Managed Care Program Annual Report (MCPAR) for Hawaii: 2022_Community Care Services (CCS) Program

Due date	Last edited	Edited by	Status
12/27/2023	12/14/2023	Priscilla Thode	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

Point of Contact

Find in the Excel Workbook
A_Program_Info

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.	mqdcmcs@dhs.hawaii.gov
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Priscilla Thode
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	pthode@dhs.hawaii.gov
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	12/14/2023

Reporting Period

Find in the Excel Workbook
A_Program_Info

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	07/01/2022
A5b	**Reporting period end date** Auto-populated from report dashboard.	06/30/2023
A6	**Program name** Auto-populated from report dashboard.	2022_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.

Find in the Excel Workbook
A_Program_Info

	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 Indepedent Living (CIL), Legal Assistance Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.

Find in the Excel Workbook
A_Program_Info

Indicator	Response
BSS entity name	Hawaii Health and Harm Reduction Center
	Hui O Hauula
	Kalihi Palama Health Center
	Kokua Kalihi Valley Comprehensive Family Services
	Koolauloa Community Health and Wellness Center
	Legal Aid Society of Hawaii
	Project Vision Hawaii (Statewide)
	Waianae Coat Comprehensive Health Center
	Waikiki Health
	Waimanalo Health Center
	We Are Oceania
	Hawaii Island Community Health Center Hilo / Kona
	Hamakua Health Center
	Kumukahi Health + Wellness Kea'au and Kailua-Kona
	Hawaii Island YMCA
	Kalanihale
	Hana Health
	IMUA Family Services
	Lanai Community Health Center
	Malama I Ke Ola
	Maui Aids Foundation
	Molokai Community Health Center
	Hoola Lahui Hawaii
	Malama Pono Health Services
	Marshallese Association of Kauai

Topic I. Program Characteristics and Enrollment

Find in the Excel Workbook
B_State

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.	5,510
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.	5,510

Topic III. Encounter Data Report

Find in the Excel Workbook
B_State

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

Find in the Excel Workbook
B_State

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.	3 provider audits for review of opioid prescribing, and 1 audit of DME CPAP prescriptions and usage.
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 (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 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 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.
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	Yes

	indicator to assess plan reporting performance? Select one.	
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 §455.104 and required by 42 CFR 438.602(g)(3).	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 of the encounter and financial data submitted by the plans, what is the link(s) to the audit results? Refer to 42 CFR	https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/consumer-guides/HI2021-22_EQR_TechRpt_F1.pdf

438.602(e).

Topic I: Program Characteristics

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1I.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); June 9, 2021 (date of full execution)
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	06/09/2021
C1I.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
C1I.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)
C1I.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
C1I.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
C1I.5	**Program enrollment** Enter the average number of	5,510

	Enter the average number of individuals enrolled in this managed care program per month during the reporting year (i.e., average member months).	
C1I.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 were no major changes

Topic III: Encounter Data Report

Find in the Excel Workbook
C1_Program_Set

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)).	Other, specify – Encounter data is increasingly used for rate setting although it is not currently used for all aspects of rate setting; MQD also uses encounter data for monitoring and reporting, contract oversight, program integrity, & policy making and decision making.
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 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 & 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.	NA
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 period.	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

Find in the Excel Workbook
C1_Program_Set

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.	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.
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.	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.

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 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.H.1.b:DHS shall review the grievance and contact the Member with a determination within ninety (90) calendar days from the day the request for a grievance review is received;

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Find in the Excel Workbook
C1_Program_Set

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 standards.	Some gaps identified include reduced availablity on neighbor islands (i.e. all islands other than Oahu). THe MCP has addressed these gaps by transporting members to other islands to seek care. Additionally, single case aggreements or limited access agreements have been completed to ensure members on all islands have access to services. More specifically, the MCP has increased the number of pyschologists on Hawaii Island, Maui, Kauai, and Oahu in response to gaps identified.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	The state has developed a robust reporting package around provider network adequacy that also contains key performance indicators (KPIs) to measure progress toward meeting contract standards. Additionally, the state co-leads several workgroups with participation from the MCPs. Two specifically on quality and provider have discussed provider network adequacy as key focus areas.

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

Access measure total count: 5

Complete

C2.V.1 General category: 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.3 Standard type

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.1 General category: 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.3 Standard type

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.1 General category: 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.3 Standard type

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.1 General category: 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.3 Standard type

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.1 General category: General quantitative availability and accessibility standard

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.3 Standard type

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)

Find in the Excel Workbook
C1_Program_Set

Number	Indicator	Response
C1IX.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/gethelp
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))? 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 Partners are all required to provide assistance to beneficiaries by phone, via computer, in-person and must offer interpretation/translation services if need be along with any auxilliary aids and services when requested.
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).	Members will typically engage our BSS entities out in the community at events or fairs and will communicate and issues they may have with services or eligibility. The BSS entity will then provide this information to our Health Care Outreach team and we in turn will help to identify who can assist with the issue, complaint or grievance. We will try to resolve the issue before it escalates to the point of a grievance and appeal.
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?	Via monthly reports which shows how many outreach events they do, how many residents they assist or enroll either into Medicaid or the Federal Health Insurance Marketplace.

Topic X: Program Integrity

Find in the Excel Workbook
C1_Program_Set

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 I. Program Characteristics & Enrollment

Find in the Excel Workbook
D1_Plan_Set

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.** 5,510
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%

Topic II. Financial Performance

Find in the Excel Workbook
D1_Plan_Set

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.	**WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.** 91%
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.** 01/01/2021

N/A	Enter the end date.	**WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.** 12/31/2021

Topic III. Encounter Data

Find in the Excel Workbook
D1_Plan_Set

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) month 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 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.** 98%
D1III.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

Appeals Overview

Find in the Excel Workbook
D1_Plan_Set

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.** 9
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.** 3
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 (regardless of whether the enrollee was actively receiving LTSS at the time that the appeal was filed).	**WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.** N/A
D1IV.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,	**WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.** N/A

	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** 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.** 8
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 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.** 2

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.** 9
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.** 2
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	**WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.** 0

	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.	
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.** 0
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

Topic IV. Appeals, State Fair Hearings & Grievances

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.

Find in the Excel Workbook
D1_Plan_Set

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.** N/A
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, 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".	**WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.** N/A
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	**WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.** 0

	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".	
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.** 9
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.** N/A
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".	**WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.** N/A
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.** N/A

	"N/A".	
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.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.** 1

Topic IV. Appeals, State Fair Hearings & Grievances

State Fair Hearings

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of State Fair Hearing requests filed 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

Topic IV. Appeals, State Fair Hearings & Grievances

Grievances Overview

Find in the Excel Workbook
D1_Plan_Set

Number	Indicator	Response
D1IV.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.** 10
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.** 2
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.** N/A
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 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	**WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.** N/A

	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 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 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.** N/A

Topic IV. Appeals, State Fair Hearings & Grievances

Grievances by Service

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

Find in the Excel Workbook
D1_Plan_Set

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.** N/A
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, 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
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.** 25
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 were related to outpatient	**WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.** 4

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

	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".	5
D1IV.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 cover services other than those in items D1.IV.15a-i, enter "N/A".	**WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.** 4

Topic IV. Appeals, State Fair Hearings & Grievances

Grievances by Reason

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

Find in the Excel Workbook
D1_Plan_Set

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.** 11
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.** 13

D1IV.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.** 3
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.** 0
D1IV.16e	**Resolved grievances related to plan communications** Enter the total number of 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.	**WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.** 2

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 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 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 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	**WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.** 0

	were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	
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.

Find in the Excel Workbook
D2_Plan_Measures

Quality & performance measure total count: 20

Complete

D2.VII.1 Measure Name: Ambulatory Care- Total (per member years)ED Visits - Total (all ages)

1 / 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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

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

596.36

Complete

D2.VII.1 Measure Name: Ambulatory Care—Total (per member years) Outpatient Visits - (Total All Ages)

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

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

2657.62

Complete

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

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

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

58.87%

Complete

D2.VII.1 Measure Name: Antidepressant Medication Management - Effective Continuation Phase Treatment- Total 4 / 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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

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

46.75%

Complete

D2.VII.1 Measure Name: Diagnosed Mental Health Disorders - Total 5 / 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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

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

99.30%

Complete

D2.VII.1 Measure Name: Follow-Up After ED Visit for Substance Use- 30-Day Follow-Up- 18+ Years

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

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

68.16%

Complete

D2.VII.1 Measure Name: "Follow-Up After ED Visit for Substance Use-7-Day Follow-Up—18+ Years "

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

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

42.46%

Complete

D2.VII.1 Measure Name: "Follow-Up After Hospitalization for Mental Illness 30-Day Follow-Up—18-64 Years "

8 / 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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

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

62.00%

Complete

D2.VII.1 Measure Name: "Follow-Up After Hospitalization for Mental Illness - 7-Day Follow-Up—18-64 Years "

9 / 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

Medicaid Adult Core Set

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

No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

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

38.50%

Complete

D2.VII.1 Measure Name: "Follow-Up After ED Visit for Mental Illness 30-Day Follow-Up—HEDIS Total (18+ Years) " 10 / 20

D2.VII.2 Measure Domain

Behavioral health care

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

3499

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

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

89.91%

Complete

D2.VII.1 Measure Name: "Follow-Up After ED Visit for Mental Illness - 7-Day Follow-Up—18–64 Years " 11 / 20

D2.VII.2 Measure Domain

Behavioral health care

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

3499

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

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

73.03%

Complete

D2.VII.1 Measure Name: "Initiation and Engagement of Substance Use Disorder Treatment - Engagement—Alcohol Use Disorder—18+ Years "

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

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

89.91%

Complete

D2.VII.1 Measure Name: "Initiation and Engagement of Substance Use Disorder Treatment - Engagement—Opioid 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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

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

9.38%

Complete

D2.VII.1 Measure Name: "Initiation and Engagement of Substance Use Disorder Treatment - Engagement—Other Substance Use Disorder —18–64 Years "

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

Medicaid Adult Core Set

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

No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

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

5.70%

Complete

D2.VII.1 Measure Name: "Initiation and Engagement of Substance Use Disorder Treatment - Engagement—Total—18+ Years "

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

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

30.00%

Complete

D2.VII.1 Measure Name: "Initiation and Engagement of Substance Use Disorder Treatment - Initiation—Alcohol Use Disorder—18+ Years "

16 / 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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

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

35.71%

Complete

D2.VII.1 Measure Name: "Initiation and Engagement of Substance Use Disorder Treatment - Initiation—Opioid Use Disorder—18+ Years "

17 / 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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

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

66.59%

Complete

D2.VII.1 Measure Name: "Initiation and Engagement of Substance Use Disorder Treatment - Initiation—Other Substance Use Disorder—18+ Years "

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

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

35.82%

Complete

D2.VII.1 Measure Name: "Initiation and Engagement of Substance Use Disorder Treatment - Initiation—Total—Total "

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, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

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

30.38%

Complete

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

Medicaid Adult Core Set

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

No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

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

67.28%

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. Include any pending or unresolved actions.

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.

Find in the Excel Workbook
D3_Plan_Sanctions

Sanction total count:

0 - No sanctions entered

Topic X. Program Integrity

Find in the Excel Workbook

D1_Plan_Set

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.** 3
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.** 12
D1X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened 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?	**WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.** 2.14:1,000
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.** 1
D1X.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.** 0.17:1,000
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 State Medicaid Agency (SMA) and MFCU concurrently

D1X.7	**Count of program integrity referrals to the state** Enter the total number of program integrity referrals made during the reporting year.	**WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.** 8
D1X.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 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.1) as the denominator.	**WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.** 1.42:1,000
D1X.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, at minimum, 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 42 CFR 438.8(f)(2).	**WellCare Health Insurance of Arizona, Inc, dba 'Ohana Health Plan, Inc.** The plan provided quarterly reports on overpayments identified and recovered. The most recent report was for 4-1-23 to 6-30-23
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 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.

Find in the Excel Workbook
E_BSS_Entities

Number	Indicator	Response
EIX.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).	**Hawaii Health and Harm Reduction Center** Other Community-Based Organization Subcontractor **Hui O Hauula** Other Community-Based Organization **Kalihi Palama Health Center** Other Community-Based Organization **Kokua Kalihi Valley Comprehensive Family Services** Other Community-Based Organization **Koolauloa Community Health and Wellness Center** Other Community-Based Organization **Legal Aid Society of Hawaii** Legal Assistance Organization **Project Vision Hawaii (Statewide)** Subcontractor **Waianae Coat Comprehensive Health Center** Other Community-Based Organization **Waikiki Health** Other Community-Based Organization **Waimanalo Health Center** Other Community-Based Organization **We Are Oceania** Other Community-Based Organization **Hawaii Island Community Health Center**

Hilo / Kona

Other Community-Based Organization

Hamakua Health Center

Other Community-Based Organization

Kumukahi Health + Wellness Kea'au and Kailua-Kona

Subcontractor

Hawaii Island YMCA

Subcontractor

Kalanihale

Other Community-Based Organization

Hana Health

Other Community-Based Organization

IMUA Family Services

Subcontractor

Lanai Community Health Center

Other Community-Based Organization

Malama I Ke Ola

Subcontractor

Maui Aids Foundation

Subcontractor

Molokai Community Health Center

Other Community-Based Organization

Hoola Lahui Hawaii

Other Community-Based Organization

Malama Pono Health Services

Subcontractor

		Marshallese Association of Kauai Other Community-Based Organization
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).	**Hawaii Health and Harm Reduction Center** Enrollment Broker/Choice Counseling Beneficiary Outreach Other, specify – Education and Enrollment assistance. Assisting beneficiaries to report any changes that will affect their eligibility. **Hui O Hauula** Enrollment Broker/Choice Counseling Beneficiary Outreach Other, specify – Education and Enrollment assistance. Assisting beneficiaries to report any changes that will affect their eligibility. **Kalihi Palama Health Center** Enrollment Broker/Choice Counseling Beneficiary Outreach Other, specify – Outreach, education and enrollment assistance, updating member contact information to assist with preparation for start of redeterminations **Kokua Kalihi Valley Comprehensive Family Services** Enrollment Broker/Choice Counseling Beneficiary Outreach Other, specify – Outreach, education and enrollment assistance, updating member contact information to assist with preparation for start of redeterminations. **Koolauloa Community Health and Wellness Center** Enrollment Broker/Choice Counseling Beneficiary Outreach Other, specify – Outreach, education and enrollment assistance, updating member contact information to assist with preparation for start of redeterminations.

Legal Aid Society of Hawaii

Other, specify – Outreach, education and enrollment assistance, updating member contact information to assist with preparation for start of redeterminations.

Project Vision Hawaii (Statewide)

Other, specify – Outreach, education and enrollment assistance, updating member contact information to assist with preparation for start of redeterminations.

Waianae Coat Comprehensive Health Center

Other, specify – Outreach, education and enrollment assistance, updating member contact information to assist with preparation for start of redeterminations.

Waikiki Health

Other, specify – Outreach, education and enrollment assistance, updating member contact information to assist with preparation for start of redeterminations.

Waimanalo Health Center

Other, specify – Outreach, education and enrollment assistance, updating member contact information to assist with preparation for start of redeterminations.

We Are Oceania

Other, specify – Outreach, education and enrollment assistance, updating member contact information to assist with preparation for start of redeterminations.

Hawaii Island Community Health Center Hilo / Kona

Other, specify – Outreach, education and enrollment assistance, updating member contact information to assist with preparation for start of redeterminations.

Hamakua Health Center

Other, specify – Outreach, education and enrollment assistance, updating member contact information to assist with preparation for start of redeterminations.

Kumukahi Health + Wellness Kea'au and Kailua-Kona

Other, specify – Outreach, education and enrollment assistance, updating member contact information to assist with preparation for start of redeterminations.

Hawaii Island YMCA

Other, specify – Outreach, education and enrollment assistance, updating member contact information to assist with preparation for start of redeterminations.

Kalanihale

Other, specify – Outreach, education and enrollment assistance, updating member contact information to assist with preparation for start of redeterminations.

Hana Health

Other, specify – Outreach, education and enrollment assistance, updating member contact information to assist with preparation for start of redeterminations.

IMUA Family Services

Other, specify – Outreach, education and enrollment assistance, updating member contact information to assist with preparation for start of redeterminations.

Lanai Community Health Center

Other, specify – Outreach, education and enrollment assistance, updating member contact information to assist with preparation for start of redeterminations.

Malama I Ke Ola

Other, specify – Outreach, education and enrollment assistance, updating member

contact information to assist with preparation for start of redeterminations.

Maui Aids Foundation

Other, specify – Outreach, education and enrollment assistance, updating member contact information to assist with preparation for start of redeterminations.

Molokai Community Health Center

Other, specify – Outreach, education and enrollment assistance, updating member contact information to assist with preparation for start of redeterminations.

Hoola Lahui Hawaii

Other, specify – Outreach, education and enrollment assistance, updating member contact information to assist with preparation for start of redeterminations.

Malama Pono Health Services

Other, specify – Outreach, education and enrollment assistance, updating member contact information to assist with preparation for start of redeterminations.

Marshallese Association of Kauai

Other, specify – Outreach, education and enrollment assistance, updating member contact information to assist with preparation for start of redeterminations.