

Managed Care Program Annual Report (MCPAR) for Hawaii: 2024_Community Care Services (CCS) Program

Due date	Last edited	Edited by	Status
12/27/2025	12/05/2025	Megan Hironaka	Submitted

Indicator	Response
Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Not Selected
Did you submit or do you plan on submitting a Network Adequacy and Access Assurances (NAAAR) Report for this program for this reporting period through the MDCT online tool? If "No", please complete the following questions under	Plan to submit on 12/01/2025

Indicator	Response
each plan.	

Section A: Program Information

Point of Contact

Number	Indicator	Response
A1	State name Auto-populated from your account profile.	Hawaii
A2a	Contact name First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Jon D. Fujii - Health Care Services Branch Administrator
A2b	Contact email address Enter email address. Department or program-wide email addresses ok.	mqdcpcs@dhs.hawaii.gov
A3a	Submitter name CMS receives this data upon submission of this MCPAR report.	Megan Hironaka
A3b	Submitter email address CMS receives this data upon submission of this MCPAR report.	mhironaka@dhs.hawaii.gov
A4	Date of report submission CMS receives this date upon submission of this MCPAR report.	12/05/2025

Reporting Period

Number	Indicator	Response
A5a	Reporting period start date Auto-populated from report dashboard.	07/01/2024
A5b	Reporting period end date Auto-populated from report dashboard.	06/30/2025
A6	Program name Auto-populated from report dashboard.	2024_Community Care Services (CCS) Program

Add plans (A.7)

Enter the name of each plan that participates in the program for which the state is reporting data.

Indicator	Response
Plan name	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.

Add BSS entities (A.8)

Enter the names of Beneficiary Support System (BSS) entities that support enrollees in the program for which the state is reporting data. Learn more about BSS entities at 42 CFR 438.71. See Glossary in Excel Workbook for the definition of BSS entities.

Examples of BSS entity types include a: State or Local Government Entity, Ombudsman Program, State Health Insurance Program (SHIP), Aging and Disability Resource Network (ADRN), Center for Independent Living (CIL), Legal Assistance Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.

Indicator	Response
BSS entity name	Hamakua Health Center
	Hana Health
	Hawaii Health Systems Corporation
	Queen's Health Systems
	Maui Health Systems
	Kumukahi Health + Wellness
	Malama Pono
	Hawaii Health and Harm Reduction
	Kalanihale
	Hawaii Island Community Health Center
	Hoola Lahui Hawaii
	Kalihi Palama Health Center
	Kokua Kalihi Valley
	Koolauloa Community Health Center
	Lanai Community Health Center
	Legal Aid Society of Hawaii
	Molokai Community Health Center
	We Are Oceania
	Project Vision Hawaii
	IMUA Family Services
	Hui O Hauula
	Executive Office on Aging
	Hawaii Public Health Institute
	Institute of Human Services
	Malama I Ke Ola
	One Stop for Micronesians on Hawaii Island
	Vibrant Hawaii

Add In Lieu of Services and Settings (A.9)

 **Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.**

This section must be completed if any ILOSs *other than short term stays in an Institution for Mental Diseases (IMD)* are authorized for this managed care program. **Enter the name of each ILOS offered as it is identified in the managed care plan contract(s).** [Guidance on In Lieu of Services on Medicaid.gov.](#)

Indicator	Response
ILOS name	Not answered

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	Statewide Medicaid enrollment Enter the average number of individuals enrolled in Medicaid per month during the reporting year (i.e., average member months). Include all FFS and managed care enrollees and count each person only once, regardless of the delivery system(s) in which they are enrolled.	6,258
BI.2	Statewide Medicaid managed care enrollment Enter the average number of individuals enrolled in any type of Medicaid managed care per month during the reporting year (i.e., average member months). Include all managed care programs and count each person only once, even if they are enrolled in multiple managed care programs or plans.	6,258

Topic III. Encounter Data Report

Number	Indicator	Response
BIII.1	Data validation entity Select the state agency/division or contractor tasked with evaluating the validity of encounter data submitted by MCPs. Encounter data validation includes verifying the accuracy, completeness, timeliness, and/or consistency of encounter data records submitted to the state by Medicaid managed care plans. Validation steps may include pre-acceptance edits and post-acceptance analyses. See Glossary in Excel Workbook for more information.	State Medicaid agency staff

Topic X: Program Integrity

Number	Indicator	Response
BX.1	Payment risks between the state and plans Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities. If no PI activities were performed, enter "No PI activities were performed during the reporting period" as your response. "N/A" is not an acceptable response.	Three (3) provider audits for review of opioid prescribing, and one (1) audit for review of patients in hospice for extended periods of time.
BX.2	Contract standard for overpayments Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State has established a hybrid system
BX.3	Location of contract provision stating overpayment standard Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	Section 12.1 D and 6.8.2
BX.4	Description of overpayment contract standard Briefly describe the overpayment standard selected in indicator B.X.2.	"The BHO is required to recover and report all overpayments. "Overpayment" as used in this Section is defined in 42 CFR § 438.2. Per 42 CFR § 438.608, the BHO is responsible for the prompt reporting of overpayments identified or recovered, specifying the overpayments due to potential fraud, and reporting on all its recoveries of overpayments to DHS. b. The overpayment shall be reported in the reporting period in which the overpayment is identified. In addition, once recovery of overpayments is completed, the BHO shall replace the encounter data to reflect the correct payment

amounts. It is understood the BHO may not be able to complete recovery of overpayment until after the reporting period. However, the BHO shall properly account for any outstanding recovering in future reports, so that all overpayment activities are fully disclosed to DHS and addressed in the encounter data submitted by the BHO. c. The BHO shall report to DHS the full overpayment identified. The BHO may negotiate and retain a lesser repayment amount with the provider, however, the full overpayment amount shall be used: 1) By the BHO, when submitting replacement encounter data; and 2) By DHS, when setting capitation rates for the BHO."

BX.5

State overpayment reporting monitoring

Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting?

The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment topics (whether annually or promptly). This indicator is asking the state how it monitors that reporting.

Overpayments are reported quarterly, and overpayments must be reported in the reporting period in which they are discovered.

BX.6

Changes in beneficiary circumstances

Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).

MQD communicates these changes via the 834 daily file to the health plan. The KOLEA eligibility system sends the file daily to HPMMIS. These files are processed nightly in HPMMIS. Subsequently, HPMMIS runs the daily enrollment batch jobs, which produces the data for the daily 834 files. To reconcile, MQD also sends a monthly 834 file to each health plan. This file contains the entire current client data for the following month.

BX.7a

Changes in provider circumstances: Monitoring plans

Does the state monitor whether plans report provider "for cause" terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.

Yes

BX.7b	Changes in provider circumstances: Metrics Does the state use a metric or indicator to assess plan reporting performance? Select one.	Yes
BX.7c	Changes in provider circumstances: Describe metric Describe the metric or indicator that the state uses.	Health plan must notify DHS within 3 days of any termination for cause involving FWA
BX.8a	Federal database checks: Excluded person or entities During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	No
BX.9a	Website posting of 5 percent or more ownership control Does the state post on its website the names of individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to 42 CFR 438.602(g)(3) and 455.104.	Yes
BX.9b	Website posting of 5 percent or more ownership control: Link What is the link to the website? Refer to 42 CFR 602(g)(3).	https://medquest.hawaii.gov/
BX.10	Periodic audits If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness	https://medquest.hawaii.gov/content/dam/for_msanddocuments/resources/consumer-guides/HI2023-24_EQR_TechRpt_F1.pdf

of the encounter and financial data submitted by the plans, provide the link(s) to the audit results. Refer to 42 CFR 438.602(e). If no audits were conducted, please enter “No such audits were conducted during the reporting year” as your response. “N/A” is not an acceptable response.

Topic XIII. Prior Authorization



Beginning June 2026, Indicators B.XIII.1a-b-2a-b must be completed. Submission of this data before June 2026 is optional.

Number	Indicator	Response
N/A	Are you reporting data prior to June 2026?	Not reporting data

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C11.1	Program contract Enter the title of the contract between the state and plans participating in the managed care program.	Community Care Services Program (CCS) That Provides Behavioral Health Services to Medicaid Eligible Adults Who Have a Serious Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI)
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	06/09/2021
C11.2	Contract URL Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://medquest.hawaii.gov/en/resources/solicitations-contract.html
C11.3	Program type What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)
C11.4a	Special program benefits Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-service should not be listed here.	None of the above – Behavioral Health services for SMI and SPMI population
C11.4b	Variation in special benefits What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter “N/A” if not applicable.	N/A
C11.5	Program enrollment Enter the average number of individuals enrolled in this managed care program per	6,258

month during the reporting year (i.e., average member months).

C11.6

Changes to enrollment or benefits

There are no major changes to the population or benefits during the reporting year.

Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year. If there were no major changes, please enter "There were no major changes to the population or benefits during the reporting year" as your response. "N/A" is not an acceptable response.

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	Uses of encounter data For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting
		Monitoring and reporting
		Contract oversight
		Program integrity
		Policy making and decision support
C1III.2	Criteria/measures to evaluate MCP performance What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Timeliness of initial data submissions
		Timeliness of data corrections
		Timeliness of data certifications
		Use of correct file formats
		Provider ID field complete
C1III.3	Encounter data performance criteria contract language Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	Overall data accuracy (as determined through data validation)
C1III.3	Encounter data performance criteria contract language Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract section references, not page numbers.	Section 6

C1III.4	Financial penalties contract language Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	Section 14 and Appendix L (encounter data 20-23)
C1III.5	Incentives for encounter data quality Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	N/A
C1III.6	Barriers to collecting/validating encounter data Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting year. If there were no barriers, please enter "The state did not experience any barriers to collecting or validating encounter data during the reporting year" as your response. "N/A" is not an acceptable response.	Staffing and system limitations are continued barriers. The state is actively seeking solutions to increase staffing through contracts; and looking towards how the current or a future encounter data system can be designed to support the submission and validation of high quality encounter data.

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	State’s definition of “critical incident”, as used for reporting purposes in its MLTSS program If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for “critical incidents” within the managed care program? Respond with “N/A” if the managed care program does not cover LTSS.	N/A
C1IV.2	State definition of “timely” resolution for standard appeals Provide the state’s definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	COMMUNITY CARE SERVICES PROGRAM (CCS) THAT PROVIDES BEHAVIORAL HEALTH SERVICES TO MEDICAID ELIGIBLE ADULTS WHO HAVE A SERIOUS MENTAL ILLNESS (SMI) OR SERIOUS AND PERSISTENT MENTAL ILLNESS (SPMI) RFP-MQD-2021-010 § 9.8.G.4: For standard resolution of an appeal, the BHO shall resolve the appeal and provide a written notice of disposition to the parties as expeditiously as the Member’s health condition requires, but no more than thirty (30) calendar days from the day the BHO receives the appeal.
C1IV.3	State definition of “timely” resolution for expedited appeals Provide the state’s definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.	COMMUNITY CARE SERVICES PROGRAM (CCS) THAT PROVIDES BEHAVIORAL HEALTH SERVICES TO MEDICAID ELIGIBLE ADULTS WHO HAVE A SERIOUS MENTAL ILLNESS (SMI) OR SERIOUS AND PERSISTENT MENTAL ILLNESS (SPMI) RFP-MQD-2021-010 § 9.8.H.4: . For expedited resolution of an appeal, the BHO shall resolve the appeal and provide written notice to the affected parties as expeditiously as the Member’s health condition requires, but no more than seventy-two (72) hours from the time the BHO received the expedited appeal request. The BHO shall make reasonable efforts to also provide oral notice to the Member with the appeal determination.
C1IV.4	State definition of “timely” resolution for grievances Provide the state’s definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution	COMMUNITY CARE SERVICES PROGRAM (CCS) THAT PROVIDES BEHAVIORAL HEALTH SERVICES TO MEDICAID ELIGIBLE ADULTS WHO HAVE A SERIOUS MENTAL ILLNESS (SMI) OR SERIOUS AND PERSISTENT MENTAL ILLNESS (SPMI) RFP-MQD-2021-010 § 9.8.E.6.b: Convey a disposition, in writing, of the grievance

of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.

resolution as expeditiously as the Member's health condition requires and within thirty (30) calendar days of the initial expression of dissatisfaction

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Number	Indicator	Response
C1V.1	Gaps/challenges in network adequacy What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting access standards. If the state and MCPs did not encounter any challenges, please enter "No challenges were encountered" as your response. "N/A" is not an acceptable response.	The biggest challenge would be the limited availability of providers in rural areas which is largely due to the State's unique geograpy. However, for the fiscal year ending June 2025, no challenges were encountered by the BHO.
C1V.2	State response to gaps in network adequacy How does the state work with MCPs to address gaps in network adequacy?	Network Adequacy is monitored via quarterly reporting to identify gaps and also areas for improvement. The BHO generally addresses deficiencies by providing members with air and ground transportation in order to receive services. The BHO will also identify non-participating providers that are willing to see their members on a case-by-case basis to initiate single-case or limited-access agreements and also use this opportunity for recruitment. If a gap should appear and recruitment efforts stall, the BHO can consider submitting a waiver request for the specialty type.

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	BSS website List the website(s) and/or email address(es) that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	https://medquest.hawaii.gov/en/resources/community-partners.html
C1IX.2	BSS auxiliary aids and services How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2)? 42 CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	Community Based Organizations (COB) offer in-person assistance, by phone, virtual Microsoft Teams and will utilize translated materials. They offer interpretive services and auxiliary aids when requested. COBs with our eligibility Navigator portal will also assist residents with uploading any documents being requested in order to make determinations, or resolve any eligibility issues
C1IX.3	BSS LTSS program data How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	COBs assist residents in applying for LTSS, along with assisting them to submit their required documents.
C1IX.4	State evaluation of BSS entity performance What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	Med-QUEST Health Care Outreach Branch staff communicate daily with all COBs, answer their questions and guide them in assisting Medicaid members or are seeking to apply for Medicaid.

Topic X: Program Integrity

Number	Indicator	Response
C1X.3	Prohibited affiliation disclosure Did any plans disclose prohibited affiliations? If the state took action, enter those actions under D: Plan-level Indicators, Section VIII - Sanctions (Corresponds with Tab D3 in the Excel Workbook). Refer to 42 CFR 438.610(d).	No

Topic XII. Mental Health and Substance Use Disorder Parity

Number	Indicator	Response
C1XII.4	Does this program include MCOs? If “Yes”, please complete the following questions.	Yes
C1XII.5	Are ANY services provided to MCO enrollees by a PIHP, PAHP, or FFS delivery system? (i.e. some services are delivered via fee for service (FFS), prepaid inpatient health plan (PIHP), or prepaid ambulatory health plan (PAHP) delivery system)	Yes
C1XII.6	Did the State or MCOs complete the most recent parity analysis(es)?	MCO
C1XII.7a	Have there been any events in the reporting period that necessitated an update to the parity analysis(es)? (e.g. changes in benefits, quantitative treatment limits (QTLs), non-quantitative treatment limits (NQTLs), or financial requirements; the addition of a new managed care plan (MCP) providing services to MCO enrollees; and/or deficiencies corrected)	No
C1XII.8	When was the last parity analysis(es) for this program completed? States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state completed its most recent summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date any MCO sent the state its parity analysis (the state may have multiple reports, one for each MCO).	06/02/2025
C1XII.9	When was the last parity analysis(es) for this program	12/18/2018

submitted to CMS?

States with ANY services provided to MCO enrollees by an entity other than an MCO should report the date the state's most recent summary parity analysis report was submitted to CMS. States with NO services provided to MCO enrollees by an entity other than an MCO should report the most recent date the state submitted any MCO's parity report to CMS (the state may have multiple parity reports, one for each MCO).

C1XII.10a	In the last analysis(es) conducted, were any deficiencies identified?	No
C1XII.12a	Has the state posted the current parity analysis(es) covering this program on its website? The current parity analysis/analyses must be posted on the state Medicaid program website. States with ANY services provided to MCO enrollees by an entity other than MCO should have a single state summary parity analysis report. States with NO services provided to MCO enrollees by an entity other than the MCO may have multiple parity reports (by MCO), in which case all MCOs' separate analyses must be posted. A "Yes" response means that the parity analysis for either the state or for ALL MCOs has been posted.	Yes
C1XII.12b	Provide the URL link(s). Response must be a valid hyperlink/URL beginning with "http://" or "https://". Separate links with commas.	https://medquest.hawaii.gov/en/resources/reports.html

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	Plan enrollment Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 6,258
D1I.2	Plan share of Medicaid What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? Numerator: Plan enrollment (D1.I.1)Denominator: Statewide Medicaid enrollment (B.I.1)	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 100%
D1I.3	Plan share of any Medicaid managed care What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care?Numerator: Plan enrollment (D1.I.1)Denominator: Statewide Medicaid managed care enrollment (B.I.2)	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 100%
D1I.4: Parent	Organization: The name of the parent entity that controls the Medicaid Managed Care Plan. If the managed care plan is owned or controlled by a separate entity (parent), report the name of that entity. If the managed care plan is not controlled by a separate entity, please report the managed care plan name in this field.	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. Centene Corporation

Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	Medical Loss Ratio (MLR) What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR. Write MLR as a percentage: for example, write 92% rather than 0.92.	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 92%
D1II.1b	Level of aggregation What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. Program-specific statewide
D1II.2	Population specific MLR description Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable. See glossary for the regulatory definition of MLR.	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. N/A
D1II.3	MLR reporting period discrepancies Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. Yes
N/A	Enter the start date.	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.

N/A

Enter the end date.

**WellCare Health Insurance of Arizona,
Inc, dba 'Ohana Health Plan, Inc.**06/30/2024

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	Definition of timely encounter data submissions Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. Encounter data shall be submitted to DHS, at a minimum, on a monthly basis, and no later than the end of the month following the month when financial liability was processed, paid, denied, voided, or adjusted/corrected. Health Plans shall submit one hundred (100) percent of encounter data within fifteen (15) months from the date of service, including all adjusted and resubmitted encounters.
D1III.2	Share of encounter data submissions that met state's timely submission requirements What percent of the plan's encounter data file submissions (submitted during the reporting year) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract year when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received from the managed care plan for the reporting year.	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 99%

D1III.3	Share of encounter data submissions that were HIPAA compliant What percent of the plan's encounter data submissions (submitted during the reporting year) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting year.	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 100%
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Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Number	Indicator	Response
D1IV.1	Appeals resolved (at the plan level) Enter the total number of appeals resolved during the reporting year. An appeal is “resolved” at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary’s representative) chooses to file a request for a State Fair Hearing or External Medical Review.	WellCare Health Insurance of Arizona, Inc, dba ‘Ohana Health Plan, Inc. 29
D1IV.1a	Appeals denied Enter the total number of appeals resolved during the reporting period (D1.IV.1) that were denied (adverse) to the enrollee.	WellCare Health Insurance of Arizona, Inc, dba ‘Ohana Health Plan, Inc. 20
D1IV.1b	Appeals resolved in partial favor of enrollee Enter the total number of appeals (D1.IV.1) resolved during the reporting period in partial favor of the enrollee.	WellCare Health Insurance of Arizona, Inc, dba ‘Ohana Health Plan, Inc. 0
D1IV.1c	Appeals resolved in favor of enrollee Enter the total number of appeals (D1.IV.1) resolved during the reporting period in favor of the enrollee.	WellCare Health Insurance of Arizona, Inc, dba ‘Ohana Health Plan, Inc. 13
D1IV.2	Active appeals Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.	WellCare Health Insurance of Arizona, Inc, dba ‘Ohana Health Plan, Inc. 7
D1IV.3	Appeals filed on behalf of LTSS users Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter “N/A” if not applicable. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year	WellCare Health Insurance of Arizona, Inc, dba ‘Ohana Health Plan, Inc. 0

(regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).

D1IV.4

Number of critical incidents filed during the reporting year by (or on behalf of) an LTSS user who previously filed an appeal

WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.

0

For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter "N/A".Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter "N/A".The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user.To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.

D1IV.5a

Standard appeals for which timely resolution was provided

WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.

24

Enter the total number of standard appeals for which timely resolution was provided

by plan within the reporting year. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.

D1IV.5b	Expedited appeals for which timely resolution was provided Enter the total number of expedited appeals for which timely resolution was provided by plan within the reporting year. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 5
D1IV.6a	Resolved appeals related to denial of authorization or limited authorization of a service Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service. (Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 21
D1IV.6b	Resolved appeals related to reduction, suspension, or termination of a previously authorized service Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 0
D1IV.6c	Resolved appeals related to payment denial Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 7

D1IV.6d	Resolved appeals related to service timeliness Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 0
D1IV.6e	Resolved appeals related to lack of timely plan response to an appeal or grievance Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 1
D1IV.6f	Resolved appeals related to plan denial of an enrollee's right to request out-of-network care Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. N/A
D1IV.6g	Resolved appeals related to denial of an enrollee's request to dispute financial liability Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 0

Appeals by Service

Number of appeals resolved during the reporting period related to various services.

Note: A single appeal may be related to multiple service types and may therefore be counted in multiple categories.

Number	Indicator	Response
D1IV.7a	Resolved appeals related to general inpatient services Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter “N/A”.	WellCare Health Insurance of Arizona, Inc, dba ‘Ohana Health Plan, Inc. 0
D1IV.7b	Resolved appeals related to general outpatient services Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter “N/A”.	WellCare Health Insurance of Arizona, Inc, dba ‘Ohana Health Plan, Inc. 0
D1IV.7c	Resolved appeals related to inpatient behavioral health services Enter the total number of appeals resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter “N/A”.	WellCare Health Insurance of Arizona, Inc, dba ‘Ohana Health Plan, Inc. 0
D1IV.7d	Resolved appeals related to outpatient behavioral health services Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or	WellCare Health Insurance of Arizona, Inc, dba ‘Ohana Health Plan, Inc. 2

substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".

D1IV.7e	Resolved appeals related to covered outpatient prescription drugs Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 21
D1IV.7f	Resolved appeals related to skilled nursing facility (SNF) services Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A".	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 0
D1IV.7g	Resolved appeals related to long-term services and supports (LTSS) Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".(Appeals related to denial of payment for a service already rendered should be counted in indicator D1.IV.6c).	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 0
D1IV.7h	Resolved appeals related to dental services Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A".	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 0

D1IV.7i	Resolved appeals related to non-emergency medical transportation (NEMT) Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter "N/A".	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 0
D1IV.7k:	Resolved appeals related to durable medical equipment (DME) & supplies Enter the total number of appeals resolved by the plan during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter "N/A".	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. N/A
D1IV.7l:	Resolved appeals related to home health / hospice Enter the total number of appeals resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover this type of service, enter "N/A".	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. N/A
D1IV.7m:	Resolved appeals related to emergency services / emergency department Enter the total number of appeals resolved by the plan during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include appeals related to emergency outpatient behavioral health – those should be included in indicator D1.IV.7d. If the managed care plan does not cover this type of service, enter "N/A".	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 0
D1IV.7n:	Resolved appeals related to therapies Enter the total number of appeals resolved by the plan during the reporting year that were related to speech language pathology services or occupational, physical, or respiratory therapy services. If	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. N/A

the managed care plan does not cover this type of service, enter "N/A".

D1IV.7o**Resolved appeals related to other service types**

Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-n paid primarily by Medicaid, enter "N/A".

WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.

6

State Fair Hearings

Number	Indicator	Response
D1IV.8a	State Fair Hearing requests Enter the total number of State Fair Hearing requests resolved during the reporting year with the plan that issued an adverse benefit determination.	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 0
D1IV.8b	State Fair Hearings resulting in a favorable decision for the enrollee Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 0
D1IV.8c	State Fair Hearings resulting in an adverse decision for the enrollee Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 0
D1IV.8d	State Fair Hearings retracted prior to reaching a decision Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the reporting year prior to reaching a decision.	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 0
D1IV.9a	External Medical Reviews resulting in a favorable decision for the enrollee If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. n/a

D1IV.9b

**External Medical Reviews
resulting in an adverse
decision for the enrollee**

If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).

**WellCare Health Insurance of Arizona,
Inc, dba 'Ohana Health Plan, Inc.**

n/a

Grievances Overview

Number	Indicator	Response
D1IV.10	Grievances resolved Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. A grievance is “resolved” when it has reached completion and been closed by the plan.	WellCare Health Insurance of Arizona, Inc, dba ‘Ohana Health Plan, Inc. 21
D1IV.11	Active grievances Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.	WellCare Health Insurance of Arizona, Inc, dba ‘Ohana Health Plan, Inc. 4
D1IV.12	Grievances filed on behalf of LTSS users Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	WellCare Health Insurance of Arizona, Inc, dba ‘Ohana Health Plan, Inc. 1
D1IV.13	Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed a grievance For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting year by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been “related” to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user. If the managed care plan does not cover LTSS,	WellCare Health Insurance of Arizona, Inc, dba ‘Ohana Health Plan, Inc. 0

the state should enter “N/A” in this field. Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter “N/A” in this field. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.

D1IV.14**Number of grievances for which timely resolution was provided**

Enter the number of grievances for which timely resolution was provided by plan during the reporting year. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.

WellCare Health Insurance of Arizona, Inc, dba ‘Ohana Health Plan, Inc.

5

Grievances by Service

Report the number of grievances resolved by plan during the reporting period by service.

Number	Indicator	Response
D1IV.15a	Resolved grievances related to general inpatient services Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter “N/A”.	WellCare Health Insurance of Arizona, Inc, dba ‘Ohana Health Plan, Inc. 0
D1IV.15b	Resolved grievances related to general outpatient services Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care not specifically listed in this section (e.g., primary and preventive services, specialist care, diagnostic and lab testing). Do not include grievances related to outpatient behavioral health services - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter “N/A”.	WellCare Health Insurance of Arizona, Inc, dba ‘Ohana Health Plan, Inc. 0
D1IV.15c	Resolved grievances related to inpatient behavioral health services Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter “N/A”.	WellCare Health Insurance of Arizona, Inc, dba ‘Ohana Health Plan, Inc. 13
D1IV.15d	Resolved grievances related to outpatient behavioral health services Enter the total number of grievances resolved by the plan during the reporting year that	WellCare Health Insurance of Arizona, Inc, dba ‘Ohana Health Plan, Inc. 3

were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".

D1IV.15e	Resolved grievances related to coverage of outpatient prescription drugs Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 0
D1IV.15f	Resolved grievances related to skilled nursing facility (SNF) services Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 0
D1IV.15g	Resolved grievances related to long-term services and supports (LTSS) Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 0
D1IV.15h	Resolved grievances related to dental services Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A".	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. N/A

D1IV.15i	Resolved grievances related to non-emergency medical transportation (NEMT) Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 1
D1IV.15k	Resolved grievances related to durable medical equipment (DME) & supplies Enter the total number of grievances resolved by the plan during the reporting year that were related to DME and/or supplies. If the managed care plan does not cover this type of service, enter "N/A".	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. n/a
D1IV.15l	Resolved grievances related to home health / hospice Enter the total number of grievances resolved by the plan during the reporting year that were related to home health and/or hospice. If the managed care plan does not cover this type of service, enter "N/A".	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. n/a
D1IV.15m	Resolved grievances related to emergency services / emergency department Enter the total number of grievances resolved by the plan during the reporting year that were related to emergency services and/or provided in the emergency department. Do not include grievances related to emergency outpatient behavioral health - those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. n/a
D1IV.15n	Resolved grievances related to therapies Enter the total number of grievances resolved by the plan during the reporting year that were related to speech language pathology services or occupational, physical, or	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. n/a

respiratory therapy services. If the managed care plan does not cover this type of service, enter "N/A".

D1IV.15o**Resolved grievances related to other service types**

Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-n paid primarily by Medicaid, enter "N/A".

WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.

4

Grievances by Reason

Report the number of grievances resolved by plan during the reporting period by reason.

Number	Indicator	Response
D1IV.16a	Resolved grievances related to plan or provider customer service Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 3
D1IV.16b	Resolved grievances related to plan or provider care management/case management Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 11
D1IV.16c	Resolved grievances related to network adequacy or access to care/services from plan or provider Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 2
D1IV.16d	Resolved grievances related to quality of care Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 2
D1IV.16e	Resolved grievances related to plan communications Enter the total number of grievances resolved by the plan during the	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.

reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.

0

D1IV.16f

Resolved grievances related to payment or billing issues

Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.

WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.

1

D1IV.16g

Resolved grievances related to suspected fraud

Enter the total number of grievances resolved by the plan during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetrated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.

WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.

0

D1IV.16h

Resolved grievances related to abuse, neglect or exploitation

Enter the total number of grievances resolved by the plan during the reporting year that were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.

WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.

0

D1IV.16i

Resolved grievances related to lack of timely plan response to a prior authorization/service authorization or appeal (including requests to expedite or extend appeals)

Enter the total number of grievances resolved by the plan during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).

WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.

0

D1IV.16j	Resolved grievances related to plan denial of expedited appeal Enter the total number of grievances resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their representative have the right to file a grievance.	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 0
D1IV.16k	Resolved grievances filed for other reasons Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 1

Topic VII: Quality & Performance Measures

Report on individual measures in each of the following eight domains: (1) Primary care access and preventive care, (2) Maternal and perinatal health, (3) Care of acute and chronic conditions, (4) Behavioral health care, (5) Dental and oral health services, (6) Health plan enrollee experience of care, (7) Long-term services and supports, and (8) Other. For composite measures, be sure to include each individual sub-measure component.



Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Substance Use - 30 Days (Total) 1 / 20

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

3488

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.

78.26%



Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Substance Use - 7 Days (Total) 2 / 20

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

3488

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 01/01/2024

D2.VII.8 Measure Description

N/A

Measure results

56.52%



Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness - 30 Days (Total)

3 / 20

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

576

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.

79.18%



Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness- 7 Days (total)

4 / 20

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

576

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.

59.73%



Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Mental Illness - 30 Days (Total) 5 / 20

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

3489

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.

84.04%



Complete

D2.VII.1 Measure Name: Follow-Up After Emergency Department Visit for Mental Illness - 7 days (Total) 6 / 20

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

3489

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

62.77%



Complete

D2.VII.1 Measure Name: Engagement of SUD Treatment—Alcohol Use Disorder (Total) 7 / 20

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

4

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.

8.20%



Complete

D2.VII.1 Measure Name: Engagement of SUD Treatment—Opioid Use Disorder (Total) 8 / 20

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

4

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.

7.14%



Complete

D2.VII.1 Measure Name: Engagement of SUD Treatment—Other Drug Use Disorder (Total) 9 / 20

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

4

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.

8.93%



Complete

D2.VII.1 Measure Name: Engagement of SUD Treatment—Total (Total) 10 / 20

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

4

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

8.63%



Complete

D2.VII.1 Measure Name: Initiation of SUD Treatment—Alcohol Use Disorder (Total)

11 / 20

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

4

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.

27.87%



Complete

D2.VII.1 Measure Name: Initiation of SUD Treatment—Opioid Use Disorder (Total)

12 / 20

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

4

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

26.19%



Complete

D2.VII.1 Measure Name: Initiation of SUD Treatment—Other Drug Use Disorder (Total) 13 / 20

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

4

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.

30.61%



Complete

D2.VII.1 Measure Name: Initiation of SUD Treatment—Total (Total) 14 / 20

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

4

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.

29.68%



Complete

D2.VII.1 Measure Name: Adherence to Antipsychotic Medications for Individuals With Schizophrenia 15 / 20

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

1879

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.

71.93%



Complete

D2.VII.1 Measure Name: Ambulatory Care - Emergency Dept Visits/1000 MY (Total)* 6 / 20

D2.VII.2 Measure Domain

Utilization & Risk Adjusted Utilization

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

468.09



Complete

D2.VII.1 Measure Name: Ambulatory Care - Outpatient Visits/1000 MY (Total) 17 / 20**D2.VII.2 Measure Domain**

Utilization & Risk Adjusted Utilization

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.

2425.49



Complete

D2.VII.1 Measure Name: Antidepressant Medication Management - Effective Acute Phase Treatment 18 / 20**D2.VII.2 Measure Domain**

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

105

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

57.74%



Complete

D2.VII.1 Measure Name: Antidepressant Medication Management - Effective Continuation Phase Treatment

19 / 20

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

105

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

Medicaid Adult Core Set

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.

37.36%



Complete

D2.VII.1 Measure Name: Diagnosed Mental Health Disorders - Total

20 / 20

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

N/A

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Program-specific rate

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2024 - 12/31/2024

D2.VII.8 Measure Description

N/A

Measure results

Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. The state should include all sanctions the state issued regardless of what entity identified the non-compliance (e.g. the state, an auditing body, the plan, a contracted entity like an external quality review organization).

42 CFR 438.66(e)(2)(viii) specifies that the MCPAR include the results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with a contracted MCO, PIHP, PAHP, or PCCM entity to improve performance.



D3.VIII.1 Intervention type: All compliance-related notices or letters (e.g. warnings, non-compliance)

1 / 1

D3.VIII.2 Plan performance issue	D3.VIII.3 Plan name
Reporting (timeliness, completeness, accuracy)	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.

D3.VIII.4 Reason for intervention

Failed to meet data quality standards for the Provider Grievances and Claims Report (PGC).

Sanction details

D3.VIII.5 Instances of non-compliance	D3.VIII.6 Sanction amount
1	N/A
D3.VIII.7 Date assessed	D3.VIII.8 Remediation date non-compliance was corrected
09/16/2024	Yes, remediated 11/24/2025
D3.VIII.9 Corrective action plan	
No	

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	Dedicated program integrity staff Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 1
D1X.2	Count of opened program integrity investigations How many program integrity investigations were opened by the plan during the reporting year?	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 40
D1X.4	Count of resolved program integrity investigations How many program integrity investigations were resolved by the plan during the reporting year?	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 11
D1X.6	Referral path for program integrity referrals to the state What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. Makes referrals to the SMA and MFCU concurrently
D1X.7	Count of program integrity referrals to the state Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of unduplicated referrals.	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 40
D1X.9a:	Plan overpayment reporting to the state: Start Date What is the start date of the reporting period covered by the plan's latest overpayment recovery report submitted to the state?	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 04/01/2025
D1X.9b:	Plan overpayment reporting to the state: End Date What is the end date of the reporting period covered by the plan's latest overpayment	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. 06/30/2025

recovery report submitted to the state?

D1X.9c:	Plan overpayment reporting to the state: Dollar amount From the plan's latest annual overpayment recovery report, what is the total amount of overpayments recovered?	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. \$73,300.31
D1X.9d:	Plan overpayment reporting to the state: Corresponding premium revenue What is the total amount of premium revenue for the corresponding reporting period (D1.X.9a-b)? (Premium revenue as defined in MLR reporting under 438.8(f)(2))	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. \$17,461,292
D1X.10	Changes in beneficiary circumstances Select the frequency the plan reports changes in beneficiary circumstances to the state.	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. Weekly

Topic XI: ILOS



Beginning December 2025, this section must be completed by states that authorize ILOS. Submission of this data before December 2025 is optional.

If ILOSs are authorized for this program, report for each plan: if the plan offered any ILOS; if "Yes", which ILOS the plan offered; and utilization data for each ILOS offered. If the plan offered an ILOS during the reporting period but there was no utilization, check that the ILOS was offered but enter "0" for utilization.

Number	Indicator	Response
D4XI.1	ILOSs offered by plan Indicate whether this plan offered any ILOS to their enrollees.	WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc. Not answered

Topic XIII. Prior Authorization

⚠ Beginning June 2026, Indicators D1.XIII.1-15 must be completed. Submission of this data including partial reporting on some but not all plans, before June 2026 is optional; if you choose not to respond prior to June 2026, select “Not reporting data”.

Number	Indicator	Response
N/A	Are you reporting data prior to June 2026? If “Yes”, please complete the following questions under each plan.	Not reporting data

Topic XIV. Patient Access API Usage

⚠ Beginning June 2026, Indicators D1.XIV.1-2 must be completed. Submission of this data before June 2026 is optional; if you choose not to respond prior to June 2026, select “Not reporting data”.

Number	Indicator	Response
N/A	Are you reporting data prior to June 2026? If “Yes”, please complete the following questions under each plan.	Not reporting data

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

Per 42 CFR 438.66(e)(2)(ix), the Managed Care Program Annual Report must provide information on and an assessment of the operation of the managed care program including activities and performance of the beneficiary support system. Information on how BSS entities support program-level functions is on the Program-Level BSS page.

Number	Indicator	Response
EIX.1	BSS entity type What type of entity performed each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	Hamakua Health Center Other, specify – Federally Qualified Health Centers Hana Health Other Community-Based Organization Other, specify – Federally Qualified Health Center Hawaii Health Systems Corporation Other, specify – Health Systems (hospitals in Kona and Hilo) Queen's Health Systems Other, specify – Health Systems (Hospitals) Maui Health Systems Other, specify – Health Systems (hospital) Kumukahi Health + Wellness Other Community-Based Organization Other, specify – Kokua Services Contract State funded by DHS Med-QUEST Malama Pono Other Community-Based Organization Other, specify – Kokua Services Contract Subcontractor Hawaii Health and Harm Reduction Other Community-Based Organization Subcontractor Other, specify – Kokua Services Contract subcontractor Kalanihale Other Community-Based Organization

Other, specify – Kokua Services Contractor

Hawaii Island Community Health Center

Other Community-Based Organization

Subcontractor

Other, specify – Federally Qualified Health Center, Kokua Services Contract subcontractor

Hoola Lahui Hawaii

Other Community-Based Organization

Other, specify – Native Hawaii Health Center, Rural Health Center

Kalihi Palama Health Center

Other Community-Based Organization

Other, specify – Federally Qualified Health Center

Kokua Kalihi Valley

Other Community-Based Organization

Other, specify – Federally Qualified Health Center

Koolauloa Community Health Center

Other Community-Based Organization

Other, specify – Federally Qualified Health Center

Lanai Community Health Center

Other Community-Based Organization

Other, specify – Federally Qualified Health Center

Legal Aid Society of Hawaii

Legal Assistance Organization

Other Community-Based Organization

Other, specify – Kokua Services Contractor
State funded by DHS Med-QUEST

Molokai Community Health Center

Other Community-Based Organization

Other, specify – Federally Qualified Health
Center

We Are Oceania

Other Community-Based Organization

Other, specify – Kokua Services Contract
State Funded by DHS Med-QUEST

Project Vision Hawaii

Other Community-Based Organization

Other, specify – Kokua Services Contract
State funded by DHS Med-QUEST

IMUA Family Services

Other Community-Based Organization

Hui O Hauula

Other Community-Based Organization

Executive Office on Aging

State Government Entity

Aging and Disability Resource Network
(ADRN)

Hawaii Public Health Institute

Other Community-Based Organization

Institute of Human Services

Other Community-Based Organization

Malama I Ke Ola

Other Community-Based Organization

Other, specify – Federally Qualified Health
Center

One Stop for Micronesians on Hawaii Island

Other Community-Based Organization

Vibrant Hawaii

Other Community-Based Organization

Waianae Coast Comprehensive Community Health Center

Other Community-Based Organization

Other, specify – Federally Qualified Health Centers

Waikiki Health

Other Community-Based Organization

Other, specify – Federally Qualified Health Centers

Waimanalo Health Center

Other Community-Based Organization

Other, specify – Federally Qualified Health Center

EIX.2

BSS entity role

What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).

Hamakua Health Center

Enrollment Broker/Choice Counseling

Beneficiary Outreach

Other, specify – Provides outreach, education and enrollment assistance to Hawaii residents

Hana Health

Enrollment Broker/Choice Counseling

Beneficiary Outreach

Other, specify – Provides outreach, education and enrollment assistance to Hawaii residents.

Hawaii Health Systems Corporation

Enrollment Broker/Choice Counseling

Other, specify – Provides outreach, education and enrollment assistance to Hawaii residents.

Queen's Health Systems

Beneficiary Outreach

Other, specify – Provides outreach, education and enrollment assistance to Hawaii residents.

Maui Health Systems

Enrollment Broker/Choice Counseling

Beneficiary Outreach

Other, specify – Provides outreach, education and enrollment assistance to Hawaii residents.

Kumukahi Health + Wellness

Enrollment Broker/Choice Counseling

Beneficiary Outreach

LTSS Complaint Access Point

Other, specify – Provides outreach, education and enrollment assistance to Hawaii residents.

Malama Pono

Enrollment Broker/Choice Counseling

Beneficiary Outreach

LTSS Complaint Access Point

Other, specify – Provides outreach, education and enrollment assistance to Hawaii residents.

Hawaii Health and Harm Reduction

Enrollment Broker/Choice Counseling

Beneficiary Outreach

LTSS Complaint Access Point

Other, specify – Provides outreach, education and enrollment assistance to Hawaii residents.

Kalanihale

Enrollment Broker/Choice Counseling

Beneficiary Outreach

LTSS Complaint Access Point

Other, specify – Provides outreach, education and enrollment assistance to Hawaii residents.

Hawaii Island Community Health Center

Enrollment Broker/Choice Counseling

Beneficiary Outreach

LTSS Complaint Access Point

Other, specify – Provides outreach, education and enrollment assistance to Hawaii residents.

Hoola Lahui Hawaii

Enrollment Broker/Choice Counseling

Beneficiary Outreach

LTSS Complaint Access Point

Other, specify – Provides outreach, education and enrollment assistance to Hawaii residents.

Kalihi Palama Health Center

Enrollment Broker/Choice Counseling

Beneficiary Outreach

LTSS Complaint Access Point

Other, specify – Provides outreach, education and enrollment assistance to Hawaii residents.

Kokua Kalihi Valley

Enrollment Broker/Choice Counseling

Beneficiary Outreach

LTSS Complaint Access Point

Other, specify – Provides outreach, education and enrollment assistance to Hawaii residents.

Koolauloa Community Health Center

Enrollment Broker/Choice Counseling

Beneficiary Outreach

LTSS Complaint Access Point

Other, specify – Provides outreach, education and enrollment assistance to Hawaii residents.

Lanai Community Health Center

Enrollment Broker/Choice Counseling

Beneficiary Outreach

LTSS Complaint Access Point

Other, specify – Provides outreach, education and enrollment assistance to Hawaii residents.

Legal Aid Society of Hawaii

Enrollment Broker/Choice Counseling

Beneficiary Outreach

LTSS Complaint Access Point

Other, specify – Provides outreach, education and enrollment assistance to Hawaii residents.

Molokai Community Health Center

Enrollment Broker/Choice Counseling

Beneficiary Outreach

LTSS Complaint Access Point

Other, specify – Provides outreach, education and enrollment assistance to Hawaii residents.

We Are Oceania

Enrollment Broker/Choice Counseling

Beneficiary Outreach

LTSS Complaint Access Point

Other, specify – Provides outreach, education and enrollment assistance to Hawaii residents.

Project Vision Hawaii

Enrollment Broker/Choice Counseling

Beneficiary Outreach

LTSS Complaint Access Point

Other, specify – Provides outreach, education and enrollment assistance to Hawaii residents.

IMUA Family Services

Enrollment Broker/Choice Counseling

Beneficiary Outreach

LTSS Complaint Access Point

Other, specify – Provides outreach, education and enrollment assistance to Hawaii residents.

Hui O Hauula

Enrollment Broker/Choice Counseling

Beneficiary Outreach

LTSS Complaint Access Point

Other, specify – Provides outreach, education and enrollment assistance to Hawaii residents.

Executive Office on Aging

Enrollment Broker/Choice Counseling

Beneficiary Outreach

LTSS Complaint Access Point

Other, specify – Provides education and enrollment assistance to Hawaii residents.

Hawaii Public Health Institute

Enrollment Broker/Choice Counseling

Beneficiary Outreach

LTSS Complaint Access Point

Other, specify – Provides outreach, education and enrollment assistance to Hawaii residents.

Institute of Human Services

Enrollment Broker/Choice Counseling

Beneficiary Outreach

LTSS Complaint Access Point

Other, specify – Provides outreach, education and enrollment assistance to Hawaii residents.

Malama I Ke Ola

Enrollment Broker/Choice Counseling

Beneficiary Outreach

LTSS Complaint Access Point

Other, specify – Provides outreach, education and enrollment assistance to Hawaii residents.

One Stop for Micronesians on Hawaii Island

Enrollment Broker/Choice Counseling

Beneficiary Outreach

LTSS Complaint Access Point

Other, specify – Provides outreach, education and enrollment assistance to Hawaii residents.

Vibrant Hawaii

Enrollment Broker/Choice Counseling

Beneficiary Outreach

LTSS Complaint Access Point

Other, specify – Provides outreach, education and enrollment assistance to Hawaii residents.

Waianae Coast Comprehensive Community Health Center

Enrollment Broker/Choice Counseling

Beneficiary Outreach

LTSS Complaint Access Point

Other, specify – Provides outreach, education and enrollment assistance to Hawaii residents.

Waikiki Health

Enrollment Broker/Choice Counseling

Beneficiary Outreach

LTSS Complaint Access Point

Other, specify – Provides outreach, education and enrollment assistance to Hawaii residents.

Waimanalo Health Center

Enrollment Broker/Choice Counseling

Beneficiary Outreach

LTSS Complaint Access Point

Other, specify – Provides outreach, education and enrollment assistance to Hawaii residents.

Section F: Notes

Notes

Use this section to optionally add more context about your submission. If you choose not to respond, proceed to “Review & submit.”

Number	Indicator	Response
F1	Notes (optional)	Not answered