Managed Care Program Annual Report (MCPAR) for Hawaii: QUEST Integration

Due date	Last edited	Edited by	Status
06/29/2023	06/29/2023	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

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	Jon D. Fujii - Health Care Services Branch Administrator

	email address that will allow anyone with questions to quickly reach someone who can provide answers.	
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.	Stacie Coats
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	scoats@dhs.hawaii.gov
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	06/29/2023

Reporting Period

Find in the Excel Workbook
A_Program_Info

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	01/01/2022
A5b	**Reporting period end date** Auto-populated from report dashboard.	12/31/2022
A6	**Program name** Auto-populated from report dashboard.	QUEST Integration

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

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	Imua Family Services
	Kumukahi Health + Wellness
	Legal Aid Society of Hawaii
	Project Vision Hawaii
	We Are Oceania
	Kalihi Palama Health Center
	Kokua Kalihi Valley Commprehensive Family Services
	Koolauloa Community Health & Wellness Center
	Waianae Coast Comprehensive Health Center

Waikiki Health

Waimanalo Health Center

Bay Clinic

Hawaii Island 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 Center

Topic I. Program Characteristics and Enrollment

Find in the Excel Workbook
B_State

Number	Indicator	Response
BI.1	**Statewide Medicaid enrollment** Enter the total number of individuals enrolled in Medicaid as of the first day of the last	458,520

	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.	
BI.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.	458,418

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.	Data analysis and audits were conducted regarding drug screening confirmative and presumptive testing, and CPAP and sleep studies.
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
BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain	The Health Plan shall recover and report all overpayments, unless otherwise prohibited under this RFP or federal or state law. “Overpayment” as used in this section is defined in 42 CFR §438.2. All overpayments identified by the Health Plan shall be reported to DHS in accordance with §6.2.F. The overpayment shall be reported in the reporting period in which the overpayment is identified. It is understood the Health Plan may not be able to complete recovery of overpayment until after the reporting period. The Health Plan shall report to DHS the full overpayment identified.

	overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	
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. 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 reconcillation, MQD sends a monthly 834 file which contains the enrire current client data for the next month. MQD also asks MCOs to submit an 1179A Form to report Changes in Circumstances for our members, including change to household composition, member names, member addresses, or additional insurance. MQD reviews submitted 1179A information and completes updates in our KOLEA eligibility system; these changes are then communicated back to the health plan via 834.
BX.7a	**Changes in provider circumstances: Monitoring plans** Does the state monitor whether plans report provider “for cause” terminations in a timely manner under	Yes

	42 CFR 438.608(a)(4)? Select one.	
BX.7b	**Changes in provider circumstances: Metrics** Does the state use a metric or indicator to assess plan reporting performance? Select one.	Yes
BX.7c	**Changes in provider circumstances: Describe metric** Describe the metric or indicator that the state uses.	The State measures the percent of "for cause" suspensions or terminations that are reported to the State within 3 business days as a Key Performance Indicator on the Program Integrity report.
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	No

	entities and subcontractors? Refer to §455.104 and required by 42 CFR 438.602(g)(3).	
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 438.602(e).	https://medquest.hawaii.gov/content/dam/formsanddocuments/resources/consumer-guides/HI2021-22_EQR_TechRpt_F1.pdf

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.	QUEST Integration (QI) Managed Care to Cover Medicaid and Other Eligible Individuals RFP-MQD-2021-008
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	Managed Care Organization (MCO)

	services covered under the program? Select one.	
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 Long-term services and supports (LTSS) Transportation
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 total number of individuals enrolled in the managed care program as of the first day of the last month of the reporting year.	458,418
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 are no major changes to the Medicaid population or benefits provided by the managed care program during the reporting year.

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)).	Rate setting Monitoring and reporting Contract oversight Program integrity Policy making and decision support Other, specify – Evaluations
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 certifications Use of correct file formats Provider ID field complete Other, specify – other types of encounter data validation for accuracy and completeness are used in addition.
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 6.4
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 G (Encounter Data - 16-19)
C1III.5	**Incentives for encounter data quality**	N/A

	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.	
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.	An event, preventable or nonpreventable, that caused harm to a patient as a result of medical care, institutional/ residential care, or resulted from provider preventable conditions or healthcare acquired conditions.
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.	Contract RFP-MQD-2021-008: 9.5.I.9 If the Health Plan denies a request for expedited resolution of an appeal, it shall transfer the appeal to the standard timeframe of no longer than thirty (30) days from the day the Health Plan receives the appeal, with a possible fourteen (14) days extension.
C1IV.3	**State definition of "timely" resolution for expedited appeals**	"Contract RFP-MQD-2021-008: 9.5.I.5 For expedited resolution of an appeal, the Health Plan shall resolve the appeal and provide

	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.	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 Health Plan received the appeal. The Health Plan shall make reasonable efforts to also provide oral notice of the appeal determination to the Member. Contract RFP-MQD-2021-008: 9.5.I.7,a-e The Health Plan may extend the expedited appeal resolution time frame by up to fourteen additional (14) days if the Member requests the extension or the Health Plan 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 Health Plan denies a request for expedited resolution of an appeal, it shall: a. Transfer the appeal to the time frame for standard resolution; b. Make reasonable efforts to give the Member prompt oral notice of the delay or denial; c. Within two (2) 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; d. Inform the Member orally and in writing that they may file a grievance with the Health Plan for the delay or denial 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."
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.	Contract RFP-MQD-2021-008: 9.5.E.7.b Convey a disposition, in writing, of the grievance resolution as expeditiously as the Member's health condition requires, but no later than thirty (30) days of the initial expression of dissatisfaction; and Contract RFP-MQD-2021-008: 9.5.E.9-The Health Plan may extend the timeframe for processing a grievance by up to fourteen (14) days if the Member requests the extension; or if the Health Plan shows that there is need for additional information and that the delay is in the Member's interest.

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.	Provider shortages / recruitment among Oahu rural neighborhoods and neighboring islands are the State's biggest challenges.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	The MCPS continously monitor their provider networks to identify potential or existing gaps which are then relayed to the 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 available in the member's immediate demographic area, the MCPS will coordinate transportation to ensure the member can receive services until the network gap is filled. The MCPS can fly members to other islands (or out-of-state) to receive care. Willing providers can also be flown to the neighbor islands. Another method for connecting members with providers is telehealth via phone or "virtual visits." If a MCPS network is unable to provide a particular service, 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

Access measure total count: 4

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

1 / 4

C2.V.2 Measure standard

The MCO shall meet the following geographic access standards for all members: Hospitals (30 min 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	(free text, specify) Urban and Rural	Adult and pediatric

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 / 4

C2.V.2 Measure standard

The MCO shall meet the following geographic access standards for all members: Primary Care Providers (30 min 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
Primary care	(free text, specify) Urban and Rural	Adult and pediatric

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 / 4

C2.V.2 Measure standard

The MCO shall meet the following geographic access standards for all members: Pharmacies (15 min 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
(free text, specify) Pharmacies	(free text, specify) Urban and Rural	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: Exceptions to time and distance standards

4 / 4

C2.V.2 Measure standard

The MCO shall meet the following geographic access standards for LTSS members:Adult Day Care/Adult Day Health (30 min 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
LTSS-adult day care	(free text, specify) Urban and Rural	MLTSS

C2.V.7 Monitoring Methods

Geomapping

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 Organizations who are contracted and/or have business associate agreements with Med-QUEST, are trained and provided access to the Navigator portal of our KOLEA eligibility system, where these organization may assist residents in applying for health coverage, report changes, etc. This can be done, by virtual meeting, phone, in-person or with an interpreter.
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).	Assist with application information and required supplemental documentation needed to additionally support requests for LTSS.
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?	For community organizations that are contracted by DHS Med-QUEST Division, these organizations are required to submit monthly reports that support their contract agreement and aligns with their awarded proposal. For other organizations,the Health Care Outreach Branch works closely with all the Navigators (Kokua) identified at these organizations and we monitor the assistance they provide residents, we have monthly Statewide meetings, where organizations can bring up any challenges or issues they may need help

with. They also report on successes they experience.

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** What is the total number of individuals enrolled in each plan as of the first day of the last month of the reporting year?	**AlohaCare** 83,525 **Hawaii Medical Service Association (HMSA)** 222378 **Kaiser Permanente** 51357 **Ohana Health Plan** 40241 **UnitedHealthcare Community Plan** 60,917

Number	Indicator	Response
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)	**AlohaCare** 18.2% **Hawaii Medical Service Association (HMSA)** 48.5% **Kaiser Permanente** 11.2% **Ohana Health Plan** 8.8% **UnitedHealthcare Community Plan** 13.3%
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)	**AlohaCare** 18.2% **Hawaii Medical Service Association (HMSA)** 48.5% **Kaiser Permanente** 11.2% **Ohana Health Plan** 8.8% **UnitedHealthcare Community Plan** 13.3%

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	**AlohaCare** 90.8%%

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.

Hawaii Medical Service Association (HMSA)

92.7%%

Kaiser Permanente

91.7%%

Ohana Health Plan

93.6%%

UnitedHealthcare Community Plan

90.6%%

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.

AlohaCare

Program-specific statewide

Hawaii Medical Service Association (HMSA)

Program-specific statewide

Kaiser Permanente

Program-specific statewide

Ohana Health Plan

Program-specific statewide

UnitedHealthcare Community Plan

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.

AlohaCare

N/A

Hawaii Medical Service Association (HMSA)

N/A

Kaiser Permanente

N/A

Ohana Health Plan

N/A

UnitedHealthcare Community Plan

		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?	**AlohaCare** Yes **Hawaii Medical Service Association (HMSA)** Yes **Kaiser Permanente** Yes **Ohana Health Plan** Yes **UnitedHealthcare Community Plan** Yes
N/A	Enter the start date.	**AlohaCare** 01/01/2021 **Hawaii Medical Service Association (HMSA)** 01/01/2021 **Kaiser Permanente** 01/01/2021 **Ohana Health Plan** 01/01/2021 **UnitedHealthcare Community Plan** 01/01/2021
N/A	Enter the end date.	**AlohaCare** 12/31/2021 **Hawaii Medical Service Association (HMSA)** 12/31/2021 **Kaiser Permanente** 12/31/2021

Ohana Health Plan

12/31/2021

UnitedHealthcare Community Plan

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.	**AlohaCare** 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. **Hawaii Medical Service Association (HMSA)** 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. **Kaiser Permanente** 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. **Ohana Health Plan** 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. **UnitedHealthcare Community Plan** 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.	**AlohaCare** 83% **Hawaii Medical Service Association (HMSA)** 91% **Kaiser Permanente** 94% **Ohana Health Plan** 71% **UnitedHealthcare Community Plan** 96%

Number	Indicator	Response
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.	**AlohaCare** 100% **Hawaii Medical Service Association (HMSA)** 100% **Kaiser Permanente** 100% **Ohana Health Plan** 100% **UnitedHealthcare Community Plan** 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 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.	**AlohaCare** 197 **Hawaii Medical Service Association (HMSA)** 950 **Kaiser Permanente** 9 **Ohana Health Plan** 132 **UnitedHealthcare Community Plan** 128
D1IV.2	**Active appeals**	**AlohaCare**

	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.	1 **Hawaii Medical Service Association (HMSA)** 133 **Kaiser Permanente** 2 **Ohana Health Plan** 11 **UnitedHealthcare Community Plan** 16
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).	**AlohaCare** 16 **Hawaii Medical Service Association (HMSA)** 0 **Kaiser Permanente** 0 **Ohana Health Plan** 22 **UnitedHealthcare Community Plan** 16
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, enter "N/A". Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and	**AlohaCare** N/A **Hawaii Medical Service Association (HMSA)** N/A **Kaiser Permanente** N/A **Ohana Health Plan** N/A

	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.	**UnitedHealthcare Community Plan** N/A
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.	**AlohaCare** 154 **Hawaii Medical Service Association (HMSA)** 460 **Kaiser Permanente** 6 **Ohana Health Plan** 86 **UnitedHealthcare Community Plan** 52
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.	**AlohaCare** 36 **Hawaii Medical Service Association (HMSA)** 286

	See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**Kaiser Permanente** 0 **Ohana Health Plan** 32 **UnitedHealthcare Community Plan** 6
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).	**AlohaCare** 0 **Hawaii Medical Service Association (HMSA)** 0 **Kaiser Permanente** 0 **Ohana Health Plan** 3 **UnitedHealthcare Community Plan** 0
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.	**AlohaCare** 0 **Hawaii Medical Service Association (HMSA)** 0 **Kaiser Permanente** 0 **Ohana Health Plan** 0 **UnitedHealthcare Community Plan** 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.	**AlohaCare** 0 **Hawaii Medical Service Association (HMSA)** 6 **Kaiser Permanente** 3 **Ohana Health Plan** 12 **UnitedHealthcare Community Plan** 0
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).	**AlohaCare** 0 **Hawaii Medical Service Association (HMSA)** 0 **Kaiser Permanente** 0 **Ohana Health Plan** 0 **UnitedHealthcare Community Plan** 0
D1IV.6e	**Resolved appeals related to lack of timely plan response to an appeal or grievance** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR §438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	**AlohaCare** 0 **Hawaii Medical Service Association (HMSA)** 0 **Kaiser Permanente** 0 **Ohana Health Plan**

		3 **UnitedHealthcare Community Plan** 0
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).	**AlohaCare** 0 **Hawaii Medical Service Association (HMSA)** 0 **Kaiser Permanente** 0 **Ohana Health Plan** 0 **UnitedHealthcare Community Plan** 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.	**AlohaCare** 0 **Hawaii Medical Service Association (HMSA)** 0 **Kaiser Permanente** 2 **Ohana Health Plan** 0 **UnitedHealthcare Community Plan** 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".	**AlohaCare** 0 **Hawaii Medical Service Association (HMSA)** 0 **Kaiser Permanente** 0 **Ohana Health Plan** 0 **UnitedHealthcare Community Plan** 0
D1IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, 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".	**AlohaCare** 2 **Hawaii Medical Service Association (HMSA)** 498 **Kaiser Permanente** 1 **Ohana Health Plan** 29 **UnitedHealthcare Community Plan** 43
D1IV.7c	**Resolved appeals related to inpatient behavioral health services**	**AlohaCare**

	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".	0 **Hawaii Medical Service Association (HMSA)** 0 **Kaiser Permanente** 0 **Ohana Health Plan** 7 **UnitedHealthcare Community Plan** 0
D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".	**AlohaCare** 0 **Hawaii Medical Service Association (HMSA)** 4 **Kaiser Permanente** 1 **Ohana Health Plan** 2 **UnitedHealthcare Community Plan** 0
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".	**AlohaCare** 155 **Hawaii Medical Service Association (HMSA)** 322 **Kaiser Permanente** 0 **Ohana Health Plan** 89

UnitedHealthcare Community Plan

94

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".

AlohaCare

0

Hawaii Medical Service Association (HMSA)

2

Kaiser Permanente

1

Ohana Health Plan

0

UnitedHealthcare Community Plan

2

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".

AlohaCare

5

Hawaii Medical Service Association (HMSA)

1

Kaiser Permanente

1

Ohana Health Plan

3

UnitedHealthcare Community Plan

0

D1IV.7h

Resolved appeals related to dental services

Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A".

AlohaCare

0

Hawaii Medical Service Association (HMSA)

1

Kaiser Permanente

		0 **Ohana Health Plan** 0 **UnitedHealthcare Community Plan** 1
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".	**AlohaCare** 3 **Hawaii Medical Service Association (HMSA)** 4 **Kaiser Permanente** 0 **Ohana Health Plan** 0 **UnitedHealthcare Community Plan** 1
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".	**AlohaCare** 34 **Hawaii Medical Service Association (HMSA)** 40 **Kaiser Permanente** 3 **Ohana Health Plan** 5 **UnitedHealthcare Community Plan** 12

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 requests for a State Fair Hearing filed during the reporting year by plan that issued the adverse benefit determination.	**AlohaCare** 0 **Hawaii Medical Service Association (HMSA)** 8 **Kaiser Permanente** 0 **Ohana Health Plan** 2 **UnitedHealthcare Community Plan** 3
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.	**AlohaCare** 0 **Hawaii Medical Service Association (HMSA)** 3 **Kaiser Permanente** 0 **Ohana Health Plan** 0 **UnitedHealthcare Community Plan** 2
D1IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered	**AlohaCare** 0 **Hawaii Medical Service Association (HMSA)**

	during the reporting year that were adverse for the enrollee.	4 **Kaiser Permanente** 0 **Ohana Health Plan** 0 **UnitedHealthcare Community Plan** 2
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) prior to reaching a decision.	**AlohaCare** 0 **Hawaii Medical Service Association (HMSA)** 1 **Kaiser Permanente** 0 **Ohana Health Plan** 1 **UnitedHealthcare Community Plan** 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).	**AlohaCare** N/A **Hawaii Medical Service Association (HMSA)** N/A **Kaiser Permanente** N/A **Ohana Health Plan** N/A **UnitedHealthcare Community Plan** N/A

Number	Indicator	Response
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).	**AlohaCare** N/A **Hawaii Medical Service Association (HMSA)** N/A **Kaiser Permanente** N/A **Ohana Health Plan** N/A **UnitedHealthcare Community Plan** 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.	**AlohaCare** 430 **Hawaii Medical Service Association (HMSA)** 210 **Kaiser Permanente** 297 **Ohana Health Plan** 310 **UnitedHealthcare Community Plan** 383
D1IV.11	**Active grievances**	**AlohaCare**

	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.	01 **Hawaii Medical Service Association (HMSA)** 58 **Kaiser Permanente** 0 **Ohana Health Plan** 39 **UnitedHealthcare Community Plan** 6
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.	**AlohaCare** 112 **Hawaii Medical Service Association (HMSA)** 04 **Kaiser Permanente** 0 **Ohana Health Plan** 97 **UnitedHealthcare Community Plan** 50
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 -	**AlohaCare** 0 **Hawaii Medical Service Association (HMSA)** 0 **Kaiser Permanente** 0 **Ohana Health Plan** 0

	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 grievance preceded the filing of the critical incident.	**UnitedHealthcare Community Plan** 0
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.	**AlohaCare** 427 **Hawaii Medical Service Association (HMSA)** 199 **Kaiser Permanente** 297 **Ohana Health Plan** 308 **UnitedHealthcare Community Plan**

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".	**AlohaCare** 01 **Hawaii Medical Service Association (HMSA)** 0 **Kaiser Permanente** 0 **Ohana Health Plan** 0 **UnitedHealthcare Community Plan** 0
D1IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, 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".	**AlohaCare** 55 **Hawaii Medical Service Association (HMSA)** 98 **Kaiser Permanente** 37 **Ohana Health Plan** 13

		UnitedHealthcare Community Plan 49
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".	**AlohaCare** 17 **Hawaii Medical Service Association (HMSA)** 0 **Kaiser Permanente** 0 **Ohana Health Plan** 0 **UnitedHealthcare Community Plan** 0
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 mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**AlohaCare** 3 **Hawaii Medical Service Association (HMSA)** 4 **Kaiser Permanente** 21 **Ohana Health Plan** 2 **UnitedHealthcare Community Plan** 3
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	**AlohaCare** 18 **Hawaii Medical Service Association (HMSA)** 12 **Kaiser Permanente**

	cover this type of service, enter "N/A".	3 **Ohana Health Plan** 2 **UnitedHealthcare Community Plan** 3
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".	**AlohaCare** 0 **Hawaii Medical Service Association (HMSA)** 2 **Kaiser Permanente** 0 **Ohana Health Plan** 0 **UnitedHealthcare Community Plan** 0
D1IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	**AlohaCare** 32 **Hawaii Medical Service Association (HMSA)** 2 **Kaiser Permanente** 0 **Ohana Health Plan** 8 **UnitedHealthcare Community Plan** 0
D1IV.15h	**Resolved grievances related to dental services**	**AlohaCare** 4

	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".	**Hawaii Medical Service Association (HMSA)** 2 **Kaiser Permanente** 3 **Ohana Health Plan** 0 **UnitedHealthcare Community Plan** 10
D1IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)** Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".	**AlohaCare** 244 **Hawaii Medical Service Association (HMSA)** 50 **Kaiser Permanente** 7 **Ohana Health Plan** 87 **UnitedHealthcare Community Plan** 281
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".	**AlohaCare** 65 **Hawaii Medical Service Association (HMSA)** 68 **Kaiser Permanente** 94 **Ohana Health Plan** 195 **UnitedHealthcare Community Plan**

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.	**AlohaCare** 171 **Hawaii Medical Service Association (HMSA)** 152 **Kaiser Permanente** 117 **Ohana Health Plan** 57 **UnitedHealthcare Community Plan** 149
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	**AlohaCare** 1 **Hawaii Medical Service Association (HMSA)** 2 **Kaiser Permanente** 0 **Ohana Health Plan** 53

provider care or case management process.

UnitedHealthcare Community Plan

12

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.

AlohaCare

212

Hawaii Medical Service Association (HMSA)

5

Kaiser Permanente

65

Ohana Health Plan

73

UnitedHealthcare Community Plan

171

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.

AlohaCare

49

Hawaii Medical Service Association (HMSA)

35

Kaiser Permanente

34

Ohana Health Plan

2

UnitedHealthcare Community Plan

9

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

AlohaCare

4

Hawaii Medical Service Association (HMSA)

6

Kaiser Permanente

	the clarity or accuracy of enrollee materials or other plan communications or to an enrollee's access to or the accessibility of enrollee materials or plan communications.	0 **Ohana Health Plan** 29 **UnitedHealthcare Community Plan** 0
D1IV.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.	**AlohaCare** 4 **Hawaii Medical Service Association (HMSA)** 6 **Kaiser Permanente** 29 **Ohana Health Plan** 20 **UnitedHealthcare Community Plan** 8
D1IV.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 the Inspector General.	**AlohaCare** 0 **Hawaii Medical Service Association (HMSA)** 0 **Kaiser Permanente** 0 **Ohana Health Plan** 0 **UnitedHealthcare Community Plan** 2
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation**	**AlohaCare** 0

	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.	**Hawaii Medical Service Association (HMSA)** 0 **Kaiser Permanente** 2 **Ohana Health Plan** 16 **UnitedHealthcare Community Plan** 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 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).	**AlohaCare** 0 **Hawaii Medical Service Association (HMSA)** 1 **Kaiser Permanente** 0 **Ohana Health Plan** 0 **UnitedHealthcare Community Plan** 0
D1IV.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. 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	**AlohaCare** 0 **Hawaii Medical Service Association (HMSA)** 0 **Kaiser Permanente** 1 **Ohana Health Plan** 1 **UnitedHealthcare Community Plan**

	appeal, the enrollee or their representative have the right to file a grievance.	0
D1IV.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.	**AlohaCare** 27 **Hawaii Medical Service Association (HMSA)** 32 **Kaiser Permanente** 72 **Ohana Health Plan** 96 **UnitedHealthcare Community Plan** 24

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: 8

Complete

D2.VII.1 Measure Name: Well-Child Visits for Age 15 Months to 30 Months—Two or More Well-Child Visits 1 / 8

D2.VII.2 Measure Domain

Primary care access and preventative care

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

NQF 1392

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, 01/01/2021 - 12/31/2021

D2.VII.8 Measure Description

N/A

Measure results

AlohaCare

59.23%

Hawaii Medical Service Association (HMSA)

72.86%

Kaiser Permanente

80.51%

Ohana Health Plan

59.82%

UnitedHealthcare Community Plan

52.88%

Complete

D2.VII.1 Measure Name: Prenatal and Postpartum Care -- Timeliness of Prenatal Care

D2.VII.2 Measure Domain

Maternal and perinatal health

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

NQF 1517

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, 01/01/2021 - 12/31/2021

D2.VII.8 Measure Description

N/A

Measure results

AlohaCare

82.48%

Hawaii Medical Service Association (HMSA)

84.48%

Kaiser Permanente

89.62%

Ohana Health Plan

79.58%

UnitedHealthcare Community Plan

78.35%

Complete

D2.VII.1 Measure Name: Comprehensive Diabetes Care -- Hemoglobin A1c (HbA1c) Control < 8.0% (Total)

3 / 8

D2.VII.2 Measure Domain

Care of acute and chronic conditions

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

NQF 0057

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, 01/01/2021 - 12/31/2021

D2.VII.8 Measure Description

N/A

Measure results

AlohaCare

48.66%

Hawaii Medical Service Association (HMSA)

48.05%

Kaiser Permanente

52.64%

Ohana Health Plan

52.55%

UnitedHealthcare Community Plan

57.42%

Complete

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

D2.VII.2 Measure Domain

Behavioral health care

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

NQF 0576

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, 01/01/2021 - 12/31/2021

D2.VII.8 Measure Description

N/A

Measure results

AlohaCare

48.23%

Hawaii Medical Service Association (HMSA)

60.66%

Kaiser Permanente

67.70%

Ohana Health Plan

67.10%

UnitedHealthcare Community Plan

62.72%

Complete

D2.VII.1 Measure Name: Total Eligibles Receiving Any Dental Services

5 / 8

D2.VII.2 Measure Domain

Dental and oral health services

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

State-specific

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

Yes

D2.VII.8 Measure Description

Adult and Child dental are handled by our FFS program and not included in MCPAR reporting.

Measure results

AlohaCare

N/A

Hawaii Medical Service Association (HMSA)

N/A

Kaiser Permanente

N/A

Ohana Health Plan

N/A

UnitedHealthcare Community Plan

N/A

Complete

D2.VII.1 Measure Name: CAHPS getting needed care

6 / 8

D2.VII.2 Measure Domain

Health plan enrollee experience of 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, 01/01/2021 - 12/31/2021

D2.VII.8 Measure Description

N/A

Measure results

AlohaCare

79.20%

Hawaii Medical Service Association (HMSA)

78.50%

Kaiser Permanente

79.60%

Ohana Health Plan

80.40%

UnitedHealthcare Community Plan

77.80%

Complete

D2.VII.1 Measure Name: Long-Term Services and Supports (LTSS) Comprehensive Care Plan and Update: Care Plan with Core Elements Documented

D2.VII.2 Measure Domain

Long-term services and supports

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

CMS Core Set

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

No, 10/01/2020 - 09/30/2021

D2.VII.8 Measure Description

CMS MTLSS Technical Specifications found here: https://www.medicaid.gov/medicaid/managed-care/downloads/mltss-tech-specs-res-manual-2022-updated.pdf

Measure results

AlohaCare

40.63%

Hawaii Medical Service Association (HMSA)

3.13%

Kaiser Permanente

10.11%

Ohana Health Plan

12.50%

UnitedHealthcare Community Plan

6.25%

Complete

D2.VII.1 Measure Name: Plan All Cause Readmission -- O/E Ratio—Total

8 / 8

D2.VII.2 Measure Domain

Hospital Readmission

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

NQF 1789

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, 01/01/2021 - 12/31/2021

D2.VII.8 Measure Description

N/A

Measure results

AlohaCare

0.7363

Hawaii Medical Service Association (HMSA)

0.7854

Kaiser Permanente

0.6959

Ohana Health Plan

0.8388

UnitedHealthcare Community Plan

0.9014

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).	**AlohaCare** 6 **Hawaii Medical Service Association (HMSA)** 7 **Kaiser Permanente**

		1 **Ohana Health Plan** 3 **UnitedHealthcare Community Plan** 1
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations have been opened by the plan in the past year?	**AlohaCare** 3 **Hawaii Medical Service Association (HMSA)** 19 **Kaiser Permanente** 1 **Ohana Health Plan** 29 **UnitedHealthcare Community Plan** 84
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?	**AlohaCare** 0.04:1,000 **Hawaii Medical Service Association (HMSA)** 0.036:1000 **Kaiser Permanente** 0.019:1000 **Ohana Health Plan** 0.63:1000 **UnitedHealthcare Community Plan** 1.36:1000
D1X.4	**Count of resolved program integrity investigations**	**AlohaCare** 0

How many program integrity investigations have been resolved by the plan in the past year?

Hawaii Medical Service Association (HMSA)

6

Kaiser Permanente

1

Ohana Health Plan

48

UnitedHealthcare Community Plan

44

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?

AlohaCare

0:0

Hawaii Medical Service Association (HMSA)

0.027:1000

Kaiser Permanente

0.019:1000

Ohana Health Plan

1.06:1000

UnitedHealthcare Community Plan

0.71:1000

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.

AlohaCare

Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently

Hawaii Medical Service Association (HMSA)

Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently

Kaiser Permanente

Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently

Ohana Health Plan

		Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently **UnitedHealthcare Community Plan** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently
D1X.7	**Count of program integrity referrals to the state** Enter the count of program integrity referrals that the plan made to the state in the past year. Enter the count of unduplicated referrals	**AlohaCare** 4 **Hawaii Medical Service Association (HMSA)** 15 **Kaiser Permanente** 1 **Ohana Health Plan** 3 **UnitedHealthcare Community Plan** 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.2) as the denominator.	**AlohaCare** 0.05:1,000 **Hawaii Medical Service Association (HMSA)** 0.067:1000 **Kaiser Permanente** 0.019:1000 **Ohana Health Plan** 0.07:1000 **UnitedHealthcare Community Plan** 0.13:1000
D1X.9	**Plan overpayment reporting to the state** Describe the plan's latest annual overpayment recovery report submitted to the state as	**AlohaCare** The plan provides a quarterly overpayments report. The latest report was for the quarter ending 1/31/2023.

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).

The report includes MCO overpayments discovered and recovered. We are planning to create an additional annual report, and the data that we're reporting in the MCPAR this year is a compilation of data from different sources. For CY 2022, AlohaCare reported $4,119,215 in recovered overpayments. The ratio of recovered overpayments to premium revenue is 0.9%.

Hawaii Medical Service Association (HMSA)

The plan provides a quarterly overpayments report. The latest report was for the quarter ending 1/31/2023. The report includes MCO overpayments discovered and recovered. We are planning to create an additional annual report, and the data that we're reporting in the MCPAR this year is a compilation of data from different sources. For CY 2022, HMSA reported $4,368,114 in recovered overpayments. The ratio of recovered overpayments to premium revenue is 0.4%.

Kaiser Permanente

The plan provides a quarterly overpayments report. The latest report was for the quarter ending 1/31/2023. The report includes MCO overpayments discovered and recovered. We are planning to create an additional annual report, and the data that we're reporting in the MCPAR this year is a compilation of .data from different sources. For CY 2022, Kaiser reported $527,904 in recovered overpayments. The ratio of recovered overpayments to premium revenue is 0.3%

Ohana Health Plan

The plan provides a quarterly overpayments report. The latest report was for the quarter ending 1/31/2023. The report includes MCO overpayments discovered and recovered. We are planning to create an additional annual report, and the data that we're reporting in the MCPAR this year is a compilation of data from different sources. For CY 2022, Ohana reported $10,596,807 in recovered

		overpayments. The ratio of recovered overpayments to premium revenue is 3%. **UnitedHealthcare Community Plan** The plan provides a quarterly overpayments report. The latest report was for the quarter ending 1/31/2023. The report includes MCO overpayments discovered and recovered. We are planning to create an additional annual report, and the data that we're reporting in the MCPAR this year is a compilation of data from different sources. For CY 2022, United reported $10,037,167 in recovered overpayments. The ratio of recovered overpayments to premium revenue is 2%.
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**AlohaCare** Monthly **Hawaii Medical Service Association (HMSA)** Monthly **Kaiser Permanente** Monthly **Ohana Health Plan** Monthly **UnitedHealthcare Community Plan** Monthly

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).	**Imua Family Services** Other Community-Based Organization **Kumukahi Health + Wellness** Other Community-Based Organization **Legal Aid Society of Hawaii** Other Community-Based Organization **Project Vision Hawaii** Other Community-Based Organization **We Are Oceania** Other Community-Based Organization **Kalihi Palama Health Center** Other, specify – undefined **Kokua Kalihi Valley Commprehensive Family Services** Other, specify – undefined **Koolauloa Community Health & Wellness Center** Other, specify – undefined **Waianae Coast Comprehensive Health Center** Other, specify – undefined **Waikiki Health** Other, specify – undefined **Waimanalo Health Center** Other, specify – undefined **Bay Clinic** Other, specify – undefined **Hawaii Island Community Health Center**

Other, specify – undefined

Hana Health

Other, specify – undefined

Malama I Ke Ola

Other, specify – undefined

Lanai Community Health Center

Other, specify – undefined

Molokai Community Health Center

Other, specify – undefined

Hoola Lahui Hawaii

Other, specify – undefined

Hamakua Health Center

Other, specify – undefined

Adventist Health Castle

Other, specify – undefined

Catholic Charities of Hawaii

Other Community-Based Organization

Executive Office on Aging

State Government Entity

Hawaii Health Systems Corporation

Other, specify – undefined

Hui O Hauula

Other Community-Based Organization

Marshallese Association of Kauai

Other Community-Based Organization

Maui Health Systems

Other, specify – undefined

		Marshallese Community Organization of Hawaii Other Community-Based Organization **One Stop Center for Micronesians of Hawaii Island** Other Community-Based Organization **Queen's Medical Center** Other, specify – undefined
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).	**Imua Family Services** Other, specify – undefined **Kumukahi Health + Wellness** Other, specify – undefined **Legal Aid Society of Hawaii** Other, specify – undefined **Project Vision Hawaii** Other, specify – undefined **We Are Oceania** Other, specify – undefined **Kalihi Palama Health Center** Other, specify – undefined **Kokua Kalihi Valley Commprehensive Family Services** Other, specify – undefined **Koolauloa Community Health & Wellness Center** Other, specify – undefined **Waianae Coast Comprehensive Health Center** Other, specify – undefined **Waikiki Health**

Other, specify – undefined

Waimanalo Health Center

Other, specify – undefined

Bay Clinic

Other, specify – undefined

Hawaii Island Community Health Center

Other, specify – undefined

Hana Health

Other, specify – undefined

Malama I Ke Ola

Other, specify – undefined

Lanai Community Health Center

Other, specify – undefined

Molokai Community Health Center

Other, specify – undefined

Hoola Lahui Hawaii

Other, specify – undefined

Hamakua Health Center

Other, specify – undefined

Adventist Health Castle

Other, specify – undefined

Catholic Charities of Hawaii

Other, specify – undefined

Executive Office on Aging

Other, specify – undefined

Hawaii Health Systems Corporation

Other, specify – undefined

Hui O Hauula

Other, specify – undefined

Marshallese Association of Kauai

Other, specify – undefined

Maui Health Systems

Other, specify – undefined

Marshallese Community Organization of Hawaii

Other, specify – undefined

One Stop Center for Micronesians of Hawaii Island

Other, specify – undefined

Queen's Medical Center

Other, specify – undefined