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Federally Qualified Health Centers
Rural Health Clinics

2027 Program
(Effective January 1, 2027)

Pay for Quality

P R O G R A M G U I D E



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Introduction

Thank you for your hard work and dedication to providing care to our members. Your clinical and engagement efforts are appreciated and continue to improve the health and well-being of the communities you serve.

In 2027, HMSA will launch a quality program that aligns our clinical quality metrics with the priorities identified by the state, employer groups, and other stakeholders. This program will be available to all eligible primary care providers. As a result, the FQHC/RHC Pay-for-Quality Program no longer includes quality incentive measures, and HMSA will no longer attribute members to PCPs under the FQHC/RHC Pay-for-Quality Program.

To continue working collaboratively with FQHCs/RHCs on the services and support they provide to their patients and communities, this program guide updates the engagement components to reflect HMSA's new clinical measure targets for the Race, Ethnicity, and Language (REL) measure.

Summary of Material Changes for 2027 Program (Released November 2026)

Program Summary and Payment Details

- Updated engagement measures and payment milestones and removed quality measures.
- Updated the payment timeline to include two payment milestones

Engagement Measures

- Updated the SDOH Initiative: Race, Ethnicity, and Language Engagement Measure to require FQHCs/RHCs to target one of three utilization measures for intervention planning and implementation.

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Program Eligibility

FQHCs and RHCs must participate with HMSA under an FQHC/RHC medical group agreement, and a letter of agreement for the Pay-for-Quality Program must be in effect at the end of the measurement period.

FQHCs and RHCs must be participating with HMSA plans as follows:

COMMERCIAL

1. Participation in HMSA's PPO and/or HMO plans at the end of the measurement period.

QUEST

1. Participation in HMSA QUEST at the end of the measurement period.

MEDICARE ADVANTAGE

1. Participation in HMSA's Medicare Advantage plan at the end of the measurement period.

FQHCs and RHCs must practice in the state of Hawaii at the end of the measurement period.

Eligibility Conditions

FQHCs and RHCs must agree to:

- Participate fully in the Pay-for-Quality Program and the engagement activities necessary to evaluate their performance and improvement.
- Accept HMSA's determination of the pay-for-quality score and understand that the score will serve as the basis for any pay-for-quality award from HMSA. FQHCs and RHCs may request reconsideration of their score and/or award but must follow established procedures for reconsideration (see Inquiries and Requests for Reconsideration section on page 8).
- FQHCs/RHCs must maintain, at their sole cost and expense, adequate records related to their obligations under the Pay-for-Quality Program. The Department of Health and Human Services, the comptroller general, and/or their designees have the right of access and entry to this information and to FQHCs'/RHCs' facilities, including computer and other electronic systems, that pertain to any aspect of FQHC/RHCs' performance that results in payments from HMSA for the purposes of audit, evaluation, and/or inspection.[1]

Note: Exceptions to eligibility criteria may be made at HMSA's sole discretion.

[1] Required by regulations promulgated under the Affordable Care Act, 45 C.F.R. § 158.501.

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Patient Attribution to PCPs

Effective September 1, 2026, HMSA will use a claims-based attribution methodology to determine attribution of members with a HMSA Commercial PPO, HMO, QUEST or Medicare Advantage plan.

1. Each month, a member will be attributed to a PCP using a rolling 18-month claims look back for eligible PCP specialties. Eligible claims will be counted at the provider group level, while attribution will be assigned to an individual provider within the group. See the Provider Resource Center for a list of CPT codes that are used in calculating attribution. Services performed in urgent care settings are excluded in the attribution calculation.
2. The member will be attributed to the provider group who was most frequently seen or, in cases of a tie, most recently seen.
3. The member will then be attributed to the provider within the group who was most frequently seen or, in the case of a tie, most recently seen.

For new HMSA members, including newborns, new members will be attributed to a PCP after a claim is submitted for services rendered to the new member. Selection of a PCP by a member, or assignment of a PCP to a member by HMSA, is not an element in determining attribution under the claims-attribution approach. Members with more than one HMSA plan will be attributed to only one provider.

PCPs must be participating in the line of business associated with the member's plan. Members of BlueCard Programs and FEP members will not be counted towards a PCP's attribution.

Example:
Attribution Month: September 2026
Claims lookback based on date of service: April 1, 2025 – Sept. 30, 2026
Attribution for September 2026 will be reflected in patient attribution reports in October.

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Patient Population and Member Eligibility

Patient Population Identification

COMMERCIAL

Members enrolled in HMSA's commercial plans (PPO and HMO) are eligible for the program.

BlueCard members and Federal Employee Program (FEP) members will not be included in the program due to data limitations.

If a member is enrolled in a HMSA Commercial plan and another plan, the member will only be counted for one of the performance measure sets as follows:

- If a HMSA commercial member also has coverage under a QUEST plan, the member will be counted for the QUEST plan performance measure set.
- If a HMSA commercial member also has coverage under a Medicare Advantage plan, the member will be counted for the Medicare Advantage plan performance measure set.

QUEST

Members enrolled in HMSA's QUEST plan (including ABD members) are eligible for the program.

If a member is enrolled in a HMSA QUEST plan and another plan, the member will only be counted for only one of the performance measure sets as follows:

- If a HMSA QUEST member also has coverage under a HMSA Commercial plan, the member will be counted for the QUEST plan performance measure set.
- If a HMSA QUEST member also has coverage under a Medicare Advantage plan, the member will be counted for the Medicare Advantage plan performance measure set.

MEDICARE ADVANTAGE

Members enrolled in HMSA's Medicare Advantage plans are eligible for the program.

If a member is enrolled in a HMSA Medicare Advantage plan and another plan, the member will be counted for only one of the performance measure sets as follows:

- If a HMSA Medicare Advantage member also has coverage under a HMSA Commercial plan, the member will be counted for the Medicare Advantage plan performance measure set.
- If a HMSA Medicare Advantage member also has coverage under QUEST, the member will be counted for the Medicare Advantage plan performance measure set.

Program Summary

Engagement Measures

The 2027 program consists of two engagement measures:

- Annual FQHC/RHC Provider Survey
- Social Determinants of Health (SDOH) Initiatives - Race, Ethnicity, and Language (REL)

Key Dates and Deliverables

Engagement Measures

SDOH Initiatives – Race, Ethnicity, and Language (REL)
(Please see pages 9-12 for additional details of milestone requirements.)

DEADLINE	MILESTONE
June 30, 2027	**Milestone 1:** Select one of the utilization focus measures (Acute Hospital Utilization, Emergency Department Utilization, or Plan All-Cause Readmission) and establish an intervention strategy for the SDOH REL initiative. Include any active implementation of the intervention strategy in the narrative.
Dec. 31, 2027	**Milestone 2:** Describe the active implementation and impact of the intervention strategy. Evaluate results and identify barriers, successes, and lessons learned to improve implementation in 2028.

Annual FQHC/RHC Provider Survey

DEADLINE	MILESTONE
Sept. 30, 2027	Complete provider survey

Notes:

- If an FQHC/RHC is unable to meet a milestone submission deadline, contact the HMSA Quality Team or its HMSA Provider Engagement Lead to request an extension or exception.
- SDOH Initiative REL milestone submissions must be submitted in the order in which they are due. For example, Milestone 1 must be submitted before Milestone 2. If HMSA doesn't receive a submission for Milestone 1 by the due date, HMSA may evaluate the circumstances on a case-by-case basis to determine whether to accept a late submission.

Payment Details

Engagement measure milestones are due according to the schedule below and will be paid in the indicated payment month once HMSA receives the required milestones by the deadline and reviews them for completeness.

A FQHC/RHC may earn $10.00 PMPY (per member, per year) based on the FQHC/RHC's attribution for December 2026, up to a maximum payment of $50,000. This engagement payment will be paid as two equal installments in the payment months indicated below.

If a FQHC/RHC hasn't sufficiently satisfied the requirements of the engagement measures, HMSA reserves the right to not disburse payment and/or recoup payments made.

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Program Summary

PAYMENT MONTH	MILESTONE	DUE DATE
July 2027	Milestone 1	June 30, 2027
January 2028	• Annual FQHC/RHC Provider Survey • Milestone 2	• Sept. 30, 2027 (Survey) • Dec. 31, 2027 (Milestone 2)

If an FQHC or RHC is eligible to receive an award, HMSA will send the award check and remittance report to the payee(s) who the group administration designated for HMSA claims payments as of the end of the measurement period.

If an FQHC or RHC ends its participation in the FQHC/RHC Pay-for-Quality Program or fails to meet the eligibility requirements, the FQHC or RHC forgoes any FQHC/RHC engagement payment earned and won't receive payment for the measurement period. HMSA reserves the right to recoup payments issued if a FQHC/RHC does not satisfy the requirements of the engagement measures.

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Inquiries and Requests for Reconsideration

Inquiries

An inquiry is defined as a request for additional information about the FQHC/RHC Pay-for-Quality Program. General inquiries about the program (not specific to scores or results) will be answered at any time throughout the year.

Send inquiries by:

- Letter. Mail to:
  HMSA
  Attn: Quality Management – 6-QM
  P.O. Box 860
  Honolulu, HI 96808-0860
- Secure email. Send to:
  - PSInquiries@hmsa.com
  - Quality-FQHC@hmsa.com

Requests for Reconsideration

Reconsideration is defined as a request for HMSA to change a determination and/or a payment.

Requests for reconsideration will be accepted only in writing within 30 business days after HMSA issues the 2027 engagement payments. Requests for reconsideration must include sufficient information and supporting data for HMSA to evaluate the request.

If a request is approved, the FQHC/RHC's payment will be adjusted accordingly.

Request for Reconsideration Process

1. Submit the necessary documents and information to HMSA.

   Secure email: Send to Quality-FQHC@hmsa.com

   Mail:
   HMSA
   Attn: Quality Management – 6-QM
   P.O. Box 860
   Honolulu, HI 96808-0860

2. HMSA will review and respond to your request within 60 business days of the date HMSA receives it.

3. If you're dissatisfied with HMSA's response to your request for reconsideration, additional dispute resolution remedies are available to you under your HMSA participating provider agreement.

Engagement Measures

Annual FQHC/RHC Provider Survey

Description

HMSA values learning from the provider experience. Since 2020, HMSA has administered surveys to PCPs and clinics that participate in the FQHC/RHC Pay-for-Quality Program. The survey helps evaluate the program, quality improvement efforts, and provider satisfaction.

Requirements

The survey will be available in early September 2027. Clinic administrators and PCPs must complete the survey by Sept. 30, 2027.

Social Determinants of Health (SDOH) Initiatives – Race, Ethnicity, Language (REL)

Description

Comprehensive patient data on race, ethnicity, and language (REL) help identify disparities in quality of care and help target quality improvement interventions that support health equity. This engagement measure asks you to consider the population you serve and use disaggregated REL data to develop, report on, and evaluate a health disparity initiative.

To receive full credit for this measure and be eligible for engagement payments, each FQHC/RHC must submit the information outlined for each milestone to HMSA by the indicated deadlines.

Please submit the information in a Microsoft Word document (or other similar format) by email to Quality-FQHC@hmsa.com

Requirements

MILESTONE 1 (Due June 30, 2027)

Utilization Measure

Select one of the following utilization measures to target:

1. Acute Hospital Utilization (AHU)
2. Emergency Department Utilization (EDU)
3. Plan All-Cause Readmission (PCR)

Initial Report (PLAN) – Establish intervention strategy

- Review the measure description for the selected utilization measure for MY2027 (AHU, EDU, or PCR).
- Review historical/baseline performance data and the current patient registry and identify a population to target based on REL stratification.
- Conduct a population analysis and identify contributing factors.
- Describe the planned REL-focused intervention for the selected utilization measure:
    - Define clear objective(s) for the intervention.
    - Identify the timeline for implementation and the steps needed to accomplish the year's objective.
    - Discuss any predicted outcomes.

(Milestone 1 requirements continued on next page)

Engagement Measures

Milestone 1 requirements (continued):

Progress Update (DO/STUDY) – Discuss any active implementation (if applicable)

- If the clinic can begin implementation before June 30, discuss any progress on active implementation of the REL-focused initiative and its impact on the selected utilization measure.
- Describe activities completed, including community partnerships or outreach efforts, if applicable.
- Identify barriers encountered, adjustments or modifications needed to the strategy, and next steps.

MILESTONE 2 (Due Dec. 31, 2027)

Progress Update (DO/STUDY) – Discuss implementation

- Discuss implementation of the REL-focused initiative and its impact on the selected utilization measure.
- Describe activities completed, including community partnerships or outreach efforts, if applicable.
- Identify barriers encountered, adjustments or modifications needed to the strategy, and next steps.

Final Report (ACT) – Evaluate results

- Provide the final reported measure data and compare to the baseline.
- Discuss the impact on the targeted REL population.
- Identify lessons learned and recommendations for future improvement.

Utilization Measure Specifications

Acute Hospital Utilization (AHU)

Measure Description: For patients 18 years of age and older, the risk-adjusted ratio of observed-to-expected acute inpatient and observation stay discharges during the measurement period (Jan. 1 – Dec. 31).

Calculation of denominator:

1. Identify all acute and nonacute inpatient stays and observation stays:
    a. Exclude non-acute inpatient stays.
    b. Identify the discharge date for the stay.

2. For discharges with one or more direct transfers, use the last discharge.

3. For the remaining acute inpatient and observation stay discharges, exclude inpatient and observation stay discharges for the following criteria:
    a. A principal diagnosis of mental health or substance use disorder on the discharge claim.
    b. A principal diagnosis of live-born infant or maternity-related principal diagnosis on the discharge claim.
    c. A maternity-related stay on the discharge claim.
    d. A planned hospital stay using any of the following on the discharge claim:
        i. A principal diagnosis of maintenance chemotherapy.
        ii. A principal diagnosis of rehabilitation.
        iii. An organ transplant.
        iv. A potentially planned procedure without a principal acute diagnosis.

Engagement Measures

4. Remove discharges for outliers and report these persons as outliers:
    a. Medicare enrollees with four or more inpatient or observation stay discharges.
    b. Medicaid enrollees with six or more inpatient or observation stay discharges during the measurement period.
    c. Commercial enrollees with three or more inpatient or observation stay discharges during the measurement period.

5. Calculate the total using all discharges identified after completing steps 1-4.

Emergency Department Utilization (EDU)

Measure Description: For patients 18 years of age or older, the risk-adjusted ratio of observed-to-expected emergency department (ED) visits during the measurement period.

Calculation of observed events:

1. Count each visit to an ED once, regardless of the intensity or duration of the visit. Count multiple ED visits on the same date of service as one visit. Identify all ED visits during the measurement period using either of the following:
    a. An ED Visit.
    b. A procedure code with an ED place of service code.

    *Do not include ED visits that result in an inpatient stay or an observation stay.

2. Exclude encounters with any of the following:
    a. A principal diagnosis of mental health or substance use disorder.
    b. Psychiatry.
    c. Electroconvulsive therapy.

3. For the remaining ED visits, calculate the number of visits per person and remove visits for outlier persons:
    a. Medicare enrollees 18-64 years of age with six or more ED visits in the measurement period.
    b. Medicare enrollees 65 years of age and older with four or more ED visits in the measurement period.
    c. Commercial enrollees 18 years of age and older with four or more ED visits in the measurement period.
    d. Medicaid enrollees 18-64 years of age with nine or more ED visits in the measurement period.

4. Calculate the total using all ED visits identified after completing steps 1-3.

Plan All-Cause Readmissions (PCR)

Measure Description: For patients 18 years of age and older, the risk-adjusted ratio of observed-to-expected unplanned acute readmissions (inpatient and observation stays) for any diagnosis within 30 days of an acute hospitalization (inpatient and observation stays).

Calculation of denominator:

1. Identify all acute inpatient and observation stay discharges on or between Jan. 1 and Dec. 1 of the measurement period. To identify acute inpatient and observation stay discharges:
    a. Identify all acute and nonacute inpatient stays and observation stays.
    b. Exclude nonacute inpatient stays.
    c. Identify the discharge date for the stay.

    * Inpatient and observation stays where the discharge date from the first setting and the admission date to the second setting are two or more calendar days apart must be considered distinct stays.

Engagement Measures

2. For discharges with one or more direct transfers, use the last discharge.

3. Exclude hospital stays where the index admission date is the same as the index discharge date.

4. Exclude hospital stays for any of the following reasons:
    a. The person died during the stay
    b. A principal diagnosis of pregnancy or a condition originating in the perinatal period on the discharge claim
    c. Remove hospital stays for outliers:
        i. Enrollees in Medicaid and Medicare in the initial population with four or more index hospital stays between Jan. 1 and December of the measurement period.
        ii. Commercial enrollees in the initial population with three or more index hospital stays between Jan. 1 and Dec. 1 of the measurement period.

Calculation of numerator:

1. Identify all acute inpatient and observation stays with an admission date on or between January 3 and December 31 of the measurement period.
    a. Identify all acute and nonacute inpatient stays and observation stays
    b. Exclude nonacute inpatient stays
    c. Identify the admission date for the stay

2. Using the stays identified in #1, identify direct transfers between acute inpatient and observation using the following definitions:
    a. When a discharge date from the initial stay precedes the admission date to a subsequent stay by 1 calendar day or less;
    b. Direct transfers may occur between different facilities between acute inpatient and observation, observation and acute inpatient, or observation and observation.

3. Exclude stays with any of the following criteria on the discharge claim:
    a. A principal diagnosis of pregnancy or a condition originating in the perinatal period
    b. A planned stay using any of the following:
        i. A principal diagnosis of maintenance chemotherapy
        ii. A principal diagnosis of rehabilitation
        iii. An organ transplant
        iv. A potentially planned procedure without a principal acute diagnosis

4. For each index hospital stay identified in the denominator, determine if any of the stays identified in the numerator have an admission date within 30 days after the index discharge date.

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