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

Due Date	Last edited	Edited By	Status
12/27/2022	12/29/2022	Stacie Coats	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

Section A: Program Information

Point of Contact

Number	Indicator	Response
A.1	**State name**	Hawaii

Number	Indicator	Response
	Auto-populated from your account profile.	
A.2a	**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 Fujii
A.2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	jfujii@dhs.hawaii.gov
A.3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Stacie Coats
A.3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	scoats@dhs.hawaii.gov
A.4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	12/29/2022

Reporting Period

Number	Indicator	Response
A.5a	**Reporting period start date** Auto-populated from report dashboard.	07/01/2021
A.5b	**Reporting period end date** Auto-populated from report dashboard.	06/30/2022
A.6	**Program name** Auto-populated from report dashboard.	Community Care Services (CCS) Program

Add plans (A.7)

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

Add BSS entities (A.8)

	Indicator	Response
	BSS entity name	Imua Family Services (Maui) Kumukahi Health & Wellness (Statewide) Legal Aid Society of Hawaii (Statewide) Project Vision Hawaii (Statewide) We Are Oceania (Primarily Oahu) Kalihi Palama Health Center

Indicator	Response
	Kokua Kalihi Valley Comprehensive Family Services
	Koolau Community Health & Wellness Center
	Waianae Coats Comprehensive Health Center
	Waikiki Health
	Waimanalo Health Center
	Bay Clinic
	West Hawaii Community Health Center
	Hana Health
	Malama I Ke Ola
	Lanai Community Health Center
	Molokai Community Health Center
	Hoola Lahui Hawaii
	Hamakua Health Center
	Adventist Health Castle
	Catholic Charities of Hawaii
	Executive Office on Aging
	Hawaii Health Systems Corporation
	Hui O Hauula
	Marshallese Association of Kauai
	Maui Health Systems
	Marshallese Community Organization of Hawaii
	One Stop Center for Micronesians of Hawaii Island
	Queen's Medical Centers

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
B.I.1	**Statewide Medicaid enrollment** Enter the total number of individuals enrolled in Medicaid as of the first day of the last month of the reporting year. Include all FFS and managed care enrollees, and count each person only once, regardless of the delivery system(s) in which they are enrolled.	448,161
B.I.2	**Statewide Medicaid managed care enrollment** Enter the total, unduplicated number of individuals enrolled in any type of Medicaid managed care as of the first day of the last month of the reporting year. Include enrollees in all programs, and count each person only once, even if they are enrolled in more than one managed care program or more than one managed care plan.	448,033

Topic III. Encounter Data Report

Number	Indicator	Response

Number	Indicator	Response
B.III.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
B.X.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	No such activities were conducted during the reporting period.

Number	Indicator	Response
	under/overutilization, and other activities.	
B.X.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
B.X.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
B.X.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain overpayments, requires the plans to return overpayments, or administers a hybrid system) 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

Number	Indicator	Response
		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.
B.X.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 pieces (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.
B.X.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. Daily files are received from KOLEA eligibility system to HPMMIS enrollment system. These files are processed nightly, and subsequently the daily enrollment batch jobs are run and produce the data for the 834 daily file to the health plan. For reconciliation, MQD sends a monthly 834 file which contains the entire current client data for the next month.

Number	Indicator	Response
B.X.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 **Changes in provider circumstances: Metrics** Yes **Changes in provider circumstances: Describe metric** Health plan must notify DHS within 3 days of any termination for cause involving FWA.
B.X.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
B.X.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of	No

Number	Indicator	Response
	individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to §455.104 and required by 42 CFR 438.602(g)(3).	
B.X.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, what is the link(s) to the audit results? Refer to 42 CFR 438.602(e).	https://medquest.hawaii.gov/en/resources/consumer-guides.html

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C1.I.1	**Program contract** Enter the title and date 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); June 9, 2021 (date of full execution)
		06/09/2021
C1.I.2	**Contract URL** Provide the hyperlink to the	https://medquest.hawaii.gov/en/resources/solicitations-contract.html

Number	Indicator	Response
	model contract or landing page for executed contracts for the program reported in this program.	
C1.I.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)
C1.I.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.	Behavioral health
C1.I.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
C1.I.5	**Program enrollment** Enter the total number of	5,212

Number	Indicator	Response
	individuals enrolled in the managed care program as of the first day of the last month of the reporting year.	
C1.I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year.	There are no changes to the CCS population on enrolment or benefits in this reporting year.

Topic III: Encounter Data Report

Number	Indicator	Response
C1.III.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)).	Other, specify The State uses encounter data for all the options provided although multi-selection wasn't allowed in the template. We validate encounter data submission and continue to work on data completeness, accuracy and timeliness to support rate setting; we are working on building a health analytics module that will utilize encounter data for quality and performance measurement; there are multiple ways in which the State leverages encounter data to support various types of monitoring and reporting functions; encounter data submission itself is monitored as part of contract oversight, but in addition, the encounter data is mined as needed to provide oversight for a variety of purposes; the State uses a combination of managed care reports and encounter data to support program integrity functions; finally, all encounter data available to the State is extensively leveraged to provide data support policy making and other

Number	Indicator	Response
		programmatic decisions.
C1.III.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).	Other, specify The State is developing a detailed encounter data quality monitoring process that will assess timeliness, accuracy, and completeness of encounter data using the State's definitions specified in the BHO's managed care contract.
C1.III.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 6.11
C1.III.4	**Financial penalties contract language** Provide reference(s) to the contract section(s) that describes any financial	CCS contract section 14.21 describes remedies for non-performance of contract.

Number	Indicator	Response
	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.	
C1.III.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.	There are no formal incentives currently for encounter data quality, but that MCOs are incentivized to improve encounter data quality through a variety of strategies. For example, data used for risk scoring and the calculation of settlements for certain risk corridors exclusively rely on submitted encounter data. MQD is working to iteratively increase the impact of encounter data quality on MCOs and implementing a variety of strategies to improve quality.
C1.III.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 period.	The State continues to struggle to find dedicated resources and funding to support the substantial work involved in validating managed care plan encounter data. We continue to brainstorm ways to enhance the rigor and extent to which we perform data quality monitoring and oversight and have made substantial progress over the past 2-3 years.

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1.IV.1	**State's definition of "critical incident," as used for reporting purposes in its MLTSS program** If this report is being completed	N/A

Number	Indicator	Response
	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.	
C1.IV.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.	CCS-RFP- MQD- 2021-010 Section 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. CCS-RFP-MQD- 2021-010 Section 9.8.G.5The BHO may extend the resolution time frame by up to fourteen (14) additional calendar days if the Member requests the extension, or the BHO shows (to the satisfaction of DHS, upon its request for review) that there is need for additional information and how the delay shall be in the Member's best interest. For any extension not requested by a Member, the BHO shall give the Member written notice of the reason for the delay.

Number	Indicator	Response
C1.IV.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.	CCS-RFP- MQD- 2021-010 Section 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. CCS-RFP- MQD- 2021-010 Section 9.8.H.6 a-e The BHO may extend the expedited appeal resolution time frame by up to fourteen (14) additional calendar days if the Member requests the extension or the BHO needs additional information and demonstrates to DHS how the delay shall be in the Member's best interest. For any extension not requested by the Member or if the BHO denies a request for expedited resolution of an appeal, it shall: a. Transfer the appeal to the timeframe for standard resolution; b. Make reasonable efforts to give the Member prompt oral notice of the delay; c. Within two (2) calendar days give the Member written notice of the reason for the decision to extend the timeframe or deny a request for expedited resolution of an appeal. Follow-up within two (2) calendar days with written notice of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with the decision; d. Inform the Member orally and in writing that they may file a grievance with the BHO for the delay of the expedited process, if he or she disagrees with that decision; and e. Resolve the appeal as expeditiously as the Member's health condition requires and no later than the date the extension expires.

Number	Indicator	Response
C1.IV.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 of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.	CCS-RFP- MQD- 2021-010 Section 9.8.E.6.b.Convey a disposition, in writing, of 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

Number	Indicator	Response
C1.V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting standards.	Provider shortages / recruitment among Rural neighborhoods are the State's biggest challenges.
C1.V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	The MCPS continuously monitor their provider networks to identify potential or existing gaps which are then relayed to State in quarterly reports. If consistent gaps are identified the State will communicate with the MCPS on implementing corrective actions over a period of time. If these steps do not remedy the situation, then penalties may be considered. When access to care is not avaliable in the member's immediate demographic area, the MCPS will coordinate transportation to ensure the members can receive services until the network gap is filled. The MCP can fly members

Number	Indicator	Response
		to other islands (or out-of-state) to receive care. Willing providers can also be flown to the rural locations. Another method for connecting members with providers is telehealth via phone calls or "virtual visits." If a MCPS network us unable to provide a particular services, then an out-of-network provider can be used.

Topic V. Availability, Accessibility and Network Adequacy

Access Measures

Describe the measures the state uses to monitor availability, accessibility, and network adequacy. Report at the program level.

Revisions to the Medicaid managed care regulations in 2016 and 2020 built on existing requirements that managed care plans maintain provider networks sufficient to ensure adequate access to covered services by: (1) requiring states to develop quantitative network adequacy standards for at least eight specified provider types if covered under the contract, and to make these standards available online; (2) strengthening network adequacy monitoring requirements; and (3) addressing the needs of people with long-term care service needs (42 CFR 438.66; 42 CFR 438.68).

42 CFR 438.66(e) specifies that the MCPAR must provide information on and an assessment of the availability and accessibility of covered services within the MCO, PHIP, or PAHP contracts, including network adequacy standards for each managed care program.

Find in the Excel Workbook
C2_Program_State

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard 1 / 5

C2.V.2 Measure standard

The BHO shall meet the following geographic access standards for all

members: Hospitals (30 minute driving time - Urban; 60 minute driving time - Rural)

C2.V.1 General category

Maximum time to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hospital	Urban and Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

2 / 5

C2.V.2 Measure standard

The BHO shall meet the following geographic access standards for all members: Mental Health Providers (30 minute driving time - Urban; 60 minute driving time - Rural)

C2.V.1 General category

Maximum time to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Urban and Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

3 / 5

C2.V.2 Measure standard

The BHO shall meet the following geographic access standards for all members: Pharmacies (15 minute driving time - Urban; 60 minute driving time - Rural)

C2.V.1 General category

Maximum time to travel

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Pharmacy	Urban and Rural	Adult

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard

4 / 5

C2.V.2 Measure standard

The BHO shall have a sufficient network to ensure Members can obtain needed health services within the acceptable wait times: Behavioral health provider visits (urgent) - Appointments within seventy-two (72) hours.

C2.V.1 General category

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Urban and Rural	Adult

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.3 Standard type: General quantitative availability and accessibility standard 5 / 5

C2.V.2 Measure standard

The BHO shall have a sufficient network to ensure Members can obtain needed health services within the acceptable wait times: Behavioral health provider visits (standard) - Appointments within twenty-one (21) calendar days.

C2.V.1 General category

Appointment wait time

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Behavioral health	Urban and Rural	Adult

C2.V.7 Monitoring Methods

Secret shopper calls

C2.V.8 Frequency of oversight methods

Quarterly

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1.IX.1	**BSS website** List the website(s) and/or email address 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
C1.IX.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	All organizations we have agreements or contracts with utilize interpreter services and offer many informational flyers in various languages which are most often needed. All Community Based Organizations offer assistance by phone, computer, in-person and will make arrangements if auxiliary aids are

Number	Indicator	Response
	disabilities, as required by 42 CFR 438.71(b)(2))? 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.	requested.
C1.IX.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).	Assist with application information and required supplemental documentation needed to additionally support requests for LTSS.
C1.IX.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?	Monthly Statewide Kokua Calls, Annual Certified Kokua Training, on-going trainings throughout the year, to provide guidance and support. Kokua Services Contracts must provide Monthly Reports, Daily activity logs.

Topic X: Program Integrity

Number	Indicator	Response
C1.X.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).	No

Number	Indicator	Response
	Refer to 42 CFR 438.610(d).	

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1.I.1	**Plan enrollment** What is the total number of individuals enrolled in each plan as of the first day of the last month of the reporting year?	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.** 5,212
D1.I.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.** 1.2%
D1.I.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	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.** 1.2%

Number	Indicator	Response
	Medicaid managed care enrollment (B.I.2)	

Topic II. Financial Performance

Number	Indicator	Response
D1.II.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.	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.** 93%
D1.II.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
D1.II.2	**Population specific MLR description**	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.**

Number	Indicator	Response
	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.	N/A
D1.II.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 07/01/2020 06/30/2021

Topic III. Encounter Data

Number	Indicator	Response
D1.III.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.** The state requires our BHO to submit encounter data at a minimum monthly, no later than the end of the month following the month when the financial liability was processed (i.e. paid, denied, voided, or adjusted/corrected). The BHO shall submit 100% of encounter data within 15 months from the date of service, including all adjusted and resubmitted encounters.

Number	Indicator	Response
D1.III.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 period) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract period 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 period.	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.** 83%
D1.III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting period) 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 period.	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.** 100%

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
D1.IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved as of the first day of the last month of 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.** 24
D1.IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.** 0
D1.IV.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 (regardless of whether the enrollee was actively receiving LTSS at the	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.** 3

Number	Indicator	Response
	time that the appeal was filed).	
D1.IV.4	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed an appeal** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period 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	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.** N/A

Number	Indicator	Response
	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.	
D1.IV.5a	**Standard appeals for which timely resolution was provided** Enter the total number of standard appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.** 13
D1.IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan during the reporting period. 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.** 10

Number	Indicator	Response
D1.IV.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.** 20
D1.IV.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
D1.IV.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.** 3

Number	Indicator	Response
D1.IV.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
D1.IV.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.** 0
D1.IV.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

Number	Indicator	Response
D1.IV.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

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
D1.IV.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.** N/A
D1.IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.** N/A

Number	Indicator	Response
	appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. 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".	
D1.IV.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.** N/A
D1.IV.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 substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.** N/A

Number	Indicator	Response
D1.IV.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.** N/A
D1.IV.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.** N/A
D1.IV.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".	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.** N/A

Number	Indicator	Response
D1.IV.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.** N/A
D1.IV.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.** N/A
D1.IV.7j	**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-i, enter "N/A".	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.** N/A

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response

Number	Indicator	Response
D1.IV.8a	**State Fair Hearing requests** Enter the total number of requests for a State Fair Hearing filed during the reporting year by plan that issued the adverse benefit determination.	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.** 0
D1.IV.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
D1.IV.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
D1.IV.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) prior to reaching a decision.	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.** 0

Number	Indicator	Response
D1.IV.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
D1.IV.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

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response

Number	Indicator	Response
D1.IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year. 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.** 33
D1.IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the first day of the last month of the reporting year.	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.** 3
D1.IV.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.** 3
D1.IV.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	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.** N/A

Number	Indicator	Response
	of critical incidents filed within the reporting period 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, 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	

Number	Indicator	Response
	grievance preceded the filing of the critical incident.	
D1.IV.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 period. 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.** 33

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
D1.IV.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.** N/A

Number	Indicator	Response
D1.IV.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, including diagnostic and laboratory services. 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.** N/A
D1.IV.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.** 1
D1.IV.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.** 4

Number	Indicator	Response
	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".	
D1.IV.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.** 1
D1.IV.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.** N/A
D1.IV.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	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.** N/A

Number	Indicator	Response
	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".	
D1.IV.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
D1.IV.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.** 2
D1.IV.15j	**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	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.** 13

Number	Indicator	Response
	cover services other than those in items D1.IV.15a-i, enter "N/A".	

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
D1.IV.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.** 13
D1.IV.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	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.** 6

Number	Indicator	Response
	management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	
D1.IV.16c	**Resolved grievances related to 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.** 5
D1.IV.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.** 6
D1.IV.16e	**Resolved grievances related to plan communications** Enter the total number of	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.** 2

Number	Indicator	Response
	grievances resolved by the plan during the 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.	
D1.IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved during the reporting period that were filed for a reason related to payment or billing issues.	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.** 7
D1.IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated 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	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.** 0

Number	Indicator	Response
	the Inspector General.	
D1.IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved 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
D1.IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved 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.** 1
D1.IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal.	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.** 0

Number	Indicator	Response
	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.	
D1.IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved during the reporting period that were filed for a reason other than the reasons listed above.	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.** 12

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.

Find in the Excel Workbook
D2_Plan_Measures

Complete

D2.VII.1 Measure Name: Follow-Up After ED Visit for AOD Abuse or Dependence 30 Day Follow Up- Total 18+ YEARS 1 / 6

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

01/01/2021 - 12/31/2021

D2.VII.8 Measure Description

N/A

Measure results

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

30.54%

Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization for Mental Illness 30 Day Follow up- Total 18+ YEARS

2 / 6

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

01/01/2021 - 12/31/2021

D2.VII.8 Measure Description

N/A

Measure results

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

88.12%

Complete

D2.VII.1 Measure Name: Follow-Up After ED Visit for Mental Illness 30 Day Follow Up- 18+ YEARS 3 / 6

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

01/01/2021 - 12/31/2021

D2.VII.8 Measure Description

N/A

Measure results

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

88.72%

Complete

D2.VII.1 Measure Name: Initiation and Engagement of AOD Abuse or Dependence Treatment - Initiation- Total- 18+ YEARS 4 / 6

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

01/01/2021 - 12/31/2021

D2.VII.8 Measure Description

N/A

Measure results

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

35.33%

Complete

D2.VII.1 Measure Name: Initiation and Engagement of AOD Abuse or Dependence Treatment - Engagement - Total 18+ YEARS 5 / 6

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

01/01/2021 - 12/31/2021

D2.VII.8 Measure Description

N/A

Measure results

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

10.00%

Complete

D2.VII.1 Measure Name: Adherence to Antipsychotic Medications for Individuals with Schizophrenia 6 / 6

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

01/01/2021 - 12/31/2021

D2.VII.8 Measure Description

N/A

Measure results

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

69.65%

Topic VIII. Sanctions

No plan-level sanctions or corrective actions have been entered for this program report.

Topic X. Program Integrity

Number	Indicator	Response
D1.X.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.** 3
D1.X.2	**Count of opened program integrity investigations** How many program integrity investigations have been opened by the plan in the past year?	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.** 0
D1.X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.** 0:5

Number	Indicator	Response
	by the plan in the past year per 1,000 beneficiaries enrolled in the plan on the first day of the last month of the reporting year?	
D1.X.4	**Count of resolved program integrity investigations** How many program integrity investigations have been resolved by the plan in the past year?	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.** 0
D1.X.5	**Ratio of resolved program integrity investigations to enrollees** What is the ratio of program integrity investigations resolved by the plan in the past year per 1,000 beneficiaries enrolled in the plan at the beginning of the reporting year?	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.** 0:5
D1.X.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 State Medicaid Agency (SMA) and MFCU concurrently **Count of program integrity referrals to the state** 0
D1.X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referral listed in the previous indicator made to the	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.** 0:5

Number	Indicator	Response
	state in the past year per 1,000 beneficiaries, using the plan's total enrollment as of the first day of the last month of the reporting year (reported in indicator D1.I.2) as the denominator.	
D1.X.9	**Plan overpayment reporting to the state** Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, for example, the following information: • The date of the report (rating period or calendar year). • The dollar amount of overpayments recovered. • The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 438.8(f)(2).	**WellCare Health Insurance of Arizona, Inc., dba Ohana Health Plan Inc.** The plan provides a quarterly overpayments report. The latest report was for the quarter ending 9/30/2022. The report includes MCO overpayments discovered and recovered.
D1.X.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.** Monthly

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

Number	Indicator	Response
E.IX.1	**BSS entity type** What type of entity was contracted to perform each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**Imua Family Services (Maui)** Other Community-Based Organization **Kumukahi Health & Wellness (Statewide)** Other Community-Based Organization **Legal Aid Society of Hawaii (Statewide)** Legal Assistance Organization **Project Vision Hawaii (Statewide)** Other Community-Based Organization **We Are Oceania (Primarily Oahu)** Other Community-Based Organization **Kalihi Palama Health Center** Other, specify FQHC **Kokua Kalihi Valley Comprehensive Family Services** Other, specify FQHC **Koolau Community Health & Wellness Center** Other, specify FQHC **Waianae Coats Comprehensive Health Center** Other, specify FQHC

Number	Indicator	Response
		Waikiki Health Other, specify FQHC **Waimanalo Health Center** Other, specify FQHC **Bay Clinic** Other, specify FQHC **West Hawaii Community Health Center** Other, specify FQHC **Hana Health** Other, specify FQHC **Malama I Ke Ola** Other, specify FQHC **Lanai Community Health Center** Other, specify FQHC **Molokai Community Health Center** Other, specify FQHC **Hoola Lahui Hawaii** Other, specify FQHC

Number	Indicator	Response
		Hamakua Health Center Other, specify FQHC **Adventist Health Castle** Other, specify Hospital facilities **Catholic Charities of Hawaii** Other Community-Based Organization **Executive Office on Aging** Other, specify State Health Insurance Assistance Program (SHIP) and also a state agency **Hawaii Health Systems Corporation** Other, specify Hospital facilities **Hui O Hauula** Other Community-Based Organization **Marshallese Association of Kauai** Other Community-Based Organization **Maui Health Systems** Other, specify Hospital facilities **Marshallese Community Organization of Hawaii** Other Community-Based Organization **One Stop Center for Micronesians of Hawaii Island**

Number	Indicator	Response
		Other Community-Based Organization **Queen's Medical Centers** Other, specify Hospital facilities
E.IX.2	**BSS entity role** What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	**Imua Family Services (Maui)** Other, specify Outreach, education, and enrollment assistance **Kumukahi Health & Wellness (Statewide)** Other, specify Outreach, education, and enrollment assistance **Legal Aid Society of Hawaii (Statewide)** Other, specify Outreach, education, and enrollment assistance **Project Vision Hawaii (Statewide)** Other, specify Outreach, education, and enrollment assistance **We Are Oceania (Primarily Oahu)** Other, specify Outreach, education, and enrollment assistance **Kalihi Palama Health Center** Other, specify Outreach, education, and enrollment assistance **Kokua Kalihi Valley Comprehensive Family Services** Other, specify Outreach, education, and enrollment assistance

Number	Indicator	Response
		Koolau Community Health & Wellness Center Other, specify Outreach, education, and enrollment assistance **Waianae Coats Comprehensive Health Center** Other, specify Outreach, education, and enrollment assistance **Waikiki Health** Other, specify Outreach, education, and enrollment assistance **Waimanalo Health Center** Other, specify Outreach, education, and enrollment assistance **Bay Clinic** Other, specify Outreach, education, and enrollment assistance **West Hawaii Community Health Center** Other, specify Outreach, education, and enrollment assistance **Hana Health** Other, specify Outreach, education, and enrollment assistance **Malama I Ke Ola** Other, specify Outreach, education, and enrollment assistance **Lanai Community Health Center** Other, specify

Number	Indicator	Response
		Outreach, education, and enrollment assistance
		Molokai Community Health Center
		Other, specify Outreach, education, and enrollment assistance
		Hoola Lahui Hawaii
		Other, specify Outreach, education, and enrollment assistance
		Hamakua Health Center
		Other, specify Outreach, education, and enrollment assistance
		Adventist Health Castle
		Other, specify Education and enrollment assistance (no outreach)
		Catholic Charities of Hawaii
		Other, specify Outreach, education, and enrollment assistance
		Executive Office on Aging
		Other, specify Outreach, education, and enrollment assistance
		Hawaii Health Systems Corporation
		Other, specify Education and enrollment assistance (no outreach)
		Hui O Hauula
		Other, specify Outreach, education, and enrollment assistance
		Marshallese Association of Kauai

Number	Indicator	Response
		Other, specify Outreach, education, and enrollment assistance **Maui Health Systems** Other, specify Education and enrollment assistance (no outreach) **Marshallese Community Organization of Hawaii** Other, specify Outreach, education, and enrollment assistance **One Stop Center for Micronesians of Hawaii Island** Other, specify Outreach, education, and enrollment assistance **Queen's Medical Centers** Other, specify Education and enrollment assistance (no outreach)