Network Adequacy and Access Assurances (NAAAR) Report for Hawaii: QI NAAAR CY 2025-HI

Submission name	Plan type	Reporting period start date	Reporting period end date	Last edited	Edited by	Status
QI NAAAR CY 2025-HI	MCO	01/01/2025	12/31/2025	06/26/2026	Grant Shiira	Submitted

Section I. State and program information

A. State information and reporting scenario

Who should CMS contact with questions regarding information reported in the NAAAR? Follow-on communications related to this report will be made to the primary contact.

Use this section to report your contact information, date of report submission, and reporting scenario.

Number	Indicator	Response
IA.1	**Contact name** First and last name of the contact person.	Grant Shiira
IA.2	**Contact email address** Enter email address. Department or program-wide email addresses are permitted.	gshiira@dhs.hawaii.gov
IA.3	**State or territory** Auto-populates from your account profile.	Hawaii
IA.4	**Date of report submission** CMS receives this date upon submission of this report.	06/26/2026
IA.5	**Reporting scenario** Enter the scenario under which the state is submitting this form to CMS. Under 42 C.F.R. § 438.207(c) - (d), the state must submit an assurance of compliance after reviewing documentation submitted by a plan under the following three scenarios:Scenario 1: At the time the plan enters into a contract with the state;Scenario 2: On an annual basis;Scenario 3: Any time there has been a significant change (as defined by the state) in the plan's operations that would affect its adequacy of capacity and services, including (1) changes in the plan's services, benefits, geographic service area, composition of or payments to its provider network, or (2) enrollment of a new population in the plan.States should complete one (1) form with information for applicable managed care plans and programs. For example, if the state submits this form under scenario 1 above, the state should submit this form only for the managed care plan (and the applicable managed care program) that entered into a new contract with the state. The state should not report on any other plans or programs under this scenario. As another	Scenario 2: Annual report

		example, if the state submits this form under scenario 2, the state should submit this form for all managed care plans and managed care programs.

B. Add plans

Enter the name of each plan that participates in the program for which the state is reporting data. If the state is submitting this form because it's entering into a contract with a plan or because there's a significant change in a plan's operations, include only the name of the applicable plan.

Plan names should match the plan names used in your Managed Care Plan Annual Report (MCPAR) for this program for the same reporting period.

	Indicator	Response
	Plan name	AlohaCare
		Hawaii Medical Service Association (HMSA)
		Kaiser Permanente
		Ohana Health Plan
		UnitedHealthcare Community Plan

C. Provider type coverage

If your standards apply to more specific provider types, select the most closely aligned provider type category and utilize the subcategory fields available in Section II. Program-level access and network adequacy standards under "Provider type covered by standard".

Number	Indicator	Response
N/A	**Select all core provider types covered in the program**	Primary Care Specialist Mental health Substance Use Disorder (SUD) OB/GYN Hospital Pharmacy LTSS

D. Analysis methods

States should use this section of the tab to report on the analyses that are used to assess plan compliance with the state's 42 C.F.R. § 438.68 and 42 C.F.R. § 438.206 standards.

Number	Indicator	Response
N/A	**Is this analysis method used to assess plan compliance?** Select "Yes" if the method is utilized to assess plan compliance with the state's standards, as required at 42 C.F.R. § 438.68.	**Geomapping** Utilized Frequency: Quarterly Plan(s): AlohaCare, Hawaii Medical Service Association (HMSA), Kaiser Permanente, Ohana Health Plan, UnitedHealthcare Community Plan **Plan Provider Directory Review** Not utilized **Secret Shopper: Network Participation** Utilized Frequency: Quarterly Plan(s): AlohaCare, Hawaii Medical Service Association (HMSA), Kaiser Permanente, Ohana Health Plan, UnitedHealthcare Community Plan **Secret Shopper: Appointment Availability** Utilized Frequency: Quarterly Plan(s): AlohaCare, Hawaii Medical Service Association (HMSA), Kaiser Permanente, Ohana Health Plan, UnitedHealthcare Community Plan **Electronic Visit Verification Data Analysis** Not utilized **Review of Grievances Related to Access** Utilized Frequency: Quarterly Plan(s): AlohaCare, Hawaii Medical Service Association (HMSA), Kaiser Permanente, Ohana Health Plan, UnitedHealthcare Community Plan **Encounter Data Analysis** Not utilized **Member to Provider Comparision** Utilized Description: We compare the complete list of eligible providers in a Health Plan by type with the number of eligible members in the specified category (children, adults, etc.) Frequency: Quarterly

Plan(s): AlohaCare, Hawaii Medical Service Association (HMSA), Kaiser Permanente, Ohana Health Plan, UnitedHealthcare Community Plan

Section II. Program-level access and network adequacy standards

II. Program-level access and network adequacy standards

Report each network adequacy standard included in managed care program contract for this program as required under 42 CFR § 438.68; select “Add standard” to report each unique standard. 42 § CFR 438.206 standards will be addressed in section III. Plan compliance.

Standard total count: 53

#	Provider	Standard type	Standard description	Analysis methods	Pop.	Region
1	Hospital	Minimum number of network providers	5 on Oahu, 1 on Maui, 1 on Kauai, 2 on Hawaii, 1 on Lanai and 1 on Molokai	Member to Provider Comparision	Adult and Pediatric	Island
2	Hospital; Emergency transportation	Minimum number of network providers	Ground and air transportation	Member to Provider Comparision	Adult and Pediatric	Statewide
3	Hospital; Non-Emergency Transportation	Minimum number of network providers	Ground and air transportation	Member to Provider Comparision	Adult and Pediatric	Statewide
4	Primary care	Provider to enrollee ratios	At least 1 PCP per 300 members	Member to Provider Comparision	Adult and Pediatric	Statewide
5	Specialist; Physician Specialist	Minimum number of network providers	Network must include physician specialists including but not limited to cardiologists, endocrinologists, general surgeons, geriatricians, hematologists, infectious disease specialists, nephrologists, neurologists, obstetricians/gynecologists, oncologists, ophthalmologists, orthopedists, otolaryngology, pediatric specialists, plastic and reconstructive surgeons, pulmonologists, radiologists and urologists.	Member to Provider Comparision	Adult and Pediatric	Statewide
6	Specialist; Laboratories	Minimum number of network providers	Laboratories with a either a Clinical Laboratory Improvement Amendments (CLIA) 1988 certificate or a waiver of a certificate of registration	Member to Provider Comparision	Adult and Pediatric	Statewide

7	Specialist; Optometrists	Minimum number of network providers	Network must include Optometrists	Member to Provider Comparision	Adult and Pediatric	Statewide
8	Pharmacy	Minimum number of network providers	Pharmacies	Member to Provider Comparision	Adult and Pediatric	Statewide
9	Specialist; Other health care providers	Minimum number of network providers	Physical and occupational therapists, audiologists, and speech-language pathologists	Member to Provider Comparision	Adult and Pediatric	Statewide
10	Specialist; Other health care providers	Minimum number of network providers	Licensed dieticians	Member to Provider Comparision	Adult and Pediatric	Statewide
11	Specialist; Other health care providers	Minimum number of network providers	Physician assistants	Member to Provider Comparision	Adult and Pediatric	Statewide
12	Specialist; Other health care providers	Minimum number of network providers	Community health workers	Member to Provider Comparision	Adult and Pediatric	Statewide
13	Specialist; Psychiatrists	Provider to enrollee ratios	1:150 Psychiatrists per members with serious mental illness or severe and persistant mental illness (SMI or SPMI) diagnosis	Member to Provider Comparision	Adult and Pediatric	Statewide
14	Mental health; Other Behavioral Health	Provider to enrollee ratios	1:100 other behavioral health providers (psychologists, licensed mental health counselors, licensed clinical social workers, APRN – behavioral health) per members with SMI or SPMI diagnosis	Member to Provider Comparision	Adult and Pediatric	Statewide

15	Mental health; Other Behavioral Health	Minimum number of network providers	Behavioral Health Providers: Licensed Therapists, Counselors, and Certified Substance Abuse Counselors (CSACs)	Member to Provider Comparision	Adult and Pediatric	Statewide
16	Mental health; Other Behavioral Health	Minimum number of network providers	Peer Support Specialists certified by the Adult Mental Health Division (AMHD) as a part of their Hawaii certified peer specialist program or a program that meets the criteria established by AMHD	Member to Provider Comparision	Adult and Pediatric	Statewide
17	Mental health; Other Behavioral Health	Minimum number of network providers	State-Licensed Special Treatment Facilities for the provision of substance abuse therapy/treatment	Member to Provider Comparision	Adult and Pediatric	Statewide
18	Specialist; Other Healthcare Providers	Minimum number of network providers	Durable medical equipment providers	Member to Provider Comparision	Adult and Pediatric	Statewide
19	Specialist; Other Healthcare Providers	Minimum number of network providers	Case management agencies	Member to Provider Comparision	Adult and Pediatric	Statewide
20	LTSS	Minimum number of network providers	LTSS Providers: Adult Day Care Facilities, Adult Day Health Facilities, Assisted Living Facilities, Community Care Foster Family Home (CCFFH), Community Care Management Agency (CCMA), Expanded Adult Residential Care Homes (E-ARCHs), Home-Delivered Meal Providers, Non-Medical Transportation Providers, Nursing Facilities (NFs), Personal Care Assistance Providers, Personal Emergency Response System (PERS) Providers, Private Duty Nursing (PDN), Respite	Member to Provider Comparision	Adult and Pediatric	Statewide

			Care Providers, and Specialized Medical Equipment and Supply Providers			
21	Specialist; Other Healthcare Providers	Minimum number of network providers	Providers of lodging and meals associated with obtaining necessary medical care	Member to Provider Comparision	Adult and Pediatric	Statewide
22	Specialist; Interpretation services	Minimum number of network providers	Sign language interpreters and interpreters for languages other than English	Member to Provider Comparision	Adult and Pediatric	Statewide
23	Specialist; Other Healthcare Providers	Minimum number of network providers	Community paramedics	Member to Provider Comparision	Adult and Pediatric	Statewide
24	Primary care; Primary Care Providers	Maximum time to travel	30 minutes driving time to an appointment	Member to Provider Comparision	Adult and Pediatric	Urban
25	Primary care; Primary Care Providers	Maximum time to travel	60 minutes driving time to an appointment	Member to Provider Comparision	Adult and Pediatric	Rural
26	Specialist	Maximum time to travel	30 minutes driving time to an appointment	Member to Provider Comparision	Adult and Pediatric	Urban
27	Specialist	Maximum time to travel	60 minutes driving time to an appointment	Member to Provider Comparision	Adult and Pediatric	Rural
28	OB/GYN	Maximum time to travel	30 minutes driving time to an appointment	Member to Provider Comparision	Adult and Pediatric	Urban
29	OB/GYN	Maximum time to travel	60 minutes driving time to an appointment	Member to Provider Comparision	Adult and Pediatric	Rural
30	LTSS; Adult Day Care/Adult Day Health	Maximum time to travel	30 minutes driving time	Member to Provider Comparision	MLTSS	Urban

31	LTSS; Adult Day Care/Adult Day Health	Maximum time to travel	60 minutes driving time	Member to Provider Comparision	MLTSS	Rural
32	Hospital	Maximum time to travel	30 minutes driving time	Member to Provider Comparision	Adult and Pediatric	Urban
33	Hospital	Maximum time to travel	60 minutes driving time	Member to Provider Comparision	Adult and Pediatric	Rural
34	Mental health; Behavioral Health Provider	Maximum time to travel	30 minutes driving time	Member to Provider Comparision	Adult and Pediatric	Urban
35	Mental health; Behavioral Health Provider	Maximum time to travel	60 minutes driving time	Member to Provider Comparision	Adult and Pediatric	Rural
36	Hospital; Emergency Services Facilities	Maximum time to travel	30 minutes driving time	Member to Provider Comparision	Adult and Pediatric	Urban
37	Hospital; Emergency Services Facilities	Maximum time to travel	60 minutes driving time	Member to Provider Comparision	Adult and Pediatric	Rural
38	LTSS	Maximum time to travel	30 minutes driving time	Member to Provider Comparision	MLTSS	Urban
39	LTSS	Maximum time to travel	60 minutes driving time	Member to Provider Comparision	MLTSS	Rural
40	Pharmacy; 24 hour Pharmacy	Maximum time to travel	30 minutes driving time	Member to Provider Comparision	Adult and Pediatric	Urban
41	Pharmacy	Maximum time to travel	15 minutes driving time	Member to Provider Comparision	Adult and Pediatric	Urban

42	Pharmacy	Maximum time to travel	60 minutes driving time	Member to Provider Comparision	Adult and Pediatric	Rural
43	Primary care; Pediatric Primary Care	Appointment wait time	Urgent care and PCP sick visits within 24 hours	Secret Shopper: Appointment Availability	Pediatric	Statewide
44	Primary care; Adult Primary Care	Appointment wait time	PCP sick visit within 72 hours	Secret Shopper: Appointment Availability	Adult	Statewide
45	Mental health; Behavioral Health Provider	Appointment wait time	Behavioral health routine visit within 21 days	Secret Shopper: Appointment Availability	Adult and Pediatric	Statewide
46	Primary care	Appointment wait time	PCP routine visit within 21 days	Secret Shopper: Appointment Availability	Adult and Pediatric	Statewide
47	Specialist; Specialist /Non -emergency	Appointment wait time	Specialist or non-emergency hospital stays within 4 weeks	Secret Shopper: Appointment Availability	Adult and Pediatric	Statewide
48	Specialist; Other Healthcare Providers	Minimum number of network providers	Home Health Agencies	Member to Provider Comparision	Adult and Pediatric	Statewide
49	Specialist; Other Healthcare Providers	Minimum number of network providers	Hospices	Member to Provider Comparision	Adult and Pediatric	Statewide
50	Hospital; Emergency Services Facilities	Appointment wait time	Emergency medical Situations - Immediate care (twenty four (24) hours a day, seven (7) days a week)	Secret Shopper: Appointment Availability	Adult and Pediatric	Statewide
51	Specialist	Minimum number of network providers	Access to family planning providers	Member to Provider Comparision	Adult and Pediatric	Statewide

52	Primary care; Facilities	Minimum number of network providers	FQHC/RHC	Member to Provider Comparision	Adult and Pediatric	Statewide
53	Specialist; Other Healthcare Providers	Minimum number of network providers	Access to certified nurse midwives, pediatric nurse practitioners, family nurse practitioners, and behavioral health nurse practitioners	Member to Provider Comparision	Adult and Pediatric	Statewide

Section III. Plan compliance

III. Plan compliance

Use this section to report on plan compliance with the state's standards, as required at 42 C.F.R. § 438.68. This section is also used to report on plan compliance with 42 C.F.R. § 438.206 standards.

AlohaCare

A. Assurance of plan compliance for 438.68

	Indicator	Response
	A. Assurance of plan compliance for 438.68 III.A.1 Indicate whether the state assures that the plan complies with the state's standards, as required at § 42 C.F.R. 438.68 (i.e., the standards previously entered by the state) based on each analysis the state conducted for the plan during the reporting period.	No, the plan does not comply on all standards based on all analyses or exceptions granted

Select "Enter/Edit" to provide details on standards that were either

non-compliant or for which an exception was granted

Non-compliant standards for 438.68

Total: 10 of 53

20 **Minimum number of network providers**

LTSS Providers: Adult Day Care Facilities, Adult Day Health Facilities, Assisted Living Facilities, Community Care Foster Family Home (CCFFH), Community Care Management Agency (CCMA), Expanded Adult Residential Care Homes (E-ARCHs), Home-Delivered Meal Providers, Non-Medical Transportation Providers, Nursing Facilities (NFs), Personal Care Assistance Providers, Personal Emergency Response System (PERS) Providers, Private Duty Nursing (PDN), Respite Care Providers, and Specialized Medical Equipment and Supply Providers

Provider type(s)

LTSS

Analysis method(s)	Region	Population
Member to Provider Comparision	Statewide	Adult and Pediatric

Plan deficiencies for AlohaCare: 42 C.F.R. § 438.68

Description

The minimum number of Private Duty Nurses and Respite Care Facilities was unmet for all four quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

AlohaCare continues to experience challenges ensuring access to LTSS providers because of Hawaii's ongoing provider shortage, particularly on neighboring islands and in rural communities.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow

a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

26 Maximum time to travel

30 minutes driving time to an appointment

Provider type(s)

Specialist

Analysis method(s)	Region	Population
Member to Provider Comparision	Urban	Adult and Pediatric

Plan deficiencies for AlohaCare: 42 C.F.R. § 438.68

Description

The 85 % drive-time threshold for 30 minutes driving time to an appointment in urban areas was unmet for pediatric specialist and geriatricians for all four quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

AlohaCare continues to experience challenges ensuring access to primary and specialty care because of Hawaii's ongoing physician shortage, particularly on neighboring islands and in rural communities. Specialty access concerns include geriatric (24) and pediatric (98) services that do not meet driving-time standards. To support provider recruitment and close network gaps, AlohaCare regularly reviews other Hawaii QUEST

health plan directories and monitors the State of Hawaii Medicaid Provider Online Enrollment (HOKU) system to identify PCP, Specialists, etc. recruitment opportunities of newly enrolled providers. AlohaCare also arranges interisland travel to Oahu for medically necessary specialty care when access is limited for remote and rural members on neighboring islands. When needed, AlohaCare issues Letters of Agreement (LOAs) to non-contracted providers willing to serve its members. Further, at its own expense, AlohaCare reimburses both network PCP and Specialist that engage via e-Consultation to confer on specialty care that can be provided in a primary care setting to address the lack of specialty care in rural and urban areas.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

27 Maximum time to travel

60 minutes driving time to an appointment

Provider type(s)

Specialist

Analysis method(s)	Region	Population
	Rural	Adult and Pediatric

Member to Provider Comparision

Plan deficiencies for AlohaCare: 42 C.F.R. § 438.68

Description

The 85 % drive-time threshold for 60 minutes driving time to an appointment in rural areas was unmet for pediatric specialist, otolaryngologists and endocrinologists for all four quarters. Additionally, geriatricians didn't meet the drive time threshold for quarters 2 and 4.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

AlohaCare continues to face challenges maintaining access to primary and specialty care due to Hawaii's ongoing physician shortage, particularly on neighboring islands and in rural communities. Specialty access concerns include endocrinology (12), otolaryngology (30), geriatrics (24), and pediatric (98) services that do not meet driving-time standards. To support provider recruitment and close network gaps, AlohaCare regularly reviews other Hawaii QUEST health plan directories and monitors the State of Hawaii Medicaid Provider Online Enrollment (HOKU) system to identify PCP, Specialists, etc. recruitment opportunities of newly enrolled providers. AlohaCare also arranges interisland travel to Oahu for medically necessary specialty care when access is limited for remote and rural members on neighboring islands. When needed, AlohaCare issues Letters of Agreement (LOAs) to non-contracted providers willing to serve its members. Further, at its own expense, AlohaCare reimburses both network PCP and Specialist that engage via e-Consultation to confer on specialty care that can be provided in a primary care setting to address the lack of specialty care in rural and urban areas.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the

issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

30 Maximum time to travel

30 minutes driving time

Provider type(s)

LTSS; Adult Day Care/Adult Day Health

Analysis method(s)	Region	Population
Member to Provider Comparision	Urban	MLTSS

Plan deficiencies for AlohaCare: 42 C.F.R. § 438.68

Description

The 95 % drive-time threshold for 30 minutes drive time to travel for Adult Day Care/Adult Day Health in an urban setting was unmet for all four quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

Adult Day Care/Adult Day Health provider availability remains limited in urban and rural areas statewide. AlohaCare is currently contracted with three providers on Oahu and four on the Neighbor Islands. We continue to monitor the Medicaid registration portal (HOKU), and other health plan directories for potential recruitment opportunities.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering

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Reassessment date

01/31/2026

31 Maximum time to travel

60 minutes driving time

Provider type(s)

LTSS; Adult Day Care/Adult Day Health

Analysis method(s)	Region	Population
Member to Provider Comparision	Rural	MLTSS

Plan deficiencies for AlohaCare: 42 C.F.R. § 438.68

Description

The 95 % threshold for 60 minutes drive time to travel for Adult Day Care/Adult Day Health in a rural setting was unmet for quarters 1 through 3.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

Adult Day Care/Adult Day Health provider availability remains limited in urban and rural areas statewide. AlohaCare is currently contracted with three providers on Oahu and four on the Neighbor Islands. We continue to monitor the Medicaid registration portal (HOKU), and other health plan directories for potential recruitment opportunities.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these

efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

43 Appointment wait time

Urgent care and PCP sick visits within 24 hours

Provider type(s)

Primary care; Pediatric Primary Care

Analysis method(s)	Region	Population
Secret Shopper: Appointment Availability	Statewide	Pediatric

Plan deficiencies for AlohaCare: 42 C.F.R. § 438.68

Description

The vendor that assessed the Secret Shopper metrics went out of business on October 2024; thus, the Secret Shopper Metrics for the entirety of CY 2025 was unable to be evaluated. The State procured a new Secret Shopper contract in July 2025 and is testing protocols with the new vendor with calls expected to resume in January 2026.

Analyses used to identify deficiencies

Secret Shopper: Appointment Availability

Frequency of compliance findings (optional): Report results by quarter:

Q1 (optional): NR

Q2 (optional): NR

Q3 (optional): NR

Q4 (optional): NR

What the plan will do to achieve compliance

The Timely Access Report is a relatively new report, and assessments of actual appointment availability have been hampered by two factors: inaccuracies in the Provider information furnished by the Health Plans and issues with Secret Shopper callers not having a Medicaid ID number which severely limits their ability to get an appointment. MQD is working with Health Plans to improve the provider data quality so that the telephones in the sampling frame are active and accurate. Moreover, MQD worked with the contractor to construct different shopper scripts to identify the callers as brand-new members who would not yet have a Medicaid ID number.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

44 Appointment wait time

PCP sick visit within 72 hours

Provider type(s)

Primary care; Adult Primary Care

Analysis method(s)	Region	Population
Secret Shopper: Appointment Availability	Statewide	Adult

Plan deficiencies for AlohaCare: 42 C.F.R. § 438.68

Description

The vendor that assessed the Secret Shopper metrics went out of business on October 2024; thus, the Secret Shopper Metrics for the entirety of CY 2025 was unable to be evaluated. The State procured a new Secret Shopper contract in July 2025 and is testing protocols with the new vendor with calls expected to resume in January 2026.

Analyses used to identify deficiencies

Secret Shopper: Appointment Availability

Frequency of compliance findings (optional): Report results by quarter:

Q1 (optional): NR

Q2 (optional): NR

Q3 (optional): NR

Q4 (optional): NR

What the plan will do to achieve compliance

The Timely Access Report is a relatively new report, and assessments of actual appointment availability have been hampered by two factors: inaccuracies in the Provider information furnished by the Health Plans and issues with Secret Shopper callers not having a Medicaid ID number which severely limits their ability to get an appointment. MQD is working with Health Plans to improve the provider data quality so that the telephones in the sampling frame are active and accurate. Moreover, MQD worked with the contractor to construct different shopper scripts to identify the callers as brand-new members who would not yet have a Medicaid ID number.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that

may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

45 Appointment wait time

Behavioral health routine visit within 21 days

Provider type(s)

Mental health; Behavioral Health Provider

Analysis method(s)	Region	Population
Secret Shopper: Appointment Availability	Statewide	Adult and Pediatric

Plan deficiencies for AlohaCare: 42 C.F.R. § 438.68

Description

The vendor that assessed the Secret Shopper metrics went out of business on October 2024; thus, the Secret Shopper Metrics for the entirety of CY 2025 was unable to be evaluated. The State procured a new Secret Shopper contract in July 2025 and is testing protocols with the new vendor with calls expected to resume in January 2026.

Analyses used to identify deficiencies

Secret Shopper: Appointment Availability

Frequency of compliance findings (optional): Report results by quarter:

Q1 (optional): NR

Q2 (optional): NR

Q3 (optional): NR

Q4 (optional): NR

What the plan will do to achieve compliance

The Timely Access Report is a relatively new report, and assessments of actual appointment availability have been hampered by two factors: inaccuracies in the Provider information furnished by the Health Plans and issues with Secret Shopper callers not having a Medicaid ID number which severely limits their ability to get an appointment. MQD is working with Health Plans to improve the provider data quality so that the telephones in the sampling frame are active and accurate. Moreover, MQD worked with the contractor to construct different shopper scripts to identify the callers as brand-new members who would not yet have a Medicaid ID number.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

46 Appointment wait time

PCP routine visit within 21 days

Provider type(s)

Primary care

Analysis method(s)	Region	Population
Secret Shopper: Appointment	Statewide	Adult and Pediatric

Availability

Plan deficiencies for AlohaCare: 42 C.F.R. § 438.68

Description

The vendor that assessed the Secret Shopper metrics went out of business on October 2024; thus, the Secret Shopper Metrics for the entirety of CY 2025 was unable to be evaluated. The State procured a new Secret Shopper contract in July 2025 and is testing protocols with the new vendor with calls expected to resume in January 2026.

Analyses used to identify deficiencies

Secret Shopper: Appointment Availability

Frequency of compliance findings (optional): Report results by quarter:

Q1 (optional): NR

Q2 (optional): NR

Q3 (optional): NR

Q4 (optional): NR

What the plan will do to achieve compliance

The Timely Access Report is a relatively new report, and assessments of actual appointment availability have been hampered by two factors: inaccuracies in the Provider information furnished by the Health Plans and issues with Secret Shopper callers not having a Medicaid ID number which severely limits their ability to get an appointment. MQD is working with Health Plans to improve the provider data quality so that the telephones in the sampling frame are active and accurate. Moreover, MQD worked with the contractor to construct different shopper scripts to identify the callers as brand-new members who would not yet have a Medicaid ID number.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance

improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

47 Appointment wait time

Specialist or non-emergency hospital stays within 4 weeks

Provider type(s)

Specialist; Specialist /Non -emergency

Analysis method(s)	Region	Population
Secret Shopper: Appointment Availability	Statewide	Adult and Pediatric

Plan deficiencies for AlohaCare: 42 C.F.R. § 438.68

Description

The vendor that assessed the Secret Shopper metrics went out of business on October 2024; thus, the Secret Shopper Metrics for the entirety of CY 2025 was unable to be evaluated. The State procured a new Secret Shopper contract in July 2025 and is testing protocols with the new vendor with calls expected to resume in January 2026.

Analyses used to identify deficiencies

Secret Shopper: Appointment Availability

Frequency of compliance findings (optional): Report results by quarter:

Q1 (optional): NR

Q2 (optional): NR

Q3 (optional): NR

Q4 (optional): NR

What the plan will do to achieve compliance

The Timely Access Report is a relatively new report, and assessments of actual appointment availability have been hampered by two factors: inaccuracies in the Provider information furnished by the Health Plans and issues with Secret Shopper callers not having a Medicaid ID number which severely limits their ability to get an appointment. MQD is working with Health Plans to improve the provider data quality so that the telephones in the sampling frame are active and accurate. Moreover, MQD worked with the contractor to construct different shopper scripts to identify the callers as brand-new members who would not yet have a Medicaid ID number.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

Exceptions standards for 438.68

Total: 0 of 53

B. Assurance of plan compliance for 438.206

	Indicator	Response
	B. Assurance of plan compliance for 438.206 III.B.1 Indicate whether the state assures that the plan complies with the availability of services standards outlined in 42 C.F.R. § 438.206 the analyses the state conducted for the plan during the reporting period.	Yes, the plan complies on all standards based on all analyses

Hawaii Medical Service Association (HMSA)

A. Assurance of plan compliance for 438.68

	Indicator	Response
	A. Assurance of plan compliance for 438.68 III.A.1 Indicate whether the state assures that the plan complies with the state's standards, as required at § 42 C.F.R. 438.68 (i.e., the standards previously entered by the state) based on each analysis the state conducted for the plan during the reporting period.	No, the plan does not comply on all standards based on all analyses or exceptions granted

Select "Enter/Edit" to provide details on standards that were either non-compliant or for which an exception was granted

Non-compliant standards for 438.68

Total: 16 of 53

9 **Minimum number of network providers**

Physical and occupational therapists, audiologists, and speech-language pathologists

Provider type(s)

Specialist; Other health care providers

Analysis method(s)	Region	Population
Member to Provider Comparision	Statewide	Adult and Pediatric

Plan deficiencies for Hawaii Medical Service Association (HMSA): 42 C.F.R. § 438.68

Description

The minimum number of Speech-Language Pathologists was unmet for all four quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

Unmet standard is consistent with documented statewide healthcare workforce shortages and provider supply limitations in Hawai'i. HMSA continues to monitor network adequacy, pursue provider recruitment and contracting opportunities, evaluate alternative access arrangements through Letters of Agreements (LOA) to send their members in need to the mainland for services, and support telehealth utilization where appropriate.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

10 Minimum number of network providers

Licensed dieticians

Provider type(s)

Specialist; Other health care providers

Analysis method(s)	Region	Population
Member to Provider Comparision	Statewide	Adult and Pediatric

Plan deficiencies for Hawaii Medical Service Association (HMSA): 42 C.F.R. § 438.68

Description

The minimum number of licensed dieticians was unmet for all four quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

Unmet standard is consistent with documented statewide healthcare workforce shortages and provider supply limitations in Hawai'i. HMSA continues to monitor network adequacy, pursue provider recruitment and contracting opportunities, evaluate alternative access arrangements through Letters of Agreements (LOA) to send their members in need to the mainland for services, and support telehealth utilization where appropriate.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan’s response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

12 Minimum number of network providers

Community health workers

Provider type(s)

Specialist; Other health care providers

Analysis method(s)	Region	Population
Member to Provider Comparision	Statewide	Adult and Pediatric

Plan deficiencies for Hawaii Medical Service Association (HMSA): 42 C.F.R. § 438.68

Description

The minimum number of Community Health Workers were unmet for all four quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

Unmet standard is consistent with documented statewide healthcare workforce shortages and provider supply limitations in Hawai'i. HMSA continues to monitor network adequacy, pursue provider recruitment and contracting opportunities, evaluate alternative access arrangements through Letters of Agreements (LOA) to send their members in need to the mainland for services, and support telehealth utilization where appropriate.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan’s response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in

accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

13 Provider to enrollee ratios

1:150 Psychiatrists per members with serious mental illness or severe and persistant mental illness (SMI or SPMI) diagnosis

Provider type(s)

Specialist; Psychiatrists

Analysis method(s)	Region	Population
Member to Provider Comparision	Statewide	Adult and Pediatric

Plan deficiencies for Hawaii Medical Service Association (HMSA): 42 C.F.R. § 438.68

Description

The minimum number of provider to enrollee ratio for psychiatrist was unmet for all four quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

Unmet standard is consistent with documented statewide behavioral health worfkorce shortages, including psychiatry and behavioral health support services. HMSA continues provider recruitment, network development, telehealth education, and alternative access arrangements to support member access via Letters of Agreements (LOAs) to send members to the mainland when appropriate.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering

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Reassessment date

01/31/2026

16 Minimum number of network providers

Peer Support Specialists certified by the Adult Mental Health Division (AMHD) as a part of their Hawaii certified peer specialist program or a program that meets the criteria established by AMHD

Provider type(s)

Mental health; Other Behavioral Health

Analysis method(s)	Region	Population
Member to Provider Comparision	Statewide	Adult and Pediatric

Plan deficiencies for Hawaii Medical Service Association (HMSA): 42 C.F.R. § 438.68

Description

The minimum number of Peer Support Specialist was unmet for all four quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

Unmet standard is consistent with documented statewide behavioral health worfkorce shortages, including psychiatry and behavioral health support services. HMSA continues provider recruitment, network development, telehealth education, and alternative access arrangements to support member access via Letters of Agreements (LOAs) to send members to the mainland when appropriate.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

20 Minimum number of network providers

LTSS Providers: Adult Day Care Facilities, Adult Day Health Facilities, Assisted Living Facilities, Community Care Foster Family Home (CCFFH), Community Care Management Agency (CCMA), Expanded Adult Residential Care Homes (E-ARCHs), Home-Delivered Meal Providers, Non-Medical Transportation Providers, Nursing Facilities (NFs), Personal Care Assistance Providers, Personal Emergency Response System (PERS) Providers, Private Duty Nursing (PDN), Respite Care Providers, and Specialized Medical Equipment and Supply Providers

Provider type(s)

LTSS

Analysis method(s)	Region	Population
Member to Provider Comparision	Statewide	Adult and Pediatric

Plan deficiencies for Hawaii Medical Service Association (HMSA): 42 C.F.R. § 438.68

Description

The minimum number of respite care facilities was unmet for all four quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

Unmet standard is consistent with documented statewide healthcare workforce shortages and provider supply limitations in Hawai'i. HMSA continues to monitor network adequacy, pursue provider recruitment and contracting opportunities, evaluate alternative access arrangements through Letters of Agreements (LOA) to send their members in need to the mainland for services, and support telehealth utilization where appropriate.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan’s response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

26 Maximum time to travel

30 minutes driving time to an appointment

Provider type(s)

Specialist

Analysis method(s)	Region	Population
Member to Provider Comparision	Urban	Adult and Pediatric

Plan deficiencies for Hawaii Medical Service Association (HMSA): 42 C.F.R. § 438.68

Description

The 85 % drive-time threshold for 30 minutes driving time to an appointment in urban areas was unmet for pediatric specialists and hematologists for all quarters 1 and 4. The drive time standard was unmet for Geriatricians for quarter 4. The drive standard was unmet for Otolaryngologists for quarters 3 and 4. Plastic and reconstructive surgeons also didn't meet the drive time threshold for quarters 1 and 3.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

Unmet standard is primarily attributable to provider geographic distribution and Hawaii's unique island geography, which may impact compliance with urban and rural time and distance access standards despite available access options. HMSA continues to evaluate telehealth services, member travel benefits, provider travel arrangements, Letters of Agreement, and targeted provider recruitment strategies to mitigate geographic access barriers.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan’s response and remediation. If the health plan does not adequately address the

issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

27 Maximum time to travel

60 minutes driving time to an appointment

Provider type(s)

Specialist

Analysis method(s)	Region	Population
Member to Provider Comparision	Rural	Adult and Pediatric

Plan deficiencies for Hawaii Medical Service Association (HMSA): 42 C.F.R. § 438.68

Description

The 85 % drive-time threshold for 60 minutes driving time to an appointment in rural areas was unmet for pediatric specialist, and hematologist for all four quarters. Additionally, geriatricians didn't meet the drive time threshold for quarters 1, 2 and 3.Infectious Disease Specialists didn't meet the drive time thresholds for quarters 2 through 4. Otolaryngologists also didn't meet the drive time threshold for quarter 1.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

Unmet standard is primarily attributable to provider geographic distribution and Hawaii's unique island geography, which may impact compliance with urban and rural time and distance access standards despite available access options. HMSA continues to evaluate telehealth services, member travel benefits, provider travel arrangements, Letters of Agreement, and targeted provider recruitment strategies to mitigate geographic access barriers.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific

specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

31 Maximum time to travel

60 minutes driving time

Provider type(s)

LTSS; Adult Day Care/Adult Day Health

Analysis method(s)	Region	Population
Member to Provider Comparision	Rural	MLTSS

Plan deficiencies for Hawaii Medical Service Association (HMSA): 42 C.F.R. § 438.68

Description

The 95 % threshold for 60 minutes drive time to travel for Adult Day Care/Adult Day Health in a rural setting was unmet for all four quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

Unmet standard is primarily attributable to provider geographic distribution and Hawaii's unique island geography, which may impact compliance with urban and rural time and distance access standards despite available access options. HMSA continues to evaluate telehealth services, member travel benefits, provider travel arrangements, Letters of Agreement, and targeted provider recruitment strategies to mitigate geographic access barriers.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan’s response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

40 Maximum time to travel

30 minutes driving time

Provider type(s)

Pharmacy; 24 hour Pharmacy

Analysis method(s)	Region	Population
Member to Provider Comparision	Urban	Adult and Pediatric

Plan deficiencies for Hawaii Medical Service Association (HMSA): 42 C.F.R. § 438.68

Description

The 95 % threshold for 30 minutes drive time to travel for 24 hr pharmacy in an urban setting was unmet for all 4 quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

Unmet standard is primarily attributable to provider geographic distribution and Hawaii's unique island geography, which may impact compliance with urban and rural time and distance access standards despite available access options. HMSA continues to evaluate telehealth services, member travel benefits, provider travel arrangements, Letters of Agreement, and targeted provider recruitment strategies to mitigate geographic access barriers.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan’s response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

43 Appointment wait time

Urgent care and PCP sick visits within 24 hours

Provider type(s)

Primary care; Pediatric Primary Care

Analysis method(s)	Region	Population
Secret Shopper: Appointment Availability	Statewide	Pediatric

Plan deficiencies for Hawaii Medical Service Association (HMSA): 42 C.F.R. § 438.68

Description

The vendor that assessed the Secret Shopper metrics went out of business on October 2024; thus, the Secret Shopper Metrics for the entirety of CY 2025 was unable to be evaluated. The State procured a new Secret Shopper contract in July 2025 and is testing protocols with the new vendor with calls expected to resume in January 2026.

Analyses used to identify deficiencies

Secret Shopper: Appointment Availability

Frequency of compliance findings (optional): Report results by quarter:

Q1 (optional): NR

Q2 (optional): NR

Q3 (optional): NR

Q4 (optional): NR

What the plan will do to achieve compliance

The Timely Access Report is a relatively new report, and assessments of actual appointment availability have been hampered by two factors: inaccuracies in the Provider information furnished by the Health Plans and issues with Secret Shopper callers not having a Medicaid ID number which severely limits their ability to get an appointment. MQD is working with Health Plans to improve the provider data quality so that the telephones in the sampling frame are active and accurate. Moreover, MQD worked with the contractor to construct different shopper scripts to identify the callers as brand-new members who would not yet have a Medicaid ID number.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow

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Reassessment date

01/31/2026

44 Appointment wait time

PCP sick visit within 72 hours

Provider type(s)

Primary care; Adult Primary Care

Analysis method(s)	Region	Population
Secret Shopper: Appointment Availability	Statewide	Adult

Plan deficiencies for Hawaii Medical Service Association (HMSA): 42 C.F.R. § 438.68

Description

The vendor that assessed the Secret Shopper metrics went out of business on October 2024; thus, the Secret Shopper Metrics for the entirety of CY 2025 was unable to be evaluated. The State procured a new Secret Shopper contract in July 2025 and is testing protocols with the new vendor with calls expected to resume in January 2026.

Analyses used to identify deficiencies

Secret Shopper: Appointment Availability

Frequency of compliance findings (optional): Report results by quarter:

Q1 (optional): NR

Q2 (optional): NR

Q3 (optional): NR

Q4 (optional): NR

What the plan will do to achieve compliance

The Timely Access Report is a relatively new report, and assessments of actual appointment availability have been hampered by two factors: inaccuracies in the Provider information furnished by the Health Plans and issues with Secret Shopper callers not having a Medicaid ID number which severely limits their ability to get an appointment. MQD is working with Health Plans to improve the provider data quality so that the telephones in the sampling frame are active and accurate. Moreover, MQD worked with the contractor to construct different shopper scripts to identify the callers as brand-new members who would not yet have a Medicaid ID number.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

45 Appointment wait time

Behavioral health routine visit within 21 days

Provider type(s)

Mental health; Behavioral Health Provider

Analysis method(s)	Region	Population
Secret Shopper: Appointment Availability	Statewide	Adult and Pediatric

Plan deficiencies for Hawaii Medical Service Association (HMSA): 42 C.F.R. § 438.68

Description

The vendor that assessed the Secret Shopper metrics went out of business on October 2024; thus, the Secret Shopper Metrics for the entirety of CY 2025 was unable to be evaluated. The State procured a new Secret Shopper contract in July 2025 and is testing protocols with the new vendor with calls expected to resume in January 2026.

Analyses used to identify deficiencies

Secret Shopper: Appointment Availability

Frequency of compliance findings (optional): Report results by quarter:

Q1 (optional): NR

Q2 (optional): NR

Q3 (optional): NR

Q4 (optional): NR

What the plan will do to achieve compliance

The Timely Access Report is a relatively new report, and assessments of actual appointment availability have been hampered by two factors: inaccuracies in the Provider information furnished by the Health Plans and issues with Secret Shopper callers not having a Medicaid ID number which severely limits their ability to get an appointment. MQD is working with Health Plans to improve the provider data quality so that the telephones in the sampling frame are active and accurate. Moreover, MQD worked with the contractor to construct different shopper scripts to identify the callers as brand-new members who would not yet have a Medicaid ID number.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication

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Reassessment date

01/31/2026

46 Appointment wait time

PCP routine visit within 21 days

Provider type(s)

Primary care

Analysis method(s)	Region	Population
Secret Shopper: Appointment Availability	Statewide	Adult and Pediatric

Plan deficiencies for Hawaii Medical Service Association (HMSA): 42 C.F.R. § 438.68

Description

The vendor that assessed the Secret Shopper metrics went out of business on October 2024; thus, the Secret Shopper Metrics for the entirety of CY 2025 was unable to be evaluated. The State procured a new Secret Shopper contract in July 2025 and is testing protocols with the new vendor with calls expected to resume in January 2026.

Analyses used to identify deficiencies

Secret Shopper: Appointment Availability

Frequency of compliance findings (optional): Report results by quarter:

Q1 (optional): NR

Q2 (optional): NR

Q3 (optional): NR

Q4 (optional): NR

What the plan will do to achieve compliance

The Timely Access Report is a relatively new report, and assessments of actual appointment availability have been hampered by two factors: inaccuracies in the

Provider information furnished by the Health Plans and issues with Secret Shopper callers not having a Medicaid ID number which severely limits their ability to get an appointment. MQD is working with Health Plans to improve the provider data quality so that the telephones in the sampling frame are active and accurate. Moreover, MQD worked with the contractor to construct different shopper scripts to identify the callers as brand-new members who would not yet have a Medicaid ID number.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

47 Appointment wait time

Specialist or non-emergency hospital stays within 4 weeks

Provider type(s)

Specialist; Specialist /Non -emergency

Analysis method(s)	Region	Population
Secret Shopper: Appointment Availability	Statewide	Adult and Pediatric

Plan deficiencies for Hawaii Medical Service Association (HMSA): 42 C.F.R. § 438.68

Description

The vendor that assessed the Secret Shopper metrics went out of business on October 2024; thus, the Secret Shopper Metrics for the entirety of CY 2025 was unable to be evaluated. The State procured a new Secret Shopper contract in July 2025 and is testing protocols with the new vendor with calls expected to resume in January 2026.

Analyses used to identify deficiencies

Secret Shopper: Appointment Availability

Frequency of compliance findings (optional): Report results by quarter:

Q1 (optional): NR

Q2 (optional): NR

Q3 (optional): NR

Q4 (optional): NR

What the plan will do to achieve compliance

The Timely Access Report is a relatively new report, and assessments of actual appointment availability have been hampered by two factors: inaccuracies in the Provider information furnished by the Health Plans and issues with Secret Shopper callers not having a Medicaid ID number which severely limits their ability to get an appointment. MQD is working with Health Plans to improve the provider data quality so that the telephones in the sampling frame are active and accurate. Moreover, MQD worked with the contractor to construct different shopper scripts to identify the callers as brand-new members who would not yet have a Medicaid ID number.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in

accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

52 Minimum number of network providers

FQHC/RHC

Provider type(s)

Primary care; Facilities

Analysis method(s)	Region	Population
Member to Provider Comparision	Statewide	Adult and Pediatric

Plan deficiencies for Hawaii Medical Service Association (HMSA): 42 C.F.R. § 438.68

Description

The minimum number of FQHC/RHC was unmet for all four quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

Unmet standard is consistent with documented statewide healthcare workforce shortages and provider supply limitations in Hawai'i. HMSA continues to monitor network adequacy, pursue provider recruitment and contracting opportunities, evaluate alternative access arrangements through Letters of Agreements (LOA) to send our members in need to the mainland for services, and support telehealth utilization where appropriate.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that

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Reassessment date

01/31/2026

Exceptions standards for 438.68

Total: 0 of 53

B. Assurance of plan compliance for 438.206

	Indicator	Response
	B. Assurance of plan compliance for 438.206 III.B.1 Indicate whether the state assures that the plan complies with the availability of services standards outlined in 42 C.F.R. § 438.206 the analyses the state conducted for the plan during the reporting period.	Yes, the plan complies on all standards based on all analyses

Kaiser Permanente

A. Assurance of plan compliance for 438.68

	Indicator	Response
	A. Assurance of plan compliance for 438.68 III.A.1 Indicate whether the state assures that the plan complies with the state's standards, as required at § 42 C.F.R. 438.68 (i.e., the standards previously entered by the state) based on each analysis the state conducted for the plan during the reporting period.	No, the plan does not comply on all standards based on all analyses or exceptions granted

Select "Enter/Edit" to provide details on standards that were either non-compliant or for which an exception was granted

Non-compliant standards for 438.68

Total: 24 of 53

2 **Minimum number of network providers**

Ground and air transportation

Provider type(s)

Hospital; Emergency transportation

Analysis method(s)	Region	Population
Member to Provider Comparision	Statewide	Adult and Pediatric

Plan deficiencies for Kaiser Permanente: 42 C.F.R. § 438.68

Description

The minimum number of ground and air emergency transportation was unmet for all four quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

The health plan responded: "We identified that this data has not been included in the HP reporting during CY 2025. We are working on adding this information for our 2026 HP reports."

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

5 Minimum number of network providers

Network must include physician specialists including but not limited to cardiologists, endocrinologists, general surgeons, geriatricians, hematologists, infectious disease specialists, nephrologists, neurologists, obstetricians/gynecologists, oncologists, ophthalmologists, orthopedists, otolaryngology, pediatric specialists, plastic and reconstructive surgeons, pulmonologists, radiologists and urologists.

Provider type(s)

Specialist; Physician Specialist

Analysis method(s)	Region	Population
Member to Provider Comparision	Statewide	Adult and Pediatric

Plan deficiencies for Kaiser Permanente: 42 C.F.R. § 438.68

Description

The minimum number of hematologists was unmet from quarters 2 through 4.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

The Health Plan says, in late 2025, they identified that Hematologists were not being categorized correctly in the HP reports because Kaiser providers are both Hematologists and Oncologists. The HP reporting requirements limit each provider to being listed only once per Provider Group, i.e. Specialists. Starting in Q4, they began duplicating their Hematologists and Oncologists for the HP report to more accurately reflect the numbers per each category. They also note that, although this categorization issue would explain failing the metric in Q2 and Q3, it does not explain why the metric failed in Q1 or Q4.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

12 Minimum number of network providers

Community health workers

Provider type(s)

Specialist; Other health care providers

Analysis method(s)	Region	Population
Member to Provider Comparision	Statewide	Adult and Pediatric

Plan deficiencies for Kaiser Permanente: 42 C.F.R. § 438.68

Description

The minimum number of community health workers was unmet for all four quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

The health plan says they actually meet this requirement for Community Health Workers with 2 FTE staff (1 on O'ahu and 1 on Maui). These providers have not been reported on the HP report because they are internal staff. MQD has to decide if we want to modify guidance for the PNA report to include CHWs who are internal employees vs contracted external providers.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

13 Provider to enrollee ratios

1:150 Psychiatrists per members with serious mental illness or severe and persistant mental illness (SMI or SPMI) diagnosis

Provider type(s)

Specialist; Psychiatrists

Analysis method(s)	Region	Population
Member to Provider Comparision	Statewide	Adult and Pediatric

Plan deficiencies for Kaiser Permanente: 42 C.F.R. § 438.68

Description

The minimum number of provider to enrollee ratio for psychiatrist was unmet for all four quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

The Health Plan continues to partner with MQD on clarifying additional Health Plan Reporting nuances and ensuring that their (Kaiser) network is as accurately reflected as possible. That said, if a network gap is identified, KP says: 1) We verify it with our Provider Teams. Kaiser utilizes different methods for members to get appropriate care for their needs. 2) If a gap is confirmed in our network, we present the gap to our Network Provider Data Management (NPDM) Workgroup. For immediate needs, we will initiate a request to our Provider Contracting and Credentialing departments to expedite their processes. 3) If we need additional approval to hire, we will present to our Hawaii Market Administrative Team (HMAT) for review and approval to hire more providers in the gap areas.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that

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Reassessment date

01/31/2026

20 Minimum number of network providers

LTSS Providers: Adult Day Care Facilities, Adult Day Health Facilities, Assisted Living Facilities, Community Care Foster Family Home (CCFFH), Community Care Management Agency (CCMA), Expanded Adult Residential Care Homes (E-ARCHs), Home-Delivered Meal Providers, Non-Medical Transportation Providers, Nursing Facilities (NFs), Personal Care Assistance Providers, Personal Emergency Response System (PERS) Providers, Private Duty Nursing (PDN), Respite Care Providers, and Specialized Medical Equipment and Supply Providers

Provider type(s)

LTSS

Analysis method(s)	Region	Population
Member to Provider Comparision	Statewide	Adult and Pediatric

Plan deficiencies for Kaiser Permanente: 42 C.F.R. § 438.68

Description

The minimum number of PERS Providers and Adult Day Care/Adult Day Health Providers were unmet for all four quarters. Additionally, the minimum number of Assisted Living Facilities/E-ARCH providers were also unmet from Quarters 2 through 4.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

The Health Plan continues to partner with MQD on clarifying additional Health Plan Reporting nuances and ensuring that their (Kaiser) network is as accurately reflected as possible. That said, if a network gap is identified, KP says: 1) We verify it with our Provider Teams. Kaiser utilizes different methods for members to get appropriate care for their needs. 2) If a gap is confirmed in our network, we present the gap to our Network Provider Data Management (NPDM) Workgroup. For immediate needs, we will initiate a request to our Provider Contracting and Credentialing departments to expedite their processes. 3) If we need additional approval to hire, we will present to our Hawaii Market Administrative Team (HMAT) for review and approval to hire more providers in the gap areas.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

21 Minimum number of network providers

Providers of lodging and meals associated with obtaining necessary medical care

Provider type(s)

Specialist; Other Healthcare Providers

Analysis method(s)	Region	Population
Member to Provider Comparision	Statewide	Adult and Pediatric

Plan deficiencies for Kaiser Permanente: 42 C.F.R. § 438.68

Description

The minimum number of lodging providers were unmet for all four quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

The Health Plan continues to partner with MQD on clarifying additional Health Plan Reporting nuances and ensuring that their (Kaiser) network is as accurately reflected as possible. That said, if a network gap is identified, KP says: 1) We verify it with our Provider Teams. Kaiser utilizes different methods for members to get appropriate care for their needs. 2) If a gap is confirmed in our network, we present the gap to our Network Provider Data Management (NPDM) Workgroup. For immediate needs, we will initiate a request to our Provider Contracting and Credentialing departments to expedite their processes. 3) If we need additional approval to hire, we will present to our Hawaii Market Administrative Team (HMAT) for review and approval to hire more providers in the gap areas.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

23 Minimum number of network providers

Community paramedics

Provider type(s)

Specialist; Other Healthcare Providers

Analysis method(s)	Region	Population
Member to Provider Comparision	Statewide	Adult and Pediatric

Plan deficiencies for Kaiser Permanente: 42 C.F.R. § 438.68

Description

The minimum number of community paramedics was unmet for all four quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

The Health Plan continues to partner with MQD on clarifying additional Health Plan Reporting nuances and ensuring that their (Kaiser) network is as accurately reflected as possible. That said, if a network gap is identified, KP says: 1) We verify it with our Provider Teams. Kaiser utilizes different methods for members to get appropriate care for their needs. 2) If a gap is confirmed in our network, we present the gap to our Network Provider Data Management (NPDM) Workgroup. For immediate needs, we will initiate a request to our Provider Contracting and Credentialing departments to expedite their processes. 3) If we need additional approval to hire, we will present to our Hawaii Market Administrative Team (HMAT) for review and approval to hire more providers in the gap areas.

Monitoring progress

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Reassessment date

01/31/2026

26 Maximum time to travel

30 minutes driving time to an appointment

Provider type(s)

Specialist

Analysis method(s)	Region	Population
Member to Provider Comparision	Urban	Adult and Pediatric

Plan deficiencies for Kaiser Permanente: 42 C.F.R. § 438.68

Description

The 85 % drive-time threshold for 30 minutes driving time to an appointment in urban areas was unmet for endocrinologists, infectious disease specialists, otolaryngologists, neurologists, and Plastic and reconstructive surgeons for all four quarters. The drive time standard was unmet for pediatric specialists for quarter 1. The drive standard was unmet for cardiologists, radiologists and urologist for quarters 1 through 3. Orthopedists surgeons also didn't meet the drive time threshold for quarters 3 and 4.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

The Health Plan continues to partner with MQD on clarifying additional Health Plan Reporting nuances and ensuring that their (Kaiser) network is as accurately reflected as possible. In general practices, KFHP provides the majority of care for QUEST members near their home address through contracted services of the Hawaii Permanente Medical Group (HPMG). Kaiser Foundation Hospitals Group (KFHP) and HPMG ensure

that QUEST members have access to the services they need. If there are services that cannot be met within the vicinity of a member's home address, KFHP will secure a means of providing the medically necessary care. As an example, HPMG providers routinely travel to multiple clinics on different islands to meet the needs of members who have limited access to care. These are float locations offered on a case-by-case basis pending current member needs. Thus, they are not often included in provider network reporting and may not be reflected here.

Monitoring progress

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Reassessment date

01/31/2026

27 Maximum time to travel

60 minutes driving time to an appointment

Provider type(s)

Specialist

Analysis method(s)	Region	Population
Member to Provider Comparision	Rural	Adult and Pediatric

Plan deficiencies for Kaiser Permanente: 42 C.F.R. § 438.68

Description

The 85 % drive-time threshold for 60 minutes driving time to an appointment in rural areas was unmet for hematologist for all four quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

The Health Plan continues to partner with MQD on clarifying additional Health Plan Reporting nuances and ensuring that their (Kaiser) network is as accurately reflected as possible. In general practices, KFHP provides the majority of care for QUEST members near their home address through contracted services of the Hawaii Permanente Medical Group (HPMG). Kaiser Foundation Hospitals Group (KFHP) and HPMG ensure that QUEST members have access to the services they need. If there are services that cannot be met within the vicinity of a member's home address, KFHP will secure a means of providing the medically necessary care. As an example, HPMG providers routinely travel to multiple clinics on different islands to meet the needs of members who have limited access to care. These are float locations offered on a case-by-case basis pending current member needs. Thus, they are not often included in provider network reporting and may not be reflected here.

Monitoring progress

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Reassessment date

01/31/2026

30 Maximum time to travel

30 minutes driving time

Provider type(s)

LTSS; Adult Day Care/Adult Day Health

Analysis method(s)	Region	Population
Member to Provider Comparision	Urban	MLTSS

Plan deficiencies for Kaiser Permanente: 42 C.F.R. § 438.68

Description

The 95 % threshold for 30 minutes drive time to travel for Adult Day Care/Adult Day Health in an urban setting was unmet for Quarter 4.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

The Health Plan continues to partner with MQD on clarifying additional Health Plan Reporting nuances and ensuring that their (Kaiser) network is as accurately reflected as possible. In general practices, KFHP provides the majority of care for QUEST members near their home address through contracted services of the Hawaii Permanente Medical Group (HPMG). Kaiser Foundation Hospitals Group (KFHP) and HPMG ensure that QUEST members have access to the services they need. If there are services that cannot be met within the vicinity of a member's home address, KFHP will secure a means of providing the medically necessary care. As an example, HPMG providers routinely travel to multiple clinics on different islands to meet the needs of members who have limited access to care. These are float locations offered on a case-by-case basis pending current member needs. Thus, they are not often included in provider network reporting and may not be reflected here.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering

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Reassessment date

01/31/2026

32 Maximum time to travel

30 minutes driving time

Provider type(s)

Hospital

Analysis method(s)	Region	Population
Member to Provider Comparision	Urban	Adult and Pediatric

Plan deficiencies for Kaiser Permanente: 42 C.F.R. § 438.68

Description

The 95 % threshold for 30 minutes drive time to travel for Hospitals in an urban setting was unmet for all four quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

The Health Plan continues to partner with MQD on clarifying additional Health Plan Reporting nuances and ensuring that their (Kaiser) network is as accurately reflected as possible. In general practices, KFHP provides the majority of care for QUEST members near their home address through contracted services of the Hawaii Permanente Medical Group (HPMG). Kaiser Foundation Hospitals Group (KFHP) and HPMG ensure that QUEST members have access to the services they need. If there are services that cannot be met within the vicinity of a member's home address, KFHP will secure a means of providing the medically necessary care. As an example, HPMG providers

routinely travel to multiple clinics on different islands to meet the needs of members who have limited access to care. These are float locations offered on a case-by-case basis pending current member needs. Thus, they are not often included in provider network reporting and may not be reflected here.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

33 Maximum time to travel

60 minutes driving time

Provider type(s)

Hospital

Analysis method(s)	Region	Population
Member to Provider Comparision	Rural	Adult and Pediatric

Plan deficiencies for Kaiser Permanente: 42 C.F.R. § 438.68

Description

The 95 % threshold for 60 minutes drive time to travel for Hospitals in an rural setting was unmet for quarters 1 and 3.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

The Health Plan continues to partner with MQD on clarifying additional Health Plan Reporting nuances and ensuring that their (Kaiser) network is as accurately reflected as possible. In general practices, KFHP provides the majority of care for QUEST members near their home address through contracted services of the Hawaii Permanente Medical Group (HPMG). Kaiser Foundation Hospitals Group (KFHP) and HPMG ensure that QUEST members have access to the services they need. If there are services that cannot be met within the vicinity of a member's home address, KFHP will secure a means of providing the medically necessary care. As an example, HPMG providers routinely travel to multiple clinics on different islands to meet the needs of members who have limited access to care. These are float locations offered on a case-by-case basis pending current member needs. Thus, they are not often included in provider network reporting and may not be reflected here.

Monitoring progress

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Reassessment date

01/31/2026

36 Maximum time to travel

30 minutes driving time

Provider type(s)

Hospital; Emergency Services Facilities

Analysis method(s)	Region	Population
Member to Provider Comparision	Urban	Adult and Pediatric

Plan deficiencies for Kaiser Permanente: 42 C.F.R. § 438.68

Description

The 95 % threshold for 30 minutes drive time to travel for Emergency Services Facilities in an urban setting was unmet for all four quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

The Health Plan continues to partner with MQD on clarifying additional Health Plan Reporting nuances and ensuring that their (Kaiser) network is as accurately reflected as possible. In general practices, KFHP provides the majority of care for QUEST members near their home address through contracted services of the Hawaii Permanente Medical Group (HPMG). Kaiser Foundation Hospitals Group (KFHP) and HPMG ensure that QUEST members have access to the services they need. If there are services that cannot be met within the vicinity of a member's home address, KFHP will secure a means of providing the medically necessary care. As an example, HPMG providers routinely travel to multiple clinics on different islands to meet the needs of members who have limited access to care. These are float locations offered on a case-by-case basis pending current member needs. Thus, they are not often included in provider network reporting and may not be reflected here.

Monitoring progress

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Reassessment date

01/31/2026

37 Maximum time to travel

60 minutes driving time

Provider type(s)

Hospital; Emergency Services Facilities

Analysis method(s)	Region	Population
Member to Provider Comparision	Rural	Adult and Pediatric

Plan deficiencies for Kaiser Permanente: 42 C.F.R. § 438.68

Description

The 95 % threshold for 60 minutes drive time to travel for emergency service facilities in an rural setting was unmet for quarters 1 and 3.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

The Health Plan continues to partner with MQD on clarifying additional Health Plan Reporting nuances and ensuring that their (Kaiser) network is as accurately reflected as possible. In general practices, KFHP provides the majority of care for QUEST members near their home address through contracted services of the Hawaii Permanente Medical Group (HPMG). Kaiser Foundation Hospitals Group (KFHP) and HPMG ensure that QUEST members have access to the services they need. If there are services that cannot be met within the vicinity of a member's home address, KFHP will secure a means of providing the medically necessary care. As an example, HPMG providers routinely travel to multiple clinics on different islands to meet the needs of members who have limited access to care. These are float locations offered on a case-by-case

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Monitoring progress

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Reassessment date

01/31/2026

39 Maximum time to travel

60 minutes driving time

Provider type(s)

LTSS

Analysis method(s)	Region	Population
Member to Provider Comparision	Rural	MLTSS

Plan deficiencies for Kaiser Permanente: 42 C.F.R. § 438.68

Description

The 95 % threshold for 60 minutes drive time to travel for respite care facilities in a rural setting was unmet for quarters 1 and 4.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

The Health Plan continues to partner with MQD on clarifying additional Health Plan Reporting nuances and ensuring that their (Kaiser) network is as accurately reflected as possible. In general practices, KFHP provides the majority of care for QUEST members near their home address through contracted services of the Hawaii Permanente Medical Group (HPMG). Kaiser Foundation Hospitals Group (KFHP) and HPMG ensure that QUEST members have access to the services they need. If there are services that cannot be met within the vicinity of a member's home address, KFHP will secure a means of providing the medically necessary care. As an example, HPMG providers routinely travel to multiple clinics on different islands to meet the needs of members who have limited access to care. These are float locations offered on a case-by-case basis pending current member needs. Thus, they are not often included in provider network reporting and may not be reflected here.

Monitoring progress

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Reassessment date

01/31/2026

40 Maximum time to travel

30 minutes driving time

Provider type(s)

Pharmacy; 24 hour Pharmacy

Analysis method(s)	Region	Population
Member to Provider Comparision	Urban	Adult and Pediatric

Plan deficiencies for Kaiser Permanente: 42 C.F.R. § 438.68

Description

The 95 % threshold for 30 minutes drive time to travel for 24 hr pharmacies in an urban setting was unmet for quarters 1.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

The Health Plan continues to partner with MQD on clarifying additional Health Plan Reporting nuances and ensuring that their (Kaiser) network is as accurately reflected as possible. In general practices, KFHP provides the majority of care for QUEST members near their home address through contracted services of the Hawaii Permanente Medical Group (HPMG). Kaiser Foundation Hospitals Group (KFHP) and HPMG ensure that QUEST members have access to the services they need. If there are services that cannot be met within the vicinity of a member's home address, KFHP will secure a means of providing the medically necessary care. As an example, HPMG providers routinely travel to multiple clinics on different islands to meet the needs of members who have limited access to care. These are float locations offered on a case-by-case basis pending current member needs. Thus, they are not often included in provider network reporting and may not be reflected here.

Monitoring progress

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Reassessment date

01/31/2026

41 Maximum time to travel

15 minutes driving time

Provider type(s)

Pharmacy

Analysis method(s)	Region	Population
Member to Provider Comparision	Urban	Adult and Pediatric

Plan deficiencies for Kaiser Permanente: 42 C.F.R. § 438.68

Description

The 95 % threshold for 15 minutes drive time to travel for pharmacies in an urban setting was unmet for quarters 2 through 4.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

The Health Plan continues to partner with MQD on clarifying additional Health Plan Reporting nuances and ensuring that their (Kaiser) network is as accurately reflected as possible. In general practices, KFHP provides the majority of care for QUEST members near their home address through contracted services of the Hawaii Permanente Medical Group (HPMG). Kaiser Foundation Hospitals Group (KFHP) and HPMG ensure that QUEST members have access to the services they need. If there are services that cannot be met within the vicinity of a member's home address, KFHP will secure a means of providing the medically necessary care. As an example, HPMG providers routinely travel to multiple clinics on different islands to meet the needs of members who have limited access to care. These are float locations offered on a case-by-case

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Monitoring progress

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Reassessment date

01/31/2026

42 Maximum time to travel

60 minutes driving time

Provider type(s)

Pharmacy

Analysis method(s)	Region	Population
Member to Provider Comparision	Rural	Adult and Pediatric

Plan deficiencies for Kaiser Permanente: 42 C.F.R. § 438.68

Description

The 95 % threshold for 60 minutes drive time to travel for pharmacies in a rural setting was unmet for quarters 2 and 3.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

The Health Plan continues to partner with MQD on clarifying additional Health Plan Reporting nuances and ensuring that their (Kaiser) network is as accurately reflected as possible. In general practices, KFHP provides the majority of care for QUEST members near their home address through contracted services of the Hawaii Permanente Medical Group (HPMG). Kaiser Foundation Hospitals Group (KFHP) and HPMG ensure that QUEST members have access to the services they need. If there are services that cannot be met within the vicinity of a member's home address, KFHP will secure a means of providing the medically necessary care. As an example, HPMG providers routinely travel to multiple clinics on different islands to meet the needs of members who have limited access to care. These are float locations offered on a case-by-case basis pending current member needs. Thus, they are not often included in provider network reporting and may not be reflected here.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

43 Appointment wait time

Urgent care and PCP sick visits within 24 hours

Provider type(s)

Primary care; Pediatric Primary Care

Analysis method(s)	Region	Population
Secret Shopper: Appointment Availability	Statewide	Pediatric

Plan deficiencies for Kaiser Permanente: 42 C.F.R. § 438.68

Description

The vendor that assessed the Secret Shopper metrics went out of business on October 2024; thus, the Secret Shopper Metrics for the entirety of CY 2025 was unable to be evaluated. The State procured a new Secret Shopper contract in July 2025 and is testing protocols with the new vendor with calls expected to resume in January 2026.

Analyses used to identify deficiencies

Secret Shopper: Appointment Availability

Frequency of compliance findings (optional): Report results by quarter:

Q1 (optional): NR

Q2 (optional): NR

Q3 (optional): NR

Q4 (optional): NR

What the plan will do to achieve compliance

The Timely Access Report is a relatively new report, and assessments of actual appointment availability have been hampered by two factors: inaccuracies in the Provider information furnished by the Health Plans and issues with Secret Shopper callers not having a Medicaid ID number which severely limits their ability to get an appointment. MQD is working with Health Plans to improve the provider data quality so that the telephones in the sampling frame are active and accurate. Moreover, MQD worked with the contractor to construct different shopper scripts to identify the callers as brand-new members who would not yet have a Medicaid ID number.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior

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Reassessment date

01/31/2026

44 Appointment wait time

PCP sick visit within 72 hours

Provider type(s)

Primary care; Adult Primary Care

Analysis method(s)	Region	Population
Secret Shopper: Appointment Availability	Statewide	Adult

Plan deficiencies for Kaiser Permanente: 42 C.F.R. § 438.68

Description

The vendor that assessed the Secret Shopper metrics went out of business on October 2024; thus, the Secret Shopper Metrics for the entirety of CY 2025 was unable to be evaluated. The State procured a new Secret Shopper contract in July 2025 and is testing protocols with the new vendor with calls expected to resume in January 2026.

Analyses used to identify deficiencies

Secret Shopper: Appointment Availability

Frequency of compliance findings (optional): Report results by quarter:

Q1 (optional): NR

Q2 (optional): NR

Q3 (optional): NR

Q4 (optional): NR

What the plan will do to achieve compliance

The Timely Access Report is a relatively new report, and assessments of actual appointment availability have been hampered by two factors: inaccuracies in the Provider information furnished by the Health Plans and issues with Secret Shopper callers not having a Medicaid ID number which severely limits their ability to get an appointment. MQD is working with Health Plans to improve the provider data quality so that the telephones in the sampling frame are active and accurate. Moreover, MQD worked with the contractor to construct different shopper scripts to identify the callers as brand-new members who would not yet have a Medicaid ID number.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

45 Appointment wait time

Behavioral health routine visit within 21 days

Provider type(s)

Mental health; Behavioral Health Provider

Analysis method(s)	Region	Population
Secret Shopper: Appointment Availability	Statewide	Adult and Pediatric

Plan deficiencies for Kaiser Permanente: 42 C.F.R. § 438.68

Description

The vendor that assessed the Secret Shopper metrics went out of business on October 2024; thus, the Secret Shopper Metrics for the entirety of CY 2025 was unable to be evaluated. The State procured a new Secret Shopper contract in July 2025 and is testing protocols with the new vendor with calls expected to resume in January 2026.

Analyses used to identify deficiencies

Secret Shopper: Appointment Availability

Frequency of compliance findings (optional): Report results by quarter:

Q1 (optional): NR

Q2 (optional): NR

Q3 (optional): NR

Q4 (optional): NR

What the plan will do to achieve compliance

The Timely Access Report is a relatively new report, and assessments of actual appointment availability have been hampered by two factors: inaccuracies in the Provider information furnished by the Health Plans and issues with Secret Shopper callers not having a Medicaid ID number which severely limits their ability to get an appointment. MQD is working with Health Plans to improve the provider data quality so that the telephones in the sampling frame are active and accurate. Moreover, MQD worked with the contractor to construct different shopper scripts to identify the callers as brand-new members who would not yet have a Medicaid ID number.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for

considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2025

46 Appointment wait time

PCP routine visit within 21 days

Provider type(s)

Primary care

Analysis method(s)	Region	Population
Secret Shopper: Appointment Availability	Statewide	Adult and Pediatric

Plan deficiencies for Kaiser Permanente: 42 C.F.R. § 438.68

Description

The vendor that assessed the Secret Shopper metrics went out of business on October 2024; thus, the Secret Shopper Metrics for the entirety of CY 2025 was unable to be evaluated. The State procured a new Secret Shopper contract in July 2025 and is testing protocols with the new vendor with calls expected to resume in January 2026.

Analyses used to identify deficiencies

Secret Shopper: Appointment Availability

Frequency of compliance findings (optional): Report results by quarter:

Q1 (optional): NR

Q2 (optional): NR

Q3 (optional): NR

Q4 (optional): NR

What the plan will do to achieve compliance

The Timely Access Report is a relatively new report, and assessments of actual appointment availability have been hampered by two factors: inaccuracies in the Provider information furnished by the Health Plans and issues with Secret Shopper callers not having a Medicaid ID number which severely limits their ability to get an appointment. MQD is working with Health Plans to improve the provider data quality so

that the telephones in the sampling frame are active and accurate. Moreover, MQD worked with the contractor to construct different shopper scripts to identify the callers as brand-new members who would not yet have a Medicaid ID number.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

47 Appointment wait time

Specialist or non-emergency hospital stays within 4 weeks

Provider type(s)

Specialist; Specialist /Non -emergency

Analysis method(s)	Region	Population
Secret Shopper: Appointment Availability	Statewide	Adult and Pediatric

Plan deficiencies for Kaiser Permanente: 42 C.F.R. § 438.68

Description

The vendor that assessed the Secret Shopper metrics went out of business on October 2024; thus, the Secret Shopper Metrics for the entirety of CY 2025 was unable to be evaluated. The State procured a new Secret Shopper contract in July 2025 and is testing protocols with the new vendor with calls expected to resume in January 2026.

Analyses used to identify deficiencies

Secret Shopper: Appointment Availability

Frequency of compliance findings (optional): Report results by quarter:

Q1 (optional): NR

Q2 (optional): NR

Q3 (optional): NR

Q4 (optional): NR

What the plan will do to achieve compliance

The Timely Access Report is a relatively new report, and assessments of actual appointment availability have been hampered by two factors: inaccuracies in the Provider information furnished by the Health Plans and issues with Secret Shopper callers not having a Medicaid ID number which severely limits their ability to get an appointment. MQD is working with Health Plans to improve the provider data quality so that the telephones in the sampling frame are active and accurate. Moreover, MQD worked with the contractor to construct different shopper scripts to identify the callers as brand-new members who would not yet have a Medicaid ID number.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

53 Minimum number of network providers

Access to certified nurse midwives, pediatric nurse practitioners, family nurse practitioners, and behavioral health nurse practitioners

Provider type(s)

Specialist; Other Healthcare Providers

Analysis method(s)	Region	Population
Member to Provider Comparision	Statewide	Adult and Pediatric

Plan deficiencies for Kaiser Permanente: 42 C.F.R. § 438.68

Description

The minimum number of midwife nurses wasn't met in Quarter 2. The minimum number of pediatric nurse practitioner was unmet from quarter 2 through 4. The minimum number of Psych Mental Health Nurse practitioner was unmet for all four quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

The Health Plan continues to partner with MQD on clarifying additional Health Plan Reporting nuances and ensuring that their (Kaiser) network is as accurately reflected as possible. That said, if a network gap is identified, KP says: 1) We verify it with our Provider Teams. Kaiser utilizes different methods for members to get appropriate care for their needs. 2) If a gap is confirmed in our network, we present the gap to our Network Provider Data Management (NPDM) Workgroup. For immediate needs, we will initiate a request to our Provider Contracting and Credentialing departments to expedite their processes. 3) If we need additional approval to hire, we will present to our Hawaii Market Administrative Team (HMAT) for review and approval to hire more providers in the gap areas.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior

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Reassessment date

01/31/2026

Exceptions standards for 438.68

Total: 0 of 53

B. Assurance of plan compliance for 438.206

	Indicator	Response
	B. Assurance of plan compliance for 438.206 III.B.1 Indicate whether the state assures that the plan complies with the availability of services standards outlined in 42 C.F.R. § 438.206 the analyses the state conducted for the plan during the reporting period.	Yes, the plan complies on all standards based on all analyses

Ohana Health Plan

A. Assurance of plan compliance for 438.68

Indicator	Response
A. Assurance of plan compliance for 438.68 III.A.1 Indicate whether the state assures that the plan complies with the state's standards, as required at § 42 C.F.R. 438.68 (i.e., the standards previously entered by the state) based on each analysis the state conducted for the plan during the reporting period.	No, the plan does not comply on all standards based on all analyses or exceptions granted

Select "Enter/Edit" to provide details on standards that were either non-compliant or for which an exception was granted

Non-compliant standards for 438.68

Total: 12 of 53

3 **Minimum number of network providers**

Ground and air transportation

Provider type(s)

Hospital; Non-Emergency Transportation

Analysis method(s)	Region	Population
Member to Provider Comparision	Statewide	Adult and Pediatric

Plan deficiencies for Ohana Health Plan: 42 C.F.R. § 438.68

Description

The minimum number of non-emergency ground and air transportation was unmet for all four quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

These providers are managed by 'Ohana's Third party transportation vendor; 'Ohana is currently investigating the data to ensure they have access to all available data as it is managed by current TPV.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

12 Minimum number of network providers

Community health workers

Provider type(s)

Specialist; Other health care providers

Analysis method(s)	Region	Population
Member to Provider Comparision	Statewide	Adult and Pediatric

Plan deficiencies for Ohana Health Plan: 42 C.F.R. § 438.68

Description

The minimum number of community health workers was unmet for all four quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

Currently 'Ohana contract with all provider types. The term "Community Health Worker" can encompass a wide range of provider types that are already captured in other provider categories such as LTSS, other BH providers, specialist, etc. State-specific guidance to crosswalk provider specialties and types that should fall under this provider category. This would allow the health plan to distinguish between roles that are already categorized elsewhere and those that should appropriately be included within this provider category.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

20 Minimum number of network providers

LTSS Providers: Adult Day Care Facilities, Adult Day Health Facilities, Assisted Living Facilities, Community Care Foster Family Home (CCFFH), Community Care Management Agency (CCMA), Expanded Adult Residential Care Homes (E-ARCHs), Home-Delivered Meal Providers, Non-Medical Transportation Providers, Nursing Facilities (NFs), Personal Care Assistance Providers, Personal Emergency Response System (PERS) Providers, Private Duty

Nursing (PDN), Respite Care Providers, and Specialized Medical Equipment and Supply Providers

Provider type(s)

LTSS

Analysis method(s)	Region	Population
Member to Provider Comparision	Statewide	Adult and Pediatric

Plan deficiencies for Ohana Health Plan: 42 C.F.R. § 438.68

Description

The minimum number of respite care facilities was unmet for all four quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

Health plan identified a mapping issue on their end thus this standard was unable to be accurately verified. The HP mentioned that it will be corrected in future reporting

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

21 Minimum number of network providers

Providers of lodging and meals associated with obtaining necessary medical care

Provider type(s)

Specialist; Other Healthcare Providers

Analysis method(s)	Region	Population
Member to Provider Comparision	Statewide	Adult and Pediatric

Plan deficiencies for Ohana Health Plan: 42 C.F.R. § 438.68

Description

The minimum number of lodging providers was unmet for all four quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

These providers are managed by 'Ohana's Third party transportation vendor; 'Ohana is currently investigating the data to ensure they have access to all available data as it is managed by current TPV.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan’s response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces

accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

22 Minimum number of network providers

Sign language interpreters and interpreters for languages other than English

Provider type(s)

Specialist; Interpretation services

Analysis method(s)	Region	Population
Member to Provider Comparision	Statewide	Adult and Pediatric

Plan deficiencies for Ohana Health Plan: 42 C.F.R. § 438.68

Description

The minimum number of sign language and other language interpreters was unmet for all four quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

These providers are managed by 'Ohana's third party interpretation vendor; 'Ohana is currently investigating the data to ensure we have access to all available data as it is managed by current TPV

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data

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Reassessment date

01/31/2026

27 Maximum time to travel

60 minutes driving time to an appointment

Provider type(s)

Specialist

Analysis method(s)	Region	Population
Member to Provider Comparision	Rural	Adult and Pediatric

Plan deficiencies for Ohana Health Plan: 42 C.F.R. § 438.68

Description

The 85 % drive-time threshold for 60 minutes driving time to an appointment in rural areas was unmet for pediatric specialist for all four quarters. Additionally, geriatricians didn't meet the drive time threshold for quarters 1 and 2.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

Currently making all efforts to contract available providers in the specialties not meeting 85%. Lack of available providers poses a challenge to improving this metric.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care

Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

40 Maximum time to travel

30 minutes driving time

Provider type(s)

Pharmacy; 24 hour Pharmacy

Analysis method(s)	Region	Population
Member to Provider Comparision	Urban	Adult and Pediatric

Plan deficiencies for Ohana Health Plan: 42 C.F.R. § 438.68

Description

The 95% threshold for 30 minutes drive time to travel for 24 hr pharmacies in an urban setting was unmet for all four quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

Currently making all efforts to contract available providers in the specialties not meeting 85%. Lack of available providers poses a challenge to improving this metric.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

43 Appointment wait time

Urgent care and PCP sick visits within 24 hours

Provider type(s)

Primary care; Pediatric Primary Care

Analysis method(s)	Region	Population
Secret Shopper: Appointment Availability	Statewide	Pediatric

Plan deficiencies for Ohana Health Plan: 42 C.F.R. § 438.68

Description

The vendor that assessed the Secret Shopper metrics went out of business on October 2024; thus, the Secret Shopper Metrics for the entirety of CY 2025 was unable to be evaluated. The State procured a new Secret Shopper contract in July 2025 and is testing protocols with the new vendor with calls expected to resume in January 2026.

Analyses used to identify deficiencies

Secret Shopper: Appointment Availability

Frequency of compliance findings (optional): Report results by quarter:

Q1 (optional): NR

Q2 (optional): NR

Q3 (optional): NR

Q4 (optional): NR

What the plan will do to achieve compliance

The Timely Access Report is a relatively new report, and assessments of actual appointment availability have been hampered by two factors: inaccuracies in the Provider information furnished by the Health Plans and issues with Secret Shopper callers not having a Medicaid ID number which severely limits their ability to get an appointment. MQD is working with Health Plans to improve the provider data quality so that the telephones in the sampling frame are active and accurate. Moreover, MQD worked with the contractor to construct different shopper scripts to identify the callers as brand-new members who would not yet have a Medicaid ID number.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

44 Appointment wait time

PCP sick visit within 72 hours

Provider type(s)

Primary care; Adult Primary Care

Analysis method(s)	Region	Population
Secret Shopper: Appointment Availability	Statewide	Adult

Plan deficiencies for Ohana Health Plan: 42 C.F.R. § 438.68

Description

The vendor that assessed the Secret Shopper metrics went out of business on October 2024; thus, the Secret Shopper Metrics for the entirety of CY 2025 was unable to be evaluated. The State procured a new Secret Shopper contract in July 2025 and is testing protocols with the new vendor with calls expected to resume in January 2026.

Analyses used to identify deficiencies

Secret Shopper: Appointment Availability

Frequency of compliance findings (optional): Report results by quarter:

Q1 (optional): NR

Q2 (optional): NR

Q3 (optional): NR

Q4 (optional): NR

What the plan will do to achieve compliance

The Timely Access Report is a relatively new report, and assessments of actual appointment availability have been hampered by two factors: inaccuracies in the Provider information furnished by the Health Plans and issues with Secret Shopper callers not having a Medicaid ID number which severely limits their ability to get an appointment. MQD is working with Health Plans to improve the provider data quality so that the telephones in the sampling frame are active and accurate. Moreover, MQD worked with the contractor to construct different shopper scripts to identify the callers as brand-new members who would not yet have a Medicaid ID number.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior

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Reassessment date

01/31/2026

45 Appointment wait time

Behavioral health routine visit within 21 days

Provider type(s)

Mental health; Behavioral Health Provider

Analysis method(s)	Region	Population
Secret Shopper: Appointment Availability	Statewide	Adult and Pediatric

Plan deficiencies for Ohana Health Plan: 42 C.F.R. § 438.68

Description

The vendor that assessed the Secret Shopper metrics went out of business on October 2024; thus, the Secret Shopper Metrics for the entirety of CY 2025 was unable to be evaluated. The State procured a new Secret Shopper contract in July 2025 and is testing protocols with the new vendor with calls expected to resume in January 2026.

Analyses used to identify deficiencies

Secret Shopper: Appointment Availability

Frequency of compliance findings (optional): Report results by quarter:

Q1 (optional): NR

Q2 (optional): NR

Q3 (optional): NR

Q4 (optional): NR

What the plan will do to achieve compliance

The Timely Access Report is a relatively new report, and assessments of actual appointment availability have been hampered by two factors: inaccuracies in the Provider information furnished by the Health Plans and issues with Secret Shopper callers not having a Medicaid ID number which severely limits their ability to get an appointment. MQD is working with Health Plans to improve the provider data quality so that the telephones in the sampling frame are active and accurate. Moreover, MQD worked with the contractor to construct different shopper scripts to identify the callers as brand-new members who would not yet have a Medicaid ID number.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

46 Appointment wait time

PCP routine visit within 21 days

Provider type(s)

Primary care

Analysis method(s)	Region	Population
Secret Shopper: Appointment Availability	Statewide	Adult and Pediatric

Plan deficiencies for Ohana Health Plan: 42 C.F.R. § 438.68

Description

The vendor that assessed the Secret Shopper metrics went out of business on October 2024; thus, the Secret Shopper Metrics for the entirety of CY 2025 was unable to be evaluated. The State procured a new Secret Shopper contract in July 2025 and is testing protocols with the new vendor with calls expected to resume in January 2026.

Analyses used to identify deficiencies

Secret Shopper: Appointment Availability

Frequency of compliance findings (optional): Report results by quarter:

Q1 (optional): NR

Q2 (optional): NR

Q3 (optional): NR

Q4 (optional): NR

What the plan will do to achieve compliance

The Timely Access Report is a relatively new report, and assessments of actual appointment availability have been hampered by two factors: inaccuracies in the Provider information furnished by the Health Plans and issues with Secret Shopper callers not having a Medicaid ID number which severely limits their ability to get an appointment. MQD is working with Health Plans to improve the provider data quality so that the telephones in the sampling frame are active and accurate. Moreover, MQD worked with the contractor to construct different shopper scripts to identify the callers as brand-new members who would not yet have a Medicaid ID number.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for

considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

47 Appointment wait time

Specialist or non-emergency hospital stays within 4 weeks

Provider type(s)

Specialist; Specialist /Non -emergency

Analysis method(s)	Region	Population
Secret Shopper: Appointment Availability	Statewide	Adult and Pediatric

Plan deficiencies for Ohana Health Plan: 42 C.F.R. § 438.68

Description

The vendor that assessed the Secret Shopper metrics went out of business on October 2024; thus, the Secret Shopper Metrics for the entirety of CY 2025 was unable to be evaluated. The State procured a new Secret Shopper contract in July 2025 and is testing protocols with the new vendor with calls expected to resume in January 2026.

Analyses used to identify deficiencies

Secret Shopper: Appointment Availability

Frequency of compliance findings (optional): Report results by quarter:

Q1 (optional): NR

Q2 (optional): NR

Q3 (optional): NR

Q4 (optional): NR

What the plan will do to achieve compliance

The Timely Access Report is a relatively new report, and assessments of actual appointment availability have been hampered by two factors: inaccuracies in the Provider information furnished by the Health Plans and issues with Secret Shopper callers not having a Medicaid ID number which severely limits their ability to get an appointment. MQD is working with Health Plans to improve the provider data quality so

that the telephones in the sampling frame are active and accurate. Moreover, MQD worked with the contractor to construct different shopper scripts to identify the callers as brand-new members who would not yet have a Medicaid ID number.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

Exceptions standards for 438.68

Total: 0 of 53

B. Assurance of plan compliance for 438.206

	Indicator	Response
	B. Assurance of plan compliance for 438.206 III.B.1 Indicate whether the state assures that the plan complies with the availability of services standards outlined in 42 C.F.R. § 438.206 the analyses the state conducted for the plan during the reporting period.	Yes, the plan complies on all standards based on all analyses

UnitedHealthcare Community Plan

A. Assurance of plan compliance for 438.68

	Indicator	Response
	A. Assurance of plan compliance for 438.68 III.A.1 Indicate whether the state assures that the plan complies with the state's standards, as required at § 42 C.F.R. 438.68 (i.e., the standards previously entered by the state) based on each analysis the state conducted for the plan during the reporting period.	No, the plan does not comply on all standards based on all analyses or exceptions granted

Select "Enter/Edit" to provide details on standards that were either non-compliant or for which an exception was granted

Non-compliant standards for 438.68

Total: 13 of 53

3 Minimum number of network providers

Ground and air transportation

Provider type(s)

Hospital; Non-Emergency Transportation

Analysis method(s)	Region	Population
	Statewide	Adult and Pediatric

Member to Provider Comparision

Plan deficiencies for UnitedHealthcare Community Plan: 42 C.F.R. § 438.68

Description

The minimum number of non-emergency ground and air transportation was unmet for all four quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

Health plan identified a mapping issue on their end thus this standard was unable to be accurately validated. The HP mentioned that it will be corrected in future reporting.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

10 Minimum number of network providers

Licensed dieticians

Provider type(s)

Specialist; Other health care providers

Analysis method(s)	Region	Population
Member to Provider Comparision	Statewide	Adult and Pediatric

Plan deficiencies for UnitedHealthcare Community Plan: 42 C.F.R. § 438.68

Description

The minimum number of licensed dieticians was unmet for quarter 1.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

The HP didn't provide any count of licensed dieticians in quarter 1 due to HP mapping issues, however they rectified this in subsequent quarters.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan’s response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

21 Minimum number of network providers

Providers of lodging and meals associated with obtaining necessary medical care

Provider type(s)

Specialist; Other Healthcare Providers

Analysis method(s)	Region	Population
Member to Provider Comparision	Statewide	Adult and Pediatric

Plan deficiencies for UnitedHealthcare Community Plan: 42 C.F.R. § 438.68

Description

The minimum number of lodging providers was unmet for all four quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

Health plan identified a mapping issue on their end thus this standard was unable to be accurately validated. The HP mentioned that it will be corrected in future reporting.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces

accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

22 Minimum number of network providers

Sign language interpreters and interpreters for languages other than English

Provider type(s)

Specialist; Interpretation services

Analysis method(s)	Region	Population
Member to Provider Comparision	Statewide	Adult and Pediatric

Plan deficiencies for UnitedHealthcare Community Plan: 42 C.F.R. § 438.68

Description

The minimum number of sign language and other language interpreters was unmet for all four quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

Health plan identified a mapping issue on their end thus this standard was unable to be accurately validated. The HP mentioned that it will be corrected in future reporting.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data

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Reassessment date

01/31/2026

27 Maximum time to travel

60 minutes driving time to an appointment

Provider type(s)

Specialist

Analysis method(s)	Region	Population
Member to Provider Comparision	Rural	Adult and Pediatric

Plan deficiencies for UnitedHealthcare Community Plan: 42 C.F.R. § 438.68

Description

The 85 % drive-time threshold for 60 minutes driving time to an appointment in rural areas was unmet for Otolaryngologists for all four quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

UHC targets these deficiencies through focused provider recruitment based on network reviews, service coordination insights, and member needs. Short-term strategies to ensure access include coordinating transportation, using provisional credentialing, and establishing single case agreements with out-of-network providers. Additional efforts include expanding telehealth access, partnering with Oʻahu-based providers to serve neighbor islands (via travel or virtual care), and identifying non-contracted providers for potential onboarding. Ongoing monitoring, cross-department collaboration, and data analysis support both immediate access solutions and long-term network development.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

30 Maximum time to travel

30 minutes driving time

Provider type(s)

LTSS; Adult Day Care/Adult Day Health

Analysis method(s)	Region	Population
Member to Provider Comparision	Urban	MLTSS

Plan deficiencies for UnitedHealthcare Community Plan: 42 C.F.R. § 438.68

Description

The 95 % threshold for 30 minutes drive time to travel for Adult Day Care/Adult Day Health in an urban setting was unmet for Quarter 4.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

UHC targets these deficiencies through focused provider recruitment based on network reviews, service coordination insights, and member needs. Short-term strategies to ensure access include coordinating transportation, using provisional credentialing, and establishing single case agreements with out-of-network providers. Additional efforts include expanding telehealth access, partnering with Oʻahu-based providers to serve neighbor islands (via travel or virtual care), and identifying non-contracted providers for potential onboarding. Ongoing monitoring, cross-department collaboration, and data analysis support both immediate access solutions and long-term network development.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

31 Maximum time to travel

60 minutes driving time

Provider type(s)

LTSS; Adult Day Care/Adult Day Health

Analysis method(s)	Region	Population
Member to Provider Comparision	Rural	MLTSS

Plan deficiencies for UnitedHealthcare Community Plan: 42 C.F.R. § 438.68

Description

The 95 % threshold for 60 minutes drive time to travel for Adult Day Care/Adult Day Health in a rural setting was unmet for all four quarters.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

UHC targets these deficiencies through focused provider recruitment based on network reviews, service coordination insights, and member needs. Short-term strategies to ensure access include coordinating transportation, using provisional credentialing, and establishing single case agreements with out-of-network providers. Additional efforts include expanding telehealth access, partnering with Oʻahu-based providers to serve neighbor islands (via travel or virtual care), and identifying non-contracted providers for potential onboarding. Ongoing monitoring, cross-department collaboration, and data analysis support both immediate access solutions and long-term network development.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

39 Maximum time to travel

60 minutes driving time

Provider type(s)

LTSS

Analysis method(s)	Region	Population
Member to Provider Comparision	Rural	MLTSS

Plan deficiencies for UnitedHealthcare Community Plan: 42 C.F.R. § 438.68

Description

The 95 % threshold for 60 minutes drive time to travel for respite care facilities in a rural setting was unmet for quarters 1, 3 and 4.

Analyses used to identify deficiencies

Member to Provider Comparision

What the plan will do to achieve compliance

UHC targets these deficiencies through focused provider recruitment based on network reviews, service coordination insights, and member needs. Short-term strategies to ensure access include coordinating transportation, using provisional credentialing, and establishing single case agreements with out-of-network providers. Additional efforts include expanding telehealth access, partnering with Oʻahu-based providers to serve neighbor islands (via travel or virtual care), and identifying non-contracted providers for potential onboarding. Ongoing monitoring, cross-department collaboration, and data analysis support both immediate access solutions and long-term network development.

Monitoring progress

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may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

43 Appointment wait time

Urgent care and PCP sick visits within 24 hours

Provider type(s)

Primary care; Pediatric Primary Care

Analysis method(s)	Region	Population
Secret Shopper: Appointment Availability	Statewide	Pediatric

Plan deficiencies for UnitedHealthcare Community Plan: 42 C.F.R. § 438.68

Description

The vendor that assessed the Secret Shopper metrics went out of business on October 2024; thus, the Secret Shopper Metrics for the entirety of CY 2025 was unable to be evaluated. The State procured a new Secret Shopper contract in July 2025 and is testing protocols with the new vendor with calls expected to resume in January 2026.

Analyses used to identify deficiencies

Secret Shopper: Appointment Availability

Frequency of compliance findings (optional): Report results by quarter:

Q1 (optional): NR

Q2 (optional): NR

Q3 (optional): NR

Q4 (optional): NR

What the plan will do to achieve compliance

The Timely Access Report is a relatively new report, and assessments of actual appointment availability have been hampered by two factors: inaccuracies in the Provider information furnished by the Health Plans and issues with Secret Shopper callers not having a Medicaid ID number which severely limits their ability to get an appointment. MQD is working with Health Plans to improve the provider data quality so that the telephones in the sampling frame are active and accurate. Moreover, MQD worked with the contractor to construct different shopper scripts to identify the callers as brand-new members who would not yet have a Medicaid ID number.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

44 Appointment wait time

PCP sick visit within 72 hours

Provider type(s)

Primary care; Adult Primary Care

Analysis method(s)	Region	Population
	Statewide	Adult

Secret Shopper: Appointment Availability

Plan deficiencies for UnitedHealthcare Community Plan: 42 C.F.R. § 438.68

Description

The vendor that assessed the Secret Shopper metrics went out of business on October 2024; thus, the Secret Shopper Metrics for the entirety of CY 2025 was unable to be evaluated. The State procured a new Secret Shopper contract in July 2025 and is testing protocols with the new vendor with calls expected to resume in January 2026.

Analyses used to identify deficiencies

Secret Shopper: Appointment Availability

Frequency of compliance findings (optional): Report results by quarter:

Q1 (optional): NR

Q2 (optional): NR

Q3 (optional): NR

Q4 (optional): NR

What the plan will do to achieve compliance

The Timely Access Report is a relatively new report, and assessments of actual appointment availability have been hampered by two factors: inaccuracies in the Provider information furnished by the Health Plans and issues with Secret Shopper callers not having a Medicaid ID number which severely limits their ability to get an appointment. MQD is working with Health Plans to improve the provider data quality so that the telephones in the sampling frame are active and accurate. Moreover, MQD worked with the contractor to construct different shopper scripts to identify the callers as brand-new members who would not yet have a Medicaid ID number.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for

considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

45 Appointment wait time

Behavioral health routine visit within 21 days

Provider type(s)

Mental health; Behavioral Health Provider

Analysis method(s)	Region	Population
Secret Shopper: Appointment Availability	Statewide	Adult and Pediatric

Plan deficiencies for UnitedHealthcare Community Plan: 42 C.F.R. § 438.68

Description

The vendor that assessed the Secret Shopper metrics went out of business on October 2024; thus, the Secret Shopper Metrics for the entirety of CY 2025 was unable to be evaluated. The State procured a new Secret Shopper contract in July 2025 and is testing protocols with the new vendor with calls expected to resume in January 2026.

Analyses used to identify deficiencies

Secret Shopper: Appointment Availability

Frequency of compliance findings (optional): Report results by quarter:

Q1 (optional): NR

Q2 (optional): NR

Q3 (optional): NR

Q4 (optional): NR

What the plan will do to achieve compliance

The Timely Access Report is a relatively new report, and assessments of actual appointment availability have been hampered by two factors: inaccuracies in the Provider information furnished by the Health Plans and issues with Secret Shopper callers not having a Medicaid ID number which severely limits their ability to get an

appointment. MQD is working with Health Plans to improve the provider data quality so that the telephones in the sampling frame are active and accurate. Moreover, MQD worked with the contractor to construct different shopper scripts to identify the callers as brand-new members who would not yet have a Medicaid ID number.

Monitoring progress

MQD continuously monitors contractor performance through quarterly reporting to track progress and ensure compliance with network adequacy standards. Despite these efforts, the State recognizes that deficiencies persist in health plan networks based on the most recent review. When a plan does not meet requirements for a specific specialty, MQD applies a structured corrective action process under its Managed Care Oversight framework. PNP (Preliminary Non-Performance Notice): Initial notification of performance or data concerns. NOC (Notice of Concern): Formal notice that may follow a PNP or be issued independently. Hard CAP (Written Deficiency Notice): Final step prior to penalties, which may include administrative or financial actions. Before initiating formal corrective measures, MQD may collaborate with health plans by offering clarification, guidance, and technical assistance. This allows plans to address issues that may stem from misunderstandings, early implementation challenges, reporting or data quality concerns, or situations where provider availability is limited. If issues continue after informal support, MQD may issue a PNP as formal written communication identifying specific performance or compliance concerns. This may be followed by a NOC, which documents prior communications and assistance, explains the basis for considering corrective action, and establishes clear timelines and expectations for the plan's response and remediation. If the health plan does not adequately address the issues outlined in the NOC, MQD may escalate to a Hard CAP. This step reinforces accountability and establishes a formal, contract-based pathway for performance improvement. Should deficiencies persist, MQD may pursue additional remedies in accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

46 Appointment wait time

PCP routine visit within 21 days

Provider type(s)

Primary care

Analysis method(s)	Region	Population
Secret Shopper: Appointment Availability	Statewide	Adult and Pediatric

Plan deficiencies for UnitedHealthcare Community Plan: 42 C.F.R. § 438.68

Description

The vendor that assessed the Secret Shopper metrics went out of business on October 2024; thus, the Secret Shopper Metrics for the entirety of CY 2025 was unable to be evaluated. The State procured a new Secret Shopper contract in July 2025 and is testing protocols with the new vendor with calls expected to resume in January 2026.

Analyses used to identify deficiencies

Secret Shopper: Appointment Availability

Frequency of compliance findings (optional): Report results by quarter:

Q1 (optional): NR

Q2 (optional): NR

Q3 (optional): NR

Q4 (optional): NR

What the plan will do to achieve compliance

The Timely Access Report is a relatively new report, and assessments of actual appointment availability have been hampered by two factors: inaccuracies in the Provider information furnished by the Health Plans and issues with Secret Shopper callers not having a Medicaid ID number which severely limits their ability to get an appointment. MQD is working with Health Plans to improve the provider data quality so that the telephones in the sampling frame are active and accurate. Moreover, MQD worked with the contractor to construct different shopper scripts to identify the callers as brand-new members who would not yet have a Medicaid ID number.

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accordance with managed care contract requirements to maintain program integrity and accountability.

Reassessment date

01/31/2026

47 Appointment wait time

Specialist or non-emergency hospital stays within 4 weeks

Provider type(s)

Specialist; Specialist /Non -emergency

Analysis method(s)	Region	Population
Secret Shopper: Appointment Availability	Statewide	Adult and Pediatric

Plan deficiencies for UnitedHealthcare Community Plan: 42 C.F.R. § 438.68

Description

The vendor that assessed the Secret Shopper metrics went out of business on October 2024; thus, the Secret Shopper Metrics for the entirety of CY 2025 was unable to be evaluated. The State procured a new Secret Shopper contract in July 2025 and is testing protocols with the new vendor with calls expected to resume in January 2026.

Analyses used to identify deficiencies

Secret Shopper: Appointment Availability

Frequency of compliance findings (optional): Report results by quarter:

Q1 (optional): NR

Q2 (optional): NR

Q3 (optional): NR

Q4 (optional): NR

What the plan will do to achieve compliance

The Timely Access Report is a relatively new report, and assessments of actual appointment availability have been hampered by two factors: inaccuracies in the Provider information furnished by the Health Plans and issues with Secret Shopper callers not having a Medicaid ID number which severely limits their ability to get an appointment. MQD is working with Health Plans to improve the provider data quality so that the telephones in the sampling frame are active and accurate. Moreover, MQD worked with the contractor to construct different shopper scripts to identify the callers as brand-new members who would not yet have a Medicaid ID number.

Monitoring progress

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Reassessment date

01/31/2026

Exceptions standards for 438.68

Total: 0 of 53

B. Assurance of plan compliance for 438.206

	Indicator	Response
	B. Assurance of plan compliance for 438.206 III.B.1 Indicate whether the state assures that the plan complies with the availability of services standards outlined in 42 C.F.R. § 438.206 the analyses the state conducted for the plan during the reporting period.	Yes, the plan complies on all standards based on all analyses