department Visit for Mental Illness	
1. ED facility is too busy, and it is not a priority for the facility to notify the health plan of member's visit to the ED. 2. Members do not identify their case manager. 3. ED staff are unable to identify members due to members not being properly identified having CCS coverage. This may occur as CCS members are often homeless and do not have proper identifications or insurance cards with them.	1. The PIP team works with Queen's ED facility who are proactive in reducing ED utilization and have its team reach out to CCS member's case managers and schedule a follow-up appointment within seven (7) days post ED visit for mental illness. 2. Queen's ED and Straub's ED facilities 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 reach out to the members to encourage the members to complete the follow-up visits within seven days post ED visit for mental illness. 3. 'Ohana Health Plan will work with the CBCMs to identify the gaps and arrange for the follow-up visit for their members and educate how the CBCMs can arrange the transportation for its members. 'Ohana Health Plan provides transportation for their members at no cost to the members when attending their follow-up appointment.

Strengths

- For both PIPs, 'Ohana CCS received an overall *High Confidence* validation rating for overall confidence to acceptable methodology for all phases of the PIP for Steps 1 through 8. The *Behavioral Health Coordination* PIP also achieved a *High Confidence* validation rating for overall confidence that the PIP achieved significant improvement.
- For the *Behavioral Health Coordination* PIP, during Remeasurement 3, the health plan sustained statistically significant improvement over the baseline in the Performance Indicator 1 rate and documented a rate of 100 percent for Performance Indicator 2 for the baseline and the remeasurement periods.

Areas for Improvement

For the *7-Day Follow-Up After Emergency Department Visit for Mental Illness* PIP, the health plan has an opportunity for improvement in achievement of statistically significant improvement in the performance indicator rate.

Recommendations

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

- ‘Ohana CCS must continually work on the PIPs throughout the year.
- For the *Behavioral Health Coordination* PIP, in addition to working with other health plans on the implementation of data sharing per the MOA with DOH agencies, the health plan must also review internal health plan-specific barriers toward implementation of MOA and initiate appropriate interventions.
- For the *7-Day Follow-Up After Emergency Department Visit for Mental Illness* PIP:
  - ‘Ohana CCS should apply lessons learned and knowledge gained while conducting the PIP to future PIPs and other quality improvement efforts.
- ‘Ohana CCS must revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers and to see if any new barriers exist that require the development of interventions to drive improvement.
- ‘Ohana CCS must submit an intervention worksheet for each intervention listed in the Barriers/Interventions table in the PIP Submission Form.
- The intervention effectiveness measure in the intervention worksheet must not be the same as the performance indicator documented in Step 5. The effectiveness measure should be designed to measure the effectiveness of the specific intervention on addressing the barrier linked to that intervention.
- ‘Ohana CCS should collect the intervention effectiveness data more frequently (e.g., monthly, quarterly) unlike the annual performance indicator data. This would help ‘Ohana CCS understand intervention effectiveness and make any updates to the interventions in a timely manner to impact remeasurement outcomes.
- Intervention effectiveness data must guide next steps for each individual intervention.

Overall Assessment of Quality, Accessibility, and Timeliness of Care

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

Conclusions

In general, ‘Ohana CCS’ performance results illustrate mixed performance across the four EQR activities. ‘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 met or exceeded the statewide compliance score for all eight standards and scored 100 percent in seven of the eight standards. ‘Ohana CCS was required to develop a CAP to address and

resolve the deficiencies identified in the review. HSAG and MQD provided feedback on the proposed corrective actions and ‘Ohana CCS was found to be in full compliance in December 2025.

Overall, more than half (63.33 percent) of ‘Ohana CCS’ measure indicator rates ranked at or above the 50th percentile, with 11 measure rates (36.67 percent) falling below the 50th percentile. ‘Ohana CCS should address performance in the Behavioral Health domain, specifically the *Antidepressant Medication Management, Diabetes Monitoring for People With Diabetes and Schizophrenia*, *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*, and *Initiation and Engagement of Substance Use Disorder Treatment* performance measures. Overall, four MQD Quality Strategy targets were met in MY 2024.

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

Finally, ‘Ohana CCS reported 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.

The *Behavioral Health Coordination* PIP received a *High Confidence* level rating for overall confidence of adherence to acceptable methodology for all phases of the PIP and a *High Confidence* rating for overall confidence that the PIP achieved significant improvement. During Remeasurement 3, the health plan sustained statistically significant improvement over the baseline in the Performance Indicator 1 rate and documented a rate of 100 percent for Performance Indicator 2 for the baseline and remeasurement periods.

The *7-Day Follow-Up After Emergency Department Visit for Mental Illness* PIP received a *High Confidence* rating for overall confidence of adherence to acceptable methodology for all phases of the PIP and a *No Confidence* rating for overall confidence that the PIP achieved significant improvement. The health plan conducted appropriate quality improvement processes to identify barriers, and it deployed interventions that were logically linked to the identified barriers. During Remeasurement 3, the health plan did not achieve any improvement over the baseline.

4. Comparative Analysis of Health Plan Performance

Introduction

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

Compliance Monitoring Review

Table 4-1 summarizes the results from the 2025 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.

Table 4-1—Standards and Compliance Scores

Standard Name	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI	'Ohana CCS	Statewide Score
I. Availability of Services	100%	100%	100%	100%	100%	100%	**100%**
II. Assurances of Adequate Capacity and Services	100%	100%	100%	100%	100%	100%	**100%**
III. Coordination and Continuity of Care	100%	100%	100%	100%	100%	100%	**100%**
IV. Confidentiality	100%	100%	100%	100%	100%	100%	**100%**
V. Coverage and Authorization of Services	100%	97% ↓	100%	100%	97% ↓	100%	**99%**
VI. Enrollee Information	95% ↓	100%	100%	100%	95% ↓	100%	**98%**
VII. Enrollee Rights and Protections	100%	100%	100%	100%	100%	100%	**100%**
VIII. Grievance and Appeal System	97%	94%	97%	81% ↓	97%	94%	**93%**
Totals	**98%**	**98%**	**99%**	**95%↓**	**98%**	**98%**	**98%**

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

and ↓ indicates health plan performance was below the statewide score.

Across all six health plans, performance was strongest in the areas of Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Confidentiality, and Enrollee Rights and Protections during the 2025 compliance reviews, with no corrective actions required.

The Grievance and Appeal System standard had the most individual elements scored as *Not Met*, followed by Coverage and Authorization of Services and Enrollee Information. 'Ohana QI had the most

individual elements requiring correction. KFHP QI had only one element scored as *Not Met*. These results suggest an overall high degree of compliance with State and federal managed care requirements. Following the 2025 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 2024 NCQA HEDIS Compliance Audit.

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

IS Standard	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
IS A—Administrative Data	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*
IS M—Medical Record Review Processes	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*
IS C—Clinical and Care Delivery Data	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*
IS R—Data Management and Reporting	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*
IS L—Case Management Data	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*	*Fully Compliant*

HEDIS Performance Measure Results

This section of the report highlights the health plans' performance for the current MY by domain of care. Each table illustrates the health plans' MY 2024 measure rates and their performance relative to NCQA's 2024 Quality Compass national Medicaid HMO percentiles for HEDIS MY 2023, where applicable. Please note there are no national benchmarks for the LTSS measures; therefore, these are not displayed. The performance level star ratings are defined as follows:

★★★★★ = 90th percentile and above
★★★★ = 75th percentile to 89th percentile
★★★ = 50th percentile to 74th percentile

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

Access and Risk-Adjusted Utilization

Table 4-3 displays the Access and Risk-Adjusted Utilization measure rates for each QI health plan.

Table 4-3—MY 2024 Comparison of Access and Risk-Adjusted Utilization Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Adults' Access to Preventive/Ambulatory Health Services					
20–44 Years	52.48% ★	64.74% ★	61.44% ★	50.41% ★	50.42% ★
45–64 Years	67.51% ★	76.57% ★★	75.03% ★	70.02% ★	71.35% ★
65+ Years	78.64% ★★	83.54% ★★★	84.24% ★★★	81.49% ★★★	92.15% ★★★★
Total	60.09% ★	70.13% ★★	68.15% ★	62.45% ★	73.03% ★★
Plan All-Cause Readmissions					
*Observed Readmissions—18–64 Years**	8.80% —	8.46% —	8.58% —	9.37% —	11.71% —
*Expected Readmissions—18–64 Years**	8.92% —	8.91% —	8.51% —	9.93% —	9.77% —
*O/E Ratio—18–64 Years**	0.9859 —	0.9493 —	1.0089 —	0.9434 —	1.1983 —
PQI 08: Heart Failure Admission Rate					
*18–64 Years**	53.55 —	31.23 —	36.20 —	85.38 —	63.56 —
*65+ Years**	195.66 —	99.62 —	93.98 —	177.24 —	173.65 —
*Total**	68.16 —	36.85 ✓ —	41.91 ✓ —	98.78 —	102.54 —
PQI 15: Asthma in Younger Adults Admission Rate					
*18–39 Years**	0.99 ✓ —	1.76 ✓ —	1.72 ✓ —	1.99 ✓ —	4.19 —

** A lower rate indicates better performance.*
— Indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.
and ✓ indicates the health plan met or exceeded the target threshold established by MQD.
MY 2024 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Within the Access and Risk-Adjusted Utilization performance measure domain, two of five QI health plans (HMSA QI and KFHP QI) met MQD's established target for *PQI 08: Heart Failure Admission Rate—Total.* In addition, four of five QI health plans (AlohaCare QI, HMSA QI, KFHP QI, and 'Ohana QI) met MQD's established target for *PQI 15: Asthma in Younger Adults Admission Rate—18–39 Years* rate.

Adults' Access to Preventive/Ambulatory Health Services—65 Years and Older ranked at or above the 50th percentile for four plans. All other measure indicators in this domain did not meet or exceed the 50th percentile or did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented.

Children's Preventive Health

Table 4-4 displays the Children's Preventive Health measure rates for each health plan compared to the national Medicaid percentiles.

Table 4-4—MY 2024 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					
Total	45.19% ★	58.37% ✓ ★★★★	46.86% ★★	43.93% ★	45.04% ★
Childhood Immunization Status					
Combination 3	39.17% ★	69.10% ✓ ★★★★	69.47% ✓ ★★★★	48.99% ★	54.99% ★
Combination 7	32.85% ★	58.15% ✓ ★★★	66.55% ✓ ★★★★★	43.77% ★	50.36% ✓ ★
Combination 10	22.87% ★★	30.90% ★★★	51.18% ✓ ★★★★★	30.72% ★★★	33.58% ★★★
DTaP	45.74% ★	76.64% ★★★★	73.06% ★★★	56.52% ★	59.12% ★
Hepatitis A	59.61% ★	82.73% ★★★	83.28% ★★★	70.14% ★	72.75% ★
Hepatitis B	52.31% ★	81.75% ★	86.53% ★★★	70.43% ★	78.35% ★
HiB	55.47% ★	84.18% ★★★	84.40% ★★★	70.72% ★	74.21% ★
Influenza	33.82% ★★	40.39% ★★★	59.82% ★★★★★	42.61% ★★★	43.07% ★★★
IPV	55.23% ★	83.94% ★★	84.62% ★★	69.86% ★	74.21% ★

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
MMR	59.85% ★	83.70% ★★	83.61% ★★	71.59% ★	73.48% ★
Pneumococcal Conjugate	46.72% ★	75.18% ★★★	71.16% ★★	55.65% ★	59.37% ★
Rotavirus	45.01% ★	68.37% ★★	78.56% ★★★★★	56.52% ★	61.80% ★
VZV	59.37% ★	82.24% ★★	82.94% ★★	70.14% ★	72.99% ★
Immunizations for Adolescents					
Combination 1	59.61% ★	74.70% ✓ ★★	73.70% ✓ ★	52.77% ★	56.20% ★
Combination 2	29.68% ★	50.61% ✓ ★★★★★	51.90% ✓ ★★★★★	28.86% ★	34.06% ★★
Meningococcal	60.34% ★	76.16% ★★	74.28% ★	53.06% ★	56.93% ★
Tdap	61.80% ★	78.59% ★	75.89% ★	55.39% ★	59.61% ★
HPV	30.17% ★	52.31% ★★★★★	53.06% ★★★★★	29.45% ★	35.28% ★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile—3–11 Years	84.29% ★★★	84.27% ★★★	96.38% ★★★★★	92.48% ★★★★★	89.40% ★★★★
BMI Percentile—12–17 Years	81.75% ★★★	89.83% ★★★★	97.48% ★★★★★	93.79% ★★★★★	92.97% ★★★★★
BMI Percentile—Total	83.23% ★★★	86.49% ✓ ★★★	96.84% ✓ ★★★★★	92.94% ✓ ★★★★★	90.51% ✓ ★★★★
Counseling for Nutrition—3–11 Years	83.77% ★★★★	78.65% ★★★	97.74% ★★★★★	82.33% ★★★★	78.80% ★★★
Counseling for Nutrition—12–17 Years	78.83% ★★★★	76.27% ★★★	98.74% ★★★★★	84.83% ★★★★	85.94% ★★★★★
Counseling for Nutrition—Total	81.71% ✓ ★★★★	77.70% ★★★	98.16% ✓ ★★★★★	83.21% ✓ ★★★★	81.02% ✓ ★★★★
Counseling for Physical Activity—3–11 Years	82.20% ★★★★★	73.60% ★★★	97.29% ★★★★★	80.83% ★★★★	77.03% ★★★★
Counseling for Physical Activity—12–17 Years	79.56% ★★★★	76.27% ★★★	98.74% ★★★★★	84.83% ★★★★★	89.06% ★★★★★
Counseling for Physical Activity—Total	81.10% ✓ ★★★★	74.66% ★★★	97.89% ✓ ★★★★★	82.24% ✓ ★★★★★	80.78% ✓ ★★★★

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	61.95% ★★★	71.60% ✓ ★★★★★	74.69% ✓ ★★★★★	53.82% ★	58.33% ★★
Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	62.69% ★	78.09% ✓ ★★★★	83.39% ✓ ★★★★★	63.21% ★	58.70% ★

and ✓indicates the health plan met or exceeded the target threshold established by MQD.

MY 2024 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Within the Children's Preventive Health performance measure domain, KFHP QI performed best among the health plans, with 22 measure rates ranking at or above the 50th percentile and 17 measure rates ranking at or above the 90th percentile. HMSA QI also demonstrated high performance with 22 measure rates ranking at or above the 50th percentile and three measure rates ranking at or above the 90th percentile. 'Ohana QI demonstrated the lowest performance among the health plans, with 19 measure indicator rates that could be compared to benchmarks ranking below the 25th percentile.

HMSA QI, KFHP QI, and UHC CP QI met MQD's established target for *Childhood Immunization Status—Combination 7.* HMSA QI, KFHP QI, 'Ohana QI, and UHC CP QI met MQD's established target for *Weight Assessment and Counseling for Nutrition/Physical Activity—BMI Percentile—Total*. For *Weight Assessment and Counseling for Nutrition/Physical Activity—Counseling for Nutrition—Total* and *Counseling for Physical Activity—Total,* four of the five health plans (AlohaCare QI*,* KFHP QI, 'Ohana QI, UHC CP QI) met the established MQD target. HMSA QI and KFHP QI met MQD's established target for *Childhood Immunization Status—Combination 3* and *Immunization for Adolescents—Combination 1* and *Combination 2.* Finally, HMSA QI and KFHP QI met MQD's established target for both *Well-Child Visits in the First 30 Months of Life* indicators.

Women's Health

Table 4-5 displays the Women's Health measure rates for each health plan compared to the national Medicaid percentiles.

Table 4-5—MY 2024 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	44.04% ★	59.55% ✓ ★★★	61.22% ✓ ★★★	44.77% ★	41.61% ★
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	69.21% ★	79.17% ★	90.00% ✓ ★★★★	69.74% ★	73.71% ★
Postpartum Care	69.82% ★	82.64% ✓ ★★★	82.40% ✓ ★★★	76.38% ★★	74.69% ★
Timeliness of Prenatal Care—Under 21 Years	68.84% —	67.49% —	84.09% —	NA	NA
Postpartum Care—Under 21 Years	69.57% —	64.66% —	88.64% —	NA	NA

NA indicates that the 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.
and ✓ indicates the health plan met or exceeded the target threshold established by MQD.
MY 2024 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Within the Women's Health performance measure domain, KFHP QI performed best among the health plans, with three measure rates ranking at or above the 50th percentile, one of which met or exceeded the 75th percentile. AlohaCare QI and UHC CP QI demonstrated the lowest performance among the health plans, with three measure indicator rates that could be compared to benchmarks ranking below the 25th percentile. The *Prenatal and Postpartum Care—Timeliness of Prenatal Care—Under 21 Years* and *Postpartum Care—Under 21 Years* measure indicators did not have an applicable benchmark; therefore, comparisons to national benchmarks are not presented.

Additionally, KFHP QI reached MQD's established targets in this domain for *Cervical Cancer Screening*, *Prenatal and Postpartum Care—Timeliness of Prenatal Care,* and *Postpartum Care*. HMSA QI also reached MQD's established target for *Cervical Cancer Screening* and *Prenatal and Postpartum Care—Postpartum Care.*

Care for Chronic Conditions

Table 4-6 displays the Care for Chronic Conditions measure rates for each health plan compared to the national Medicaid percentiles.

Table 4-6—MY 2024 Comparison of Care for Chronic Conditions Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Asthma Medication Ratio					
5–11 Years	56.76% ★	37.43% ★	97.86% ★★★★★	NA	NA
12–18 Years	NA	41.58% ★	93.75% ★★★★★	NA	NA
19–50 Years	33.91% ★	32.27% ★	82.78% ★★★★★	58.00% ★★	52.17% ★
51–64 Years	48.61% ★	39.11% ★	89.26% ★★★★★	44.44% ★	55.47% ★
Total	41.99% ★	35.70% ★	89.38% ✓ ★★★★★	52.00% ★	53.21% ★
5–18 Years	56.06% —	38.97% —	96.81% —	NA	48.65% —
19–64 Years	38.21% —	34.25% —	85.15% —	52.33% —	53.91% —
Blood Pressure Control for Patients With Diabetes					
Blood Pressure Control for Patients With Diabetes	54.50% ★	63.14% ✓ ★★	73.10% ✓ ★★★	68.37% ✓ ★★	66.67% ✓ ★★
Concurrent Use of Opioids and Benzodiazepines*					
18–64 Years	8.85% —	12.22% —	6.48% —	17.33% —	12.26% —
65+ Years	9.57% —	11.63% —	7.32% —	15.53% —	12.59% —
Total	8.97% ✓ —	12.18% ✓ —	6.67% ✓ —	16.84% —	12.43% ✓ —
Controlling High Blood Pressure					
18–64 Years	47.00% —	54.23% —	74.71% —	65.13% —	62.96% —
65–85 Years	55.86% —	55.70% —	78.21% —	67.33% —	73.27% —
Total	49.39% ★	54.52% ★	75.52% ✓ ★★★★★	65.94% ✓ ★★★	70.56% ✓ ★★★★
Eye Exam for Patients With Diabetes					
Eye Exam for Patients With Diabetes	50.85% ★★	55.77% ★★★	70.83% ✓ ★★★★★	63.26% ✓ ★★★★	66.91% ✓ ★★★★★
Glycemic Status Assessment for Patients With Diabetes					
Glycemic Status <8.0%—18–64 Years	45.67% —	53.67% —	57.10% —	57.06% —	57.85% —

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Glycemic Status <8.0%—65–75 Years	63.16% —	72.73% —	66.23% —	73.24% —	77.66% —
Glycemic Status <8.0%—Total	48.91% ★	56.76% ✓ ★★	58.85% ✓ ★★★	59.85% ✓ ★★★	66.91% ✓ ★★★★★
*Glycemic Status >9.0%—18–64 Years**	43.88% —	36.66% —	32.72% —	31.47% —	32.74% —
*Glycemic Status >9.0%—65–75 Years**	30.26% —	15.15% —	23.38% —	19.72% —	13.30% —
*Glycemic Status >9.0%—Total**	41.36% ★	33.17% ✓ ★★★	30.92% ✓ ★★★	29.44% ✓ ★★★★	23.84% ✓ ★★★★★

NA indicates that the health plan followed the specifications, but the denominator was too small (<30) to report a valid rate.
** A lower rate indicates better performance.*
— Indicates that a comparison to benchmarks is not appropriate, or the measure did not have an applicable benchmark.
and ✓ indicates the health plan met or exceeded the target threshold established by MQD.
MY 2024 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Within the Care for Chronic Conditions performance measure domain, KFHP QI performed the best among the health plans, with 10 measure indicator rates ranking at or above the 50th percentile, seven of which met or exceeded the 90th percentile. AlohaCare QI demonstrated the lowest performance among the health plans, with nine measure indicator rates that could be compared to benchmarks ranking below the 50th percentile, eight of which were below the 25th percentile.

MQD's Quality Strategy target was met for seven of the measures by KFHP QI and six of the measures by UHC CP QI. Four of the five health plans met or exceeded MQD's Quality Strategy target for the *Blood Pressure Control for Patients With Diabetes* and *Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%—Total* and *Glycemic Status >9.0%—Total* measure indicators.

Behavioral Health

Table 4-7 displays the Behavioral Health measure rates for each health plan compared to the national Medicaid percentiles.

Table 4-7—MY 2024 Comparison of Behavioral Health Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Antidepressant Medication Management					
Effective Acute Phase Treatment—18–64 Years	59.68% —	68.30% —	77.53% —	50.00% —	68.58% —

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Effective Acute Phase Treatment—65+ Years	NA	70.21% —	NA	73.47% —	83.53% —
Effective Acute Phase Treatment—Total	60.44% ★★	68.35% ✓ ★★★★	77.96% ✓ ★★★★★	54.15% ★	74.03% ✓ ★★★★
Effective Continuation Phase Treatment—18–64 Years	38.27% —	49.75% —	52.84% —	36.84% —	50.34% —
Effective Continuation Phase Treatment—65+ Years	NA	40.43% —	NA	57.14% —	61.76% —
Effective Continuation Phase Treatment—Total	38.90% ★★	49.51% ✓ ★★★	53.32% ✓ ★★★★	40.43% ★★	54.51% ✓ ★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	73.58% ✓ ★	74.79% ✓ ★	82.93% ✓ ★★★	71.79% ✓ ★	78.34% ✓ ★★
Follow-Up After Emergency Department Visit for Mental Illness					
7-Day Follow-Up—6–17 Years	30.56% ★	34.93% ★	NA	NA	NA
7-Day Follow-Up—18–64 Years	20.45% ★	27.10% ★★	27.34% ★★	45.00% ★★★★	28.87% ★★
7-Day Follow-Up—65+ Years	NA	NA	NA	NA	17.78% ★
7-Day Follow-Up—Total	21.32% ★	27.91% ★	28.57% ★	42.65% ✓ ★★★	27.73% ★
30-Day Follow-Up—6–17 Years	44.44% ★	52.74% ★	NA	NA	NA
30-Day Follow-Up—18–64 Years	36.06% ★	44.87% ★★	42.97% ★★	62.50% ★★★★	46.83% ★★
30-Day Follow-Up—65+ Years	NA	NA	NA	NA	35.56% ★
30-Day Follow-Up—Total	37.30% ★	45.52% ★	45.96% ★	60.66% ✓ ★★★	45.43% ★
Follow-Up After Emergency Department Visit for Substance Use					
7-Day Follow-Up—13–17 Years	NA	14.89% ★★	NA	NA	NA
7-Day Follow-Up—18+ Years	25.76% ★★★	27.35% ★★★	20.63% ★★	37.41% ★★★★	21.18% ★★

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
7 -Day Follow-Up—Total	25.27% ★★★	26.89% ★★★	19.66% ★★	36.62% ★★★★	21.20% ★★
7-Day Follow-Up—18–64 Years	26.04% —	27.69% —	20.37% —	35.61% —	21.45% —
7-Day Follow-Up—65+ Years	NA	15.15% —	NA	NA	19.05% —
30-Day Follow-Up—13–17 Years	NA	34.04% ★★★	NA	NA	NA
30-Day Follow-Up—18+ Years	39.39% ★★★	41.20% ★★★	34.53% ★★	54.68% ★★★★★	35.39% ★★
30-Day Follow-Up—Total	38.55% ★★★	40.93% ★★★	33.76% ★★	53.52% ★★★★★	35.08% ★★
30-Day Follow-Up—18–64 Years	39.36% —	41.84% —	34.26% —	53.41% —	35.05% —
30-Day Follow-Up—65+ Years	NA	18.18% —	NA	NA	38.10% —
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up—6–17 Years	26.42% ★	58.33% ★★★★	57.45% ★★★★	NA	NA
7-Day Follow-Up—18–64 Years	21.79% ★	44.41% ★★★★	41.60% ★★★	48.08% ★★★★	38.46% ★★★
7-Day Follow-Up—65+ Years	NA	NA	NA	NA	40.00% ★★★★
7-Day Follow-Up—Total	22.27% ★	47.12% ✓ ★★★★	46.55% ✓ ★★★	47.75% ✓ ★★★★	38.79% ★★★
30-Day Follow-Up—6–17 Years	47.17% ★	73.44% ★★★	72.34% ★★★	NA	NA
30-Day Follow-Up—18–64 Years	36.87% ★	58.06% ★★★	60.80% ★★★	71.15% ★★★★	53.85% ★★★
30-Day Follow-Up—65+ Years	NA	NA	NA	NA	66.67% ★★★★★
30-Day Follow-Up—Total	38.66% ★	61.32% ★★★	64.37% ✓ ★★★	70.79% ✓ ★★★★	55.61% ★★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	37.10% ★	40.27% ★	64.62% ✓ ★★★★★	NA	NA
Continuation and Maintenance Phase	NA	58.06% ★★★	NA	NA	NA

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Initiation and Engagement of Substance Use Disorder Treatment					
Initiation of SUD Treatment—Total—13–17 Years	43.37% ★★★	41.98% ★★★	34.69% ★	NA	NA
Initiation of SUD Treatment—Total—18–64 Years	38.84% ★	34.69% ★	29.96% ★	34.05% ★	39.92% ★
Initiation of SUD Treatment—Total—65+ Years	38.99% ★★	33.41% ★	48.15% ★★★★	33.01% ★	35.87% ★
Initiation of SUD Treatment—Total—Total	39.01% ★	34.86% ★	31.33% ★	33.74% ★	38.87% ★
Engagement of SUD Treatment—Total—13–17 Years	9.64% ★★	24.06% ★★★★★	4.08% ★	NA	NA
Engagement of SUD Treatment—Total—18–64 Years	10.15% ★★	10.50% ★★	9.60% ★★	9.27% ★★	8.44% ★
Engagement of SUD Treatment—Total—65+ Years	4.59% ★★	4.09% ★★	3.70% ★★	7.77% ★★★	3.69% ★★
Engagement of SUD Treatment—Total—Total	9.63% ★★	10.51% ★★	8.94% ★★	9.11% ★★	7.33% ★
Screening for Depression and Follow-Up Plan					
12–17 Years	41.97% —	50.75% —	1.55% —	21.99% —	24.33% —
18–64 Years	40.88% —	30.26% —	6.27% —	18.08% —	22.21% —
65+ Years	42.46% —	32.66% —	6.79% —	31.78% —	41.34% —
Total	41.27% ✓ —	34.35% ✓ —	5.49% —	21.03% ✓ —	30.27% ✓ —
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics					
1–11 Years	NA	NA	NA	NA	NA
12–17 Years	NA	58.18% ★★	NA	NA	NA
Total	NA	58.57% ★★	NA	NA	NA
Use of Pharmacotherapy for Opioid Use Disorder					
Rate 1: Total	48.91% —	49.56% —	54.55% ✓ —	51.50% —	38.62% —
Rate 2: Buprenorphine	31.72% —	32.25% —	40.15% ✓ —	21.56% —	20.88% —

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Rate 3: Oral Naltrexone	0.48% —	1.12% ✓ —	0.76% —	0.60% —	0.63% —
Rate 4: Long-Acting, Injectable Naltrexone	0.24% —	0.19% —	0.00% —	0.00% —	0.42% ✓ —
Rate 5: Methadone	17.92% —	18.12% —	15.15% —	30.84% ✓ —	18.37% —

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.
and ✓indicates the health plan met or exceeded the target threshold established by MQD.
MY 2024 performance levels represent the following percentile comparisons:
★★★★★ *= 90th percentile and above*
★★★★ *= 75th to 89th percentile*
★★★ *= 50th to 74th percentile*
★★ *= 25th to 49th percentile*
★ *= Below 25th percentile*

Within the Behavioral Health performance measure domain, HMSA QI performed the best among the health plans, with 16 measure rates ranking at or above the 50th percentile. HMSA QI additionally had four measure rates that met or exceeded the 75th percentile and one that met or exceeded the 90th percentile. AlohaCare QI demonstrated the lowest performance among the health plans, with 23 measure indicator rates that could be compared to benchmarks ranking below the 50th percentile, 16 of which were below the 25th percentile.

Within the Behavioral Health domain, nine measure indicator rates had established Quality Strategy targets. All five QI health plans reached the established MQD targets for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* indicator. For *Antidepressant Medication Management—Effective Acute Phase Treatment—Total* and *Effective Continuation Phase Treatment—Total,* three of the five health plans (HMSA QI, KFHP QI, and UHC CP QI) met the established MQD target and performed at or above the 50th percentile. HMSA QI, KFHP QI, and 'Ohana QI met MQD's established target for the *Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total* indicator rate. Finally, AlohaCare QI HMSA QI, 'Ohana QI, and UHC CP QI met MQD's established target for the *Screening for Depression and Follow-Up Plan—Total* indicator rate.

Long-Term Services and Supports

Table 4-8 displays the long-term services and supports measure rates for each health plan.

Table 4-8—MY 2024 Comparison of Long-Term Services and Supports Measure Rates

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Long-Term Services and Supports Comprehensive Assessment and Update					
Assessment of Core Elements	41.00% ✓ —	6.81% —	22.87% ✓ —	46.23% ✓ —	41.61% ✓ —
Assessment of Supplemental Elements	39.50% ✓ —	6.81% —	18.00% ✓ —	45.50% ✓ —	39.66% ✓ —
Long-Term Services and Supports Comprehensive Care Plan and Update					
Care Plan With Core Elements Documented	43.64% ✓ —	2.92% —	15.09% ✓ —	37.96% ✓ —	18.00% ✓ —
Assessment of Supplemental Elements	43.64% ✓ —	2.92% —	15.09% ✓ —	37.47% ✓ —	18.00% ✓ —
Managed Long-Term Services and Supports Admission to a Facility from the Community					
Short-Term Stay—18–64 Years	624.49 —	1.07 —	3.47 —	836.65 —	35.78 —
Short-Term Stay—65–74 Years	84.07 —	0.47 —	4.82 —	558.06 —	20.50 —
Short-Term Stay—75–84 Years	30.28 —	0.00 —	6.09 —	389.45 —	19.97 —
Short-Term Stay—85+ Years	29.01 —	0.00 —	1.39 —	406.53 —	7.92 —
Short-Term Stay—Total	168.33 ✓ —	0.32 —	3.71 —	593.90 ✓ —	18.93 —
Medium-Term Stay—18–64 Years	167.35 —	0.53 —	3.87 —	39.77 —	4.35 —
Medium-Term Stay—65–74 Years	58.65 —	0.00 —	2.41 —	38.71 —	5.07 —
Medium-Term Stay—75–84 Years	29.46 —	0.45 —	5.33 —	34.79 —	4.74 —
Medium-Term Stay—85+ Years	14.50 —	0.32 —	3.47 —	37.09 —	4.43 —
Medium-Stay—Total	60.82 ✓ —	0.32 —	3.82 —	37.92 ✓ —	4.63 —
Long-Term Stay—18–64 Years	47.96 —	11.22 —	11.62 —	5.68 —	7.25 —
Long-Term Stay—65–74 Years	23.46 —	14.48 —	17.68 —	8.60 —	7.71 —
Long-Term Stay—75–84 Years	19.64 —	10.74 —	27.42 —	8.98 —	13.84 —
Long-Term Stay—85+ Years	18.85 —	4.14 —	21.54 —	5.93 —	9.39 —

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Long-Term Stay—Total	26.28 ✓ —	9.48 ✓ —	16.40 ✓ —	7.17 ✓ —	9.68 ✓ —
Managed Long-Term Services and Supports Minimizing Facility Length of Stay					
Observed Discharge Rate	8.99% —	NA	NA	2.62% —	12.74% —
Expected Discharge Rate	29.36% —	NA	NA	36.94% —	39.78% —
O/E Ratio	0.3064 —	NA	NA	NA	0.3203 —
Managed Long-Term Services and Supports Successful Transition After Long-Term Facility Stay					
Observed Discharge Rate	NA	NA	NA	NA	NA
Expected Discharge Rate	NA	NA	NA	NA	NA
O/E Ratio	NA	NA	NA	NA	NA

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.
and ✓indicates the health plan met or exceeded the target threshold established by MQD.

For *Long-Term Services and Supports Comprehensive Assessment and Update—Assessment of Core Elements* and *Assessment of Supplemental Elements* as well as *Long-Term Services and Supports Comprehensive Care Plan and Update—Care Plan With Core Elements* and *Assessment of Supplemental Elements,* four of the five health plans (AlohaCare QI, KFHP QI, 'Ohana QI, and UHC CP QI) met the established MQD target. For *Managed Long-Term Services and Supports Admission to a Facility from the Community—Short-Term Stay—Total* and *Medium-Stay—Total*, two of the five health plans (AlohaCare QI and 'Ohana QI) met the established MQD target. All five QI health plans reached the established MQD targets for the *Managed Long-Term Services and Supports Admission to a Facility from the Community—Long-Term Stay—Total.*

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
Women's Health					
Cervical Cancer Screening	✗	✓	✓	✗	✗
Prenatal and Postpartum Care—Timeliness of Prenatal Care	✗	✗	✓	✗	✗

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Prenatal and Postpartum Care—Postpartum Care	✗	✓	✓	✗	✗
Children's Preventive Health					
Child and Adolescent Well-Care Visits—Total	✗	✓	✗	✗	✗
Childhood Immunization Status—Combination 3	✗	✓	✓	✗	✗
Childhood Immunization Status—Combination 7	✗	✓	✓	✗	✓
Childhood Immunization Status—Combination 10	✗	✗	✓	✗	✗
Immunizations for Adolescents—Combination 1	✗	✓	✓	✗	✗
Immunizations for Adolescents—Combination 2	✗	✓	✓	✗	✗
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	✗	✓	✓	✓	✓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	✓	✗	✓	✓	✓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	✓	✗	✓	✓	✓
Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	✗	✓	✓	✗	✗
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	✗	✓	✓	✗	✗

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Access and Risk-Adjusted Utilization					
Adults' Access to Preventive/Ambulatory Health Services—Total	✗	✗	✗	✗	✗
*PQI 08: Heart Failure Admission Rate—Total**	✗	✓	✓	✗	✗
*PQI 15: Asthma in Younger Adults Admission Rate—18–39 Years**	✓	✓	✓	✓	✗
Care for Chronic Conditions					
Asthma Medication Ratio—Total	✗	✗	✓	✗	✗
Blood Pressure Control for Patients With Diabetes	✗	✓	✓	✓	✓
*Concurrent Use of Opioids and Benzodiazepines—Total**	✓	✓	✓	✗	✓
Controlling High Blood Pressure—Total	✗	✗	✓	✓	✓
Eye Exam for Patients With Diabetes	✗	✗	✓	✓	✓
Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%—Total	✗	✓	✓	✓	✓
*Glycemic Status Assessment for Patients With Diabetes—Glycemic Status >9.0%—Total**	✗	✓	✓	✓	✓
Behavioral Health					
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	✗	✓	✓	✗	✓
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	✗	✓	✓	✗	✓
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	✓	✓	✓	✓	✓

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total	✗	✗	✗	✓	✗
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total	✗	✗	✗	✓	✗
Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total	✗	✓	✓	✓	✗
Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total	✗	✗	✓	✓	✗
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	✗	✗	✓	✗	✗
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	✗	✗	✗	✗	✗
Screening for Depression and Follow-Up Plan—Total	✓	✓	✗	✓	✓
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	✗	✗	✗	✗	✗
Use of Pharmacotherapy for Opioid Use Disorder—Rate 1: Total	✗	✗	✓	✗	✗
Use of Pharmacotherapy for Opioid Use Disorder—Rate 2: Buprenorphine	✗	✗	✓	✗	✗
Use of Pharmacotherapy for Opioid Use Disorder—Rate 3: Oral Naltrexone	✗	✓	✗	✗	✗
Use of Pharmacotherapy for Opioid Use Disorder—Rate 4: Long-Acting, Injectable Naltrexone	✗	✗	✗	✗	✓

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Use of Pharmacotherapy for Opioid Use Disorder—Rate 5: Methadone	✗	✗	✗	✓	✗
Long-Term Services and Supports (LTSS)					
Long-Term Services and Supports Comprehensive Assessment and Update—Assessment of Core Elements	✓	✗	✓	✓	✓
Long-Term Services and Supports Comprehensive Assessment and Update—Assessment of Supplemental Elements	✓	✗	✓	✓	✓
Long-Term Services and Supports Comprehensive Care Plan and Update—Care Plan With Core Elements Documented	✓	✗	✓	✓	✓
Long-Term Services and Supports Comprehensive Care Plan and Update—Assessment of Supplemental Elements	✓	✗	✓	✓	✓
Managed Long-Term Services and Supports Admission to a Facility from the Community—Short-Term Stay—Total	✓	✗	✗	✓	✗
Managed Long-Term Services and Supports Admission to a Facility from the Community—Medium-Stay—Total	✓	✗	✗	✓	✗
Managed Long-Term Services and Supports Admission to a Facility from the Community—Long-Term Stay—Total	✓	✓	✓	✓	✓
Managed Long-Term Services and Supports Minimizing Facility Length of Stay—Observed Discharge Rate	✗	✗	✗	✗	✗
Managed Long-Term Services and Supports Minimizing Facility Length of Stay—Expected Discharge Rate	✗	✗	✗	✗	✗

Measure	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Percent MQD Targets Met	26.53%	46.94%	71.43%	46.94%	40.82%
Total MQD Targets Met	13	23	35	23	20

** A lower rate indicates better performance.*
✗ *Indicates that the health plan did not meet the target threshold established by MQD.*
and ✓*indicates the health plan met or exceeded the target threshold established by MQD.*

Validation of Network Adequacy

HSAG assessed the QI health plans' results across all standards and determined that the indicators in Table 4-10 and Table 4-13 were not included in the MQD-required reporting templates, resulting in an *Unable to Validate* designation for each associated indicator.

Table 4-10—QI Health Plans—Network Adequacy Standards Unable to Validate

Standard	Provider Type	Indicator
Time and Distance	Emergency Services Facilities—Urban	30-minute driving time
	Emergency Services Facilities—Rural	60-minute driving time
	Certified Substance Abuse Counselors—Urban	30-minute driving time
	Certified Substance Abuse Counselors—Rural	60-minute driving time
	State Licensed Special Treatment Facilities for the Provision of Substance Abuse Therapy—Urban	30-minute driving time
	State Licensed Special Treatment Facilities for the Provision of Substance Abuse Therapy—Rural	60-minute driving time
Mandatory Provider Types	CPs	At least one provider
	PAs	At least one provider
	State Licensed Special Treatment Facilities for the Provision of Substance Abuse Therapy/Treatment	At least one provider
	Certified Substance Abuse Counselors	At least one provider
Ratios	Behavioral Health Psychiatrists for members with an SMI or SPMI diagnosis. In geographic areas with a demonstrated	1:150 members with an SMI or SPMI diagnosis

Standard	Provider Type	Indicator
	shortage of qualified physicians, a psychiatric APRN-Rx may assume the role of psychiatrist.	
	Other Behavioral Health Providers to include Psychologists, Licensed Mental Health Counselors, Licensed Clinical Social Workers, and APRNs—Behavioral Health for members with an SMI or SPMI diagnosis.	1:100 members with an SMI or SPMI diagnosis

HSAG assessed the QI health plans' standards and indicators and determined that all QI health plans did not meet MQD's requirements for the following indicators presented in Table 4-11.

Table 4-11—QI MCOs—Network Adequacy Standards Noncompliance

Standard	Provider Type	Indicator
Mandatory Provider Types	Community Health Workers	At least one provider

HSAG assessed the QI health plans' standards and indicators and determined that all QI health plans met MQD's requirements for the following indicators presented in Table 4-12.

Table 4-12—QI MCOs—Network Adequacy Standards Compliance

Standard	Provider Type	Indicator
Provider Ratios	Hospital on Oahu	Minimum of five hospitals
	Hospital on Maui	Minimum of one hospital
	PCPs (Adult)	1:300
	PCPs (Pediatric)	1:300
Mandatory Provider Types	Audiologists	At least one provider
	Cardiologists	At least one provider
	Case Management Agencies	At least one provider
	DME	At least one provider
	Endocrinologists	At least one provider
	General Surgeons	At least one provider
	Geriatricians	At least one provider
	Hematologists	At least one provider
	Home Health Agencies and Hospices	At least one provider
	Infectious Disease Specialists	At least one provider

Standard	Provider Type	Indicator
	Laboratories which have either a CLIA 1988 certificate or a waiver of a certificate of registration	At least one provider
	LTSS: CCFFH	At least one provider
	LTSS: CCMA	At least one provider
	LTSS: E-ARCHs	At least one provider
	LTSS: NFs	At least one provider
	LTSS: Personal Care Assistance Providers	At least one provider
	Nephrologists	At least one provider
	Neurologists	At least one provider
	OB/GYNs	At least one provider
	Occupational Therapists	At least one provider
	Oncologists	At least one provider
	Ophthalmologists	At least one provider
	Orthopedists	At least one provider
	Otolaryngologists	At least one provider
	Pediatric Specialists	At least one provider
	Pharmacies	At least one provider
	Physical Therapists	At least one provider
	Plastic Reconstructive Surgeons	At least one provider
	Pulmonologists	At least one provider
	Radiologists	At least one provider
	Urologists	At least one provider
Time and Distance	24-Hour Pharmacies—Urban	60-minute driving time
	All Other Behavioral Health Provider—Urban	30-minute driving time
	All Other Behavioral Health Provider—Rural	60-minute driving time
	Cardiologists—Rural	60-minute driving time
	Nephrologists—Urban	30-minute driving time
	Neurologists—Rural	60-minute driving time
	OB/GYNs—Urban	30-minute driving time
	OB/GYNs—Rural	60-minute driving time
	Oncologists—Urban	30-minute driving time
	Oncologists—Rural	60-minute driving time

Standard	Provider Type	Indicator
	Ophthalmologists—Urban	30-minute driving time
	Ophthalmologists—Rural	60-minute driving time
	Orthopedists—Urban	30-minute driving time
	Orthopedists—Rural	60-minute driving time
	Other Specialists—Urban	30-minute driving time
	Other Specialists—Rural	60-minute driving time
	PCPs (Adult)—Urban	30-minute driving time
	PCPs (Adult)—Rural	60-minute driving time
	PCPs (Child)—Urban	30-minute driving time
	PCPs (Child)—Rural	60-minute driving time
	Pharmacies—Rural	60-minute driving time
	Radiologists—Rural	60-minute driving time
	Surgeons (All Other)—Urban	30-minute driving time
	Surgeons (All Other)—Rural	60-minute driving time

HSAG assessed 'Ohana CCS' results across all standards and determined that the indicators in Table 4-13 were not included in the MQD-required reporting templates, resulting in an *Unable to Validate* designation for each associated indicator.

Table 4-13—'Ohana CCS—Network Adequacy Standards Unable to Validate

Standard	Provider Type	Indicator
Time and Distance	Emergency Services Facilities—Urban	Within 30-minute driving time
	Emergency Services Facilities—Rural	Within 60-minute driving time
Mandatory Provider Types	CIS in Network	At least 1 provider
	Inpatient Behavioral Health Hospital Services in Network	At least 1 provider
	Outpatient Behavioral Health Hospital Services in Network	At least 1 provider
	Peer Specialist in Network	At least 1 provider

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

Strengths

- All health plans continued to demonstrate dedication to identifying gaps in provider networks throughout their service areas and identified ways to improve the accessibility and timeliness of care for members.
- In general, health plans continued to utilize processes and procedures in place to ensure efficient and accurate collection of member and provider data to support network adequacy calculation and reporting.

Opportunities for Improvement and Recommendations

- MQD provided templates with missing indicators for health plan reporting on MQD-defined network adequacy standards, including Time and Distance, Provider Ratios, and Mandatory Provider Types. HSAG has noted that there is a misalignment between the reporting template and the contractual language for the standards. HSAG recommends that MQD review its reporting template against the contractual language to align with and more accurately reflect the MQD-required indicators to ensure consistent and accurate reporting.
- HSAG determined that the provided templates did not include specifications to identify members with SMI and SPMI diagnoses. HSAG recommends that MQD identify in its methodology and templates how members with SMI and SPMI diagnoses should be determined, and the templates should be adjusted to reflect the determinations.

Validation of Performance Improvement Projects

Table 4-14 summarizes HSAG's key validation findings for the three PIPs conducted by the QI health plans.

Table 4-14—PIP Validation Findings for the QI Health Plans

Health Plan Name	Validation Rating 1			Validation Rating 2		
	Overall Confidence in Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
Behavioral Health Coordination						
AlohaCare QI	100%	100%	*High Confidence*	100%	100%	*High Confidence*

Health Plan Name	Validation Rating 1			Validation Rating 2		
	Overall Confidence in Adherence to Acceptable Methodology for All Phases of the PIP			Overall Confidence That the PIP Achieved Significant Improvement		
	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]	Percentage Score of Evaluation Elements *Met*[1]	Percentage Score of Critical Elements *Met*[2]	Confidence Level[3]
HMSA QI	100%	100%	*High Confidence*	100%	100%	*High Confidence*
KFHP QI	94%	100%	*High Confidence*	33%	100%	*Low Confidence*
ʻOhana QI	100%	100%	*High Confidence*	100%	100%	*High Confidence*
UHC CP QI	100%	100%	*High Confidence*	50%	100%	*High Confidence*
Plan All-Cause Readmissions						
AlohaCare QI	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
HMSA QI	100%	100%	*High Confidence*	33%	100%	*No Confidence*
KFHP QI	100%	100%	*High Confidence*	33%	100%	*No Confidence*
ʻOhana QI	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
UHC CP QI	100%	100%	*High Confidence*	67%	100%	*Moderate Confidence*
Screening for Depression and Follow-Up Plan						
AlohaCare QI	100%	100%	*High Confidence*	*Not Assessed*[4]		
HMSA QI	100%	100%	*High Confidence*	*Not Assessed*[4]		
KFHP QI	100%	100%	*High Confidence*	*Not Assessed*[4]		
ʻOhana QI	100%	100%	*High Confidence*	*Not Assessed*[4]		

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

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

Table 4-15 summarizes HSAG's key validation findings for the two PIPs conducted by 'Ohana CCS.

Table 4-15—PIP Validation Findings for 'Ohana CCS

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

[1] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.
[2] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.
[3] **Confidence Level**—Based on the scores assigned for individual evaluation elements and the confidence level definitions provided in the PIP Validation Tool.

CY 2025 was the fourth validation year for the *Behavioral Health Coordination*, *Plan All-Cause Readmissions,* and *7-Day Follow-Up After Emergency Department Visit for Mental Illness* PIPs and the second validation year for the *Screening for Depression and Follow-Up Plan* PIP. All the PIP topics were required by MQD and address CMS' requirements related to quality outcomes—specifically quality of, timeliness of, and access to care and services. The PIP topics are also aligned with the goals and objectives included in MQD's Quality Strategy. In addition to the PIPs, MQD encouraged the health plans to participate in a collaborative and work together toward the common goal of achieving improvement in access, quality, and timeliness of care through these PIPs.

The health plans documented that the MOA for data sharing between the health plans and DOH Behavioral Health Services Administration divisions was signed and effective January 1, 2025. At the time of PIP reporting, the health plans had documented that they were working together toward implementation of the MOA. HSAG recommends that in addition to working with other health plans on the implementation of data sharing per the MOA with DOH agencies, the health plans must also review internal health plan-specific barriers toward implementation of the MOA and initiate appropriate interventions. For the *Plan All-Cause Readmissions* PIP and the *7-Day Follow-Up After Emergency Department Visit for Mental Illness* PIP, the health plans should build on the positive momentum gained and improvement achieved. The health plans should also continue to report to MQD how they have implemented the lessons from these PIPs to improve the outcomes in the future PIPs. For the *Screening for Depression and Follow-Up Plan* PIP, the health plans are encouraged to implement interventions in a timely manner to improve remeasurement outcomes. Any system barriers toward successful initiation of interventions should be considered when selecting interventions. The PIPs are submitted to the EQRO for annual validation; however, MQD may require the health plans to provide an update on the status of their interventions quarterly.

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

Statewide Comparisons—QI Health Plans

Table 4-16 presents the 2025 scores for each QI health plan and the QI Program compared to the 2024 NCQA child Medicaid national averages. Additionally, results comparing the QI health plans to the overall QI Program are displayed below.

Table 4-16—Comparison of 2025 Child CAHPS Results

Measure	QI Program	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Global Ratings						
Rating of Health Plan	71.65%	72.35%	72.34%	74.77%	70.13%	65.66%
Rating of All Health Care	68.95%	70.54%	68.97%	70.39%	66.91%	66.67%+

Measure	QI Program	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Rating of Personal Doctor	76.22%	71.34%	76.38%	79.47%	76.00%	75.81%
Rating of Specialist Seen Most Often	77.78%	75.00%+	73.53%+	80.00%+	77.78%+	81.82%+
Composite Measures						
Getting Needed Care	80.76%	77.32%+	72.27%+ L	88.18% ↑	82.39%+	78.22%+
Getting Care Quickly	81.10% L	79.17%+ L	83.37%+	84.47%	81.21%+	75.04%+ L
How Well Doctors Communicate	94.25%	92.72%	95.96%	94.84%	92.10%	95.63%+
Customer Service	90.25%	87.25%+	84.44%+	96.21%+ ↑ H	92.32%+	87.55%+
Individual Item Measure						
Coordination of Care	87.77% H	83.02%+	80.00%+	93.00% ↑ H	85.94%+	95.24%+ ↑ H

↑ *Indicates the 2025 score is statistically significantly higher than the QI Program.*
↓ *Indicates the 2025 score is statistically significantly lower than the QI Program.*
H *Indicates the 2025 score is statistically significantly higher than the NCQA national average.*
L *Indicates the 2025 score is statistically significantly lower than the NCQA national average.*
+ *Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.*

Comparison of the QI Program's and QI health plans' 2025 scores to the 2024 NCQA child Medicaid national averages revealed the following summary results:

- The QI Program's 2025 top-box score was statistically significantly higher than the 2024 NCQA child Medicaid national average for one measure, *Coordination of Care*.
- The QI Program's 2025 top-box score was statistically significantly lower than the 2024 NCQA child Medicaid national average for one measure, *Getting Care Quickly*.
- KFHP QI's 2025 top-box scores were statistically significantly higher than the 2024 NCQA child Medicaid national average for the following measures: *Customer Service* and *Coordination of Care*.
- UHC CP QI's 2025 top-box score was statistically significantly higher than the 2024 NCQA child Medicaid national average for one measure, *Coordination of Care*.
- AlohaCare QI's and UHC CP QI's 2025 top-box score was statistically significantly lower than the 2024 NCQA child Medicaid national average for one measure, *Getting Care Quickly*.
- HMSA QI's 2025 top-box score was statistically significantly lower than the 2024 NCQA child Medicaid national average for one measure, *Getting Needed Care*.

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

- KFHP QI's 2025 top-box scores were statistically significantly higher than the QI Program's 2025 top-box scores for the following measures: *Getting Needed Care*, *Customer Service,* and *Coordination of Care.*

- UHC CP QI's 2025 top-box score was statistically significantly higher than the QI Program's 2025 top-box scores for one measure, *Coordination of Care.*

Provider Survey

Plan Comparisons and Trend Analysis

Table 4-17 presents a summary of the statistically significant differences in performance that existed between the QI health plans' 2025 scores.[41]

Table 4-17—Comparison of 2025 Provider Survey Results: Statistically Significant Differences

Measure	QI Program	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
General Positions						
Compensation Satisfaction	51.98% ▲	55.07%+	47.91%+	79.41%+ ↑	50.74%+ ▲	49.21%+
Prior Authorization Process Experience*						
Approval or Authorization Delayed	67.02%	60.20%+	73.84%+	100.00%+ ↑	68.40%+	62.90%+
Inconsistent Requirements	64.73%	60.06%+	73.25%+ ↑	85.71%+ ↑	66.04%+	58.05%+
Difficult to Navigate	64.75%	59.33%+	70.31%+ ↑	84.62%+	65.44%+	62.57%+
Labor Intensive	55.53%	53.58%+	61.50%+	84.62%+ ↑	53.45%+	51.13%+
Prior Authorization Process Impacts*						
Delayed Ability to Provide Treatments	53.47%	48.71%+	61.58%+ ↑	92.31%+ ↑	51.67%+	48.85%+
Disrupted Continuity of Care	52.62%	52.60%+	62.55%+ ↑	92.31%+ ↑	43.52%+ ↓	47.16%+
Created Administrative Burden	44.32%	39.84%+	50.11%+	76.92%+ ↑	45.39%+	39.55%+
Led to Denial of Service	59.57%	59.01%+	61.64%+	92.31%+ ↑	61.91%+	53.11%+
Formulary						
Formulary Impact on Care	37.27%	37.76%+	39.35%+	60.53%+ ↑	34.68%+	33.46%+
Non-Formulary						
Adequate Access to Non-Formulary Drugs	42.75%	44.38%+	50.53%+ ↑	76.32%+ ↑	41.97%+	25.20%+ ↓
Health Coordinators						
Helpfulness of Health Coordinators	56.24%	55.56%+	54.36%+	94.59%+ ▲↑	57.94%+	47.66%+ ↓

[41] For more detailed results on the comparative analyses, please see the 2025 Hawaii Provider Survey full report.

Measure	QI Program	AlohaCare QI	HMSA QI	KFHP QI	'Ohana QI	UHC CP QI
Specialists						
Adequate Network of Specialists	37.96%	35.22%+	48.72%+ ↑	64.10%+ ↑	23.92%+ ↓	35.16%+
Substance Abuse						
Access to Substance Abuse Treatment	42.04%	44.19%+	41.70%+	72.73%+ ▲↑	38.71%+	38.63%+ ↓

▲ *Indicates the 2025 score is statistically significantly higher than the 2023 score.*
▼ *Indicates the 2025 score is statistically significantly lower than the 2023 score.*
↑ *Indicates the 2025 score is statistically significantly higher than the QI Program.*
↓ *Indicates the 2025 score is statistically significantly lower than the QI Program.*
Results based on fewer than 11 respondents were suppressed and noted as "NA".
** Indicates the survey questions that compose the measures within this domain were included for the first time in 2025; therefore, a trend analysis was unable to be performed for these measures.*
+ Indicates fewer than 100 respondents. Caution should be exercised when evaluating these results.

Comparison of the QI health plans' 2025 scores to the QI Program revealed the following summary results:

- AlohaCare QI's 2025 top-box scores were not statistically significantly higher or lower than the QI Program's 2025 top-box scores for any measure.
- HMSA QI's 2025 top-box scores were statistically significantly higher than the QI Program's 2025 top-box scores for the following measures: *Inconsistent Requirements*, *Difficult to Navigate*, *Delayed Ability to Provide Treatments*, *Disrupted Continuity of Care*, *Adequate Access to Non-Formulary Drugs*, and *Adequate Network of Specialists*.
- KFHP QI's 2025 top-box scores were statistically significantly higher than QI Program's 2025 top-box scores for the following measures: *Compensation Satisfaction*, *Approval or Authorization Delayed*, *Inconsistent Requirements*, *Labor Intensive*, *Delayed Ability to Provide Treatments*, *Disrupted Continuity of Care*, *Created Administrative Burden*, *Led to Denial of Service*, *Formulary Impact on Care*, *Adequate Access to Non-Formulary Drugs*, *Helpfulness of Health Coordinators*, *Adequate Network of Specialists,* and *Access to Substance Abuse Treatment*.
- 'Ohana QI's 2025 top-box scores were statistically significantly lower than QI Program's 2025 top-box scores for the following measures: *Disrupted Continuity of Care* and *Adequate Network of Specialists*.
- UHC CP QI's 2025 top-box scores were statistically significantly lower than QI Program's 2025 top-box scores for the following measures: *Adequate Access to Non-Formulary Drugs*, *Helpfulness of Health Coordinators,* and *Access to Substance Abuse Treatment*.

Comparison of the QI Program's and QI health plans' 2025 scores to the corresponding 2023 scores revealed the following summary results:

- The QI Program's 2025 top-box score was statistically significantly higher than the 2023 top-box score for one measure, *Compensation Satisfaction.*

- AlohaCare QI's 2025 top-box scores were not statistically significantly higher or lower than the 2023 top-box scores for any measure.
- KFHP QI's 2025 top-box scores were statistically significantly higher than the 2023 top-box scores for the following measures: *Helpfulness of Health Coordinators* and *Access to Substance Abuse Treatment*.
- 'Ohana QI's 2025 top-box score was statistically significantly higher than the 2023 top-box score for one measure, *Compensation Satisfaction*.
- UHC CP QI's 2025 top-box scores were not statistically significantly higher or lower than the 2023 top-box scores for any measure.

5. Assessment of Follow-Up on Prior Year Recommendations

Introduction

This section of the report presents an assessment of how effectively the health plans addressed the improvement recommendations made by HSAG in the prior year (2024) as a result of the EQR activity findings for compliance monitoring, HEDIS, PIPs, NAV, CAHPS, and encounter data validation (EDV). The CCS program members were not separately sampled for the survey activities as they were included in the QI health plans' sampling; therefore, there are no separate CAHPS results related to CCS members.

Excluding the compliance monitoring section and PIPs, the improvements and corrective actions related to the EQR activity recommendations were self-reported by each health plan. HSAG reviewed this information to identify the degree to which the health plans' initiatives were responsive to the improvement opportunities. Plan responses regarding implemented improvement activities were edited for grammatical and stylistic changes only.

Compliance Monitoring Review

Formal follow-up reevaluations of the health plans' corrective actions to address the deficiencies identified in the 2022 and 2023 compliance reviews were carried over to 2024. As appropriate, HSAG conducted technical assistance for the health plans and conducted the follow-up assessments of compliance. All health plans successfully addressed the findings and recommendations from the 2022 and 2023 compliance reviews by the end of CY 2024. CY 2025 began a new three-year cycle of compliance reviews for all of the QI health plans and the CCS program.

Performance Improvement Projects

HSAG provides recommendations on the initial PIP submission to address any deficiencies noted in the PIP processes or documentation. The health plans have an opportunity to address the recommendations in the resubmission or the next annual PIP submission. HSAG is also available to provide technical assistance to the health plans as the PIP progresses and the health plans work toward implementing the recommended improvements.

AlohaCare QUEST Integration (AlohaCare QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

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

Improvement Activities Implemented

Not applicable.

2024 HEDIS Performance Measure Recommendations

HSAG recommends that AlohaCare QI focus on improving performance related to the following measures with rates that fell below the 25th percentile for the QI population:

- Within the Children's Preventive Health domain, the following recommendations were identified:
  - Regarding the *Child and Adolescent Well-Care Visits* measure, HSAG recommends that AlohaCare QI incentivize providers, members, and parents to complete visits, encourage teen-centered care through privacy and confidentiality, promote well-visits on social media or perform other outreach, and develop partnerships with community stakeholders.[42]
  - Regarding the *Total Childhood Immunization Status* measure, HSAG recommends that AlohaCare QI provide education to providers and members about the importance of vaccination for disease prevention and encourage vaccination at every opportunity, including mild illness visits.
  - Regarding the *Well-Child Visits in the First 30 Months of Life* measure, HSAG recommends that AlohaCare QI identify performance improvement efforts to improve well-child visits, drawing from other states' performance improvement initiatives. For instance, California and Virginia have focused on delays in newborn enrollment data, and Missouri and Texas focused on beneficiary barriers and implemented interventions such as utilizing patient portals and phone outreach.[43] HSAG recommends that that AlohaCare QI identify other barriers to care and conduct a focus group on identifying strategies to address barriers.
- Within the Women's Health domain, the following recommendations were identified:
  - Regarding the *Cervical Cancer Screening* measure, HSAG recommends that AlohaCare QI consider utilizing one-on-one interactions with a healthcare professional, such as community

[42] Centers for Medicare & Medicaid Services. Paving the Road to Good Health Strategies for Increasing Medicaid Adolescent Well-Care Visits. Available at: https://www.medicaid.gov/medicaid/benefits/downloads/paving-the-road-to-good-health.pdf. Accessed on: Jan 20, 2026.

[43] Centers for Medicare & Medicaid Services. Well-Child Care. Available at: https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/well-child-care/index.html. Accessed on: Jan 20, 2026.

health workers (CHWs), which have been shown to improve cervical cancer screening.[44] Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness. In addition, HSAG recommends that AlohaCare QI provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is lack of knowledge.

  - Regarding the *Prenatal and Postpartum Care* measure, HSAG recommends that AlohaCare QI consider whether there are disparities/SDOH within AlohaCare QI's population that contribute to lower access to care. Upon identification of a root cause, HSAG recommends that AlohaCare QI implement appropriate interventions to reduce barriers to care. Strategies could include providing expanded access appointments outside of business hours to accommodate work schedules or childcare needs. Many appointments can be made via telehealth; therefore, ensuring members have access to this option could potentially increase performance on this measure. Further, HSAG recommends that AlohaCare QI identify payment structure types that will incentivize quality care. Bundling payments may cause disincentives for postpartum care, as providers might receive the same payment regardless of whether the member attends the postpartum visit.[45]

- Within the Care for Chronic Conditions domain, the following recommendations were identified:
  - Regarding the *Controlling High Blood Pressure* measure, HSAG recommends that AlohaCare QI identify trends within the data to identify which demographic groups and regions report lower blood pressure. HSAG recommends providing coverage for automated home blood pressure monitors for patients, while educating members about the benefits of this approach.[46] Further, HSAG recommends providing incentives to members and providers to encourage blood pressure control.
- Within the Behavioral Health domain, the following recommendations were identified:
  - Regarding the *Follow-Up After Hospitalization for Mental Illness* measure, HSAG recommends that AlohaCare QI consider effective interventions to reduce repeat hospitalizations for people with mental illness, such as Critical Time Intervention (CTI), Assertive Community Treatment (ACT), case management, and focusing on co-occurring substance abuse disorders.[47]

[44] Popalis ML, Ramirez SI, Leach KM, et al. Improving cervical cancer screening rates: a scoping review of resources and interventions. *Cancer Causes Control*. 2022 Nov;33(11):1325–1333.
[45] Centers for Medicare & Medicaid Services. Lessons Learned About Payment Strategies to Improve Postpartum Care in Medicaid and CHIP. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/postpartum-payment-strategies.pdf. Accessed on: Jan 20, 2026.
[46] Centers for Disease Control and Prevention. The Surgeon General's Call to Action to Control Hypertension. Available at: https://www.cdc.gov/high-blood-pressure/php/cta/index.html. Accessed on: Jan 20, 2026.
[47] Kreyenbuhl J, Nossel IR, Dixon LB. Disengagement from mental health treatment among individuals with schizophrenia and strategies for facilitating connections to care: a review of the literature. *Schizophrenia Bulletin*. 2009 Jul;35(4):696–703.

Improvement Activities Implemented

Within the Children's Preventive Health domain:

Child and Adolescent Well-Care Visits, Total Childhood Immunization Status, and *Well-Child Visits in the First 30 Months of Life* measures

1. Review and obtain immunization data from the Hawaiian Immunization registry; enter into auditor-approved non-standard data base.
2. Collaborate with providers on electronic data exchange, use of CVX billing codes to capture immunization data.
3. Focused outreach to members within three months of the child's second and 13th birthdays to help the parent/guardian get the member into the PCP to close care gaps for well-visits and immunizations prior to the 2nd/13th birthday.
4. Collaboration efforts with the MCO Quality workgroup to develop and distribute a flyer for the Measles Vaccination campaign.
5. Partnerships with CHCs to promote well-visits and immunizations.
6. Participation in community events to educate the public and provide information on annual wellness visits and vaccinations.
7. Establish relationships with community-based organizations (CBOs) and community health centers (CHCs) to reach underserved populations.
8. Performed analysis on members preferred/primary language; continue to offer and make known to members and providers availability of interpretation and translation services.
9. Continue cultural competency training upon hire and annually for all AlohaCare QI staff.
10. Continue cultural competency training upon onboarding into the provider network and annually for all network providers; include completion of cultural competency training designation in Provider Directory.

Within the Women's Health domain:

Cervical Cancer Screening (CCS) measure

1. Added the CCS measure to the Provider P4P awards program.
2. Participation in community events to educate the public and provide information on preventive health care and cancer screenings.
3. Establish relationships with CBOs and CHCs to reach underserved populations.
4. Performed analysis on members' preferred/primary language; continue to offer and make known to members and providers availability of interpretation and translation services.
5. Continue cultural competency training upon hire and annually for all AlohaCare QI staff.

6. Continue cultural competency training upon onboarding into the provider network and annually for all network providers; include completion of cultural competency training designation in Provider Directory.

Prenatal and Postpartum Care measure

1. In July 2025, AlohaCare QI expanded its outreach to focus on prenatal members with history of late or no prenatal care.
2. Establish relationships with CBOs and CHCs to reach underserved populations.
3. Performed analysis on members' preferred/primary language; continue to offer and make known to members and providers availability of interpretation and translation services; a particular need for interpretation has been identified for pregnant Micronesian women (Chuuk and the Marshall Islands).
4. Continue cultural competency training upon hire and annually for all AlohaCare QI staff.
5. Continue cultural competency training upon onboarding into the provider network and annually for all network providers; include completion of cultural competency training designation in Provider Directory.

Within the Care for Chronic Conditions domain:

Controlling High Blood Pressure—Total measure

1. Continue the Member Wellness Rewards programs, which offers a financial incentive for having a blood pressure taken at least once each year (does not have to be controlled to receive the reward).
2. Performed an analysis on members in the CBP measure by race and ethnicity. Findings show that members in the two-or-more race category have the highest rate of uncontrolled blood pressure; no specific interventions can be implemented for this group since there is no data available that is race-specific.
3. Establish relationships with CBOs and CHCs to reach underserved populations.
4. Performed analysis on members' preferred/primary language; continue to offer and make known to members and providers availability of interpretation and translation services.
5. Continue cultural competency training upon hire and annually for all AlohaCare QI staff.
6. Continue cultural competency training upon onboarding into the provider network and annually for all network providers; include completion of cultural competency training designation in Provider Directory.

Within the Behavioral Health domain:

Follow-Up After Hospitalization for Mental Illness (FUH) measure

1. AlohaCare QI has added two additional behavioral healthcare providers that have committed to providing follow-up behavioral health care appointments within seven days of discharge from inpatient admission or emergency department care.

2. Created a position for a dedicated Behavioral Health Coordinator to oversee daily monitoring of five behavioral health measures, including *FUH*.
3. Training all Transitions of Care (TOC) staff to engage with members admitted for psychiatric and/or medical conditions for daily inpatient engagement and early post-discharge behavioral health intervention and follow-up.
4. TOC staff engage members on weekend hours for members that are discharged during the weekend to avoid lost opportunities.

HSAG Assessment

HSAG has determined that AlohaCare QI has addressed the prior year's recommendations.

Validation of Network Adequacy

2024 Recommendations

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

Improvement Activities Implemented

Not applicable.

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

2024 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

Survey Item	Key Drivers		
	Rating of Health Plan	*Rating of All Health Care*	*Rating of Personal Doctor*
Q4. Received care as soon as needed when care was needed right away	—	✓	—

Survey Item	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	✓	—	—
Q15. Personal doctor spent enough time	—	—	✓
Q17. Personal doctor seemed informed and up-to-date about care from other doctors or health providers	—	—	✓
Q20. Received appointment with a specialist as soon as needed	✓	—	NA

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

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

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

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

- Respondents reported not always receiving an appointment with a specialist as soon as they needed.

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

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

Improvement Activities Implemented

1. The Utilization Management Department developed an online tool to assist providers in the prior authorization process, including information on which services do not require prior authorization.
2. Member Advisory Committee (MAC)—monthly MAC meetings are held with AlohaCare QI members and AlohaCare QI staff:

- AlohaCare QI members provide valuable feedback on their experience with AlohaCare QI's providers, care and services provided.

- MAC meetings provide opportunities to discuss benefits, how to use benefits, and value-added benefits.
- Internal CAHPS workgroup meets regularly to brainstorm ideas to help improve the member experience with AlohaCare QI, its providers, and services.
- Conducted an analysis on the exchange of information between providers; findings revealed approximately 81 percent of AlohaCare QI members receive care within an integrated healthcare system where primary care and specialty care providers have access to bi-directional patient information, including test results, clinical findings, progress, and consultation notes.

HSAG Assessment

HSAG has determined that AlohaCare QI has addressed the prior year's recommendations.

Home and Community-Based Services CAHPS Survey

2024 Recommendations

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

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

Improvement Activities Implemented

Monthly MAC meetings are held with AlohaCare QI members and AlohaCare QI staff:

- AlohaCare QI members provide valuable feedback on their experience with AlohaCare QI's providers, care and services provided.
- MAC meetings provide opportunities to discuss benefits, how to use benefits, and value-added benefits.
- Internal CAHPS workgroup meets regularly to brainstorm ideas to help improve the member experience with AlohaCare QI, its providers and services.
- Review members' complaints and grievances specific to AlohaCare QI case managers; review member complaint with the case manager; track and trend and act, when appropriate.

HSAG Assessment

HSAG has determined that AlohaCare QI has addressed the prior year's recommendations.

Encounter Data Validation

2024 Recommendations

HSAG identified the following areas for improvement:

- The record omission rates for all encounter types were high. Institutional encounters had the highest record omission rate at 87.5 percent, while professional and pharmacy encounters had record omission rates of 7.6 percent and 9.1 percent, respectively. Additionally, the record surplus pharmacy encounter rate was high at 9.1 percent.
- Although matched records largely contained similar values between the MQD-submitted and the Milliman-submitted data, AlohaCare QI should ensure the following data elements have accurate values:
  - Institutional encounters: Billing Provider Type, Allowed Amount, COB Amount, All Secondary Diagnosis Codes, NDC, Discharge Status, Occurrence Span Codes, All Secondary POA Codes, and TOB Code.
  - Professional encounters: Billing Provider Type, Allowed Amount, Primary Diagnosis Code, All Secondary Diagnosis Codes, and Admission Date.
  - Pharmacy encounters: Dispensing Fee.

HSAG recommends that AlohaCare QI:

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

Improvement Activities Implemented

AlohaCare QI worked on changes to its systems and processes after reviewing the data discrepancy report. AlohaCare QI is using the Managed Care Encounter Reconciliation (MCER) files that it receives from MQD for encounter reconciliation. AlohaCare QI continues to identify areas to improve encounter acceptance rates. AlohaCare QI continues to participate in regular MQD and MCO encounter work group meetings where encounter issues and system changes are discussed.

HSAG Assessment

HSAG has determined that AlohaCare QI has addressed the prior year's recommendations.

HMSA QUEST Integration (HMSA QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

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

Improvement Activities Implemented

Not applicable.

2024 HEDIS Performance Measure Recommendations

HSAG recommends that HMSA QI focus on improving performance related to the following measures with rates that fell below the 25th percentile for the QI population:

- Within the Children's Preventive Health domain, the following measure-level recommendations were identified:
  - Regarding the *Childhood Immunization Status* measure, HSAG recommends that HMSA QI provide education to providers and members about the importance of vaccination for disease prevention and encourage vaccination at every opportunity, including mild illness visits.[48]
  - Regarding the *Well-Child Visits in the First 30 Months of Life* measure, HSAG recommends that HMSA QI identify performance improvement efforts to improve well-child visits, drawing from other states' performance improvement initiatives. For instance, California and Virginia have focused on delays in newborn enrollment data, and Missouri and Texas focused on beneficiary barriers and implemented interventions such as utilizing patient portals and phone outreach. HSAG recommends that HMSA QI identify other barriers to care and conduct a focus group on identifying strategies to address barriers.[49]
- Within the Women's Health the following measure-level recommendations were identified:
  - Regarding the *Prenatal and Postpartum Care* measure, HSAG recommends that HMSA QI consider whether there are disparities/SDOH within HMSA QI's population that contribute to lower access to care. Upon identification of a root cause, HSAG recommends that HMSA QI implement appropriate interventions to reduce barriers to care. Strategies could include providing expanded access appointments outside of business hours to accommodate work schedules or childcare needs. Many appointments can be made via telehealth; therefore, ensuring members have access to this option could potentially increase performance on this measure. Further,

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

[49] Centers for Medicare & Medicaid Services. Well-Child Care. Available at: https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/well-child-care/index.html. Accessed on: Jan 20, 2026.

HSAG recommends that HMSA QI identify payment structure types that will incentivize quality care. Bundling payments may cause disincentives for postpartum care, as providers might receive the same payment regardless of whether the member attends the postpartum visit.[50]

Improvement Activities Implemented

1. My Health Rewards Program Enhancements

HMSA QI continued its My Health Rewards program to incentivize members to complete healthcare activities, including well-child visits with immunizations and prenatal and postpartum care. In 2025, the program underwent several improvements:

- Continuous engagement: Operated uninterrupted from 2024 into 2025, eliminating prior pauses and enabling year-round engagement.
- Improved reward experience: Introduced a reloadable rewards card usable at a wide range of retailers, replacing single-activity gift cards for greater convenience and flexibility.
- Enhanced communication: Increased mailings from quarterly to monthly, improving outreach to members without valid phone numbers.

2. Member Education via QUEST Newsletter

HMSA QI provided education on well-child visits, childhood immunizations, and prenatal and postpartum care through the QUEST member newsletter. Articles promoted the My Health Rewards program, HMSA's Maternal Health webpage, and the importance of vaccination for disease prevention.

3. Provider Quality Payment Programs

HMSA QI continued two primary care provider programs, the Primary Care Payment Model (formerly Payment Transformation) and FQHC Pay-for-Quality, which tie a portion of provider compensation to quality metrics. These programs include measures for childhood immunizations and well-child visits in the first 30 months of life, with FQHC Pay-for-Quality also addressing timely prenatal and postpartum care.

4. Preventive Care Outreach

HMSA QI sends monthly age-specific mailers reminding members to complete well-child exams and immunizations. In 2025, these mailers were refreshed with messaging to address vaccine hesitancy. During the 2024–2025 review of Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

[50] Centers for Medicare & Medicaid Services. Lessons Learned About Payment Strategies to Improve Postpartum Care in Medicaid and CHIP. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/postpartum-payment-strategies.pdf. Accessed on: Jan 20, 2026.

outreach materials, HMSA QI identified and retired a redundant communication, the "5 Visits in 12 Months" letter, which overlapped with the existing 12-month well-child reminder.

5. EPSDT Portal Insert File Submission & Testing

HMSA QI submitted its first insert-file batch in July 2025 and is progressing through MQD's testing process. This milestone moves HMSA QI toward full QI-2163 compliance and positions HMSA QI to report completion next year once testing is finalized. HMSA QI is the first of the five MCOs to begin testing. Successful testing will strengthen preventive services reporting and support MQD's broader quality measurement efforts.

6. Enhancements to EPSDT Data Quality Processes

HMSA QI refined internal EPSDT reporting requirements to clearly define key well-child ages and ensure providers associated with those members could be identified for timely outreach and reminders. These refinements support more accurate and actionable preventive-care communication.

7. Cross-Departmental EPSDT Workgroup

HMSA QI established a quarterly EPSDT Workgroup across Medicaid Programs, Quality Improvement, Communications, Mailroom, and IT. This collaboration improves alignment on reporting specifications, enhances identification of age-specific outreach opportunities, and supports accurate and timely submission of EPSDT data to MQD.

8. Co-Branded Measles Flyer

HMSA QI collaborated with other health plans to create a co-branded measles flyer, currently in final brand compliance review, for distribution to providers and members.

9. Health Disparities Dashboard Development

HMSA QI is developing a dashboard to compare performance across HEDIS measures, including *Childhood Immunization Status*, *Well-Child Visits in the First 30 Months of Life*, and *Prenatal/Postpartum Care*, by gender, race/ethnicity, language, and geography. Requirements are complete, and development is nearing completion.

10. Prenatal Care Partnership

HMSA QI partnered with the University of Hawaii, School of Public Health graduate seminar (Health Promotion Theory and Methods) to identify barriers to prenatal care for Native Hawaiians and Pacific Islanders. Students conducted interviews with providers and community organizations and shared findings and recommendations in December 2025.

HSAG Assessment

HSAG has determined that HMSA QI has addressed the prior year's recommendations.

Validation of Network Adequacy

2024 Recommendations

HMSA QI indicated that the member demographic information that comes through the 834 file is considered the source of truth, regardless of when HMSA QI is informed of a change in member demographic information. HSAG recommends that HMSA QI explore its system capabilities to capture updated demographic information collected through various member-level interactions that may be more current than what is provided through the 834 file. HSAG also recommends that HMSA QI continue to monitor and address any gaps in its provider network.

Improvement Activities Implemented

The Member Data Collection Initiative is a 2025 corporate initiative.

The initiative is intended to cover the following:

- Establishing a foundational member contact and preference database using Salesforce's Data Cloud.
- Automating the ingestion of data from various systems used by member-facing staff, members, and providers.
- Establishing data governance policies.
- Establishing self-service capabilities on MyAccount so members can provide alternate contact numbers/email.
- Third-party data will also be purchased, to supplement what is currently available.

Work is scheduled to start in mid-June and should be completed by the end of the year.

HSAG Assessment

HMSA QI is implementing processes to utilize its full systems capabilities when capturing member demographics updates. HSAG has determined that HMSA QI's plans are appropriate and address the prior year's recommendations.

CAHPS—Adult Survey

2024 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

Survey Item	Key Drivers		
	Rating of Health Plan	*Rating of All Health Care*	*Rating of Personal Doctor*
Q4. Received care as soon as needed when care was needed right away	✓	✓	—
Q6. Received appointment for a checkup or routine care as soon as needed	—	✓	—
Q9. Ease of getting the care, tests, or treatment needed	✓	✓	—
Q15. Personal doctor spent enough time	✓	—	✓
Q20. Received appointment with a specialist as soon as needed	—	✓	NA
Q24. Health plan's customer service gave the information or help needed	✓	✓	NA

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

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

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

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

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

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

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

HSAG recommends that HMSA QI explore what may be driving lower experience scores and develop initiatives designed to improve quality and access to care, including a focus on improving adult members' overall experiences with their health plan, personal doctor, overall healthcare, the specialist they see most often, customer service, getting needed care in a timely manner, and discussion of cessation strategies and medications to quit smoking/using tobacco.

Improvement Activities Implemented

The Primary Care Payment Model (described above) also includes incentives for provider organizations to improve CAHPS performance in areas including *Rating of Health Plan*, *Rating of All Health Care*, and *Rating of Personal Doctor*. Provider organizations selected specific CAHPS questions and identified interventions to complete following the Plan Do Study Act (PDSA) method for continuous improvement. Examples of questions and interventions included:

- Getting appointments and care quickly: Promotion of telehealth via MyChart enrollments and marketing, posters with information on after-hours/urgent care options.
- Getting needed care: Educate PCPs on referral services available for specialty care.
- Care coordination: Provider telephonic outreach to patients, member brochures with instructions on getting lab and imaging results, and pre-visit medication questionnaires in patient portal and waiting rooms.

HSAG Assessment

HSAG has determined that HMSA QI has addressed the prior year's recommendations.

Home and Community-Based Services CAHPS Survey

2024 Recommendations

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

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

Improvement Activities Implemented

To target improvement in personal assistance, HMSA QI transitioned to a new self-directed platform that will not only meet new contract requirements but allow improved processes and technology to result in improved member and provider experience such as more frequent paychecks. For members who receive their personal assistance services from agencies, HMSA QI reinforced the important role that its health coordinators fill. Members always have a choice to change agencies if they are not satisfied with the care they receive. HMSA QI's health coordinators fill that critical role to connect with the member regularly and help ensure members' needs are being met.

To target improvement in behavioral health staff, with the transition to a new behavioral health contractor Magellan on January 1, 2025, HMSA QI integrated behavioral health case management back into its core Health Coordination team. This has resulted in better integration of physical and mental health and streamed processes for both members and HMSA QI staff.

HSAG Assessment

HSAG has determined that HMSA QI has addressed the prior year's recommendations.

Encounter Data Validation

2024 Recommendations

HSAG identified the following areas for improvement:

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

HSAG recommends that HMSA QI:

- Review and work on the action items noted in the data discrepancy report.

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

Improvement Activities Implemented

This past year, HMSA QI has made progress on the results of the EDV recommendations. A few highlights include the following

1. The high omission rate for pharmacy records was traced to encounters held due to a specific data element; that was corrected and the affected encounters are now being submitted.
2. The high surplus record rates for institutional and professional claims were determined to be primarily due to comparing all submitted encounter data records against a slimmed-down extract submitted to Milliman.
3. HMSA QI has worked to identify and correct most of the data element discrepancies that were actionable. Coordination of benefits in particular, has recently been addressed for institutional and partially address for professional claims, pending additional clarification from MQD.
4. HMSA QI has implemented the encounter data submission of benefits outside of the claims processing system as required by MQD, such as plan staff services, self-directed services, travel and routine vision.

HSAG Assessment

HSAG has determined that HMSA QI has addressed the prior year's recommendations.

Kaiser Foundation Health Plan QUEST Integration (KFHP QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

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.

Improvement Activities Implemented

Not applicable.

2024 HEDIS Performance Measure Recommendations

HSAG recommends that KFHP QI focus on improving performance related to the following measures with rates that fell below the 25th percentile for the QI population:

- Within the Children's Preventive Health domain, the following recommendations were identified:
  - Regarding the *Child and Adolescent Well-Care Visits* measure. HSAG recommends that KFHP QI identify performance improvement efforts to improve well-child visits, drawing from other states' performance improvement initiatives. For instance, California and Virginia have focused on delays in newborn enrollment data, and Missouri and Texas focused on beneficiary barriers and implemented interventions such as utilizing patient portals and phone outreach. HSAG recommends that KFHP QI identify other barriers to care and conduct a focus group on identifying strategies to address barriers.[51]
  - Regarding the *Childhood Immunization Status* measure, HSAG recommends that KFHP QI provide education to providers and members about the importance of vaccination for disease prevention and encourage vaccination at every opportunity, including mild illness visits.[52]

Improvement Activities Implemented

- For well-child visits, e-tickets are being used to allow members to choose an appointment for themselves.
- On Oahu, KFHP QI also will use a list to proactively outreach to those needing well-child visits and send appointment reminders. If the patient has a history of two prior no-shows, a call will be placed to schedule. KFHP QI also attempts to make reminder calls by respective clinic staff before the appointments, but this is dependent on staffing.
- For Maui, call center staff is being used to outreach to members by phone to book appointments. They also do live reminder calls a few days prior.
- For immunizations, KFHP QI continues to utilize immunization lists proactively and staff are doing outreach to book appointments. KFHP QI can perform immunizations when members come in for appointments, and for others KFHP QI performs outreach calls to schedule.

HSAG Assessment

HSAG has determined that KFHP QI has addressed the prior year's recommendations.

[51] Centers for Medicare & Medicaid Services. Well-Child Care. Available at: https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/well-child-care/index.html. Accessed on: Jan 20, 2026.

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

Validation of Network Adequacy

2024 Recommendations

- KFHP did not have specific time frames during which providers were required to update data. HSAG recommends that KFHP QI establish time frames during which provider demographic changes are required to be reported to ensure that processes are in place for ongoing management and collection of updated demographic data.
- KFHP is working to implement a Medicaid Oversight Review board and conduct annual reviews for its delegated entity, Hawaii Permanente Medical Group (HPMG). HSAG recommends that KFHP QI continue to implement monitoring activities for HPMG to monitor ongoing performance of its delegated activities.

Improvement Activities Implemented

- KFHP QI submitted a policy to MQD regarding quarterly updates to the provider directory. The policy outlined the strategy with which KFHP QI implemented various outreach methods, including letters, emails, and phone calls. This new policy was reviewed by MQD and met expectations. KFHP QI received approval from DHS on November 8, 2024 to implement the process to confirm demographic updates from the KFHP Network providers.
- KFHP QI implemented a new Medicaid Oversight Review (MOR) Board to oversee the KFHP QI subcontractors and monitor their delegated activities beginning September 18, 2024. KFHP QI implemented various monitoring activities to ensure accurate and timely data from HPMG. KFHP QI collects and maintains quarterly Provider Network Adequacy Reports. KFHP QI also uses a Delegation Oversight Review Tool, which is used quarterly to review the Monthly Active Providers and the Provider Termination Report.

HSAG Assessment

HSAG has determined that KFHP QI has addressed the prior year's recommendations.

CAHPS—Adult Survey

2024 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

Survey Item	Key Drivers		
	Rating of Health Plan	***Rating of All Health Care***	***Rating of Personal Doctor***
Q4. Received care as soon as needed when care was needed right away	✓	—	—
Q17. Personal doctor seemed informed and up-to-date about care from other doctors or health providers	—	—	✓
Q24. Health plan's customer service gave the information or help needed	✓	✓	NA
Q27. Ease of filling out forms from health plan	✓	—	NA

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

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

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

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

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

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

Improvement Activities Implemented

Overall Health Plan Rating: KFHP QI focuses on both member experience and clinical quality. Key strategies include enhancing CAHPS scores through better communication, timely access, and real-time feedback with service recovery; driving preventive care; expanding digital tools for convenience; and using data-driven process improvements to reduce complaints and improve care coordination.

Customer Service: KFHP QI enhances customer service by leveraging real-time feedback to identify opportunities for improvement and act quickly. This approach enables immediate service recovery when issues arise, ensuring members feel heard and valued. Insights from feedback are also used to drive process improvement initiatives, creating sustainable changes that improve access, responsiveness, and overall experience. By combining proactive recovery with continuous improvement, KFHP QI's goal is to strengthen trust and deliver a more patient-centered care experience.

Getting Needed Care in a Timely Manner: KFHP QI remains focused on strengthening access and care delivery by strategically hiring clinicians across key specialties, including addiction medicine, oncology, cardiology, nephrology, gastroenterology, dermatology, pulmonary medicine, podiatry, care pathways, and ENT. To support this growth and manage increasing demand, specialty referral orders are being continuously updated. In parallel, the expansion of e-ticket functionality ensures patients can conveniently and promptly book appointments, improving overall access and experience in both specialties and primary care.

Receiving advice on quitting smoking/using tobacco: One of many offerings of KFHP QI's Wellness Program is the Tobacco Cessation Program. Resources can be found online via kp.org. In addition, provider and care team workflows include conversation and referral including self-referral. Outreach to referred patients is done in one month, six months and one year for engagement. Another resource for members is in partnership with the State of Hawaii Tobacco Quit Line.

HSAG Assessment

HSAG has determined that KFHP QI has addressed the prior year's recommendations.

Home and Community-Based Services CAHPS Survey

2024 Recommendations

HSAG identified the following areas for improvement:

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

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

Improvement Activities Implemented

KFHP QI will develop a process to address the HCBS CAHPS results by January 31, 2026. KFHP QI will focus on improving HCBS adult members' overall experience with personal assistance staff, behavioral health staff, and receiving transportation to medical appointments and monitoring activities in the Medicaid Oversight Review (MOR) Board. The MOR Board meets each month.

HSAG Assessment

While KFHP QI has a plan to address the HCBS CAHPS recommendations in the future, no improvement activities were implemented during 2025.

Encounter Data Validation

2024 Recommendations

HSAG identified the following areas for improvement:

- The record omission rates for all encounter types were high. Institutional encounters had the highest record omission rate at 45.7 percent, while professional and pharmacy encounters had record omission rates of 22.8 percent and 6.4 percent, respectively. Additionally, the record surplus rates for institutional and pharmacy encounters were high at 10.0 percent and 8.9 percent, respectively.
- Although matched records largely contained similar values between the MQD-submitted and the Milliman-submitted data, KFHP QI should ensure the following data elements have accurate values:
  - Institutional encounters: Servicing Provider NPI, Servicing Provider ID, Allowed Amount, Billed Amount, COB Amount, All Surgical Procedure Codes, Encounter Flag, All Secondary POA Codes, TOB Code, and Value Codes.
  - Professional encounters: Billing Provider Type, Servicing Provider ID, Allowed Amount, Billed Amount, COB Amount, MCO Paid Amount, All Secondary Diagnosis Codes, Procedure Code, Admission Date, and Discharge Date.
  - Pharmacy encounters: Billed Amount, Dispensing Fee, MCO Paid Amount, Dispensing Quantity, and Number of Refills.

HSAG recommends that KFHP QI:

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

Improvement Activities Implemented

The feedback was incorporated into the rate setting data submissions to support 2026 rates.

HSAG Assessment

HSAG has determined that KFHP QI has addressed the prior year's recommendations.

'Ohana Health Plan QUEST Integration ('Ohana QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

All measures under the scope of the audit were determined to be *Reportable*. 'Ohana QI was determined to be fully compliant with all IS standards, including IS standard L for assessing case management data; therefore, HSAG did not have any recommendations for 'Ohana QI.

Improvement Activities Implemented

Not applicable.

2024 HEDIS Performance Measure Recommendations

HSAG recommends that 'Ohana QI focus on improving performance related to the following measures with rates that fell below the 25th percentile for the QI population:

- Within the Children's Preventive Health domain, the following recommendations were identified:
  - Regarding the *Child and Adolescent Well-Care Visits* measure, HSAG recommends that 'Ohana QI promote teen-centered care by reminding providers of the need for using teen-appropriate language, treating teens as important partners in their care, and ensuring confidentiality and privacy. Further, HSAG recommends that 'Ohana QI and providers develop partnerships with community stakeholders such as schools.[53] HSAG also recommends that 'Ohana QI conduct provider education about encouraging preventive care when members are seen for sickness, sports physicals, and other reasons. Additionally, HSAG recommends that health plans promote well-visits on social media, through emails, or personalized outreach. Finally, HSAG recommends that 'Ohana QI incentivize providers, members, and parents to complete visits.

[53] Centers for Medicare & Medicaid Services. Paving the Road to Good Health: Strategies for Increasing Medicaid Adolescent Well-Care Visits. Available at: https://www.medicaid.gov/medicaid/benefits/downloads/paving-the-road-to-good-health.pdf. Accessed on: Dec 18, 2024.

  - Regarding the *Childhood Immunization Status* measure, HSAG recommends that ‘Ohana QI provide education to providers and members about the importance of vaccination for disease prevention and encourage vaccination at every opportunity, including mild illness visits.[54]
  - Regarding the *Well-Child Visits in the First 30 Months of Life* measure, HSAG recommends that ‘Ohana QI identify performance improvement efforts to improve well-child visits, drawing from other states’ performance improvement initiatives. For instance, California and Virginia have focused on delays in newborn enrollment data, and Missouri and Texas focused on beneficiary barriers and implemented interventions such as utilizing patient portals and phone outreach. HSAG recommends that health plans identify other barriers to care and conduct a focus group on identifying strategies to address barriers.[55]
- Within the Women’s Health domain, the following recommendations were identified:
  - Regarding the *Cervical Cancer Screening* measure, HSAG recommends that ‘Ohana QI consider utilizing one-on-one interactions with a healthcare professional, such as CHWs, which have been shown to improve cervical cancer screening.[56] Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness. In addition, HSAG recommends that ‘Ohana QI provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is lack of knowledge.
  - Regarding the *Prenatal and Postpartum Care* measure, HSAG recommends that ‘Ohana QI consider whether there are disparities/SDOH within ‘Ohana QI’s population that contribute to lower access to care. Upon identification of a root cause, HSAG recommends that ‘Ohana QI implement appropriate interventions to reduce barriers to care. Strategies could include providing expanded access appointments outside of business hours to accommodate work schedules or childcare needs. Many appointments can be made via telehealth; therefore, ensuring members have access to these options could potentially increase performance in this measure. Further, HSAG recommends that ‘Ohana QI identify payment structure types that will incentivize quality care. Bundling payments may cause disincentives for postpartum care, as providers might receive the same payment regardless of whether the member attends the postpartum visit.[57]
- Within the Chronic Conditions domain, the following recommendations were identified:
  - Regarding the *Controlling High Blood Pressure* measure, HSAG recommends that ‘Ohana QI identify trends within the data to identify which demographic groups and regions report lower blood pressure. HSAG recommends providing coverage for automated home blood pressure

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

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

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

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

monitors for patients, while educating members about the benefits of this approach.[58] Further, HSAG recommends providing incentives to members and providers to encourage blood pressure control.

- Within the Behavioral Health domain, the following recommendations were identified:
  - Regarding the *Follow-Up After Hospitalization for Mental Illness* measure, HSAG recommends that ‘Ohana QI consider effective interventions to reduce repeat hospitalizations for people with mental illness, such as CTI, ACT, case management, and focusing on co-occurring substance abuse disorders.[59]

Improvement Activities Implemented

Children’s Preventive Health

Child and Adolescent Well-Care Visits and Well-Child Visits in the First 30 Months of Life

- Incentive programs
  - ‘Ohana Health Plan recognizes that strong provider–member relationships are essential to delivering high quality care. To support this, ‘Ohana developed the Pay for Quality (P4Q) program to reward primary care providers for submitting documentation needed for HEDIS measures (ICD-10, CPT, CPT II, NDC). To further promote gap closure, ‘Ohana reimburses $0.01 for select CPT II codes so providers can submit them without receiving a non-payable code denial. This use of CPT II codes streamlines reporting of preventive services and test results, enabling faster and more efficient data sharing with the Health Plan.
  - Additional bonus incentives are given to providers, pediatricians, and FQHCs.
  - ‘Ohana Health Plan’s My Health Pays™ program incentivizes members to complete preventive and wellness activities, such as annual exams and screenings. Reward dollars are loaded onto a My Health Pays™ Visa® Prepaid Card after a self-attestation is completed. Members may use these rewards for essential expenses, supporting both health engagement and social needs. In 2025, the program expanded to include healthy behaviors such as updating contact information to improve member engagement and connection.
  - ‘Ohana encourages Medicaid parents and caregivers to participate in the State of Hawai‘i Well Child Incentive Program to increase completion of recommended well-child visits.
- Member activation and engagement
  - ‘Ohana Health Plan sends EPSDT Periodicity Letters to members to notify them when they are due for an EPSDT visit, supporting timely access to recommended preventive care services.

[58] Centers for Disease Control and Prevention. The Surgeon General’s Call to Action to Control Hypertension. Available at: https://www.cdc.gov/high-blood-pressure/php/cta/index.html. Accessed on: Dec 26, 2025.

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

  - ‘Ohana Health Plan conducts outbound reminder calls to members who are due for child and adolescent well-care, W15, and W30 visits to provide education and support. For members who cannot be reached by phone, reminder letters are sent to ensure outreach and engagement in recommended preventive care services.
  - ‘Ohana Health Plan conducted a call campaign targeting families with children who had Well-Child visit gaps. Staff provided education on the importance of routine care, assisted with scheduling appointments, and offered resources to help families establish a primary care provider and access appropriate specialists.
  - ‘Ohana Health Plan continued the Hallmark campaign to enhance member satisfaction, retention, and engagement in quality care activities. Selected Medicaid members received co-branded Hallmark cards with targeted inserts, such as reminders for child and adolescent well-care visits or CAHPS surveys. A total of 13,000 cards were mailed in three waves across 2024 and the first half of 2025 to support care gap closure.
- Provider activation and engagement
  - ‘Ohana Health Plan provides education to pediatric providers on delivering developmentally appropriate adolescent care, including using teen-friendly language, engaging adolescents as partners in their care, and reinforcing confidentiality and privacy.
  - ‘Ohana Health Plan also provides education to pediatric providers on delivering developmentally appropriate pediatric care and reinforcing confidentiality and privacy. A Provider Billing and Coding Tip Sheet was developed to educate providers and includes examples for appropriate coding and documentation of all types of well-child visits.
  - ‘Ohana Health Plan provides ongoing EPSDT education to providers, including guidance on completing well-child components during all visit types (including sick visits).
- Utilization of digital platforms, including social media
  - ‘Ohana Health Plan leverages social media platforms, including Facebook and Instagram, to promote well visits and preventive care services. These channels are used to educate members about the importance of routine screenings, vaccinations, and wellness visits, helping to increase engagement, support healthy behaviors, and improve timely access to care.
  - ‘Ohana partnered with Hamakua Health to install Starlink internet in Waipi‘o Valley, improving member access to telehealth, newborn follow-up, provide resources to address SDOH, and early-childhood preventive care.
  - ‘Ohana Health Plan has expanded EMR access and implemented key integrations with the Hawaii Health Information Exchange (HHIE) and other provider portals. These efforts streamline information sharing, reduce administrative burden, and support more accurate HEDIS reporting by capturing clinical care more completely. The health plan also established the Epic Payor Platform for Queen’s Clinically Integrated Physician Network and integrated multiple FQHCs through Athena and Healow platforms, further improving provider connectivity and coordinated care.
- Community partnerships
  - Mana ‘Ohana is a community based, midwifery-led model of care that offers Hawaii residents with a holistic perinatal care experience. The program includes clinical and social services

deployed when, where, and how services are needed. This program offers 'Ohana Health Plan's members exclusive access to a broad-based program designed to screen, triage, and support women and their newborns throughout the perinatal period by providing culturally anchored and responsive outreach and services that meet members where they are. The goal of the program is to reduce costs and to increase quality of care for ʻOhana members. The program aims to do this by decreasing rates of cesarean section/other birth complications, decreasing neonatal intensive care unit (NICU) infants, and increasing HEDIS quality scores (prenatal, postpartum and well child visits within the first 15 months).

- Through the Mana ʻOhana Program and partnership with Healthy Mothers Healthy Babies (HMHB), targeted outreach is conducted for W15 and W30-eligible members. HMHB provides direct member outreach and mobile services across multiple islands, including hard-to-reach areas such as Waipiʻo Valley.
- HMHB manages the maternal and child health program for ʻOhana Health Plan. HMHB outreaches to members within 10 business days of receipt of the electronic data file from ʻOhana Health Plan. HMHB prioritizes members who are later along in their pregnancy, or who for some other clinical reason take precedence (such as high-risk members). Up to three (3) outbound telephone calls are made, in the day and evening, to maximize the response rate. During engagement, HMHB staff conducts triage and assesses the need for the following:
  - Appropriate Behavioral and/or Clinical services
  - Facilitate engagement for prenatal and/or postpartum care visits
  - Identification of other needs and provide SDOH services
- HMHB engages with members with SDOH programs and on-going case management throughout pregnancy, birth, and postpartum periods. Additional follow-ups with well-child visits are conducted. HMHB mails outreach material and member educational module to each member within 14 days of the receipt of contact information.
- HMHB prepares annual reports summarizing program outcomes, including member experience, referrals to care and social programs, and engagement patterns as defined collaboratively with ʻOhana Health Plan. Reports are shared with ʻOhana's director of quality and distributed across the Health Plan. HMHB also presents findings to the executive committee or other teams upon request at mutually agreed times.

- In 2025, ʻOhana Health Plan and the Centene Foundation awarded Hawaiʻi Island Community Health Center (HICHC) a $550,000 grant to support the "Gateway to Health" project, which expands access to essential services, including well-child exams, immunizations, behavioral health care, and chronic condition management for students in underserved areas. A traditional Hawaiian blessing and dedication ceremony was held with state and county leaders before the mobile clinic began serving Hawaiʻi Island public schools on August 4, 2025. The program will roll out in phases, starting with the Honokaʻa-Kealakehe-Kohala-Konawaena complex, followed by Kaʻū-Keaʻau-Pāhoa and Hilo-Waiākea, with all designated schools expected to be served by May 2026. HICHC leadership noted that the mobile clinic will deliver comprehensive school-based care directly to students, while ʻOhana Health Plan emphasized its goal of improving access for children and families who face barriers to receiving needed healthcare.

Childhood Immunization Status

- The Fluvention® Program is a multi-layered seasonal campaign designed to promote vaccinations as the key to flu prevention. The program for all members who are eligible for a flu vaccine, with a specific focus on members who are pregnant, between six (6) months and five (5) years old, 65 years or older, and/or have a chronic condition(s), as these members have a higher risk of developing flu-related complications. This initiative strives to increase influenza vaccination rates through a collection of targeted services and activities:
  - Member Outreach and Marketing: In collaboration with Marketing, the Fluvention® team helps create member-facing materials to educate on the importance of receiving a flu shot through the following methods:
    - Interactive voice response (IVR)/on-hold messaging
    - Proactive outreach manager (POM)/auto-dialer outbound phone calls
    - Texts and/or e-mails
    - Flu-specific messaging on the health plan website and social media platforms
  - Provider Facing Materials In collaboration with Marketing, the Fluvention® team helps create provider-facing materials including:
    - Email template for provider-facing teams to utilize
    - Web article and newsletter content to equip providers with key talking points on flu vaccination
    - Leave behind flyer
  - Care management: Care managers interact directly with members to reinforce the importance of the flu vaccine and are alerted to members who have not yet had an annual flu vaccine. Member educational materials, described above, are also provided to members following outreach. Care managers are provided with talking points that encourage them to talk to pregnant members about the importance of flu vaccinations and how to address specific concerns pregnant and/or breastfeeding moms may have about vaccinations.
- Hawaii Immunization Registry and Health Information Exchanges.

Women's Health

Cervical Cancer Screening

- 'Ohana Health Plan completed an email campaign to all members with a *Cervical Cancer Screening* care gap. Communication provided education regarding the importance of cervical cancer screening and how to get access to appropriate practitioners.

Prenatal and Postpartum Care

- Incentive programs
  - 'Ohana Health Plan recognizes that strong provider–member relationships are essential to delivering high quality care. To support this, 'Ohana developed the P4Q program to reward

primary care providers for submitting documentation needed for HEDIS measures (ICD-10, CPT, CPT II, NDC). To further promote gap closure, ‘Ohana reimburses $0.01 for select CPT II codes so providers can submit them without receiving a non-payable code denial. This use of CPT II codes streamlines reporting of preventive services and test results, enabling faster and more efficient data sharing with the Health Plan.
  - ‘Ohana Health Plan’s My Health Pays™ program incentivizes members to complete preventive and wellness activities, such as annual exams and screenings. Reward dollars are loaded onto a My Health Pays™ Visa® Prepaid Card after a self-attestation is completed. Members may use these rewards for essential expenses, supporting both health engagement and social needs. In 2025, the program expanded to include healthy behaviors such as updating contact information to improve member engagement and connection.
  - Providers receive incentives through the P4Q program for delivering high-quality prenatal and postpartum care. Members are encouraged to complete recommended visits through the ‘Ohana Healthy Rewards program.
- Member activation and engagement
  - EPSDT Letter and Brochure: Mothers are sent a letter to congratulate them on their new baby and informing them of ‘Ohana’s EPSDT Program.
  - New parents receive EPSDT welcome materials and brochures that congratulate them on the birth of their child and explain the EPSDT program. Postpartum reminder letters are sent along with these welcome materials to encourage timely postpartum visit completion.
  - ‘Ohana Health Plan Baby Shower: Campaign to invite pregnant mothers to celebrate healthy pregnancy and provide resources and education for prenatal, postnatal, and childcare.
- Provider activation and engagement
  - Provider Education using HEDIS Adult Pocket Guides: Provider educational material on HEDIS-related women’s health measures.
  - ‘Ohana QI representatives engage with OB/GYN practices statewide to identify barriers to prenatal and postpartum care and collaborate on solutions addressing SDOH and provider workflow challenges.
- Utilization of digital platforms, including social media
  - Access and telehealth support: Mobile clinics and telehealth options, supported through HMHB and other partners, expand access to prenatal and postpartum care in rural communities. The installation of Starlink in Waipi‘o Valley further increases telehealth access for postpartum follow-up.
  - Data access and record retrieval: ‘Ohana utilizes remote EMR access, HHIE, and provider portals to retrieve clinical data, track compliance, and reduce the administrative burden of postpartum record requests for OB/GYN providers.
- Community partnerships
  - Strengthened Partnership with Mana ‘Ohana
    - The program, Mana 'Ohana, is a community based, midwifery-led model of care that offers Hawaii Residents with a holistic perinatal care experience. The program includes clinical and

social services deployed when, where, and how services are needed. This program offers 'Ohana Health Plan's members exclusive access to a broad-based program designed to screen, triage, and support women and their newborns throughout the perinatal period by providing culturally anchored and responsive outreach and services that meet members where they are. The goal of the program is to reduce costs and to increase quality of care for 'Ohana members. The program aims to do this by decreasing rates of cesarean section/other birth complications, decreasing NICU infants, and increasing HEDIS quality scores (prenatal, postpartum and well child visits within the first 15 months).

- HMHB manages the maternal & child health program for 'Ohana Health Plan. HMHB outreaches to members within 10 business days of receipt of the electronic data file from 'Ohana Health Plan. HMHB prioritizes members who are later along in their pregnancy, or who for some other clinical reason take precedence (such as high-risk members). Up to three (3) outbound telephone calls are made, in the day and evening, to maximize the response rate. During engagement, HMHB staff conducts triage and assesses the need for the following:
  - Appropriate Behavioral and/or Clinical services
  - Facilitate engagement for prenatal and/or postpartum care visits
  - Identification of other needs and provide SDOH services
- HMHB engages with members with SDOH programs and on-going case management throughout pregnancy, birth, and postpartum periods. Additional follow-ups with well-child visits are conducted. HMHB mails outreach material and member educational module to each member within 14 days of the receipt of contact information.
- HMHB prepares annual reports describing program outcomes. The program evaluation instrument will minimally include member experience with the program, information about referrals to care and/or social programs in and outside of HMHB, additional patterns and data around engagement to be mutually defined by the Parties. Reports will be shared with 'Ohana's Director of Quality and distributed across 'Ohana Health Plan. HMHB presents to 'Ohana Health Plan's executive committee, or other teams on request at mutually agreed upon times.
- HMHB engages with members to increase the rates of the following measures:
  - Timeliness of Prenatal and Postpartum Care
    - Increase the number of pregnant members that receive a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization.
    - Increase the number of members that had a postpartum visit on or between 7 and 84 days after delivery.

Chronic Conditions

Controlling High Blood Pressure

- Incentive programs

  - Medicaid Partnership for Quality provider incentive program:
    - ‘Ohana Health Plan understands that the provider-member relationship is a key component in ensuring superior healthcare and the satisfaction of members. ‘Ohana recognizes these important partnerships and developed the Partnership for Quality program to reward PCPs for submitting documentation for HEDIS measures (ICD10, CPT, CPT II, NDC). To help maximize gap closures, ‘Ohana pays $0.01 for certain CPT II codes to allow billing without receiving a non-payable code denial. Using CPT II codes for certain preventive care services and test results makes it easier for providers to share data with the health plan quickly and efficiently.
  - MyHealth Pays member rewards program—incentivizes members to get their annual well check visit that helps identify and address members with high blood pressure.
- Disease management (DM) program: ‘Ohana Health Plan has added three dedicated FTEs to its DM program. Rolled out in Q3 2024, hypertension was added to the list of chronic conditions that the DM team manages. The DM philosophy is that member behavior change is one of the hardest needles to move. ‘Ohana believes in high touch, high engagement with its members and strives to understand their true drivers and motivators. The DM team is experienced in case management and address members holistically and work with members on all levels. Blood pressure monitors are available to enrollees in the hypertension DM program.
  - There are multiple ways that members with high blood pressure are identified:
    - Referrals from Utilization Management for high-need cases and Health Coordination is currently the highest volume of referrals into DM.
    - The *Controlling High Blood Pressure* HEDIS measure score and risk adjustment is shared with providers. ‘Ohana meets monthly with its top-tier providers, but provides reporting to all PCPs.
      - Most of the top-tier providers are FQHCs and RHCs that serve rural areas and high-need populations.
      - Information is shared to the member level and providers have access to their members struggling with blood pressure control.
      - DM is offered to providers, and ‘Ohana is currently looking for ways to expand its relationships with them in this area (e.g., events, increased referrals, etc.).
  - Internal reporting—Quality Data team is able to provide targeted and broad reports to the DM team that identifies potential members with chronic conditions.
- Community partnerships
  - ‘Ohana Health Plan participated in the Haehuola Wellness Program in partnership with Waimānalo Health Center. This early Food Is Medicine initiative uses locally sourced food and culturally grounded nutrition programming. The 16-week pilot, guided by the FREE framework [Feed, Reconnect, Educate, Empower] included weekly plant-based meals, virtual education, group classes, and cultural field experiences.
    - Participants demonstrated weight loss, increased energy, and improved blood pressure and HbA1c levels; adopted healthier eating habits; shared nutrition practices at home; reported

improved physical and mental well-being; and reconnected with cultural traditions through foods such as *kalo* (taro) and *'uala* (Hawaiian sweet potato).

- The program highlights the impact of integrating food, culture, and community into member wellness initiatives.

Behavioral Health

Follow-Up After Hospitalization for Mental Illness

- 'Ohana Health Plan recognizes the area of opportunity to reduce readmissions effectively through wraparound efforts in supporting/tracking members from admission to discharge. To reduce readmissions, 'Ohana Health Plan aims for members to visit a qualified mental health practitioner within seven days rather than 30 days as evidenced to be more effective and crucial for improving patient outcomes, reducing readmissions, and assuring adherence to treatment plan. The following activities are the actions taken in 2025:
  - Concurrent review nurses correspond with facilities to discuss treatment, and care coordinators conduct follow-up outreach to make sure the members go for a follow-up visit. They also assess members for completion of the DHS 1157 referral form and submit applications to see if member is eligible for CCS program for appropriate coverage.
  - QI BH service coordinator team identifies mental illness-related high utilizers of ED and inpatient admissions to conduct interdisciplinary team (IDT) meetings for those who are CCS and QI Medicaid.
  - Facility responders call facilities daily to connect members with case managers and hospital staff once they are admitted in ED and inpatient (began Q4 2024—ongoing through 2025).
  - FUH team tracks members from admission to discharge via ADT reports and phone calls to facilities to obtain timely discharge dates. Workgroup also meets monthly to discuss improving processes from admission to discharge and addressing identified barriers and blind spots to improve coordination of care.

HSAG Assessment

HSAG has determined that 'Ohana QI has addressed the prior year's recommendations.

Validation of Network Adequacy

2024 Recommendations

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

Improvement Activities Implemented

Not applicable.

CAHPS—Adult Survey

2024 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

Survey Item	Key Drivers		
	Rating of Health Plan	*Rating of All Health Care*	*Rating of Personal Doctor*
Q4. Received care as soon as needed when care was needed right away	✓	✓	—
Q6. Received appointment for a checkup or routine care as soon as needed	—	✓	—
Q9. Ease of getting the care, tests, or treatment needed	✓	✓	—
Q17. Personal doctor seemed informed and up-to-date about care from other doctors or health providers	—	—	✓
Q24. Health plan’s customer service gave the information or help needed	✓	—	NA

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

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

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

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

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

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

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

HSAG recommends that ‘Ohana QI explore what may be driving lower experience scores and develop initiatives designed to improve quality and access to care, including a focus on improving adult members’ overall experiences with their health plan, their doctor’s ability to communicate, customer service, getting needed care in a timely manner, and discussion of cessation strategies and medications to quit smoking/using tobacco.

Improvement Activities Implemented

Provider-Focused Activities

- Companywide education has been deployed emphasizing CAHPS, including topics around behavioral economics. ‘Ohana Health Plan has launched several initiatives within its provider community to streamline processes and procedures which might delay or cause members to not receive care. For instance, ‘Ohana Health Plan rescinded over 50 prior authorization criteria across a variety of services and is in the process of creating “gold card” relationships with key providers. ‘Ohana Health Plan piloted innovative ideas for connecting with members and providing relevant information in a meaningful way. Examples include:
  - Partnership with a local provider group to develop and deploy educational videos featuring real providers and staff. Topics included “how to maximize your visit” to help ensure members experience at the PCP office the best it can be.
  - Advancing value-based contracting with key strategic providers which aligns goals around HEDIS and CAHPS outcomes.
  - Increased investment in provider relations teams to help identify and address barriers to members receiving the care that they need.

Member-Focused Activities

- Member growth and retention were key priorities for ‘Ohana Health Plan in 2025. To support these goals, the Quality team has launched several outreach campaigns focused on strengthening member activation and experience. With each call, ‘Ohana encourages members to take an active role in their health and establish ‘Ohana as their local, trusted health plan partner.

  - As of this year, ‘Ohana Health Plan has connected with approximately 4,480 members through a series of targeted outreach campaigns designed to support quality improvement, member engagement, and retention. Key campaigns included:
    - CAHPS Recovery Outreach (February 2025, ~75 members): Focused on member satisfaction, growth, and retention.
    - Fully Integrated Dual Eligible (FIDE)/Annual Planned Visits (APV) Outreach (March–May 2025, ~1,700 members): Supported member activation and referrals to Disease Management services.
    - Well-Child Visit Reminders (June 2025, ongoing, ~1,600 members): Promoted completion of well-child visits to support quality and retention goals.
    - HbA1c Outreach (July–August 2025, ~925 members): Engaged members around diabetes management and HbA1c testing.
    - FIDE/APV Outreach (August–September 2025, ~180 members): Aligned outreach efforts to support FIDE conversions, growth, and retention.
  - These coordinated campaigns demonstrate targeted efforts to improve health outcomes, increase preventive care engagement, and strengthen member satisfaction.
- To strengthen controls around outbound member communications and support the 2025 member engagement strategy, ‘Ohana Health Plan implemented Neustar to address longstanding issues with outbound calls being incorrectly labeled as spam. Neustar manages spam-tag remediation to ensure outbound calls display accurate caller identification, improving member trust and recognizing ‘Ohana as a verified caller. This tool enhances call deliverability and overall communication effectiveness. While recently implemented, ‘Ohana will monitor performance, document controls, and integrate reporting on Neustar’s impact as data becomes available.
- ‘Ohana Health Plan initiated the Hallmark campaign. The objective of ‘Ohana’s Hallmark campaign was to support member satisfaction/retention and address quality care gaps by engaging with members in a new, more personalized way through co-branded Hallmark cards. ‘Ohana’s traditional outreach methods have yielded low engagement rates—letters/postcards are often unopened and outbound call campaigns have low reach rates. In addition, ‘Ohana members are often wary of corporate call campaigns from Centene/WellCare due to the out-of-state phone number shown on caller ID and corporate branding on mailers may have led to confusion on ‘Ohana Health Plan’s brand identity. To address these barriers, selected cohorts of Medicaid and Medicare members were mailed a Hallmark card that expressed ‘Ohana’s appreciation for their membership along with a targeted insert—Medicaid topics included child and adolescent well-care Visits and a CAHPS survey reminder. A total of 13,000 cards were sent out with mail drops staged in three waves throughout the year, timed to align with recommended care gap closure timeframes.
- In 2025, ‘Ohana Health Plan renewed its partnership with Hallmark, introducing a bold and innovative approach to member engagement. Moving beyond traditional bulk mailings, ‘Ohana has empowered team members across ‘Ohana with the ability to send personalized cards whenever they choose, creating meaningful, one-to-one connections. These cards are thoughtfully designed to uplift member morale, celebrate milestones, and express genuine care, ultimately fostering trust and increasing health engagement. To ensure success, ‘Ohana has implemented comprehensive training sessions, provided easy-to-use tools, and shared regular performance metrics to keep the team

motivated and informed. This initiative reflects ‘Ohana’s commitment to going beyond transactional interactions and building relationships that inspire healthier lifestyles and stronger member satisfaction.
  - ‘Ohana Health Plan is leveraging the program for targeted bulk mailings to thank members and inform those transitioning to the FIDE plan. Early next year, cards will also be sent to members with high risk adjustment scores, targeting those at higher risk. These initiatives will result in thousands of cards being mailed to members.

Access to Care

- The Contracting and Network Development team focused on enhancing recruiting strategies to target specialists, including BH prescribing practitioners. The Networking department provided provider education to BH providers on the resources that the health plan has available to help with recruiting strategies. The health plan also continues to educate members on utilizing telemedicine and virtual visits.
- An opportunity was also identified to partner with Hazel Health, a telehealth provider, to improve children’s immediate access to BH healthcare in times when there are limited BH practitioners available.

HSAG Assessment

HSAG has determined that ‘Ohana QI has addressed the prior year’s recommendations.

Home and Community-Based Services CAHPS Survey

2024 Recommendations

For ‘Ohana QI, the following measures scored statistically significantly lower than AHRQ’s 2024 CAHPS Database benchmark:

- *Reliable and Helpful Staff*
- *Staff Listen and Communicate Well*
- *Choosing the Services that Matter to You*
- *Transportation to Medical Appointments*
- *Planning Your Time and Activities*

HSAG recommends that ‘Ohana QI explore what may be driving lower experience scores and develop initiatives designed to improve quality and access to care, including a focus on improving adult members’ overall experiences with the reliability of staff, staff’s ability to listen and communicate, ability to choose services that matter to the individual, receiving transportation to medical appointments, and ability to plan their time and activities.

Improvement Activities Implemented

- *Reliable and Helpful Staff*
  - Re-modeled health coordinator and care coordinator responsibilities. Transition included having a singular point-of-contact, the health coordinator, for members to outreach when needing assistance. Health coordinators provide assistance to members as they outreach, and the member is supported by the care coordinator for ongoing follow-up until resolution is confirmed. This re-model also reduced the number of members assigned to each health coordinator, enabling improved ability of the health coordinators to dedicate toward assisting member needs or concerns as they arise.
- *Staff Listen and Communicate Well*
  - Members continue to be supported by a health coordination team, with the health coordinator as their point of contact should needs arise.
  - Health coordinators outreach members for completion of Health & Functional Assessments, comprehensive Health Action Plan updates, and quarterly Health Action Plan reviews.
  - All health coordination staff maintain Person-Centered Thinking, including Person-Centered Care Planning, certification.
- *Choosing the Services that Matter to You*
  - Health coordinators utilize options counseling and review the LTSS Choice Form with the member, POA, or guardian to ensure all available options are presented and the member has choices in their selections.
  - Health coordinators utilize person-centered thinking and planning when developing Health Action Plans.
  - All health coordination staff complete annual person-centered training to ensure members can plan services, schedule their time, and choose activities that align with their preferences
- Health Coordinators are provided with continuous training on up-to-date processes and procedures including member benefits, to provide education to their members regarding services that are available.
- Streamlined Community Health Worker partnership with Case Manager/Health Coordinator to provide a better member experience.
- Improved email communication with Intelliride:
  - The vendor created one email address that includes all the agents who work on 'Ohana Health Plan travel requests. This provides transparency for all requests to all agents and the supervisor. The 'Ohana Health Plan Utilization Management Supervisor meets regularly with the Intelliride Supervisor to address any concerns and escalations and the two contacts are in touch with each other as situations occur.
- Vivia Pilot Program
  - Unique home care solution: shifting from a time-based model to a task-based model, allowing caregivers to care for up to 10x more members
    - Vivia's caregiving staff are full-time employees with guaranteed hours.

    - Vivia furnishes transportation for its employees via company car, to serve a geographic neighborhood of At-Risk and LTSS members
    - Payment transformation pilot of "Per Visit" reimbursement
    - Member requires PA1 or PA2 services that are short in duration and/or intermittent and can be provided with a visit that is less than 2 hours per day.
  - There has been a statewide staffing shortage at home care agencies and as a result, staffing Personal Assistance (PA) 1 and PA2 services for members has been difficult during/since the pandemic. Vivia has been able to start services fairly quickly and has staffed some 'Ohana members who have been without agency services for over 1 year. This will hopefully improve overall member satisfaction with HCBS.
- The Member Advisory Committee is a group of members, parents, guardians, member advocacy groups, and health plan staff as appropriate, that reviews and reports on a variety of quality and service issues. The health plan understands that the ability to effectively engage stakeholders, including members/family members/caregivers, advocates, and community organizations in the quality program is a crucial component of 'Ohana's collaborative efforts to enhance a patient-centered service delivery system, to optimize clinical outcomes, and to positively affect program operations

HSAG Assessment

HSAG has determined that 'Ohana QI has addressed the prior year's recommendations.

Encounter Data Validation

2024 Recommendations

HSAG identified the following areas for improvement:

- The record omission and record surplus rates for institutional and professional encounters were high. Professional encounters had the highest record omission and record surplus rates at 45.5 percent and 33.3 percent, respectively. Institutional encounters had a record omission rate of 22.3 percent and a record surplus rate of 17.3 percent.
- Although matched records largely contained similar values between the MQD-submitted and the Milliman-submitted data, 'Ohana QI should ensure the following data elements have accurate values:
  - Institutional encounters: Detail First Date of Service, Detail Last Date of Service, Billing Provider Type, Servicing Provider ID, Allowed Amount, COB Amount, Coinsurance Amount, MCO Paid Amount, All Surgical Procedure Codes, DRG Code, MCO Paid Date, and TOB Code.
  - Professional encounters: Billing Provider Type, Servicing Provider ID, Allowed Amount, COB Amount, Primary Diagnosis Code, All Secondary Diagnosis Codes, Procedure Code Modifiers, and NDC.

– Pharmacy encounters: Billed Amount, Dispensing Fee, New or Refill Flag, and Number of Refills.

HSAG recommends that ‘Ohana QI:

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

Improvement Activities Implemented

- Review and work on the action items noted in the data discrepancy report:

  Table 3—Institutional: Of the 941,462 records, ‘Ohana submitted to MQD, 162,465 (17.3 percent) records could not be matched to the data submitted to Milliman.

  1. The code to create the Milliman file was pulling the previous version of the HP_CLM_NUM

  Improvement Activity: The logic that creates the Milliman file has been updated to pull the latest HP_CLM_NUM.

  2. These services were paid under a bundled arrangement. The methodology on the Milliman file was to distribute dollars across only on Paid lines and exclude $0 Billed and $0 Paid lines.

  Improvement Activity: The code used to create the Milliman file has been updated to distribute dollars across all lines.

  Table 3—Institutional: For matched claims, ‘Ohana reported $8.3 million more to MQD for the COB Amount. The discrepancy rate for the COB Amount was 38.2 percent.
  The code to create the Milliman file is using a different data source than encounters is using.

  Improvement Activity:
  ‘Ohana QI determined the encounters values are accurate. The logic that creates the Milliman file has been updated to mirror what encounters is currently using.

  Table 6—Institutional: The discrepancy rate for DRG Code was 72.5 percent.
  From the Encounters standpoint, MQD sent new DRG guidance in mid-2022. ‘Ohana incorporated those changes in September of 2023 and then corrected submissions back to 7/1/2022. The DRG used to populate the Milliman file uses a different methodology**.**

Improvement Activity:
The code used to create the Milliman file for DRG population has been updated to mimic the encounter methodology.

Table 6—Institutional: The discrepancy rate for MCO Paid Date was 16.7 percent.
Finance data is populated differently than encounters. Finance rolls up the check date to the first day of the month for reporting purposes. Encounters is using the actual check date.

Improvement Activity: The logic to create the Milliman file has been updated to use max check date.

Table 6—Institutional: The discrepancy rate for TOB Code was 9.2 percent.
1. The encounters code was not populating the type of bill correctly.

Improvement Activity: Encounters code has been modified for this scenario to report the type of bill correctly.

2. The code that creates the Milliman file is obtaining the frequency code from the provider billed claim, while encounters is submitting a frequency code based on the adjudicated version of the claim.

Improvement Activity: The logic to create the Milliman file has been modified to mirror what encounters is using.

Table 3—Institutional: For matched claims, 'Ohana reported $37.8 million more to Milliman for the Allowed Amount, resulting in a 43.2 percent discrepancy rate.
The encounters code was not directly using the allowed amt from the adjudicated claim to populate that value in the encounter.

Improvement Activity: The encounters code has been modified to show the allowed amount from the adjudicated claim.

Table 4—Professional: Among the 857,249 records in MQD's data, 285,328 records (33.3 percent) were not matched with Milliman's data.
The code to create the Milliman file was pulling the previous version of the HP_CLM_NUM

Improvement Activity: The code to create the Milliman file has been updated to pull the latest version in all scenarios.

Table 4—Professional: For matched records, 'Ohana reported $9 million more to Milliman than to MQD for the Allowed Amount field. This resulted in a 25.2 percent discrepancy rate.
The encounters code was not directly using the allowed amt from the adjudicated claim to populate that value in the encounter.

Improvement Activity: The encounters code has been modified to show the allowed amount from the adjudicated claim.

Table 4—Professional: For matched records, 'Ohana reported $3 million more to MQD than to Milliman for the COB Amount field. This resulted in an 8.9 percent discrepancy rate

The code to create the Milliman file is using a different data source than encounters is using.

Improvement Activity: 'Ohana validated that the encounters values are accurate. The code that creates the Milliman file has been updated to match encounters.

Table 7—Professional: Among the matched records with Procedure Code Modifiers populated for both data sources, 'Ohana submitted different values to MQD and to Milliman for 13.7 percent of matched records

The code that creates the Milliman file is pulled from a separate data source than encounters.

Improvement Activity: The code that creates the Milliman file has been updated to map in secondary modifiers.

Table 7—Professional: Among the matched records with the Servicing Provider ID populated for both data sources, 'Ohana submitted different values to MQD and to Milliman for 10.5 percent of matched records.

The code that is used to populate the servicing provider id is different than what is used in encounters.

Improvement Activity: The logic that creates the Milliman file has been updated to match encounters.

Table 5—Pharmacy: For matched records, 'Ohana reported $3 million more to Milliman for the Billed Amount field, resulting in a 5.7 percent discrepancy rate for matched records.

The logic that creates the Milliman file is using a calculation which is different than how Encounters is populating.

Improvement Activity: The logic that creates the Milliman file has been changed to match encounters.

- Utilize the three-year encounter file that MQD will provide monthly to ensure the data it submits to HPMMIS are processed and submitted correctly. 'Ohana QI should review any discrepancies within the file with MQD to reconcile any differences.
  - Ohana has been collaborating with MQD with the new feed and the memos associated. MQD is still adjusting the feed; once finalized, 'Ohana will perform a review on the final memo and complete the loading procedure of each file. 'Ohana will then utilize it for reconciliation starting with Q4 2025 recon per MQD direction.

- Continue to work with MQD and Milliman to ensure data submitted to HPMMIS in CY 2025 accurately reflect data needed for the CY 2026 rate setting activities.
  - Ohana has performed an internal reconciliation with Finance
  - Ohana will continue to partner with MQD and Milliman on the Encounter Data Validation audit.
  - Ohana's Q2 2025 variance was 7 percent, which is 20 percent lower than Q1 2025.

HSAG Assessment

HSAG has determined that 'Ohana QI has addressed the prior year's recommendations.

UnitedHealthcare Community Plan QUEST Integration (UHC CP QI)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

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.

Improvement Activities Implemented

Not applicable.

2024 HEDIS Performance Measure Recommendations

HSAG recommends that UHC CP QI focus on improving performance related to the following measures with rates that fell below the 25th percentile for the QI population:

- Within the Children's Preventive Health domain, the following recommendations were identified:
  - Regarding the *Child and Adolescent Well-Care Visits* measure, HSAG recommends that UHC CP QI incentivize providers, members, and parents to complete visits, encourage teen-centered care through privacy and confidentiality, promote well-visits on social media or other outreach, and develop partnerships with community stakeholders.[60]
  - Regarding the *Childhood Immunization Status* measure, HSAG recommends that UHC CP QI provide education to providers and members about the importance of vaccination for disease prevention and encourage vaccination at every opportunity, including mild illness visits.
  - Regarding the *Well-Child Visits in the First 30 Months of Life* measure, HSAG recommends that UHC CP QI identify performance improvement efforts to improve well-child visits, drawing

[60] Centers for Medicare & Medicaid Services. Paving the Road to Good Health Strategies for Increasing Medicaid Adolescent Well-Care Visits. Available at: https://www.medicaid.gov/medicaid/benefits/downloads/paving-the-road-to-good-health.pdf. Accessed on: Jan 20, 2026.

from other states' performance improvement initiatives. For instance, California and Virginia have focused on delays in newborn enrollment data, and Missouri and Texas focused on beneficiary barriers and implemented interventions such as utilizing patient portals and phone outreach. HSAG recommends that UHC CP QI identify other barriers to care and conduct a focus group on identifying strategies to address barriers.[61]

- Within the Women's Health domain, the following recommendations were identified:
  - Regarding the *Cervical Cancer Screening* measure, HSAG recommends that UHC CP QI consider utilizing one-on-one interactions with a healthcare professional, such as CHWs, which have been shown to improve cervical cancer screening.[62] Utilizing an approach that focuses on SDOH and racial/ethnic disparities is important for overall effectiveness. In addition, HSAG recommends that UHC CP QI provide education to members in need of screenings through health literacy campaigns, as one barrier to regular cervical cancer screenings is lack of knowledge.
  - Regarding the *Prenatal and Postpartum Care* measure, HSAG recommends that UHC CP QI consider whether there are disparities/SDOH within UHC CP QI's population that contribute to lower access to care. Upon identification of a root cause, HSAG recommends that UHC CP QI implement appropriate interventions to reduce barriers to care. Strategies could include providing expanded access appointments outside of business hours to accommodate work schedules or childcare needs. Many appointments can be made via telehealth; therefore, ensuring members have access to these options could potentially increase performance in this measure.

Improvement Activities Implemented

Children's Preventive Health

UHC CP QI implemented multiple outreach and engagement programs targeting children's preventive health measures:

- Annual preventive care letter and email campaign: UHC CP QI sent a preventive care letter or email to over 9,000 eligible members to reinforce the importance of screenings and encourage preventive care appointments for children. *(Completed—June 2025)*
- EPSDT program: UHC CP QI sends reminder mailers to members who are due or overdue for screenings and welcome mailers to all new members to promote EPSDT services. (*Ongoing)*
- Live calls: UHC CP QI partners with vendor TTEC, whose agents make outbound calls to households to help with appointment scheduling via three-way calls with clinics and providers. Targeted measures in this campaign include CIS, WCV, and W30. *(Started in January 2025, Ongoing)*

[61] Centers for Medicare & Medicaid Services. Well-Child Care. Available at: https://www.medicaid.gov/medicaid/quality-of-care/quality-improvement-initiatives/well-child-care/index.html. Accessed on: Jan 20, 2026.
[62] Popalis ML, Ramirez SI, Leach KM, et al. Improving cervical cancer screening rates: a scoping review of resources and interventions. *Cancer Causes Control*. 2022 Nov;33(11):1325–1333.

- Omnichannel outreach: UHC CP QI sends personalized reminders to members promoting well-child visits and immunizations among other measures based on member preference for communication: text (SMS), phone calls, and/or emails. *(Started in January 2025, Ongoing)*
- Pfizer sponsored child immunization program: UHC CP QI sends postcard reminders about the benefits of immunization. Targeted messages address missed vaccine doses for children at 6, 8, and 16 months of age. Another message encourages scheduling a 1-year well visit for children approaching 10 months. *(Started in January 2025, Ongoing)*
- Point of service member incentive program: UHC CP QI partnered with more than 20 clinics and providers statewide on a member incentive program which rewards eligible members with a $50 gift card distributed at the doctor's office after a well-child visit is completed. *(Started in January 2025, Ongoing)*

Women's Health

UHC CP QI implemented multiple outreach and engagement programs targeting women's health measures:

- Babyscripts: UHC CP QI offers this mobile application platform for pregnant members, offering rewards when enrolling and completing prenatal and postpartum visits. Rewards offered include a Healthy Living e-gift card. *(Ongoing)*
- EPSDT program: UHC CP QI sends pregnancy mailers within 21 days of confirmation and delivery mailers within 14 days of birth to encourage prenatal and postpartum visits. *(Ongoing)*
- Breast cancer screening (BCS) mailers: UHC CP QI mailed letters to two targeted groups statewide as part of an effort to reduce health disparities with breast cancer screening. *(Completed)*
  - Underperforming regions/ZIP Codes: UHC CP QI sent a letter to almost 300 members who reside in low-performing ZIP Codes statewide. The letter explained the importance of a mammogram and included helpful resources such as transportation assistance. *(Completed—May 2025)*
  - Native Hawaiians and Other Pacific Islanders: UHC CP QI mailed a letter to 300+ members statewide who were due for screening. The letter emphasized the higher incidence and mortality rates in the targeted population as a call to action. *(Completed—May 2025)*
- Hāpai Mālama: UHC CP QI offers a maternity support program for pregnant and postpartum women. Services include follow-up calls, appointment assistance, breastfeeding support, breast pump ordering, and rewards for completing prenatal, postpartum, and EPSDT/well-child visits. The program supports members at healthy, high-risk, or rising-risk levels. *(Ongoing)*
  - UHC CP QI's Hāpai Mālama program staff (CHWs) also partners with provider clinics statewide to support pregnant members or new mothers. The staff has worked with clinics such as Hawaii Island Community Health Center and Kalihi Palama Health Center, working with their pregnancy outreach teams on member engagement activities. UHC CP QI also encourages providers to engage in proactive family planning including using the One Key Question. *(Ongoing)*

- Hāpai Mālama member incentive program: UHC CP QI implemented a new member incentive to encourage timely prenatal and postpartum visits and well-child screenings (up to six visits). Gift cards are distributed by program staff (CHWs) in person or by mail after a qualifying appointment is confirmed. *(Started in Q4 2025, ongoing)*
  - Prenatal: $50 gift card for completing a prenatal visit during the first trimester.
  - Postpartum: $50 gift card for completing a postpartum visit within 7–84 days after delivery.
  - Well-child: $10 gift card per visit (up to $60 for six visits in the first 30 months of life).
- Live calls: UHC CP QI partners with vendor TTEC, whose agents make outbound calls to households to help with appointment scheduling via three-way calls with clinics and providers. Targeted measures in this campaign include Prenatal and Postpartum Care. *(Started in January 2025, ongoing)*
- Omnichannel outreach: UHC CP QI sends personalized reminders to members promoting postpartum visits among other measures based on member preference for communication: text (SMS), phone calls, and/or emails. *(Started in January 2025, ongoing)*
- WellHop: UHC CP QI has a virtual platform, WellHop, connecting pregnant women and new mothers (up to 15 months postpartum) in virtual group sessions for education and social support. Topics include pregnancy, birth, returning to work, stress reduction, and infant care. *(Ongoing)*
- Women's health email campaign: UHC CP QI sends targeted emails encouraging members to schedule a cancer screening based on their age and other risk factors. Members ages 21–39 receive messaging to promote the importance of cervical cancer screening, members ages 65–74 receive a similar message promoting breast cancer screening, and members 40–64 receive an email promoting both screenings. Emails are sent monthly as new members are identified. *(Started in August 2025, ongoing)*

In addition to member engagement activities and program, UHC CP QI also has various provider engagement activities, tools, and supports to help providers with their quality measures.

- Clinical Practice Consultants (CPCs): UHC CP QI has dedicated CPCs who work with provider offices statewide to review performance reports, identify barriers, and share best practices. CPCs also provide training as needed to improve billing or documentation practices and workflows. CPCs also collaborate with individual clinics on various initiatives, such as working with two clinics and their school-based programs focusing on EPSDT members, offering practice-based support for a clinic who needed help with member outreach to get their pediatric members in for their well child visits, and promoting self-collected HPV test to two medical groups who now utilize the testing available. (*Ongoing)*
- EPSDT Coordinator: UHC CP QI's EPSDT coordinator meets with providers in-person or virtually to review EPSDT compliance and address any concerns. The EPSDT coordinator also provides on-site or virtual training as needed related to EPSDT program requirements. The EPSDT coordinator may also collaborate with providers in developing educational materials or initiatives to improve the rate of screenings. (*Ongoing)*
- Provider incentive programs: UHC CP QI offers a Community Plan Primary Care Professional Incentive program to reward practices for meeting or exceeding quality targets. Incentive measures

include CCS, PPC, CIS,WCV, and W30. UHC CP QI also has a Health Equity Professional Incentive (HEPi) program to further promote gap closure for well child visits. Bonus payments are earned when targeted scores are met or exceeded. (*Ongoing)*

- Practice Assist: UHC CP QI offers a workflow management portal, Practice Assist, to reduce administrative burden and help providers manage patient care opportunities across multiple health plans. Practice Assist supports prospective medical record collection and helps provider offices in uploading documentation for HEDIS and other quality measures including CIS, WCV, and W30. This tool helps reduce data gaps, ensures accurate reporting, and improves compliance with preventive care standards. (*Ongoing)*

HSAG Assessment

HSAG has determined that UHC CP QI has addressed the prior year's recommendations.

Validation of Network Adequacy

2024 Recommendations

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

Improvement Activities Implemented

Not applicable.

CAHPS—Adult Survey

2024 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

Survey Item	Key Drivers		
	Rating of Health Plan	*Rating of All Health Care*	*Rating of Personal Doctor*
Q4. Received care as soon as needed when care was needed right away	✓	✓	✓
Q9. Ease of getting the care, tests, or treatment needed	✓	✓	—
Q20. Received appointment with a specialist as soon as needed	✓	✓	NA
Q24. Health plan's customer service gave the information or help needed	✓	—	NA
Q27. Ease of filling out forms from health plan	✓	—	NA

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

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

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

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

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

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

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

HSAG recommends that UHC CP QI explore what may be driving lower experience scores and develop initiatives designed to improve quality and access to care, including a focus on improving adult members' overall experiences with their health plan, their personal doctor, customer service, getting needed care in a timely manner, and discussion of cessation strategies and medications to quit smoking/using tobacco.

Improvement Activities Implemented

Access to and timeliness of care

UHC CP QI's initiatives to improve access to and timelines of care include expanding and promoting telehealth and virtual visit options. Examples include:

- UHC Doctor Chat: UHC CP QI offers UHC Doctor Chat, a chat-first platform supported by live video for members to connect with a provider from their computer, phone, or tablet for non-emergent care. UHC CP QI completed several activities to promote the platform such as adding a promotional flyer to member packets and including information in major publications such as the Member Handbook, Care Provider Manual, member newsletters, and online on the member and provider sites. UHC CP QI is also in the process of adding a promotional message to its IVR phone system for members. UHC CP QI staff also distribute a promotional flyer when appropriate at in-person events or visits.
- NurseLine/Nurse Chat: UHC CP QI offers NurseLine or Nurse Chat to members with an experienced registered nurse who can help with minor injuries, common illnesses, self-care tips and treatment options, or even managing chronic conditions. NurseLine or Nurse Chat is available 24 hours a day.
- ConferMED: UHC CP QI partnered with ConferMED in January 2025, an eConsult platform that enables PCPs to obtain a specialist consultation virtually without having to refer a member to a specialist.
- Circadian Health: UHC CP QI partnered with Circadian Health in February 2025, a telehealth specialty provider to support members with poorly controlled diabetes or members with heart failure.
- Oahu-based providers: UHC CP QI continues to work with Oahu-based medical groups who maintain office locations on the neighbor islands to support access to care, including offering incentives as appropriate.
- Out-of-state providers: UHC CP QI contracted with out-of-state providers such as UCSF Health and Rady Childern's Hospital of San Diego to expand tertiary healthcare services via in-person or telehealth visits.

Quality of care

UHC CP QI opened the Malu Kou Community Connection Center in January 2025 to provide support and services to members and the community. At Malu Kou, members can learn more about benefits like access to a PCP, prescription drug coverage, vision and eyewear coverage, and other healthcare benefits. The center also connects members with additional services such as peer support, social services, health coordination, and supportive housing.

UHC CP QI completed various initiatives and training activities to improve the member experience with customer service. Examples include:

- Random call monitoring to identify opportunities and provide ad hoc coaching recommendations for call center advocates.
- Weekly call listening sessions with focus on process adherence and resource utilization.
- Monthly call calibration sessions focused on recurring trends and improvement opportunities.
- Utilize verbatim detractor feedback from post-call surveys relating to all member-facing touchpoints.
- Solicit feedback from various functional areas to identify and address gaps or opportunities.
- Increase awareness across all functional areas of call center's scope of work to align expectations and improve collaboration.
- Update standard operating procedures (SOPs) by removing unnecessary jargon and using simple, plain language for call center advocates to follow.
- Ongoing review of metrics such as productivity reports and issue resolution trends.

HSAG Assessment

HSAG has determined that UHC CP QI has addressed the prior year's recommendations.

Home and Community-Based Services CAHPS Survey

2024 Recommendations

For UHC CP QI, the following measures scored statistically significantly lower than AHRQ's 2024 CAHPS Database benchmark:

- *Staff Listen and Communicate Well*
- *Choosing the Services that Matter to You*
- *Transportation to Medical Appointments*
- *Personal Safety and Respect*

HSAG recommends that UHC CP QI explore what may be driving lower experience scores and develop initiatives designed to improve quality and access to care, including a focus on improving adult members' overall experiences with staff members' ability to listen and communicate, ability to choose services that matter to the individual, receiving transportation to medical appointments, and their personal safety and respect.

Improvement Activities Implemented

UHC CP QI achieved certification as a Person-Centered Organization (PCO) in December 2024. As a PCO, UHC CP QI conducted all-staff training from May 2025 to November 2025 highlighting 12 critical concepts and tools to strengthen patient-centered skills and activities. Examples include sorting important to/important for, communication chart, learning log, reframing reputation, and relationship

mapping. PCO training will expand to external partners such as Community Case Management Agencies (CCMAs) starting in December 2025.

- Sorting important to/important for: UHC CP QI encouraged staff to use the concept to organize what is important to and important for a member to help achieve balance between the components. The tool is especially useful for completing Health Action Plans for members. *(Completed—June 2025)*
- Communication chart: UHC CP QI explained how the chart is used to understand how a person communicates. The tool prevents information loss during staff turnover and reduces the need for behavior plans. It records information such as how a person communicates through behavior, what it means, and how to respond. *(Completed—July 2025)*
- Learning log: UHC CP QI demonstrated how the learning log captures insights that might not otherwise be recorded. The learning log is used to understand root causes rather than just recording events. It is useful for progress notes, tracking goals and objectives, or analyzing implementation of new programs and projects. (*Completed—August 2025)*
- Reframing reputation: UHC CP QI described how the tool is used to redefine negative reputations, identify circumstances in which negative behavior can be positive, or find an effective support strategy. The tool asks questions to explore circumstances that may affect behavior and what can be done differently to support a member. *(Completed—August 2025)*
- Relationship mapping: UHC CP QI illustrated how relationship mapping reveals who is important in a member's life, who is closest to a member, and who is further away. Relationship mapping is used to identify who should contribute to a person-centered plan or description. *(Completed—August 2025)*

UHC CP QI employs multiple quality assurance processes to monitor staff performance and ensure consistency in service delivery. For member-facing BH staff, comprehensive audits are conducted monthly, followed by targeted coaching to address identified opportunities for improvement. Within Health Coordination, routine chart audits and observational ride-alongs are performed to validate adherence to established protocols. Additionally, clinical teams conduct inter-rater reliability (IRR) reviews with CCMAs to promote uniformity in documentation and minimize discrepancies across records. These activities support continuous improvement and maintain high standards of care for members.

UHC CP QI strengthened its oversight of non-emergency medical transportation (NEMT) services to ensure timely and safe access to medical appointments. UHC CP HI has multiple oversight activities for its NEMT vendor, ModivCare. These include:

- Weekly operational calls and quarterly Joint Operating Committee (JOC) meetings to review provider compliance, with UHC CP QI discretion to remove any transport provider in violation of state regulations.
- Updated statement of work to emphasize the importance of life sustaining medical appointments and the need for additional remediation and driver education.

- ModivCare has a dedicated State Regional Manager who is available to 24/7, supported by the vendor's Vice President of Account Services.
- Transportation network was expanded to improve coverage and reliability.
- ModivCare provides regular compliance reports to UHC CP QI, including any violations related to background checks, DMV abstracts, and state drug laws, or termed providers removed from its network.

UHC CP QI will transition to a new NEMT vendor, MTM Health, in 2026.

HSAG Assessment

HSAG has determined that UHC CP QI has addressed the prior year's recommendations.

Encounter Data Validation

2024 Recommendations

HSAG identified the following areas for improvement:

- The record omission and record surplus rates for all encounter types were high. Institutional and professional encounters had the highest record omission rates at 60.6 percent and 57.1 percent, respectively, while pharmacy encounters had a record omission rate of 11.1 percent. Additionally, institutional encounters and professional encounters had the highest record surplus rates at 74.8 percent and 65.0 percent, respectively, while pharmacy encounters had a record surplus rate of 10.7 percent.
- Although matched records largely contained similar values between the MQD-submitted and the Milliman-submitted data, UHC CP QI should ensure the following data elements have accurate values:
  - Institutional encounters: Detail First Date of Service, Billing Provider NPI, Billing Provider Type, Servicing Provider NPI, Servicing Provider ID, Billed Amount, Coinsurance Amount, Admission Diagnosis Code, All Secondary Diagnosis Codes, All Surgical Procedure Codes, Units of Service, Discharge Date, Occurrence Span Codes, and All Secondary POA Codes.
  - Professional encounters: Detail First Date of Service, Billing Provider NPI, Billing Provider Type, Servicing Provider ID, Coinsurance Amount, All Secondary Diagnosis Codes, Units of Service, Admission Date, and Discharge Date.
  - Pharmacy encounters: Billed Amount, Dispensing Fee, New or Refill Flag, and Number of Refills.

HSAG recommends that UHC CP QI:

- Review and work on the action items noted in the data discrepancy report.

- Utilize the three-year encounter file that MQD will provide monthly to ensure the data it submits to HPMMIS are processed and submitted correctly. UHC CP QI should review any discrepancies within the file with MQD to reconcile any differences.
- Continue to work with MQD and Milliman to ensure data submitted to HPMMIS in CY 2025 accurately reflect data needed for the CY 2026 rate setting activities.

Improvement Activities Implemented

UHC CP QI initiated the following improvement activities to address the identified encounter data accuracy findings:

- Field mapping and query logic review: The teams that prepare UHC CP QI's Milliman submissions and encounters submissions are comprised of different individuals who historically have not regularly interacted with each other on Hawaii claims data. As a result, there were field mapping and query logic discrepancies between how certain data is reported as encounters and how the data is reported in the Milliman claims submission. Following this encounter data validation exercise, the two teams met to conduct an inventory of all data fields in the Milliman submission template and agree on the proper mapping of requested fields to source claims data. This review also included query and data extraction logic. Logic errors were identified and corrected. Validation testing samples were run to compare query output in subsequent submissions to verify accuracy.
- Improved coordination and communication: While the Milliman submission and encounter teams still work separately from each other, there is better coordination and communication to enhance work product consistency. After Milliman releases the data specification file for each annual rate development submission, the teams compare the specification file to the previous year's file and note changes. Any new fields or changes to descriptions and comments for existing fields are jointly reviewed by both teams to ensure the proper source data is identified and captured in updated query logic. The encounters team validates a sample of the Milliman output to ensure consistency with encounter data. Finally, the Milliman reporting team has improved documentation of all changes to mapping logic, query processes and submission protocols to minimize the likelihood of discrepancies caused by staff turnover.
- Treatment of data in fields that are not required: Not all data fields in the Milliman submission are flagged as encounters. In past submissions, such fields were often left blank. The Milliman submission team has enhanced their query logic to reduce the number of these omissions to minimize differences between encounter and Milliman reported claim detail.
- Investigate feasibility of utilizing encounters system for Milliman reporting: While the underlying data is the same, encounters reporting and Milliman reporting are created using different systems. The Milliman submission for 2026 rate development continued to be sourced from the same system as previous rate development submissions, but UHC CP QI continues to research whether the encounters system could be utilized instead.

HSAG Assessment

HSAG has determined that UHC CP QI has addressed the prior year's recommendations.

‘Ohana Community Care Services (‘Ohana CCS)

Validation of Performance Measures—NCQA HEDIS Compliance Audits

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.

Improvement Activities Implemented

Not applicable.

2024 HEDIS Performance Measure Recommendations

HSAG recommends that ‘Ohana CCS focus on improving performance related to the following measures:

- Within the Behavioral Health domain, the following recommendations were identified:
  - Regarding the *Antidepressant Medication Management* measure, HSAG recommends that ‘Ohana CCS consider clinical recommendations shown to improve adherence to antidepressants, such as assessing depressive symptoms at baseline and each follow-up, as well as providing psychoeducation to members and their families.[63]
  - Regarding the *Initiation and Engagement of Substance Use Disorder Treatment* measure, HSAG recommends that ‘Ohana CCS review patient data for any patterns present by ZIP Code and other demographics for case management prioritization. For instance, one study suggests that members who are male and have a schizophrenia spectrum disorder diagnosis are less likely to initiate treatment, while current drug dependence and recent arrest were associated with lowered odds of engaging in treatment. Current drug dependence is associated with factors that make scheduling and attending treatment appointments difficult, such as severe symptoms, chaotic living situations, and self-care and life functioning issues.[64]

Improvement Activities Implemented

- ‘Ohana Health Plan CCS recognizes opportunities to improve adherence to antidepressants, including assessing depressive symptoms at baseline and each follow-up. In 2025, the following actions were implemented to support these efforts:
  - Patient Health Questionnaire (PHQ)-9 assessments are completed at the initial BH evaluation and during the annual BH assessment to establish baseline and ongoing symptom monitoring.

[63] Solmi M, Miola A, Croatto G, et al. How can we improve antidepressant adherence in the management of depression? A targeted review and 10 clinical recommendations. *Brazilian Journal of Psychiatry*. 2021;43(2):189–202.
[64] Brown CH, Bennett ME, Li L, Bellack AS. Predictors of initiation and engagement in substance abuse treatment among individuals with co-occurring serious mental illness and substance use disorders. *Addictive Behaviors.* 2010;36(5):439-47.

Follow-up actions are determined by the score: members with high scores are contacted the next day for reassessment, while those with lower scores are followed up within two weeks.

- Ohana Health Plan's CCS staff re-trained all community-based case managers (CBCMs) for PHQ-9 and treatment plan in accordance with the outcomes.

Initiation and Engagement of Substance Use Disorder Treatment

- 'Ohana Health Plan CCS recognizes opportunities to improve engagement and completion of treatment for members with SUD during the initiation and engagement phases. In 2025, the following actions were implemented to support these efforts:
  - Beginning in late 2024, facility responders call hospitals daily to connect case managers with hospital staff, ensuring continuity and coordination of care for all members, with particular focus on those with substance use disorders.
  - 'Ohana Health Plan conducts monthly interdisciplinary team meetings focused on members with high emergency department and inpatient utilization, including those with SUD. These meetings aim to improve post-discharge treatment engagement and address member needs through coordinated care planning.
  - BH Medical Director reviews all court ordered members and cases that have been peer reviewed to provide recommendations as needed such as residential treatment.
  - During IDT meetings, CBCMs and 'Ohana Health Plan CCS staff discuss treatment options and care needs for members with substance use disorders, particularly those discharging from Hawai'i State Hospital or other facilities. These discussions address barriers such as housing instability, with members often placed in temporary housing (e.g., Kupaa Hale) or referred to residential treatment programs like Hina Mauka to support recovery and reduce the risk of relapse.

HSAG Assessment

HSAG has determined that 'Ohana CCS has addressed the prior year's recommendations.

Validation of Network Adequacy

2024 Recommendations

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

Improvement Activities Implemented

Not applicable.

Appendix A. Methodologies for Conducting EQR Activities

Introduction

In CY 2025, 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 network adequacy
- Validation of PIPs
- A survey of child Medicaid members using the CAHPS survey
- A survey of members receiving HCBS using the HCBS CAHPS survey
- A survey of QI providers

Table A-1 provides a timeline for conducting each of the EQR activities.

Table A-1—Timeline for EQR Activities

Activity	EQR Activity Start Date	EQR Activity End Date
Compliance Review	1/9/2025	12/31/2025
PMV	10/29/2024	7/15/2025
NAV	2/6/2025	12/12/2025
PIPs	1/27/2025	12/5/2025
CAHPS	10/16/2024	9/11/2025
Provider Survey	11/19/2024	1/9/2026

For each EQR activity conducted in 2025, this appendix presents the following information, as required by 42 CFR §438.364:

- Objectives
- Technical methods of data collection and analysis
- Descriptions of data obtained
- How conclusions were drawn

Compliance Monitoring Reviews

Table A-2 delineates the compliance review activities as well as the standards reviewed during the current three-year compliance review cycle (2025 through 2027).

Table A-2—Three-Year Compliance Review Schedule

	Year One (2025)	Year Two (2026)	Year Three (2027)
Standard	**Review of Standards**		**CAP Review**
Availability of Services	✓		Review of Standards/Elements that received a *Not Met* score during the 2025 and 2026 reviews.
Assurances of Adequate Capacity and Services	✓		
Coordination and Continuity of Care	✓		
Confidentiality	✓		
Coverage and Authorization of Services	✓		
Enrollee Information	✓		
Enrollee Rights and Protections	✓		
Grievance and Appeal System	✓		
Provider Selection		✓	
Subcontractual Relationships and Delegation		✓	
Quality Assessment and Performance Improvement		✓	
Health Information Systems		✓	
Practice Guidelines		✓	
Disenrollment: Requirements and Limitations		✓	

HSAG divided the federal regulations into 15 standards consisting of related regulations and contract requirements. Table A-3 describes the standards and associated regulations and requirements reviewed for each standard.

Table A-3—Compliance Standards and Regulations

Standard Title	Regulations Included
Availability of Services	438.68 438.206 438.14 42 USC §1396o(a)
Assurances of Adequate Capacity and Services	438.207
Confidentiality	438.224 45 CFR parts 160 and 164, subparts A & E

Standard Title	Regulations Included
	45 CFR 164.404 45 CFR 164.408 45 CFR 164.410
Coordination and Continuity of Care	438.208
Coverage and Authorization of Services	422.113 431.211 431.213 431.214 438.14 438.114 438.210 438.3 438.404 42 USC §1396 Title V of ARRA 2009, §5006
Enrollee Information	438.10
Enrollee Rights and Protections	422.128 438.100 438.110
Disenrollment: Requirements and Limitations	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

Standard Title	Regulations Included
Quality Assessment and Performance Improvement	438.330
Subcontractual Relationships and Delegation	438.230

Objectives

The primary objective for HSAG's reviews was to provide meaningful information to MQD and the health plans regarding the health plans' compliance with requirements in eight 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.

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 the following:

- Member appeal records
- Member grievance records
- Service authorization denials

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 health plans also presented on an SHCN or LTSS member to demonstrate the systems, processes, procedures, and communication strategy deployed during all phases of care coordination. In addition, HSAG used observations gained from accessing each health plan's Medicaid website to assess a member's experience in using the posted member information and provider directory.

The information and findings that resulted from HSAG's review of standards and files will be used by 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

Before beginning the compliance review, HSAG developed a standardized data collection tool to conduct the reviews. The requirements included in the tool were selected based on applicable federal and State regulations and laws and on the requirements set forth in the contract agreement between MQD and each health plan, as they related to the scope of the review.

Pre-on-Site Review Activities included:

- Developing the compliance review tool, checklists, 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 assistance session and was available for further assistance via telephone and e-mail up to the date of each health 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-on-site review of the selected member appeal, member grievance, and service authorization denial files.

On-Site Activities during the reviews included:

- An opening session, with introductions and a review of the agenda and logistics.
- Interviews with the health plans' key administrative and program staff members.
- Observation of the select tracking and reporting systems the health plans were requested to demonstrate.
- A closing conference during which HSAG summarized its preliminary findings from the review.

HSAG reviewers documented their observations and findings for each health plan in the data collection (compliance review) tool. HSAG then analyzed the information to determine the health plan's performance for each of the individual requirements in the standards. HSAG rated each element as *Met* or *Not Met* to document whether the health plans complied with the requirements. HSAG documented the opportunities for performance improvement based on its findings. Areas that were *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 plan's compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by each organization, including the following:

- Committee meeting agendas, minutes, and handouts
- Written policies and procedures
- Program descriptions, work plans, and annual evaluations
- Management/monitoring reports related to the areas for review
- Provider manual
- Member handbook and other member communications
- Staff training materials and attendance logs
- Records and files related to a sample of member appeals, member grievances, and service authorization denials 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-4 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-4—Description of File Review 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	June 1, 2024–May 31, 2025
Member appeal, member grievance, and service authorization denial files	July 1, 2024–December 31, 2024
Information obtained through interviews	June 16, 2025–June 20, 2025

How Conclusions Were Drawn

To draw conclusions about the health plan's strengths and opportunities for improvement, HSAG aggregated and analyzed the data resulting from its desk and on-site review activities. The data that HSAG aggregated and analyzed included for each health plan:

- Observations, demonstrations, interview responses, and file and document review findings regarding each health plan's performance in complying with the requirements.
- The scores assigned to the health plan's performance for each requirement.
- The health plan's total percentage-of-compliance score for each of the eight standards.
- The health plan's overall percentage-of-compliance score calculated across the eight standards.
- The actions required to bring the health plan's performance into compliance with the requirements that received a score of *Not Met*.

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 2025 to one or more of those domains of care. Each standard may involve the assessment of more than one domain of care due to the combination of individual requirements within each standard. Table A-5 depicts assignment of the standards to the domains of care.

Table A-5—Assignment of Compliance Standards to the Quality, Timeliness, and Access Domains

Compliance Review Standard	Quality	Timeliness	Access
Availability of Services		✓	✓
Assurances of Adequate Capacity and Services		✓	✓
Coordination and Continuity of Care	✓	✓	✓
Confidentiality	✓		
Coverage and Authorization of Services	✓	✓	✓
Enrollee Information	✓		
Enrollee Rights and Protections	✓	✓	✓
Grievance and Appeal System	✓	✓	✓

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 2024 validation activities. Both HEDIS and non-HEDIS measures were validated using the same methodology, which is described in further detail in the following section.

Table A-6—Validated Performance Measures

Performance Measure	QI	CCS	Methodology
Access and Risk-Adjusted Utilization			
Adults' Access to Preventive/Ambulatory Health Services	✓		Admin
*Ambulatory Care**		✓	Admin
*Plan All-Cause Readmissions**	✓		Admin
*PQI 08: Heart Failure Admission Rate**	✓		Admin
*PQI 15: Asthma in Younger Adults Admission Rate**	✓		Admin
Children's Preventive Health			
Child and Adolescent Well-Care Visits	✓		Admin
Childhood Immunization Status	✓		Hybrid^
Immunizations for Adolescents	✓		Hybrid^
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	✓		Hybrid
Well-Child Visits in the First 30 Months of Life	✓		Admin
Women's Health			
Cervical Cancer Screening	✓		Hybrid^
Prenatal and Postpartum Care	✓		Hybrid^^
Care for Chronic Conditions			
Asthma Medication Ratio	✓		Admin
Blood Pressure Control for Patients With Diabetes	✓		Hybrid
*Concurrent Use of Opioids and Benzodiazepines**	✓		Admin

Performance Measure	QI	CCS	Methodology
Controlling High Blood Pressure	✓		Hybrid
Eye Exam for Patients With Diabetes	✓		Hybrid
Glycemic Status Assessment for Patients With Diabetes *	✓		Hybrid
Behavioral Health			
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		✓	Admin
Antidepressant Medication Management	✓	✓	Admin
Diabetes Monitoring for People With Diabetes and Schizophrenia		✓	Admin
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	✓	✓	Admin
Diagnosed Mental Health Disorders		✓	Admin
Follow-Up After Emergency Department Visit for Mental Illness	✓	✓	Admin
Follow-Up After Emergency Department Visit for Substance Use	✓	✓	Admin
Follow-Up After Hospitalization for Mental Illness	✓	✓	Admin
Follow-Up Care for Children Prescribed ADHD Medication	✓		ECDS
Initiation and Engagement of Substance Use Disorder Treatment	✓	✓	Admin
Screening for Depression and Follow-Up Plan	✓		Admin
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	✓		Admin
Use of Pharmacotherapy for Opioid Use Disorder	✓		Admin
Long-Term Services and Supports (LTSS)			
LTSS Comprehensive Assessment and Update	✓		CMR[1]
LTSS Comprehensive Care Plan and Update	✓		CMR[1]
Managed Long-Term Services and Supports Admission to a Facility from the Community	✓		Admin
Managed Long-Term Services and Supports Minimizing Institutional Length of Stay	✓		Admin
Managed Long-Term Services and Supports Successful Transition After Long-Term Facility 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.

^^ QI health plans were allowed to report *Prenatal and Postpartum Care—Under 21 Years* measure indicators via the administrative or hybrid 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 2024, Volume 5: HEDIS Compliance Audit: Standards, Policies and Procedures*. The measurement period reviewed for the health plans was MY 2024 and followed the NCQA HEDIS timeline for reporting rates.

The same process was followed for each performance measure validation conducted by HSAG and included:

1. Audit validation activities such as development of measure-specific worksheets; validation of sample frames for survey measures; a review of completed plan responses to the HEDIS Record of Administration, Data Management, and Processes (Roadmap); medical record review validation; supplemental data validation; source code review for non-HEDIS measures; planning for the virtual audit review; and preliminary rate review.
2. Virtual audit review activities such as interviews with staff members, primary source verification, query review and inspection of dated job logs, and computer database and file structure review.
3. Follow-up and reporting activities, including final rate review and submission of a final audit report.

HSAG validated the health plans' IS capabilities for accurate reporting. The review team focused specifically on aspects of the health plans' systems that could affect the selected measures. Items reviewed included coding and data capture, transfer, and entry processes for medical data and case management record data; data capture, transfer, and entry processes for membership data; data capture, transfer, and entry processes for provider data; medical record data abstraction processes; case management record review validation for the LTSS measures reported using the case management review methodology, the use of supplemental data sources; and data integration and measure calculation. If an area of noncompliance was noted with any IS standard, the audit team determined if the issue resulted in significant, minimal, or no impact to the final reported rate.

The measures verified by the HSAG review team received an audit result consistent with one of the seven NCQA categories listed in the following table.

Table A-7—NCQA Audit Results

NCQA Category for Measure Audit Result	Comment
R	*Reportable.* A reportable rate was submitted for the measure.
*NA**	*Small Denominator.* The health plan followed the specifications, but the denominator was too small (e.g., <30) to report a valid rate. a. For Effectiveness of Care (EOC) measures, EOC-like measures and the *Antibiotic Utilization for Respiratory Conditions* measure, when the denominator is fewer than 30. b. For all risk-adjusted utilization measures when the denominator is fewer than 150.

NCQA Category for Measure Audit Result	Comment
	c. 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 Record of Administration, Data Management and Processes (Roadmap).
- 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 2024 NCQA Quality Compass national Medicaid HMO percentiles for HEDIS MY 2023 and to the previous year's rates, where applicable. Measure rates reported by the health plans, but not audited by HSAG in MY 2024, are not presented within this report. Additionally, certain measures do not have applicable benchmarks. For these reasons, the HEDIS MY 2024 rate, relative difference, and MY 2024 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 2024. MQD Quality Strategy targets for the QI population and CCS program are defined in Table A-8 and Table A-9. For the following measures, lower rates indicate better performance: *Concurrent Use of Opioids and Benzodiazepines—Total, Heart Failure Admission Rate—Total,* and *Plan All-Cause Readmissions—Index Total Stays—Observed Readmissions—Total.*

Table A-8—MQD QI Quality Strategy Measures and Targets

Measure	MQD Quality Strategy Target
Access and Risk-Adjusted Utilization	
Adults' Access to Preventive/Ambulatory Health Services—Total	1% Improvement Goal
*PQI 08: Heart Failure Admission Rate—Total**	1% Improvement Goal
*PQI 15: Asthma in Younger Adults Admission Rate—18–39 Years **	1% Improvement Goal
Children's Preventive Care	
Child and Adolescent Well-Care Visits	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
Immunizations for Adolescents—Combination 1	1% Improvement Goal
Immunizations for Adolescents—Combination 2	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
Well-Child Visits in the First 30 Months of Life—Well-Child Visits for Age 15 Months–30 Months—Two or More Well-Child Visits	1% Improvement Goal
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total	1% Improvement Goal
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total	1% Improvement Goal
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	1% Improvement Goal
Women's Health	
Cervical Cancer Screening	1% Improvement Goal

Measure	MQD Quality Strategy Target
Prenatal and Postpartum Care—Timeliness of Prenatal Care	1% Improvement Goal
Prenatal and Postpartum Care—Postpartum Care	1% Improvement Goal
Care for Chronic Conditions	
Asthma Medication Ratio—Total	1% Improvement Goal
Glycemic Status Assessment for Patients With Diabetes—Glycemic Status <8.0%—Total	1% Improvement Goal
Glycemic Status Assessment for Patients With Diabetes—Glycemic Status >9.0%—Total	1% Improvement Goal
Eye Exam for Patients With Diabetes	1% Improvement Goal
Blood Pressure Control for Patients With Diabetes	1% Improvement Goal
*Concurrent Use of Opioids and Benzodiazepines—Total**	1% Improvement Goal
Controlling High Blood Pressure—Total	1% Improvement Goal
Behavioral Health	
Antidepressant Medication Management—Effective Acute Phase Treatment—Total	1% Improvement Goal
Antidepressant Medication Management—Effective Continuation Phase Treatment—Total	1% Improvement Goal
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	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
Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Total	1% Improvement Goal
Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Total	1% Improvement Goal
Screening for Depression and Follow-Up Plan—Total	1% Improvement Goal
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	1% Improvement Goal
Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase	1% Improvement Goal
Follow-Up Care for Children Prescribed ADHD Medication—Continuation and Maintenance Phase	1% Improvement Goal
Use of Pharmacotherapy for Opioid Use Disorder—Rate 1: Total	1% Improvement Goal
Use of Pharmacotherapy for Opioid Use Disorder—Rate 2: Buprenorphine	1% Improvement Goal
Use of Pharmacotherapy for Opioid Use Disorder—Rate 3: Oral Naltrexone	1% Improvement Goal

Measure	MQD Quality Strategy Target
Use of Pharmacotherapy for Opioid Use Disorder—Rate 4: Long-Acting, Injectable Naltrexone	1% Improvement Goal
Use of Pharmacotherapy for Opioid Use Disorder—Rate 5: Methadone	1% Improvement Goal
Long-Term Services and Supports (LTSS)	
LTSS Comprehensive Assessment and Update—Assessment of Core Elements	1% Improvement Goal
LTSS Comprehensive Assessment and Update—Assessment of Supplemental Elements	1% Improvement Goal
LTSS Comprehensive Care Plan and Update—Care Plan With Core Elements Documented	1% Improvement Goal
LTSS Comprehensive Care Plan and Update—Assessment of Supplemental Elements	1% Improvement Goal
Managed Long-Term Services and Supports Admission to a Facility from the Community—Short-Term Stay—Total	1% Improvement Goal
Managed Long-Term Services and Supports Admission to a Facility from the Community—Medium-Stay—Total	1% Improvement Goal
Managed Long-Term Services and Supports Admission to a Facility from the Community—Long-Term Stay—Total	1% Improvement Goal
Managed Long-Term Services and Supports Minimizing Institutional Length of Stay— Observed Discharge Rate	1% Improvement Goal
Managed Long-Term Services and Supports Minimizing Institutional Length of Stay—Expected Discharge Rate	1% Improvement Goal

Table A-9—MQD CCS Quality Strategy Measures and Targets

Measure	MQD Quality Strategy Target
Behavioral Health	
Adherence to Antipsychotic Medications for Individuals with Schizophrenia—Total	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 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

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to care provided by the health plans, HSAG assigned each of the validated performance measures to one or more of these three domains of care. This assignment to domains of care is depicted in Table A-10.

Table A-10—Assignment of Performance Measures to the Quality, Timeliness, and Access Domains

Performance Measure	Quality	Timeliness	Access
Access and Risk-Adjusted Utilization			
Adults' Access to Preventive/Ambulatory Health Services			✓
Ambulatory Care			✓
Plan All-Cause Readmissions	✓		
PQI 08: Heart Failure Admission Rate	✓		
PQI 15: Asthma in Younger Adults Admission Rate	✓		
Children's Preventive Health			
Child and Adolescent Well-Care Visits	✓		✓
Childhood Immunization Status	✓		✓
Immunization for Adolescents	✓		✓
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	✓		
Well-Child Visits in the First 30 Months of Life	✓		✓
Women's Health			
Cervical Cancer Screening	✓		
Prenatal and Postpartum Care	✓	✓	✓
Care for Chronic Conditions			
Asthma Medication Ratio	✓		
Blood Pressure Control for Patients With Diabetes	✓		
Concurrent Use of Opioids and Benzodiazepines	✓		
Controlling High Blood Pressure	✓	✓	
Eye Exam for Patients With Diabetes	✓		
Glycemic Status Assessment for Patients With Diabetes	✓		
Behavioral Health			
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	✓		✓
Antidepressant Medication Management	✓		
Diabetes Monitoring for People With Diabetes and Schizophrenia	✓	✓	✓
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medication	✓	✓	✓
Diagnosed Mental Health Disorders	✓	✓	✓

Performance Measure	Quality	Timeliness	Access
Follow-Up After Emergency Department Visit for Mental Illness	✓	✓	✓
Follow-Up After Emergency Department Visit for Substance Use	✓	✓	✓
Follow-Up After Hospitalization for Mental Illness	✓	✓	✓
Follow-Up Care for Children Prescribed ADHD Medication	✓	✓	✓
Initiation and Engagement of Substance Use Disorder Treatment	✓	✓	✓
Screening for Depression and Follow-Up Plan	✓		✓
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	✓		✓
Use of Pharmacotherapy for Opioid Use Disorder	✓		
Long-Term Services and Supports (LTSS)			
LTSS Comprehensive Assessment and Update	✓	✓	
LTSS Comprehensive Care Plan and Update	✓	✓	
Managed Long-Term Services and Supports Admission to a Facility from the Community	✓		
Managed Long-Term Services and Supports Minimizing Institutional Length of Stay	✓		
Managed Long-Term Services and Supports Successful Transition After Long-Term Facility Stay	✓		

Validation of Network Adequacy

Objectives

Title 42 CFR §438.350(a) requires states that contract with MCOs, PIHPs, or PAHPs have a qualified EQRO perform an EQR that includes validation of network adequacy to ensure provider networks are sufficient to provide timely and accessible care to Medicaid and CHIP beneficiaries across the continuum of services. This report will sometimes collectively refer to these MCOs and PIHP as "health plans." If states elect to conduct NAV for each health plan, the EQRO will validate the indicators produced by MQD as if they were calculated by the health plan, and validate the health plans' systems and processes, as well as source data provided to the state, to inform network adequacy analysis activities.

The objectives of the validation of network adequacy are to:

- Assess the accuracy of MQD-defined network adequacy indicators reported by MQD and the health plans.

- Evaluate the collection of provider data, reliability and validity of network adequacy data, methods used to assess network adequacy, and systems and processes used.
- Determine an indicator-level validation rating, which refers to the overall confidence that an acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators, as set forth by MQD.

Technical Methods of Data Collection and Analysis

HSAG collected network adequacy data from MQD and the health plans via a secure file transfer protocol (SFTP) site and via virtual NAV audits. HSAG used the collected data to conduct the validation of network adequacy in accordance with the Centers for Medicare & Medicaid Services (CMS) EQR *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023 (CMS EQR Protocol 4).[65]

HSAG conducted a virtual review with MQD and the health plans. HSAG collected information using several methods, including interviews, system demonstrations, review of source data output files, primary source verification (PSV), observation of data processing, and review of final network adequacy indicator-level reports. The virtual review activities performed for each included the following:

- Opening meeting
- Review of the Information Systems Capabilities Assessment Tool (ISCAT) and supporting documentation
- Evaluation of underlying systems and processes
- Overview of data collection, integration, methods, and control procedures
- Network adequacy source data and results
- Closing conference

HSAG conducted interviews with MQD and key health plan staff members who were involved with the calculation and reporting of network adequacy indicators.

HSAG evaluated and assessed the systems, processes, and methods MQD used to calculate results generated for each network adequacy indicator in the scope of the 2025 NAV activities, on behalf of the health plans. Plan-specific network adequacy results for standards and indicators calculated by MQD along with the plan-specific validation rating determinations are determined at the plan-level and are inclusive of activities conducted by MQD.

[65] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: January 20, 2026.

Description of Data Obtained

HSAG prepared a document request packet that was submitted to MQD and each health plan outlining the activities conducted during the validation process. The document request packet included a request for documentation to support HSAG's ability to assess MQD and each health plan's information systems and processes, network adequacy indicator methodology, and accuracy of network adequacy reporting at the indicator level. Documents requested included an ISCAT, a timetable for completion, and instructions for submission. HSAG worked with MQD and the health plans to identify all data sources informing calculation and reporting at the network adequacy indicator level. HSAG obtained the following data and documentation from MQD and each health plan to conduct the NAV audits:

- Information systems data from the ISCAT
- Network adequacy logic for calculation of network adequacy indicators
- Network adequacy data files
- Network adequacy monitoring data
- Supporting documentation, including policies and procedures, data dictionaries, system flow diagrams, system log files, and data collection process descriptions

How Conclusions Were Drawn

To draw conclusions about the quality, timeliness, and accessibility of care provided by the health plans, HSAG assigned each of the standards reviewed for NAV activities to one or more of three domains of care. This assignment to domains of care is depicted in Table A-11.

Table A-11—Assignment of NAV Audit Activities to the Quality, Timeliness, and Access Domains

NAV Standard	Quality	Timeliness	Access
Time and Distance—CCS	✓	✓	✓
Access and Availability—CCS	✓	✓	✓
Mandatory Provider Types—CCS	✓	✓	✓
Time and Distance—QI	✓	✓	✓
Mandatory Provider Types—QI	✓	✓	✓
Provider-to Enrollee Ratios—QI	✓	✓	✓

HSAG calculated each network adequacy indicator's validation score by identifying the number of *Met* and *Not Met* elements recorded in the HSAG CMS EQR Protocol 4 Worksheet 4.6, noted in Table A-12.

Table A-12—Validation Score Calculation

Worksheet 4.6 Summary
A. Total number of *Met* elements
B. Total number of *Not Met* elements

Worksheet 4.6 Summary
Score = A / (A + B) x 100
Number of *Not Met* elements determined to have significant bias on the results.

The overall validation rating refers to HSAG's overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. CMS EQR Protocol 4 defines validation rating designations at the indicator level, which are defined in Table A-13 and assigned by HSAG once HSAG has calculated the validation score for each indicator.

Table A-13—Indicator-Level Validation Rating Categories

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

Significant bias was determined based on the magnitude of errors detected and not solely based on the number of elements *Met* or *Not Met*. HSAG determined that a *Not Met* element had significant bias on the results by:

- Requesting that the health plan provide a root cause analysis of the finding.
- Working with the health plan to quantify the estimated impact of an error, omission, or other finding on the indicator calculation.
- Reviewing the root cause, proposed corrective action, timeline for corrections, and estimated impact, within HSAG's NAV Oversight Review Committee, to determine the degree of bias.
- Finalizing a bias determination within HSAG's NAV Oversight Review Committee based on the following threshold:
  - The impact biased the reported network adequacy indicator result by more than 5 percentage points, the impact resulted in a change in network adequacy compliance (i.e., the indicator result changed from compliant to noncompliant or changed from noncompliant to compliant), or the impact was unable to be quantified and therefore was determined to have the potential for significant bias.

By assessing each health plan's performance and NAV reporting process, HSAG identified areas of strength and opportunities for improvement. Along with each area of opportunity, HSAG has also provided a recommendation to help target improvement. Table A-14 provides a list of network adequacy standards and indicators HSAG validated.

Table A-14—QI Provider Ratios

Provider Ratios	
Provider Type (Adult and Pediatric)	**Provider Ratio**
Primary Care Physicians (PCPs)	1:300
Behavioral Health—Psychiatrist	*1:150 Members with a serious mental illness (SMI) or severe and persistent mental illness (SPMI) diagnosis.
Other Behavioral Health Providers to include Psychologists, Licensed Mental Health Counselors, Licensed Clinical Social Workers, and Advanced Practice Registered Nurses (APRNs)—Behavioral Health	1:100 Members with a SMI or SPMI diagnosis
Hospitals	A minimum of five [5] on Oahu, one [1] on Maui, one [1] on Kauai, two [2] on Hawaii (one [1] in East Hawaii and one [1] in West Hawaii), one (1) on Lanai, and one (1) on Molokai

*In geographic areas with a demonstrated shortage of qualified physicians, a psychiatric APRN-Rx may assume the role of a psychiatrist.

Table A-15 lists the network adequacy indicators for QI Time and Distance that HSAG validated.

Table A-15—QI Time and Distance

Time and Distance		
Provider/Facility Type (Adult and Pediatric)	**Urban; Honolulu Metropolitan Statistical Area (MSA)**	**Rural**
PCPs (Adult and Pediatric)	30-minute driving time	60-minute driving time
Specialists (Adult and Pediatric)	30-minute driving time	60-minute driving time
Obstetricians/Gynecologists (OB/GYNs)	30-minute driving time	60-minute driving time
Adult Day Care/Adult Day Health	30-minute driving time	60-minute driving time
Hospitals	30-minute driving time	60-minute driving time
Behavioral Health Provider (Adult and Pediatric)	30-minute driving time	60-minute driving time
Emergency Services Facilities	30-minute driving time	60-minute driving time
Long-Term Services and Supports (LTSS) Providers	30-minute driving time	60-minute driving time
24-Hour Pharmacy	60-minute driving time	NA*
Pharmacies	15-minute driving time	60-minute driving time

Table A-16 lists the network adequacy indicators for QI Minimum Required Provider Types that HSAG validated.

Table A-16—QI Minimum Required Provider Types

Minimum Required Provider Types
Primary and Acute Care
Home Health Agencies and Hospices
Durable Medical Equipment (DME)
Case Management Agencies
Laboratories which have either a Clinical Laboratory Improvement Amendments (CLIA) 1988 certificate or a waiver of a certificate of registration
Optometrists
Physical Therapists
Occupational Therapists
Speech-Language Pathologists
Audiologists
Licensed Dietitians
Physician Assistants (PAs)
Community Health Workers
Providers of lodging and meals associated with obtaining necessary medical care
Sign language interpreters and interpreters for languages other than English
Community Paramedics (CPs)
Cardiologists
Endocrinologists
General Surgeons
Geriatricians
Hematologists
Infectious Disease Specialists
Nephrologists
Neurologists
OB/GYNs
Oncologists
Ophthalmologists
Orthopedists
Otolaryngologists
Pediatric Specialists
Plastic and Reconstructive Surgeons
Pulmonologists

Minimum Required Provider Types
Radiologists
Urologists
Emergency Transportation Providers (both ground and air)
Non-Emergency Transportation (NET) Providers (both ground and air)
Pharmacies
LTSS and Behavioral Health
Adult Day Care Facilities
Adult Day Health Facilities
Assisted Living Facilities
Community Care Foster Family Home (CCFFH)
Community Care Management Agency (CCMA)
Expanded Adult Residential Care Homes (E-ARCHs)
Home-Delivered Meal Providers
Non-Medical Transportation Providers
Nursing Facilities (NFs)
Personal Care Assistance Providers
Personal Emergency Response System (PERS) Providers
Private Duty Nursing (PDN)
Respite Care Providers
State Licensed Special Treatment Facilities for the Provision of Substance Abuse Therapy/Treatment
Certified Substance Abuse Counselors

Table A-17 lists the network adequacy indicators for CCS Time and Distance that HSAG validated.

Table A-17—CCS Time and Distance

Time and Distance Standards		
Provider/Facility Type (Adult and Pediatric)	**Urban; Honolulu Metropolitan Statistical Area (MSA)**	**Rural**
Emergency Services Facilities	Thirty (30) minute driving time	Sixty (60) minute driving time
Mental Health Providers	Thirty (30) minute driving time	Sixty (60) minute driving time
Hospitals	Thirty (30) minute driving time	Sixty (60) minute driving time
24-Hour Pharmacy	Sixty (60) minute driving time	NA
Pharmacies	Fifteen (15) minute driving time	Sixty (60) minute driving time

Table A-18 lists the network adequacy indicators for CCS Minimum Required Provider Types that HSAG validated.

Table A-18—CCS Minimum Required Provider Types

Minimum Required Provider Types
Behavioral Healthcare Specialist services as provided by Psychiatrists, Psychologists, Social Workers, Certified Substance Abuse Counselors (CSACs), and Advanced Practice Nurses trained in psychology
Case Management
Inpatient Behavioral Health Hospital Services
Outpatient Behavioral Health Hospital Services
Mental Health Rehabilitation Services
Substance Use Disorder (SUD) Services
Day Treatment Programs
Psychosocial Rehabilitation (PSR)/Clubhouse
Pharmacies
Laboratory Services
Crisis Services: Mobile Crisis Response, Crisis Residential Services
Interpretation Services
Supportive Housing
Community Integration Services (CIS)
Representative Payee
Supported Employment
Peer Specialist

Validation of Performance Improvement Projects

Objectives

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

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

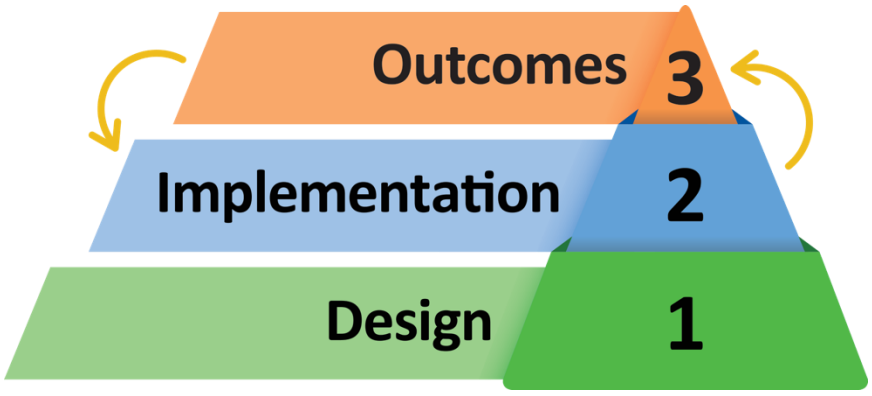
- Measuring performance using objective quality indicators.
- Implementing system interventions to achieve improvement in quality.
- Evaluating effectiveness of the interventions.
- Planning and initiating of activities for increasing or sustaining improvement.

Technical Methods of Data Collection and Analysis

HSAG, as the State's EQRO, validated the PIPs through an independent review process. In its PIP evaluation and validation, HSAG used CMS EQR *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023.[66]

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.

Figure A-1—Stages of the PIP Process



Once a plan establishes its PIP design, the PIP progresses into the Implementation stage (Steps 7 and 8). During this stage, the plan evaluates and analyzes its data, identifies barriers to performance, and develops interventions targeted to improve outcomes. The implementation of effective improvement strategies is necessary to improve outcomes. The Outcomes stage (Step 9) is the final stage, which involves the evaluation of statistically, clinically, or programmatically significant improvement, and sustained improvement based on reported results and statistical testing. Sustained improvement is achieved when outcomes exhibit statistically significant improvement over the baseline performance over comparable time periods. This stage is the culmination of the previous two stages. If the outcomes do not improve, plans should revise their causal/barrier analysis processes and adapt quality improvement strategies and interventions accordingly.

HSAG uses a standardized scoring methodology to rate a PIP's compliance with each of the nine steps listed in CMS EQR Protocol 1. With MQD's input and approval, HSAG developed a PIP Validation

[66] 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: Jan 20, 2026.

Tool to ensure uniform assessment of PIPs. This tool is used to evaluate each of the PIPs for the following nine CMS EQR Protocol 1 steps:

Table A-19—CMS EQR Protocol Steps

Protocol Steps	
Step Number	**Description**
1	Review the Selected PIP Topic
2	Review the PIP Aim Statement
3	Review the Identified PIP Population
4	Review the Sampling Method
5	Review the Selected Performance Indicator(s)
6	Review the Data Collection Procedures
7	Review the Data Analysis and Interpretation of PIP Results
8	Assess the Improvement Strategies
9	Assess the Likelihood That Significant and Sustained Improvement Occurred

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be *Met*.

Description of Data Obtained

HSAG obtained the data needed to conduct the PIP validations from the health plans' PIP Submission Forms. These forms provided detailed information about each health plan's PIPs. In 2025, the QI health plans submitted three PIPs and the CCS health plan submitted two PIPs and provided detailed information about the PIP design (Steps 1–6), provided baseline and remeasurement data (Step 7), and documented improvement strategies (Step 8) in the PIP Submission Forms.

The PIP topics that were validated in 2024 are included in Table A-20.

Table A-20—PIP Topics in 2025

Health Plan	PIP Topic
All QI health plans	• *Behavioral Health Coordination* • *Plan All-Cause Readmissions* • *Screening for Depression and Follow-Up Plan*
'Ohana CCS	• *Behavioral Health Coordination* • *7-Day Follow-Up After Emergency Department Visit for Mental Illness*

How Conclusions Were Drawn

In alignment with CMS EQR Protocol 1, HSAG assigns two PIP validation confidence ratings, summarizing overall PIP performance. One validation rating reflects HSAG's confidence that the health plan adhered to acceptable methodology for all phases of the PIP and the second rating reflects HSAG's confidence with the achievement of statistically significant improvement in outcomes. For each applicable validation rating, HSAG reports the percentage of applicable evaluation elements that received a *Met* validation score and the corresponding confidence level: *High Confidence, Moderate Confidence, Low Confidence, or No Confidence*. The confidence level definitions for each validation rating are as follows:

Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP

- *High Confidence*: High confidence in reported PIP results. The health plan received a *Met* score for all critical evaluation elements and a *Met* score for 90 percent to 100 percent of all evaluation elements across all steps.
- *Moderate Confidence*: Moderate confidence in reported PIP results. The health plan received a *Met* score for all critical evaluation elements and a *Met* score for 80 percent to 89 percent of all evaluation elements across all steps.
- *Low Confidence*: Low confidence in reported PIP results. Across all steps, the health plan received a *Met* score for 65 percent to 79 percent of all evaluation elements or a *Partially Met* score for one or more critical evaluation elements.
- *No Confidence*: No confidence in reported PIP results. Across all steps, the health plan received a *Met* score for less than 65 percent of all evaluation elements or a *Not Met* score for one or more critical evaluation elements.

Overall Confidence That the PIP Achieved Significant Improvement

- *High Confidence*: All performance indicators demonstrated statistically significant improvement over the baseline.
- *Moderate Confidence*: One of the three scenarios below occurred:
  - All performance indicators demonstrated improvement over the baseline, and some but not all performance indicators demonstrated statistically significant improvement over the baseline.
  - All performance indicators demonstrated improvement over the baseline, and none of the performance indicators demonstrated statistically significant improvement over the baseline.
  - Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
- *Low Confidence:* The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator or some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated statistically significant improvement over the baseline.

- *No Confidence:* The remeasurement methodology was not the same as the baseline methodology for all performance indicators or none of the performance indicators demonstrated improvement over the baseline.

To draw conclusions about the quality and timeliness of, and access to services provided by the Medicaid health plans, HSAG assigned each component reviewed for validation of PIPs to one or more of these three domains. While the focus of a health plan's PIP may have been to improve performance related to healthcare quality, timeliness, or access, PIP validation activities were designed to evaluate the validity and quality of the health plan's process for conducting valid PIPs. Therefore, HSAG assigned all PIPs to the quality domain. Other domains were assigned based on the content and outcome of the PIP. This assignment to domains is depicted in Table A-21.

Table A-21—Assignment of PIPs to the Quality, Timeliness, and Access Domains

Performance Improvement Project	Quality	Timeliness	Access
Behavioral Health Coordination	✓	✓	✓
Plan-All Cause Readmissions	✓	✓	✓
7-Day Follow-Up After Emergency Department Visit for Mental Illness	✓	✓	✓
Screening for Depression and Follow-Up Plan	✓	✓	✓

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Objectives

The primary objective of the CAHPS 5.1H Child Medicaid Health Plan Survey was to obtain information effectively and efficiently on parents'/caretakers' 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.

Technical Methods of Data Collection and Analysis

Data Collection was accomplished through administration of the CAHPS 5.1H Child Medicaid Health Plan Survey (without the Children with Chronic Conditions [CCC]measurement set) to a sample of child Medicaid members enrolled in each of the QI health plans. Child Medicaid members included as eligible for the survey were 17 years of age or younger as of December 31, 2024. All parents/caretakers of sampled child Medicaid members completed the surveys from February to May 2025. The survey administration protocol employed was a mixed mode methodology, which allowed for three methods by which parents/caretakers of child members could complete the survey: (1) mail, (2) Internet, or (3) telephone. A cover letter was mailed to all parents/caretakers of sampled child members that provided two options by which they could complete the survey: (1) complete the paper-based survey and return it using the pre-addressed, postage-paid return envelope, or (2) complete the web-based survey via a URL

or quick response (QR) code and designated username. All parents/caretakers of sampled child members received an English version of the survey with the option to request to complete the survey in one of four alternate, non-English languages (i.e., Chinese, Ilocano, Korean, and Vietnamese). Non-respondents received a reminder postcard, followed by a second survey mailing and a second reminder postcard. Computer Assisted Telephone Interviewing (CATI) was conducted for parents/caretakers of sampled child members who had not completed a survey or who had requested to complete the survey in one of the four alternate, non-English languages. A series of up to three CATI calls was made to each non-respondent at different times of the day, on different days of the week, and in different weeks. It is important to note the CAHPS 5.1H Child Medicaid Health Plan Survey is only made available by NCQA in English and Spanish. Therefore, 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 during CATI.[67]

The child CAHPS survey included a set of standardized items (41 questions) that assessed parents'/caretakers' of child members perspectives on their child's care. Data from survey respondents were aggregated into a database for analysis. An analysis of the CAHPS survey results was conducted using NCQA HEDIS Specifications for Survey Measures.[68] NCQA requires a minimum of 100 respondents on each item in order to report the item as a valid CAHPS survey result; however, for this report, results are reported for a CAHPS measure even when the NCQA minimum reporting threshold of 100 respondents was not met. Therefore, caution should be exercised when interpreting results for those measures with fewer than 100 respondents. If a minimum of 100 respondents for a measure was not achieved, the result of the measure was denoted with a cross (+).

The survey questions were categorized into nine measures of experience. These measures included four global ratings, four composite scores, and one individual item measure. The global measures (also referred to as global ratings) reflect overall member experience with the health plan, health care, personal doctors, and specialists. The composite measures are sets of questions grouped together to address different aspects of care (e.g., *Getting Needed Care* or *Getting Care Quickly*). The individual item measure is an individual question that looks at coordination of care.

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 and one individual item measure, the percentage of respondents who chose a positive response was calculated. CAHPS composite and individual item measure questions' response choices were: "Never," "Sometimes," "Usually," and "Always." 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).

[67] National Committee for Quality Assurance. *HEDIS® Measurement Year 2024*, *Volume 3: Specifications for Survey Measures*. Washington, DC: NCQA Publication, 2024.

[68] Ibid.

HSAG performed a trend analysis of the resulting scores for each CAHPS measure.[69] The QI health plan's and the QI Program's 2025 scores were compared to their corresponding 2023 scores.[70] A *t* test was performed to determine whether child Medicaid results in 2025 were statistically significantly different from results in 2023. A difference was considered statistically significant if the two-sided *p* value of the *t* test was less than 0.05. The two-sided *p* value of the *t* test is the probability of observing a test statistic as extreme as or more extreme than the one actually observed by chance. Scores that were statistically significantly higher in 2025 than in 2023 are noted with upward triangles (▲). Scores that were statistically significantly lower in 2025 than in 2023 are noted with downward triangles (▼). Scores in 2025 that were not statistically significantly different from scores in 2023 are not noted with triangles.

Also, HSAG performed program comparisons of the resulting scores for each CAHPS measure. The QI health plans' 2025 scores were compared to the QI Program (i.e., a combination of the five QI health plans) to determine if there were any statistically significant differences.[71] QI health plan scores that were statistically significantly higher than the QI Program are noted with upward arrows (↑). QI health plan scores that were statistically significantly lower than the QI Program are noted with downward arrows (↓). QI health plan scores that were not statistically significantly different than the QI Program are not noted with arrows.

Additionally, HSAG performed national average comparisons of the resulting scores for each CAHPS measure. The QI health plan's and the QI Program's 2025 scores were compared to NCQA's 2024 Quality Compass Benchmark and Compare Quality Data.[72] Scores that were statistically significantly higher than the 2024 NCQA child Medicaid national averages are noted with an (H). Scores that were statistically significantly lower than the 2024 NCQA child Medicaid national averages are noted with an (L). Scores that were not statistically significantly different than the 2024 NCQA child Medicaid national averages are not noted with an (H) or (L).

Description of Data Obtained

The CAHPS survey response rate is the total number of completed surveys divided by all eligible members of the sample. A survey was assigned a disposition code of "completed" if parents/caretakers of eligible child members answered at least three of the designated five questions: 3, 10, 22, 26, and 31. Eligible members included the entire sample (including any oversample) minus ineligible members. Ineligible members of the sample met one or more of the following criteria: were deceased, were invalid (they did not meet the eligible population criteria), or the respondent had a language barrier (the survey

[69] HSAG recalculated the 2023 top-box scores to report scores out to two decimal places. Therefore, the 2023 results in this report will not match previous reports.

[70] The child Medicaid population was last surveyed in 2023; therefore, the 2025 child Medicaid CAHPS scores are compared to the corresponding 2023 scores.

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

[72] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2024*. Washington, DC: NCQA, September 2024.

was made available in English, Chinese, Ilocano, Korean, and Vietnamese). This information was recorded by the survey vendor and provided to HSAG in the data received. Following the administration of the child CAHPS survey, HSAG provided MQD with an aggregate report inclusive of the plan-specific results. The plan-specific results are summarized in Section 3, and statewide comparisons results of all QI health plans and the QI Program 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 QI health plans, HSAG assigned each of the measures and the corresponding survey items (i.e., questions) to one or more of these three domains. This assignment to domains is depicted in Table A-22.

Table A-22—Assignment of CAHPS Survey Measures to the Quality, Timeliness, and Access Domains

CAHPS Topic	Quality	Timeliness	Access
Global Ratings			
Rating of Health Plan	✓		
Rating of All Health Care	✓		
Rating of Personal Doctor	✓		
Rating of Specialist Seen Most Often	✓		
Composite Measures			
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
How Well Doctors Communicate	✓		
Customer Service	✓		
Individual Item Measure			
Coordination of Care	✓		

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

Data collection was accomplished through the administration of the Hawaii Provider Survey to a 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, 2025, 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 via a URL or quick response (QR) code and designated username. The survey was administered from July to September 2025. The survey administered to KFHP providers included 16 questions, and the survey administered to non-KFHP providers included 18 questions on a broad range of topics.

The 2023 and 2025 Hawaii Provider Survey results for participating QI health plans were presented on the following nine domains of satisfaction:[73]

- **General Positions**—presents providers' levels of satisfaction with the reimbursement rate (pay schedule) or compensation and timeliness of claims payments.
- **Prior Authorization Process Experience**—presents providers' experiences with the prior authorization process and its impact on providers' abilities to deliver quality care.
- **Prior Authorization Process Impacts**—presents the impacts the prior authorization process has on providers' abilities to deliver quality care.
- **Formulary**—presents the impact formularies have on providers' abilities to deliver quality care.
- **Non-Formulary**—presents providers' assessments of access to non-formulary drugs.
- **Health Coordinators**—presents providers' assessments of the help provided by health coordinators.
- **Specialists**—presents providers' assessments of the network of specialists.
- **Substance Abuse**—presents providers' assessments of the availability of substance abuse treatment for patients.
- **Mental Health Providers**—presents providers' assessments of the availability of mental health providers, including psychiatrists.[74]

Response options to each question (i.e., measure) within these domains were classified into 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.[75] 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

[73] The 2025 Hawaii Provider Survey was modified, such that questions related to the health plans' prior authorization process and mental health providers were expanded. Given the modifications to the survey, the domains for 2025 and 2023 do not align; therefore, a trend analysis was unable to be performed for the corresponding domains.

[74] The mental health providers domain results are not included in this report. For the number and percentage of responses for each measure within the mental health providers domain, please see the 2025 Hawaii Provider Survey full report.

[75] For this report, only the top-box scores are displayed. For more detailed results on the other response categories, please see the 2025 Hawaii Provider Survey full report.

providers indicated that they were not currently accepting new patients for AlohaCare QI in Question 1, the response would be included in the results pertaining to AlohaCare QI if a response had been provided. Therefore, providers may have rated a QI 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.[76]

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, and between the 2025 and corresponding 2023 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 denoted with arrows. QI health plan scores that were statistically significantly higher than the QI Program are denoted with a black upward (↑) arrow. QI health plan scores that were statistically significantly lower than the QI Program are denoted with a black downward (↓) arrow. QI health plan scores that were not statistically significantly different than the QI Program are not denoted with arrows.

Statistically significant differences between the 2025 scores and the corresponding 2023 scores are denoted with directional triangles. Scores that were statistically significantly higher in 2025 than in 2023 are denoted with black upward triangles (▲). Scores that were statistically significantly lower in 2025 than in 2023 are denoted with black downward triangles (▼). Scores in 2025 that were not statistically significantly different from scores in 2023 are not denoted with triangles.

Description of Data Obtained

The survey covered topics for primary care and specialty providers including the experience and 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, access to substance abuse treatment, and availability of mental health providers. 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.

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 results of all QI health plans and the QI Program are summarized in Section 4 of this report.

[76] Since one provider may be associated with multiple QI health plans, the proportion of responses for the QI Program includes the total number of responses rather than only responses from unique providers.

How Conclusions Were Drawn

To draw conclusions about the quality and timeliness of, and access to services provided by the QI health plans, HSAG assigned each of the measures to one or more of these three domains. This assignment to domains is depicted in Table A-23.

Table A-23—Assignment of Provider Survey Measures to the Quality, Timeliness, and Access Domains

Provider Survey Topic	Quality	Timeliness	Access
General Positions			
Compensation Satisfaction	NA	NA	NA
Timeliness of Claims Payments	NA	NA	NA
Prior Authorization Process Experience			
Approval or Authorization Delayed	✓	✓	
Inconsistent Requirements	✓		
Difficult to Navigate	✓		
Labor Intensive	✓		
Prior Authorization Process Impacts			
Delayed Ability to Provide Treatments	✓	✓	
Disrupted Continuity of Care	✓		
Created Administrative Burden	✓		
Led to Denial of Service	✓		
Formulary			
Formulary Impact on Care	✓		
Non-Formulary			
Adequate Access to Non-Formulary Drugs	✓		✓
Health Coordinators			
Helpfulness of Health Coordinators	✓		
Specialists			
Adequate Network of Specialists			✓
Substance Abuse			
Access to Substance Abuse Treatment			✓

NA *Indicates that the measure is not appropriate to classify into a performance domain (i.e., quality, timeliness, access).*

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 2025 Target**	**RY 2025 Result**
			1	**2**	**3**	**4**		
AAP	Adults' Access to Preventive/Ambulatory Health Services: Total	NCQA		✓	✓	✓	73.60%	68.01%
ADD	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	NCQA	✓				47.53%	43.17%♦
ADD	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	NCQA	✓				63.47%	55.64%♦
AMR	Asthma Medication Ratio	NCQA	✓		✓	✓	64.33%	53.00%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing+	NCQA	✓				42.33%	51.50%♦ ✓
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing+	NCQA	✓				23.33%	24.25%♦ ✓
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing+	NCQA	✓				22.33%	21.93%♦
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA	✓				63.39%	54.90%
BCS	Breast Cancer Screening+	NCQA			✓		54.80%	51.12%♦
BPD	Blood Pressure Control for Patients With Diabetes	NCQA				✓	60.23%	63.75% ✓
CBP	Controlling High Blood Pressure (<140/90)	NCQA			✓	✓	59.51%	60.42% ✓
CCP-AD; CCP-CH	Contraceptive Care—Postpartum Women: Long-Acting Reversible Method of Contraception (LARC)—3 Days+	OPA	✓	✓			3.01%	5.09% ✓
CCP-AD; CCP-CH	Contraceptive Care—Postpartum Women: Long-Acting Reversible Method of Contraception (LARC)—90 Days+	OPA	✓	✓			NT	19.96%

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 2025 Target**	**RY 2025 Result**
			1	**2**	**3**	**4**		
CCP-AD; CCP-CH	Contraceptive Care-Postpartum Women: Most or Moderately Effective Contraception—3 Days+	OPA	✓	✓			9.32%	10.82% ✓
CCP-AD; CCP-CH	Contraceptive Care-Postpartum Women: Most or Moderately Effective Contraception—90 Days+	OPA	✓	✓			NT	45.58%
CCS	Cervical Cancer Screening	NCQA			✓		57.48%	54.21%
CCW-AD; CCW-CH	Contraceptive Care-All Women: Long-Acting Reversible Method of Contraception (LARC)+	OPA	✓	✓			5.06%	4.26%
CCW-AD; CCW-CH	Contraceptive Care-All Women: Most Effective or Moderately Effective Method of Contraception+	OPA	✓	✓			23.37%	19.18%
CDF-CH; CDF-AD	Screening for Depression and Follow-Up Plan: Negative Screen for Depression During an Outpatient Visit Using A Standardized Tool	CMS	✓		✓		19.97%	30.94% ✓
CHL	Chlamydia Screening in Women: Chlamydia Screening in Women (Total)+	NCQA	✓		✓		50.66%	52.03% ✓
CIS	Childhood Immunization Status: Combination 3	NCQA	✓				57.59%	61.93% ✓
CIS	Childhood Immunization Status: Combination 7	NCQA	✓				49.57%	53.54% ✓
CIS	Childhood Immunization Status: Combination 10	NCQA	✓				39.49%	32.26%
COL	Colorectal Cancer Screening+	NCQA			✓		48.00%	40.89%♦
DEV-CH	Developmental Screening in the First Three Years of Life+	OHSU	✓				24.86%	26.66% ✓
EED	Eye Exam for Patients With Diabetes	NCQA			✓	✓	62.15%	59.25%

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 2025 Target**	**RY 2025 Result**
			1	**2**	**3**	**4**		
Falls1	Falls: Screening for Future Fall Risk: Part 1: Screening	NCQA			✓		49.04%	—
Falls2	Falls: Screening for Future Fall Risk: Part 2: Risk Assessment	NCQA			✓		75.74%	—
Falls3	Falls: Screening for Future Fall Risk: Part 3: Plan of Care	NCQA			✓		59.07%	—
GSD[#]	Glycemic Status Assessment for Patients With Diabetes: Glycemic Status <8.0%	NCQA				✓	52.45%	57.82% ✓
GSD[#]	Glycemic Status Assessment for Patients With Diabetes: Glycemic Status >9.0%*	NCQA				✓	35.99%	32.26% ✓
HVL-AD	HIV Viral Load Suppression[+]	HRSA			✓	✓	3.78%	11.24% ✓
IMA	Immunizations for Adolescents: Combination 1 (Meningococcal, Tdap)	NCQA	✓				68.91%	69.65% ✓
IMA	Immunizations for Adolescents: Combination 2 (Meningococcal, Tdap, HPV)	NCQA	✓				39.74%	44.76% ✓
PPC	Prenatal and Postpartum Care: Timeliness of Prenatal Care	NCQA		✓			86.29%	77.56%
PPC	Prenatal and Postpartum Care: Postpartum Care	NCQA		✓			79.89%	79.23%
SSD	Diabetes Screening for People w/ Schizophrenia or Bipolar Dx using Antipsychotics	NCQA			✓		70.84%	75.30% ✓
W30	Well-Child Visits in the First 30 Months of Life: 15 Months	NCQA	✓				65.64%	68.51% ✓
W30	Well-Child Visits in the First 30 Months of Life: 30 Months	NCQA	✓				70.69%	74.03% ✓
WCC	Weight Assessment and Counseling for Nutrition/Physical Activity: BMI Percentile Documentation	NCQA	✓				83.32%	87.54% ✓
WCC	Weight Assessment and Counseling for Nutrition/Physical Activity: Counseling for Nutrition	NCQA	✓				80.19%	81.07% ✓
WCC	Weight Assessment and Counseling for Nutrition/Physical Activity: Counseling for Physical Activity	NCQA	✓				77.75%	79.00% ✓
WCV	Child and Adolescent Well-Care Visits	NCQA	✓				47.42%	53.01% ✓
CAHPS 5.1H	Composite Measure: Getting Needed Care: Composite Measure: Getting Needed Care (CHIP)	AHRQ	✓				80.48%	—

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 2025 Target**	**RY 2025 Result**
			1	**2**	**3**	**4**		
CAHPS 5.1H	Composite Measure: Getting Needed Care: Composite Measure: Getting Needed Care (Child)	AHRQ	✓				78.13%	80.76% ✓
CAHPS 5.1H	Composite Measure: Getting Care Quickly: Composite Measure: Getting Care Quickly (CHIP)	AHRQ	✓				80.07%	—
CAHPS 5.1H	Composite Measure: Getting Care Quickly: Composite Measure: Getting Care Quickly (Child)	AHRQ	✓				81.29%	81.10%
CAHPS 5.1H	Composite Measure: How Well Doctors Communicate: Composite Measure: How Well Doctors Communicate (CHIP)	AHRQ	✓				97.51%	—
CAHPS 5.1H	Composite Measure: How Well Doctors Communicate: Composite Measure: How Well Doctors Communicate (Child)	AHRQ	✓				95.27%	94.25%
CAHPS 5.1H	Composite Measure: Customer Service: Composite Measure: Customer Service (CHIP)	AHRQ	✓				90.88%	—
CAHPS 5.1H	Composite Measure: Customer Service: Composite Measure: Customer Service (Child)	AHRQ	✓				88.64%	90.25% ✓
CAHPS 5.1H	Individual Measures: Coordination of Care: Individual Measures: Coordination of Care (CHIP)	AHRQ	✓				88.74%	—
CAHPS 5.1H	Individual Measures: Coordination of Care: Individual Measures: Coordination of Care (Child)	AHRQ	✓				87.11%	87.77% ✓
CAHPS 5.1H	Global Rating Measure: Rating of Health Plan: Global Rating Measure: Rating of Health Plan (CHIP)	AHRQ	✓				76.91%	—
CAHPS 5.1H	Global Rating Measure: Rating of Health Plan: Global Rating Measure: Rating of Health Plan (Adults)	AHRQ	✓		✓	✓	63.45%	64.86% ✓
CAHPS 5.1H	Global Rating Measure: Rating of All Health Care: Global Rating Measure: Rating of All Health Care (CHIP)	AHRQ	✓				66.81%	—

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 2025 Target**	**RY 2025 Result**
			1	**2**	**3**	**4**		
CAHPS 5.1H	Global Rating Measure: Rating of All Health Care: Global Rating Measure: Rating of All Health Care (Adults)	AHRQ			✓	✓	60.15%	57.81%
CAHPS 5.1H	Global Rating Measure: Rating of All Health Care: Global Rating Measure: Rating of All Health Care (Child)	AHRQ	✓				70.18%	68.95%
CAHPS 5.1H	Global Rating Measure: Rating of Personal Doctor: Global Rating Measure: Rating of Personal Doctor (CHIP)	AHRQ	✓				79.25%	—
CAHPS 5.1H	Global Rating Measure: Rating of Personal Doctor: Global Rating Measure: Rating of Personal Doctor (Adults)	AHRQ			✓		67.05%	67.80% ✓
CAHPS 5.1H	Global Rating Measure: Rating of Personal Doctor: Global Rating Measure: Rating of Personal Doctor (Child)	AHRQ	✓				80.07%	76.22%

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 2025 Target**	**RY 2025 Result**
			5	**6**		
ADD	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	NCQA	✓	✓	47.53%	43.17%♦
ADD	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	NCQA	✓	✓	63.47%	55.64%♦
AMM	Antidepressant Medication Management: Effective Acute Phase Treatment	NCQA	✓	✓	62.14%	68.11% ✓
AMM	Antidepressant Medication Management: Effective Continuation Phase Treatment	NCQA	✓	✓	44.98%	48.52% ✓
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing+	NCQA	✓	✓	42.33%	51.50%♦ ✓

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 2025 Target**	**RY 2025 Result**
			5	**6**		
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing+	NCQA	✓	✓	23.33%	24.25%♦ ✓
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing+	NCQA	✓	✓	22.33%	21.93%♦
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA	✓	✓	63.39%	54.90%
CDF-CH; CDF-AD	Screening for Depression and Follow-Up Plan: Negative Screen for Depression During an Outpatient Visit Using A Standardized Tool	CMS	✓		19.97%	30.94% ✓
COB-AD	Concurrent Use of Opioids and Benzodiazepines*	PQA		✓	12.85%	11.94% ✓
DMH	Diagnosed Mental Health Disorders+	NCQA	✓	✓	NT	19.48%
FUA	Follow-Up After Emergency Department Visit for Substance Use: 30-Day Follow-Up (Total)	NCQA	✓	✓	NT	40.32%
FUA	Follow-Up After Emergency Department Visit for Substance Use: 7-Day Follow-Up (Total)	NCQA	✓	✓	NT	26.16%
FUH	Follow-Up After Hospitalization for Mental Illness: 30-Day Follow-Up	NCQA	✓	✓	62.28%	58.61%
FUH	Follow-Up After Hospitalization for Mental Illness: 7-Day Follow-Up	NCQA	✓	✓	41.21%	42.38% ✓
FUM	Follow-Up After Emergency Department Visit for Mental Illness: 30-Day Follow-Up (Total)	NCQA	✓	✓	49.67%	45.82%
FUM	Follow-Up After Emergency Department Visit for Mental Illness: 7-Day Follow-Up (Total)	NCQA	✓	✓	33.09%	28.42%
HPCMI-AD	Diabetes Care for People with SMI: HbA1c Poor Control (>9.0%)*+	NCQA	✓	✓	48.69%	33.63% ✓
IET	Initiation and Engagement of AOD Abuse or Dependence Treatment: Initiation of AOD Treatment (Total)	NCQA	✓	✓	NT	35.95%

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 2025 Target**	**RY 2025 Result**
			5	**6**		
IET	Initiation and Engagement of Substance Use Disorder Treatment: Engagement of SUD Treatment (Total)	NCQA	✓	✓	NT	9.59%
OHD-AD	Use of Opioids at High Dosage in Persons Without Cancer*+	PQA	✓	✓	10.30%	6.95% ✓
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Total (Rate 1)	CMS		✓	51.93%	48.14%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Buprenorphine (Rate 2)	CMS		✓	32.15%	29.49%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Oral Naltrexone (Rate 3)	CMS		✓	1.01%	0.88%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Long-Acting, Injectable Naltrexone (Rate 4)	CMS		✓	0.27%	0.20%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Methadone (Rate 5)	CMS		✓	20.81%	19.43%
SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia+	NCQA	✓	✓	71.37%	67.53%
SSD	Diabetes Screening for People w/ Schizophrenia or Bipolar Dx using Antipsychotics	NCQA		✓	70.84%	75.30% ✓

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 2025 Target**	**RY 2025 Result**
			7	**8**	**9**	**10**		
ACP	Advance Care Planning: Medicaid ABD—40-64 Years+	NCQA			✓		NT	8.38%

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 2025 Target**	**RY 2025 Result**
			7	**8**	**9**	**10**		
ACP	Advance Care Planning: Medicaid ABD—65+ Years+	NCQA			✓		0.35%	31.79% ✓
ACP	Advance Care Planning: Medicaid non-ABD—40-64 Years+	NCQA			✓		5.88%	2.34%
ACP	Advance Care Planning: Medicaid non-ABD—65+ Years+	NCQA			✓		1.47%	36.07% ✓
ACP	Advance Care Planning: LTSS—18+ Years+	NCQA			✓		7.12%	52.04% ✓
ADD	Follow-Up Care for Children Prescribed ADHD Medication: Initiation Phase	NCQA	✓	✓			47.53%	43.17%♦
ADD	Follow-Up Care for Children Prescribed ADHD Medication: Continuation and Maintenance Phase	NCQA	✓	✓			63.47%	55.64%♦
AMM	Antidepressant Medication Management: Effective Acute Phase Treatment	NCQA		✓			62.14%	68.11% ✓
AMM	Antidepressant Medication Management: Effective Continuation Phase Treatment	NCQA		✓			44.98%	48.52% ✓
AMR	Asthma Medication Ratio	NCQA	✓				64.33%	53.00%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing+	NCQA	✓				42.33%	51.50%♦ ✓
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing+	NCQA	✓				23.33%	24.25%♦ ✓
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing+	NCQA	✓				22.33%	21.93%♦
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA	✓				63.39%	54.90%
BPD	Blood Pressure Control for Patients With Diabetes	NCQA	✓	✓			60.23%	63.75% ✓
COB-AD	Concurrent Use of Opioids and Benzodiazepines*	PQA	✓	✓			12.85%	11.94% ✓
EED	Eye Exam for Patients With Diabetes	NCQA	✓	✓			62.15%	59.25%
FUA	Follow-Up After Emergency Department Visit for Substance Use: 30-Day Follow-Up (Total)	NCQA	✓	✓			NT	40.32%

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 2025 Target**	**RY 2025 Result**
			7	**8**	**9**	**10**		
FUA	Follow-Up After Emergency Department Visit for Substance Use: 7-Day Follow-Up (Total)	NCQA	✓	✓			NT	26.16%
FUH	Follow-Up After Hospitalization for Mental Illness: 30-Day Follow-Up	NCQA	✓	✓			62.28%	58.61%
FUH	Follow-Up After Hospitalization for Mental Illness: 7-Day Follow-Up	NCQA	✓	✓			41.21%	42.38% ✓
FUM	Follow-Up After Emergency Department Visit for Mental Illness: 30-Day Follow-Up (Total)	NCQA	✓	✓			49.67%	45.82%
FUM	Follow-Up After Emergency Department Visit for Mental Illness: 7-Day Follow-Up (Total)	NCQA	✓	✓			33.09%	28.42%
GSD#	Glycemic Status Assessment for Patients With Diabetes: Glycemic Status <8.0%	NCQA	✓	✓			52.45%	57.82% ✓
GSD#	Glycemic Status Assessment for Patients With Diabetes: Glycemic Status >9.0%*	NCQA	✓	✓			35.99%	32.26% ✓
HPCMI-AD	Diabetes Care for People with SMI: HbA1c Poor Control (>9.0%)*+	NCQA	✓	✓			48.69%	33.63% ✓
IET	Initiation and Engagement of Substance Use Disorder Treatment: Initiation of SUD Treatment (Total)	NCQA	✓	✓			NT	35.95%
IET	Initiation and Engagement of Substance Use Disorder Treatment: Engagement of SUD Treatment (Total)	NCQA	✓	✓			NT	9.59%
SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia+	NCQA	✓	✓			71.37%	67.53%
SSD	Diabetes Screening for People w/ Schizophrenia or Bipolar Dx using Antipsychotics	NCQA	✓	✓			70.84%	75.30% ✓
PQI01	PQI 01: Diabetes Short-Term Complications Admission Rate*+	AHRQ	✓	✓			8.18	10.05
PQI03	PQI 03: Diabetes Long-Term Complications Admission Rate*+	AHRQ	✓	✓			15.08	22.11
PQI05	PQI 05: COPD or Asthma in Older Adults Admission Rate*+	AHRQ	✓	✓			18.30	26.13
PQI07	PQI 07: Hypertension Admission Rate*+	AHRQ	✓	✓			3.29	4.42

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 2025 Target**	**RY 2025 Result**
			7	**8**	**9**	**10**		
PQI08	PQI 08: Heart Failure Admission Rate*	AHRQ	✓	✓			44.28	57.02
PQI14	PQI 14: Uncontrolled Diabetes Admission Rate*+	AHRQ	✓	✓			1.95	2.63
PQI15	PQI 15: Asthma in Younger Adults Admission Rate*	AHRQ	✓	✓			2.50	1.84 ✓
PQI16	PQI 16: Lower-Extremity Amputation among Patients with Diabetes Admission Rate*+	AHRQ	✓	✓			4.37	6.37
PQI92	PQI 92: Chronic Conditions Composite*+	AHRQ	✓	✓			85.76	118.90
LTSS-CPU	LTSS Comprehensive Care Plan and Update: Assessment of Core Elements	CMS	✓				10.22%	19.18% ✓
LTSS-CPU	LTSS Comprehensive Care Plan and Update: Assessment of Supplemental Elements	CMS	✓				10.22%	19.13% ✓
LTSS-PCP	LTSS Shared Care Plan with Primary Care Practitioner+	CMS	✓	✓			18.95%	13.88%
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment after Inpatient Discharge+	CMS	✓				10.95%	10.79%
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment and Care Plan after Inpatient Discharge+	CMS	✓				1.35%	4.80% ✓
CAHPS 5.1H	Composite Measure: How Well Doctors Communicate: Composite Measure: How Well Doctors Communicate (CHIP)	AHRQ	✓	✓			97.51%	—
CAHPS 5.1H	Composite Measure: How Well Doctors Communicate: Composite Measure: How Well Doctors Communicate (Adults)	AHRQ	✓	✓			93.32%	92.49%
CAHPS 5.1H	Composite Measure: How Well Doctors Communicate: Composite Measure: How Well Doctors Communicate (Child)	AHRQ	✓	✓			95.27%	94.25%
CAHPS 5.1H	Individual Measures: Coordination of Care: Individual Measures: Coordination of Care (CHIP)	AHRQ	✓	✓			88.74%	—
CAHPS 5.1H	Individual Measures: Coordination of Care: Individual Measures: Coordination of Care (Adults)	AHRQ	✓	✓			84.15%	88.89% ✓

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 2025 Target**	**RY 2025 Result**
			7	**8**	**9**	**10**		
CAHPS 5.1H	Individual Measures: Coordination of Care: Individual Measures: Coordination of Care (Child)	AHRQ	✓	✓			87.11%	87.77% ✓

Goal 4—Support community initiatives to improve population health					
Objective 11—Assess and address social determinants of health needs					
PM Code	**Performance Measure Name**	**Measure Steward**	**Objective**	**RY 2025 Target**	**RY 2025 Result**
			11		
LTSS-CAU	LTSS Comprehensive Assessment and Update: Assessment of Core Elements	CMS	✓	19.29%	31.48% ✓
LTSS-CAU	LTSS Comprehensive Assessment and Update: Assessment of Supplemental Elements	CMS	✓	17.71%	29.58% ✓
LTSS-CPU	LTSS Comprehensive Care Plan and Update: Assessment of Core Elements	CMS	✓	10.22%	19.18% ✓
LTSS-CPU	LTSS Comprehensive Care Plan and Update: Assessment of Supplemental Elements	CMS	✓	10.22%	19.13% ✓
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment after Inpatient Discharge+	CMS	✓	10.95%	10.79%
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment and Care Plan after Inpatient Discharge+	CMS	✓	1.35%	4.80% ✓

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 2025 Target**	**RY 2025 Result**
			12	**13**		
LTSS-AIF	LTSS Admission to an Institution from the Community: Short Term Stay	CMS	✓	✓	35.82	73.57 ✓
LTSS-AIF	LTSS Admission to an Institution from the Community: Medium-Term Stay	CMS	✓	✓	7.49	11.73 ✓
LTSS-AIF	LTSS Admission to an Institution from the Community: Long-Term Stay	CMS		✓	3.97	12.28 ✓
LTSS-CAU	LTSS Comprehensive Assessment and Update: Assessment of Core Elements	CMS	✓	✓	19.29%	31.48% ✓
LTSS-CAU	LTSS Comprehensive Assessment and Update: Assessment of Supplemental Elements	CMS	✓	✓	17.71%	29.58% ✓
LTSS-CPU	LTSS Comprehensive Care Plan and Update: Assessment of Core Elements	CMS	✓	✓	10.22%	19.18% ✓
LTSS-CPU	LTSS Comprehensive Care Plan and Update: Assessment of Supplemental Elements	CMS	✓	✓	10.22%	19.13% ✓
LTSS-ILOS	LTSS Minimizing Institutional Length of Stay: Observed Rate	CMS	✓	✓	17.53%	14.34%
LTSS-ILOS	LTSS Minimizing Institutional Length of Stay: O/E Ratio	CMS	✓	✓	0.5540	0.4433
LTSS-PCP	LTSS Shared Care Plan with Primary Care Practitioner+	CMS	✓	✓	18.95%	13.88%
LTSS-TRAN	LTSS Successful Transition After Long-Term Institutional Stay: Observed Rate	CMS	✓	✓	70.53%	15.76%
LTSS-TRAN	LTSS Successful Transition After Long-Term Institutional Stay: O/E Ratio	CMS	✓	✓	1.0844	0.2534
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment after Inpatient Discharge+	CMS	✓	✓	10.95%	10.79%
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment and Care Plan after Inpatient Discharge+	CMS	✓	✓	1.35%	4.80% ✓

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 2025 Target**	**RY 2025 Result**
			14	**15**		
AAP	Adults' Access to Preventive/Ambulatory Health Services: Total	NCQA	✓		73.60%	68.01%
ACP	Advance Care Planning: Medicaid ABD—40-64 Years+	NCQA	✓	✓	NT	8.38%
ACP	Advance Care Planning: Medicaid ABD—65+ Years+	NCQA	✓	✓	0.35%	31.79% ✓
ACP	Advance Care Planning: Medicaid non-ABD—40-64 Years+	NCQA	✓	✓	5.88%	2.34%
ACP	Advance Care Planning: Medicaid non-ABD—65+ Years+	NCQA	✓	✓	1.47%	36.07% ✓
ACP	Advance Care Planning: LTSS—18+ Years+	NCQA	✓	✓	7.12%	52.04% ✓
AMR	Asthma Medication Ratio	NCQA		✓	64.33%	53.00%
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose Testing+	NCQA		✓	42.33%	51.50%♦ ✓
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Cholesterol Testing+	NCQA		✓	23.33%	24.25%♦ ✓
APM	Metabolic Monitoring for Children and Adolescents on Antipsychotics: Blood Glucose and Cholesterol Testing+	NCQA		✓	22.33%	21.93%♦
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA		✓	63.39%	54.90%
BPD	Blood Pressure Control for Patients With Diabetes	NCQA		✓	60.23%	63.75% ✓
COB-AD	Concurrent Use of Opioids and Benzodiazepines*	PQA		✓	12.85%	11.94% ✓
DMH	Diagnosed Mental Health Disorders+	NCQA		✓	NT	19.48%
EED	Eye Exam for Patients With Diabetes	NCQA		✓	62.15%	59.25%
ENPA	Enrollment by Product Line-Total Medicaid: Enrollment by Product Line-Total Medicaid member-months	NCQA	✓		NT	5,019,679
FUA	Follow-Up After Emergency Department Visit for Substance Use: 30-Day Follow-Up (Total)	NCQA		✓	NT	40.32%
FUA	Follow-Up After Emergency Department Visit for Substance Use: 7-Day Follow-Up (Total)	NCQA		✓	NT	26.16%
FUH	Follow-Up After Hospitalization for Mental Illness: 30-Day Follow-Up	NCQA		✓	62.28%	58.61%
FUH	Follow-Up After Hospitalization for Mental Illness: 7-Day Follow-Up	NCQA		✓	41.21%	42.38% ✓

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 2025 Target**	**RY 2025 Result**
			14	**15**		
FUM	Follow-Up After Emergency Department Visit for Mental Illness: 30-Day Follow-Up (Total)	NCQA		✓	49.67%	45.82%
FUM	Follow-Up After Emergency Department Visit for Mental Illness: 7-Day Follow-Up (Total)	NCQA		✓	33.09%	28.42%
GSD[#]	Glycemic Status Assessment for Patients With Diabetes: Glycemic Status <8.0%	NCQA		✓	52.45%	57.82% ✓
GSD[#]	Glycemic Status Assessment for Patients With Diabetes: Glycemic Status >9.0%*	NCQA		✓	35.99%	32.26% ✓
HPCMI-AD	Diabetes Care for People with SMI: HbA1c Poor Control (>9.0%)*[+]	NCQA		✓	48.69%	33.63% ✓
IET	Initiation and Engagement of Substance Use Disorder Treatment: Initiation of SUD Treatment (Total)	NCQA		✓	NT	35.95%
IET	Initiation and Engagement of Substance Use Disorder Treatment: Engagement of SUD Treatment (Total)	NCQA		✓	NT	9.59%
OHD-AD	Use of Opioids at High Dosage in Persons Without Cancer*[+]	PQA		✓	10.30%	6.95% ✓
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Total (Rate 1)	CMS		✓	51.93%	48.14%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Buprenorphine (Rate 2)	CMS		✓	32.15%	29.49%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Oral Naltrexone (Rate 3)	CMS		✓	1.01%	0.88%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Long-Acting, Injectable Naltrexone (Rate 4)	CMS		✓	0.27%	0.20%
OUD-AD	Use of Pharmacotherapy for Opioid Use Disorder: Methadone (Rate 5)	CMS		✓	20.81%	19.43%
PCR	Plan All-Cause Readmissions: Index Total Stays-Observed/Expected Ratio-Total*	NCQA		✓	NT	0.9917
PQI01	PQI 01: Diabetes Short-Term Complications Admission Rate*[+]	AHRQ		✓	8.18	10.05
PQI03	PQI 03: Diabetes Long-Term Complications Admission Rate*[+]	AHRQ		✓	15.08	22.11
PQI05	PQI 05: COPD or Asthma in Older Adults Admission Rate*[+]	AHRQ		✓	18.30	26.13
PQI07	PQI 07: Hypertension Admission Rate*[+]	AHRQ		✓	3.29	4.42
PQI08	PQI 08: Heart Failure Admission Rate*	AHRQ		✓	44.28	57.02

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 2025 Target**	**RY 2025 Result**
			14	**15**		
PQI14	PQI 14: Uncontrolled Diabetes Admission Rate*+	AHRQ		✓	1.95	2.63
PQI15	PQI 15: Asthma in Younger Adults Admission Rate*	AHRQ		✓	2.50	1.84 ✓
PQI16	PQI 16: Lower-Extremity Amputation among Patients with Diabetes Admission Rate*+	AHRQ		✓	4.37	6.37
LTSS-PCP	LTSS Shared Care Plan with Primary Care Practitioner+	CMS		✓	18.95%	13.88%
LTSS-TRAN	LTSS Successful Transition After Long-Term Institutional Stay: Observed Rate	CMS		✓	70.53%	15.76%
LTSS-TRAN	LTSS Successful Transition After Long-Term Institutional Stay: O/E Ratio	CMS		✓	1.0844	0.2534
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment after Inpatient Discharge+	CMS		✓	10.95%	10.79%
LTSS-UAD	LTSS Re-Assessment/Care Plan Update After Inpatient Discharge: Reassessment and Care Plan after Inpatient Discharge+	CMS		✓	1.35%	4.80% ✓
CAHPS 5.1H	Composite Measure: Getting Needed Care (CHIP)	AHRQ	✓	✓	80.48%	—
CAHPS 5.1H	Composite Measure: Getting Needed Care (Adults)	AHRQ	✓	✓	81.58%	81.41%
CAHPS 5.1H	Composite Measure: Getting Needed Care (Child)	AHRQ	✓	✓	78.13%	80.76% ✓
CAHPS 5.1H	Composite Measure: Getting Care Quickly (CHIP)	AHRQ	✓	✓	80.07%	—
CAHPS 5.1H	Composite Measure: Getting Care Quickly (Adults)	AHRQ	✓	✓	78.07%	79.84% ✓
CAHPS 5.1H	Composite Measure: Getting Care Quickly (Child)	AHRQ	✓	✓	81.29%	81.10%
CAHPS 5.1H	Composite Measure: How Well Doctors Communicate (CHIP)	AHRQ		✓	97.51%	—

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 2025 Target**	**RY 2025 Result**
			14	**15**		
CAHPS 5.1H	Composite Measure: How Well Doctors Communicate (Adults)	AHRQ		✓	93.32%	92.49%
CAHPS 5.1H	Composite Measure: How Well Doctors Communicate (Child)	AHRQ		✓	95.27%	94.25%
CAHPS 5.1H	Individual Measures: Coordination of Care (CHIP)	AHRQ		✓	88.74%	—
CAHPS 5.1H	Individual Measures: Coordination of Care (Adults)	AHRQ		✓	84.15%	88.89% ✓
CAHPS 5.1H	Individual Measures: Coordination of Care (Child)	AHRQ		✓	87.11%	87.77% ✓
CAHPS 5.1H	Global Rating Measure: Rating of Health Plan (CHIP)	AHRQ	✓		76.91%	—
CAHPS 5.1H	Global Rating Measure: Rating of Health Plan (Adults)	AHRQ	✓		63.45%	64.86% ✓
CAHPS 5.1H	Global Rating Measure: Rating of Health Plan (Child)	AHRQ	✓		74.87%	71.65%
CAHPS 5.1H	Global Rating Measure: Rating of All Health Care (CHIP)	AHRQ	✓		66.81%	—
CAHPS 5.1H	Global Rating Measure: Rating of All Health Care (Adults)	AHRQ	✓	✓	60.15%	57.81%
CAHPS 5.1H	Global Rating Measure: Rating of All Health Care (Child)	AHRQ	✓		70.18%	68.95%
CAHPS 5.1H	Global Rating Measure: Rating of Specialist Seen Most Often (CHIP)	AHRQ	✓		78.23%	—
CAHPS 5.1H	Global Rating Measure: Rating of Specialist Seen Most Often (Adults)	AHRQ	✓		72.20%	70.09%

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 2025 Target**	**RY 2025 Result**
			14	**15**		
CAHPS 5.1H	Global Rating Measure: Rating of Specialist Seen Most Often (Child)	AHRQ	✓		76.91%	77.78% ✓
CAHPS 5.1H	Global Rating Measure: Rating of Personal Doctor (CHIP)	AHRQ	✓		79.25%	—
CAHPS 5.1H	Global Rating Measure: Rating of Personal Doctor (Adults)	AHRQ	✓		67.05%	67.80% ✓
CAHPS 5.1H	Global Rating Measure: Rating of Personal Doctor (Child)	AHRQ	✓		80.07%	76.22%

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 2025 Target**	**RY 2025 Result**
			16	**17**		
CCS	Cervical Cancer Screening	NCQA		✓	57.48%	54.21%
CIS	Childhood Immunization Status: Combination 3	NCQA		✓	57.59%	61.93% ✓
FUH	Follow-Up After Hospitalization for Mental Illness: 7-Day Follow-Up	NCQA		✓	41.21%	42.38% ✓
GSD[#]	Glycemic Status Assessment for Patients With Diabetes: Glycemic Status <8.0%	NCQA		✓	52.45%	57.82% ✓
PCR	Plan All-Cause Readmissions: Index Total Stays-Observed/Expected Ratio-Total*	NCQA		✓	NT	0.9917
PPC	Prenatal and Postpartum Care: Timeliness of Prenatal Care	NCQA		✓	86.29%	77.56%
PPC	Prenatal and Postpartum Care: Postpartum Care	NCQA		✓	79.89%	79.23%
W30	Well-Child Visits in the First 30 Months of Life: 15 Months	NCQA		✓	65.64%	68.51% ✓
CAHPS 5.1H	Composite Measure: Getting Needed Care (CHIP)	AHRQ		✓	80.48%	—

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 2025 Target**	**RY 2025 Result**
			16	**17**		
CAHPS 5.1H	Composite Measure: Getting Needed Care (Adults)	AHRQ		✓	81.58%	81.41%
CAHPS 5.1H	Composite Measure: Getting Needed Care (Child)	AHRQ		✓	78.13%	80.76% ✓
CAHPS 5.1H	Global Rating Measure: Rating of Specialist Seen Most Often (CHIP)	AHRQ		✓	78.23%	—
CAHPS 5.1H	Global Rating Measure: Rating of Specialist Seen Most Often (Adults)	AHRQ		✓	72.20%	70.09%
CAHPS 5.1H	Global Rating Measure: Rating of Specialist Seen Most Often (Child)	AHRQ		✓	76.91%	77.78% ✓
CAHPS 5.1H	Global Rating Measure: Rating of Personal Doctor (CHIP)	AHRQ		✓	79.25%	—
CAHPS 5.1H	Global Rating Measure: Rating of Personal Doctor (Adults)	AHRQ		✓	67.05%	67.80% ✓
CAHPS 5.1H	Global Rating Measure: Rating of Personal Doctor (Child)	AHRQ		✓	80.07%	76.22%

Note: The results in Appendix B are limited to the QI Program.
* A lower rate indicates better performance for this measure.
Performance measure code and measure name changed from prior year.
♦ E-measure rate is compared to an administrative measure target.
+ Performance measure was not audited by HSAG.
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.
and ✓ indicates that the RY 2025 performance measure rate was at or above the RY 2025 target.