HAWAI‘I

MEMBER HANDBOOK

COMMUNITY CARE SERVICES (CCS)

OHANA℠ HEALTH PLAN

CAD_71348E State Approved 05182021

CCS_MS1_INITIAL_v2 CCS MHB

HI1ZBHMHB71348E_0321

‘Ohana Community Care Services (CCS)...

Your Behavioral Health Plan

‘Ohana CCS is a managed behavioral healthcare plan for Medicaid members who qualify for more behavioral health services than regular Medicaid offers. ‘Ohana CCS is contracted by the Department of Human Services to provide behavioral health services statewide. We work with different types of providers in our network.

These include:

- Doctors
- Licensed clinical staff
- Specialists
- Hospitals
- Labs
- Other healthcare facilities in our provider network.

These providers give our members the behavioral healthcare services they need.

One of the special benefits of CCS is Case Management. As a member, you may choose a Case Manager from one of our CCS Case Management Agencies. Your Case Manager will work with you to make sure you get your treatment. (You will find out more about Case Management later in this booklet.)

‘Ohana CCS is your managed *behavioral* healthcare plan. You get your *medical* healthcare through your QUEST Integration healthcare plan. Be sure to carry both ID cards with you. This is so you can get care when you need it.

As you work with everyone at ‘Ohana CCS, you will see that we put you and your family first. We do this so you get better behavioral healthcare. We make every effort to make sure you get the care you need to stay healthy.

This handbook tells you more about your benefits. It also tells you how your behavioral health plan works. Please read it. Keep it in a safe place. We hope it answers most of your questions. For more help, please call Customer Service toll-free at **1-866-401-7540 (TTY 711)**. You can call us 24 hours a day, 7 days a week. Our friendly staff can answer all of your questions. You can also visit us at **www.ohanahealthplan.com**.

We are on Facebook and Twitter. Come get social with us today!

@OhanaHealthPlan

www.facebook.com/OhanaHealthPlan

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We're Here to Help

We're Here to Help

You may call Customer Service or your Case Manager/Agency when you need help.

Help from 'Ohana CCS Customer Service

Call Customer Service toll-free 24 hours a day, 7 days a week with questions about:

- Benefits
- Replacing a lost or stolen 'Ohana ID card
- Filing a grievance
- Changing your Case Management Agency
- Finding a list of Case Management Agencies in our network
- Finding a list of drugstores in our network
- Getting materials in a different language or format

Customer Service Toll-Free Phone Number
1-866-401-7540 (TTY 711)

You can also write to Customer Service at:
'Ohana CCS Customer Service
949 Kamokila Blvd.
3rd Floor, Suite 350
Kapolei, HI 96707

We Care about Your Privacy!

'Ohana has a responsibility to protect and keep your information confidential, as required by law. The Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule requires us to verify your identity when you call 'Ohana. We do this to protect your privacy. To make changes or access information, you need to tell us your:

- First and last name
- Date of birth
- Address (mailing or residence)

Other ʻOhana Offices	
ʻOhana Health Plan– Maui Office 285 W. Kaʻahumanu Ave. Suite 101B Kahului, HI 96732	ʻOhana Health Plan – Big Island Office 194 Kilauea Ave. Suites 102 and 103 Hilo, HI 96720

Our Service Area

ʻOhana serves the following areas:

- Kauaʻi
- Molokaʻi
- Lanaʻi
- Oʻahu
- Maui
- Hawaiʻi

If you do not speak English, we can help. We want you to know how to use your behavioral healthcare plan no matter what language you speak. Just call us and we will find a way to talk to you in your own language. We have translation services available. We also have information in large print, Braille and audio. All of these services are available at no cost. Our **TTY** phone number is **711**.

Help from Your Case Manager/Agency

You can choose a Case Management Agency to coordinate your care. The agency will assign you to a Case Manager. Your Case Manager will be your main connection to the plan. They will make sure you get access to the behavioral health providers and timely care you need.

Once you are enrolled in CCS, a Care Coordinator will get in touch with you to help you choose a Case Manager/Agency. You may also choose a Case Manager/Agency by calling Customer Service. We will pick one for you if you do not choose one.

It is important to build a partnership with your Case Manager. They will work one-on-one with you to coordinate medical and pharmacy care. They will also help with additional support services like:

- Assistance with obtaining food and housing
- Securing and maintaining eligibility for general assistance or Social Security benefits
- Medication management and monitoring

- Hospital discharge planning
- Crisis services

Your member ID card will have contact information so you can reach your Case Manager/Agency. You can also call Customer Service. We can help you get in touch with your Case Manager/Agency.

You will have face-to-face visits with your Case Manager. You will get details about how often you will have these meetings. You will find more about Case Managers and Agencies later in this booklet.

Sometimes you may want to call a nurse for urgent behavioral health questions. You can call our 24-Hour Nurse Advice Line at **1-800-919-8807**. You can call them any time. You can even call them after business hours, on holidays or on weekends. A nurse will help you. They may be able to answer many of your questions. They can help you when you do not feel well. Please see the *Nurse Advice Line* section later in this handbook. If you are in crisis, call your Case Manager. You can also use the Crisis Line of Hawai'i at **1-808-832-3100** for O'ahu or **1-800-753-6879** for Neighbor Islands.

Other Important Phone Numbers

Who to Call For Help	Toll-Free Phone Number
Crisis Line of Hawai'i	O'ahu: **1-808-832-3100** Neighbor Islands: **1-800-753-6879**
24-Hour Nurse Advice Line	**1-800-919-8807**
TTY	**711**
Transportation Requests (IntelliRide)	**1-866-790-8858**
Transportation Ride Assist Line (IntelliRide)	**1-866-481-9699**
Pharmacy	**1-866-401-7540 (TTY 711)**
Hawai'i Med-QUEST Division	**1-800-316-8005**
24-Hour 'Ohana Customer Service	**1-866-401-7540 (TTY 711)**

Visit Our Website to Stay Informed

Remember to go to our website often. You can get the latest information on:

- Member rights and responsibilities
- Benefit updates
- Local providers
- How to get utilization management guidelines
- Changing your address

Plus, you can order and view your ʻOhana CCS ID card. You can also update your address and phone number. Log in at **www.ohanaccs.com** today!

Ombudsman Program

The Hawaiʻi Department of Human Services (DHS) oversees the Medicaid Ombudsman Program. This program allows Koan Risk Solutions, an independent reviewer, to look into concerns about Medicaid health plans. Their website is www.himedicaidombudsman.com. Their findings can help health plans reach these goals:

- Making sure you have access to care
- Promoting quality of your care
- Making sure members like you are satisfied with CCS services

The Ombudsman Program is available to all members. You can learn more by contacting Koan Risk Solutions toll-free at **1-888-488-7988 (TTY 711)** or **1-808-746-3324** on Oahu. Their website is **www.himedicaidombudsman.com**. You can also call, email or fax them. Their contact information is below:

Island	Phone Number
Oʻahu	**1-808-746-3324**
Hawaiʻi	**1-888-488-7988**
Maui and Lanaʻi	**1-888-488-7988**
Molokaʻi	**1-888-488-7988**
Kauaʻi	**1-888-488-7988**
Email: **hiombudsman@koanrisksolutions.com**	**TTY: 711**
Oʻahu fax: **1-808-356-1645**	

The ‘Ohana CCS Dictionary

WORDS/PHRASES

Advance Directive: A legal paper that tells your doctor and family how you wish to be cared for when you are ill and need care to prolong life. It goes into effect when you are so ill that you cannot make decisions for yourself.

Adverse Benefit Determination: The denial, restriction, reduction, suspension or termination of the type or level of service.

Appeal: A request for review of an adverse benefit determination.

Behavioral Health Provider: Case Managers, agencies, doctors, licensed clinical staff, specialists, hospitals, labs, pharmacies and other healthcare facilities that are part of our provider network. The providers in our network give you the care services offered by Medicaid and coordinate your behavioral healthcare needs.

Benefits: Healthcare we cover.

Case Manager: Your Case Management Agency assigns a Case Manager to you. The Case Manager from that agency helps you coordinate your behavioral health needs. They help you get the care you need.

Case Management Agency: The Case Management Agency oversees the Case Managers within their organization who provide behavioral health services.

CCS: Community Care Services is a state Medicaid insurance program. It provides behavioral health services to Medicaid-eligible adults who are also eligible for behavioral health services beyond what regular Medicaid covers.

WORDS/PHRASES

Covered Services: Services and benefits that you are entitled to under Hawaii’s Medicaid program.

Cultural Competency: A set of interpersonal skills that lets individuals increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with members.

Disenrollment: The steps to follow when you want to leave ‘Ohana CCS.

Emergency Room Care: Emergency services provided in an emergency room.

Emergency Medical Condition: A very serious medical condition that must be treated right away.

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

Emergency Services: Any covered inpatient and outpatient service by a qualified provider that are needed to evaluate or stabilize an emergency medical condition.

Excluded Services: Healthcare services that health insurance or plans don’t pay for or cover.

Fraud: False information given on purpose. This can be done by a member or provider. This false information can lead to someone getting a service or benefit that is not allowed. It can also lead to a provider getting paid for services that were not performed.

Generic Drug: A drug with same basic ingredients as a brand-name drug.

WORDS/PHRASES

Grievance: When you let us know you are not satisfied with a provider, the plan or a benefit. You can do this in writing or tell us verbally. You can file a grievance at any time.

Health Insurance: A contract that requires health insurers to pay some or all healthcare costs in exchange for a premium.

Health Maintenance Organization (HMO): A company that works with a group of doctors, pharmacies, labs and hospitals. They do this to give quality healthcare to their members (also see *Managed Care Plan*).

Hospital Outpatient Care: Care in a hospital that usually doesn’t require an overnight stay.

Hospitalization: Care that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Inpatient: A person who stays in a hospital for a period usually longer than 24 hours.

Managed Care Plan: A plan that you can choose to help you with all your healthcare needs. Managed care plans like ‘Ohana CCS work with you, your Case Manager/Agency and other health providers to coordinate your behavioral healthcare. Providers include Case Managers, agencies, doctors, licensed clinical staff, specialists, hospitals, labs, pharmacies and others.

Medically Necessary Services: Health services you need to get well and stay healthy.

Medicare: A federal health insurance program for people age 65 or older, or with certain disabilities.

WORDS/PHRASES

Med-QUEST Division (MQD): A division of the state Department of Human Services. It administers the Medicaid programs, including QUEST Integration and CCS.

Member: A person who has joined our plan.

Network: The facilities, providers and suppliers health insurers or plans that have contracted with ‘Ohana to provide healthcare services.

Non-Participating Provider: A provider who doesn’t have a contract with health insurers or plans to provide services to members.

‘Ohana CCS ID Card: An ID card that shows you are a member of our plan.

Outpatient: A person who gets health treatment, usually at a hospital, but does not need to stay overnight.

Over-the-Counter Drugs: Drugs that are not behind the drugstore counter and do not require a doctor’s order.

Participating Providers: Those who work with the plan to give healthcare to members. They include Case Managers, agencies, licensed clinical staff, doctors, hospitals, pharmacies, labs and others.

Pharmacy Network: A group of drugstores that members can use.

Post-Stabilization: Follow-up care after you leave the hospital to make sure you get better.

WORDS/PHRASES

Preferred Drug List (PDL): A list of medicines approved by the Pharmacy and Therapeutics (P&T) Committee.* These drugs are safe and cost less. You can find more information about the list and the medications we cover in the *Prescription Drug Services* section of this handbook.

*The P&T Committee consists of ‘Ohana CCS doctors and pharmacists.

Prescription Drugs: A drug for which your doctor writes an order.

Prescription Drug Coverage: Health insurance or plan that helps pay for prescription drugs and medications.

Primary Care Provider (PCP): Your personal doctor or advanced practice registered nurse or a licensed physician assistant. They manage all your medical healthcare needs.

Prior Authorization: When we have to approve treatment or medicines before you receive them.

Quality Care: Safe, accessible and timely care in the proper setting. Care is coordinated and continuous. It is not periodic.

QUEST Integration: A managed care program. It provides healthcare benefits, including acute and long-term care services to eligible individuals, families, and children under the Medicaid state plan.

Referral: When your Case Manager/Agency sends you to see another health provider.

Specialist: A doctor who focuses on a specific field of medicine.

Treatment: The care you get from doctors and facilities.

WORDS/PHRASES

Third Party Liability (TPL): Any other health insurance plan or carrier or program, that is, or may be, liable to pay all or part of the Member’s healthcare expenses, including:

- Individual
- Group
- Employer-related
- Self-insured or self-funded
- Commercial carrier
- Automobile insurance
- Worker’s compensation

Urgent Care: The diagnosis and treatment of medical conditions which are serious or acute but pose no immediate threat to life or health but which require medical attention within 24 hours.

Medicare Basics

Medicare is a federal insurance program that pays for certain healthcare expenses. It is available to U.S. citizens and permanent residents age 65 or older. It is also available for some people with disabilities younger than 65. Different parts of the Medicare insurance program cover different services. The parts of Medicare are:

- **Medicare Part A** – covers inpatient hospital stays
- **Medicare Part B** – covers physician and outpatient services
- **Medicare Part C** – provides all Part A and Part B services. May also cover Part D. These plans also have extra benefits.
- **Medicare Part D** – covers prescription drugs for people on Medicare

Getting Started With Us

Getting Started With Us

How to Get The Most From Your Plan

Here are a couple of things to remember as you get started with ʻOhana CCS.

Check Your ID Card and Put It in a Safe Place

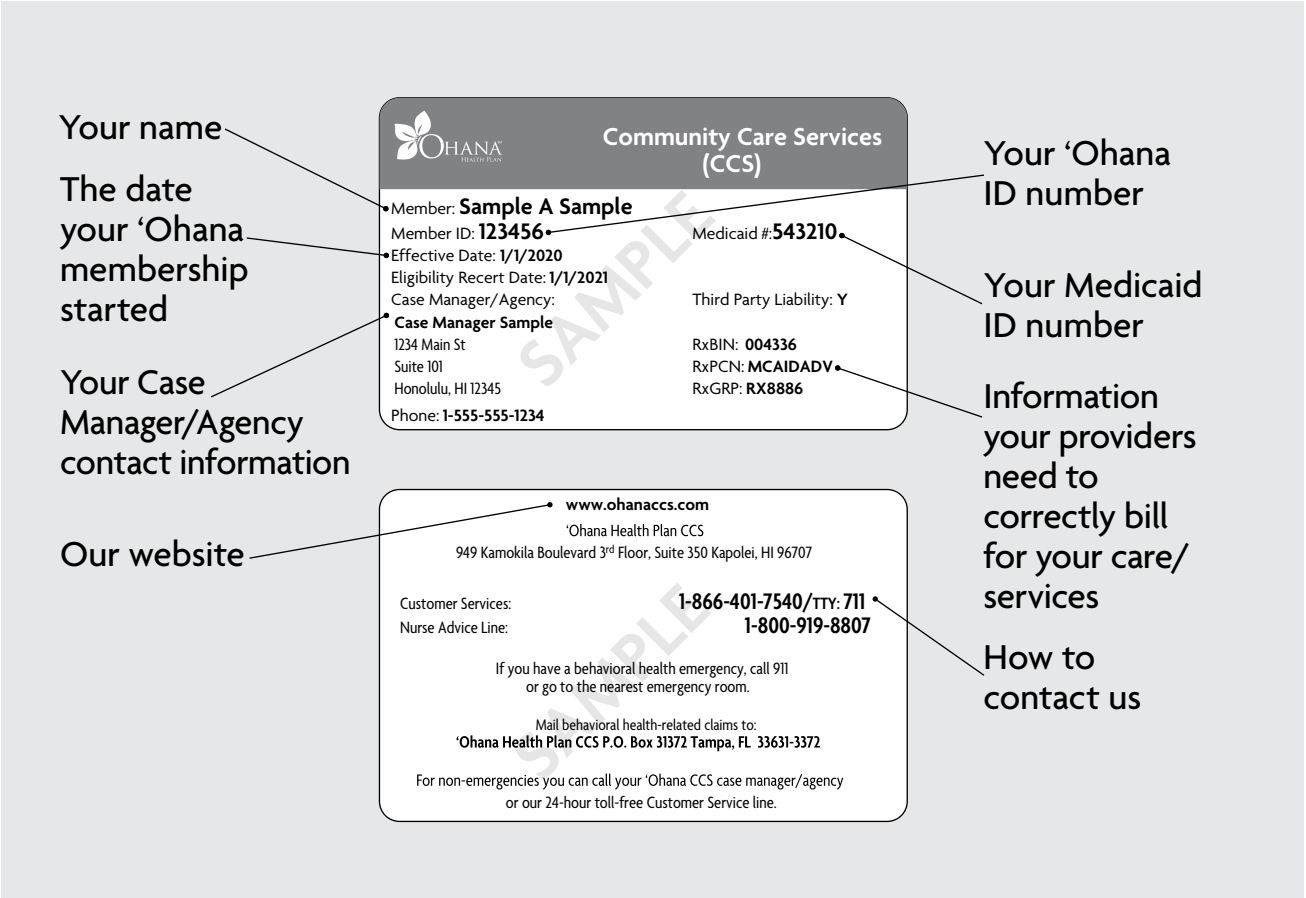
You should have received your ʻOhana CCS member ID card in the mail. Keep this card and your QUEST Integration Medicaid card with you at all times.

You need your card each time you get behavioral health services. This means that you need your card when you:

- See your Case Manager/Agency or healthcare provider
- Go to these places for behavioral health services:
  - Emergency room
  - Urgent care center
  - Hospital
- Pick up prescriptions from the pharmacy
- Have mental health exams

Call ʻOhana CCS Customer Service as soon as possible if:

- You did not get your card yet
- Anything on your card is wrong
- You lose your card



Choose Your Case Management Agency

Now that you are enrolled in CCS, 'Ohana will contact you. We will ask you to choose a Case Management Agency. You can also call Customer Service to select a Case Manager/ Agency. They can give you information about the Case Manager/Agency. This includes background and qualifications. If we do not hear from you and we cannot reach you within two days of enrollment, we will select a Case Management Agency for you.

Get to Know Your Case Manager and Agency

The Case Management Agency you choose will connect you with a Case Manager. They will set up a face-to-face behavioral health assessment within 21 days. Your Case Manager will also work with others involved in your care to make a treatment plan to meet your health goals. They will also link you with benefits for your behavioral healthcare needs. Their goal is to help you get the care you need.

You can reach your Case Manager or Agency by calling the agency office. Your Case

Management Agency's name and telephone number is printed on your 'Ohana CCS ID card. It is important to build a partnership with your Case Management Agency.

It gives them a chance to get to know your needs. This is so they can help you get care. You may change your Case Management Agency three times a calendar year. Please see below for details.

Changing Your Case Manager/Agency

You can change your Case Manager while staying with the same agency. Just call the agency to ask for a new Case Manager.

You may also change your Case Management Agency. To do this, you can call Customer Service. The changes will take effect the first day of the next month. You may change your Case Management Agency up to three times a year.

We will send you a new 'Ohana CCS ID card after we make the change. Please use your old card to receive services until your new card comes in the mail. Once you have your new 'Ohana CCS ID card, make sure the information is correct. Then destroy the old 'Ohana CCS ID card.

You can get a list of our Case Management Agencies:

- In your Provider Directory
- At **www.ohanahealthplan.com**
- By calling Customer Service

Get to Know Your 24-Hour Nurse Advice Line

You can use our 24-Hour Nurse Advice Line at no cost to you. You can call them 24 hours a day, 7 days a week. You can call every day of the year. Call toll-free at **1-800-919-8807**. Call any time you need health advice.

A nurse is there to help. You may call the Nurse Advice Line before you call a doctor or go to the hospital. We also have a CCS Hotline for your care management needs **24/7: 1-866-401-7540**.

In an Emergency

For a health emergency, go to the hospital or call **911**. Please read the *Emergency Services* section of this book. It tells you how you can get care. It also gives examples of emergencies.

In an emergency, go to the hospital or call **911** first.

Call Us, Tell Us

Do you have questions? Call us. We can get translators for all languages. We have materials in Ilocano, Chinese (traditional), Korean, Vietnamese, large print, audio tapes and Braille. Members with a hearing impairment can get sign language services. You get all of these services at no cost. For more help, please call Customer Service toll-free at **1-866-401-7540 (TTY 711)**. You can call us 24 hours a day, 7 days a week. We will return your call within one business day. You may also write Customer Service at:

‘Ohana CCS Customer Service
949 Kamokila Blvd.
3rd Floor, Suite 350
Kapolei, HI 96707

It is also important for you to tell us if there is a major change in your life.

For example, if you:

- Change your name and/or address
- Get married or divorced
- Get health insurance from another company
- Address change
- Change in income
- Legal encumbrances, conditional release, jail diversion, released on conditions, and mental health court, or receiving services from DOH-AMHD
- Institutionalization, imprisonment, long term care facility, state hospital

In addition to notifying us of the change, you should also notify DHS. ‘Ohana is also required to report these changes to DHS.

‘Ohana Coordination of Benefits

‘Ohana will let DHS know if you have any other health insurance plan or program that may be responsible to pay for your healthcare services. We will also coordinate benefits with any other coverage that you may have. This is referred to as Third Party Liability (TPL).

In addition, ‘Ohana shall provide our Members any notices issued by the Hawai‘i Department of Human Services.

‘Ohana CCS Members Have Certain Rights and Responsibilities

You have rights as an ‘Ohana CCS member. You also have responsibilities. You can read about these later in this handbook. You are now ready to begin using all of the benefits you get with ‘Ohana CCS. We look forward to serving you.

Making Appointments

The state has certain rules in place to make sure you get to your appointments in a timely manner. This is also called access to care.

This table gives you an idea of how long it should take to get to an appointment.

Type of Behavioral Health Provider	If You Live in an Urban Area	If You Live in a Rural Area
Hospitals, emergency services facilities, mental health providers	30-minute driving time	60-minute driving time
Pharmacies	15-minute driving time	60-minute driving time
24-hour pharmacy	60-minute driving time	N/A

How long you wait to get an appointment depends on the kind of care you need. Keep these times in mind as you set your appointments. You should:

- Get emergency care right away (both in and out of our service area) 24 hours a day, 7 days a week (prior authorization is not needed for emergency services, but emergency services outside of the United States are not covered)
- Get urgent care within 72 hours
- Get regular care within 21 calendar days
- Get specialist and non-emergency hospital stays within 4 weeks
- Get follow-up care after a hospital stay as needed

You should not have to wait more than 45 minutes once you arrive at your appointment. Call us if you have trouble getting care. We can help you make appointments too.

Your Health Plan

Covered Services

Our network of providers gives you the care you need. It includes Case Managers/ Agencies, hospitals and other providers. They perform Medicaid-covered behavioral health services you are entitled to.

We will tell you how to obtain the following provider information:

- Name, address, telephone numbers
- Professional qualifications
- Specialty
- Residency completion
- Board certification status

Behavioral Health Services, Coverage and Limits

Services	Coverage and Limits
Community Integration Services (CIS)	Case management help to find and maintain housing **Pre-Tenancy Services** 1. Identify eligible individuals; 2. Screening/assessments; 3. Develop housing support plan; 4. Housing search; 5. Applications prep and submission; 6. Identify resources/costs for start-up needs; 7. Identify equipment, technology, and other modifications needed; 8. Ensure housing is safe; 9. Moving assistance; 10. Individualized housing crisis plan; 11. Skill and acquisition development; and 12. Independent living skills/financial literacy.

Services	Coverage and Limits
Community Integration Services (CIS) ***(continued)***	Tenancy Services 1. Individual Housing and Tenancy Sustaining Services; 2. Community Transition Services (CTS); Other Housing & Tenancy Services 1. Job skills training/employment activities; 2. Peer supports; 3. Non-medical transportation; 4. Support groups; 5. Caregiver or family support; 6. Outreach services; 7. Health management; 8. Counseling and therapies; 9. Service assessments; 10. Service plan development; 11. Independent living skills and financial literacy; 12. Equipment, technology and other modifications; 13. Home management; and 14. Other supplemental services as needed.
Crisis Services	• 24 hours a day, 7 days a week emergency/crisis intervention • Crisis hotline • Crisis residential services • Crisis stabilization • Mobile crisis response

Services	Coverage and Limits
Behavioral Health Outpatient Services to include:	• Continuous treatment teams • Family/collateral therapeutic support and education • Individual/group therapy and counseling • Treatment/service planning • Other medically necessary therapeutic services
Diagnostic Services	• Psychiatric or psychological evaluation and treatment (including neuropsychological evaluation) • Psychological testing • Psychosocial history • Screening for and monitoring treatment of mental illness and substance use (includes substance use disorders) • Other medically necessary behavioral health diagnostic services to include labs
Emergency Department (ED) Services	• Any covered inpatient and outpatient services given by a qualified provider. These services are needed to evaluate or stabilize an emergency medical condition. • An emergency medical condition must be a result of serious mental illness (SMI) or serious and persistent mental illness (SPMI) diagnosis. • The health plan may not deny payment for these services when a representative from the health plan instructed the member to seek services.

Services	Coverage and Limits
Inpatient Psychiatric Hospitalization (24 hours)	• Diagnostic services • Medical supplies, equipment and drugs • Nursing care • Other medically necessary services • Other practitioner services as needed • Physical, occupational, speech and language therapy • Post-stabilization services • Psychiatric services • Room and board
Intensive Case Management	• Case assessment • Case planning (service planning, care planning) • Coordination with member's health plan and primary care provider (PCP) • Ongoing monitoring and care coordination • Outreach
Medication Management	• Medication counseling and education • Medication evaluation • Psychotropic medications
Methadone Management Services	• Includes the provision of methadone or suitable alternative (that is, LAAM or buprenorphine) as well as outpatient counseling services

Services	Coverage and Limits
Out-of-State and Off-Island Coverage	Provides for any medically necessary covered services that are prearranged when not available on your island or in Hawai'i. This includes: • Referrals to an out-of-state or off-island specialist or facility • Transportation to and from the referral destination • Lodging & meals • Member attendant (if authorized) Requires prior authorization
Partial Hospitalization or Intensive Outpatient Hospitalization, including:	• Diagnostic tests • Medical supplies • Medication management • Prescribed drugs • Therapeutic services including individual, family and group therapy, and aftercare • Other medically necessary services
Peer Specialist	Support from behavioral health peers
Prescription Drugs	The plan covers behavioral health drugs listed on our Preferred Drug List (PDL). This includes psychotropic medications. This list also has drugs that may have limits like prior authorization, quantity limits, step therapy, age limits or gender limits. Alternative drugs may be covered with a prior authorization.

Services	Coverage and Limits
Psychosocial Rehabilitation/ Clubhouse Services	• Day treatment • Intensive day treatment • Residential treatment services • Social/recreational therapy services • Work assessment service
Representative Payee	Financial management services
Substance Use Disorder (SUD) Services	‘Ohana Health Plan CCS coordinates with Department of Health Alcohol and Drug Abuse Division (DOH-ADAD) to help meet the needs of our members with Substance Use Disorders by linking members with the ADAD specialists within our Provider Network. For help accessing these providers for substance use disorder treatment, please work with your CCS case manager, or contact our Customer Service Representatives toll free at **1-866-401-7540** or **TTY 711**. You also can access ADAD providers and substance use disorder treatment 24/7 by calling the Hawaii CARES line: Oahu: **1-808-832-3100** Neighbor Islands: **1-800-753-6879** All medically necessary services to include: • Residential treatment • Intensive outpatient treatment

Services	Coverage and Limits
Supportive Employment Services	• Discovery – pre-employment service • Work assessment service • Job coaching
Telehealth Services	Services may include, but are not limited to: • Real-time video conferencing • Secure interactive and non-interactive web communication, and • Secure transfer of your medical records. Your doctor can use high-quality images and lab reports for your care. Services not covered include: • Standard phone calls, faxes or email – in combination or individually – are not considered telehealth services • Getting your medication by filling out an online form is not a telehealth service If you get in-person care that needs prior approval, you will need prior approval to get the same care through telehealth. Providers will tell you if they offer telehealth services. Your provider will bill the plan for these services.

Services	Coverage and Limits
Transportation	Provides for both emergency and non-emergency ground and air services to and from medically necessary provider appointments for members who: • Have no means of transportation • Live in areas not served by public transportation • Cannot access public transportation due to a mental condition • Do not live in a: – Community care foster family home – Adult residential care home – Expanded adult residential care home or – Domiciliary home Transportation is not provided to day programs that are not medically necessary. Authorization is required for any ground transportation to a location greater than 50 miles from pick-up location. Other transportation services may require prior authorization.
Urgent Care Services	Covered as medically necessary. No prior authorization is required.
Other Services	• Maintenance of member's medical assistance eligibility • Other medically necessary practitioner services provided by licensed and/or certified healthcare providers • Other medically necessary therapeutic services, including services that would prevent hospitalization

Receiving Non-Covered Services

You can still get a service that is not covered. However, you will have to pay the provider directly. You and your provider must make an agreement in writing.

Providers may not bill you when they are not paid by the health plan because they did not follow our procedures.

You will not lose Medicaid benefits if you do not pay for services that are not covered by the health plan.

Services Not Covered by ʻOhana CCS and Med-QUEST Division
• Behavioral healthcare in a foreign country • Cosmetic procedures • Investigational and experimental procedures • Services that are not for the treatment of a behavioral health condition

Prescription Drug Services

Prescriptions and Pharmacy Access

How do I get a prescription?

Prescriptions must be written by a plan doctor.

Which drugstores will fill my prescription?

Prescriptions must be filled at a drugstore in our network. A list of these drugstores is in the pharmacy section of your Provider Directory. It is also at **www.ohanahealthplan.com**. You may also be able to get your prescriptions by 'Ohana CCS's mail-order service. Contact Customer Service to find out about this program.

What is the process for getting a prescription filled?

Be sure to take all healthcare ID cards with you when you get a prescription filled. Take your Medicare, QUEST Integration and CCS ID cards. There is no co-pay for prescribed medications for Medicaid-only members. There may be a co-pay if you have other insurance coverage such as Medicare.

Pharmacy Lock-In

As our valued member, we want you to know about 'Ohana Lock-In Program.

What is the Pharmacy Lock-In Program?

Seeing many different doctors for your care can be dangerous if each doctor prescribes similar drugs for you without knowing what the other one is prescribing. We are committed to you having a clear understanding of these possible dangers and protecting you from that. If we identify that you are in that situation, this program will help you more effectively manage your prescription drug and medical care needs. If you are identified for this program, you will get all of your controlled substance prescriptions from one assigned pharmacy and/or one prescriber. This will help your pharmacist and doctor understand your prescription needs.

- Once you are identified and enrolled in this program, you will get a letter from us. We'll also let your doctor and pharmacy know. However, if you do not want to be in the 'Ohana Lock-In Program, you can file an appeal with us. (See the *Member*

Grievance and Appeals Procedures section in this handbook.) If your assigned pharmacy does not immediately have your medication, you'll be able to get a 72-hour emergency supply at another pharmacy as long as your doctor is in our network.

There is no cost to you and this is a voluntary service. For questions about our 'Ohana Lock-In Program or to begin working with a Care Team, please call us toll-free at **1-866-401-7540 (TTY 711)**.

Preferred Drug List

What medicines does 'Ohana CCS pay for?

'Ohana CCS pays for medicines on our Preferred Drug List (PDL). Doctors and pharmacists decide which drugs should be on this list. Your doctor or provider will use the list when prescribing drugs for your behavioral health needs. Some drugs will require approval through a Coverage Determination Request (CDR). Your doctor handles this. (CDRs are for drugs that require prior authorization and those not listed on the PDL.) The PDL has drugs that may have limits such as prior authorization, quantity limits, step therapy, age limits or gender limits. You can see the list at **www.ohanahealthplan.com**.

Are there medicines 'Ohana CCS will not pay for?

The plan does not pay for medicines to treat medical conditions not related to your behavioral health. For example:

- Medications for pain management
- Medications covered by another Medicaid or Medicare plan

Can I get any medicine I want?

You will get all medicines that are medically necessary for your behavioral healthcare. All drugs your doctors order for you may be covered if they are on the Preferred Drug List (see previous page). Call Customer Service with any questions. In some cases, we make you try another drug before approving the one you first asked for. We may not approve the drug you asked for if you do not try the alternative drug first.

Are generic drugs as good as brand-name drugs?

Yes. Generic drugs work the same as brand drugs. They have the same active ingredients as brand drugs.

Direct Member Reimbursement

What is a medication Direct Member Reimbursement (DMR)?

Sometimes you may pay for medications out of pocket at a retail drugstore. This can happen if you forget to show your healthcare ID cards. After such a purchase, you have 36 months to send us a claim form and your receipts to recover your costs. This is called Direct Member Reimbursement, or DMR. To get a copy of the claim form, call Customer Service toll-free at **1-866-401-7540 (TTY 711)**. You can reach us 24 hours a day, 7 days a week. You can also go to **www.ohanahealthplan.com**.

Where do I send my DMR request?

Send the form to:

‘Ohana CCS Health Plan
Reimbursement Department
P.O. Box 31577
Tampa, FL 33631-3577

What do I need to include with each DMR request for approval?

- A completed, signed DMR form
- A detailed prescription receipt (we do not accept handwritten receipts) or pharmacy printout with this information:
  - Member name
  - Pharmacy name
  - Physician name
  - Drug name
  - Drug strength
  - Quantity dispensed
  - A day’s supply and
  - The amount you paid
- A cash register receipt that shows the date the prescription was paid for and what amount was paid

All the above information must be included. Otherwise, we will deny the DMR. You can send in your request again with the missing information.

How much will I get back?

If we find that medication is a covered benefit, you will get a check for the plan-contracted price. This is not the retail price.

How long should I expect to wait for my reimbursement?

It usually takes 4 to 6 weeks from the date you mail in the DMR form. Be sure that your form is complete and has all the information. Otherwise, we may deny or delay your request. Formulary guidelines apply to all reimbursement requests.

What if I don't like the decision that was made?

You may not like the decision we make. You have the right to appeal it. See the *Member Grievances and Appeals Procedures* section of this handbook for more information on your right to appeal.

Telehealth Services

Do you have trouble getting around? Do you live in a rural part of the state? If so, telehealth services may be for you. This covered plan benefit is just like an in-person doctor visit except that you and your provider are not limited by your locations. You can get the care you need without driving a long distance.

Services may include:

- Real-time video conferencing
- Secure interactive and non-interactive web communication
- Secure transfer of your medical records. Your doctor can use high-quality images and lab reports for your care

Services not covered include:

- Standard phone calls, faxes or email – combined or separate
- Getting your medication by filling out an online form

Any in-person care that needs prior approval will need the same prior approval through Telehealth Services.

Providers will tell you if they offer telehealth services. They will bill us for these services. If you would like to know more about telehealth services, call us toll-free at **1-866-401-7540 (TTY 711)** or visit **www.ohanahealthplan.com.**

Transportation

We will get you where you need to go in an emergency. We also provide non-emergency transportation (NET) services to and from medically necessary behavioral health appointments for members who:

- Have no means of transportation
- Live in areas not served by public transportation
- Cannot access public transportation due to their health condition

When you call for NET services, we will first look for no-cost options. These include:

- The use of your own vehicle
- Family, friends, volunteer services or the facility serving you

If these options are not available, we will look at another way to meet your NET needs. On O'ahu, there are two options: bus and TheHandi-Van services. We will give you bus passes or TheHandi-Van passes to get to your appointments. On all other islands, bus service will be used if available.

Bus service will be used:

- If your physical condition allows it (you are able to walk on your own or use a wheelchair); and
- If you live less than a half mile from a bus stop; and
- If your destination is no more than a half mile from a bus stop.

Taxi service will be used:

- If you are physically unable to take the bus (you are not able to walk on your own and do not use a wheelchair); or
- If you live more than a half mile from a bus stop; or
- If your destination is more than a half mile from a bus stop.

TheHandi-Van service will be used:

- If you live on O'ahu; and
- If your physical condition does not allow you to ride the bus; and
- You are certified for this service.

You must be certified to ride TheHandi-Van. TheHandi-Van Eligibility Center is at The First Insurance Center, 1100 Ward Ave., Suite 835, Honolulu, HI 96814-1613. The center is open Monday–Friday from 8 a.m. to 5 p.m. Hawaii Standard Time. Please call **1-808-538-0033** to learn more or to set up an in-person interview.

Questions?

- What if your medical provider says you are unable to ride the bus or TheHandi-Van?
- What if you don't have bus or TheHandi-Van service in your area?

We will work with you to find another way to get you where you need to go.

Also talk with your provider about ongoing appointments. They can request NET for you.

3 steps for using your transportation benefit

1. Schedule a ride by calling IntelliRide toll-free. The number is **1-866-790-8858**. Customer Service can also help.
2. Call at least three business days before your off-island or out-of-state appointment. For ground transportation on your home island, please call IntelliRide at least 48 hours before your appointment. You can schedule a ride as long as 30 days before your appointment.
3. Be ready at least 15 minutes before your pick-up time.

NET service reminders

- NET services are for medical appointments like doctor visits. They are not for trips to the pharmacy, community events or other non-medical trips.
- If you ask for a ride less than 72 hours ahead of time, we will get you one if we decide it's for an urgent reason. We may ask you to reschedule if it's not urgent.

Call right away to cancel or reschedule a ride – at least 1 hour before your pick-up time.

This helps give better service for everyone.

If you are not sure when you will be finished with your appointment, please call the Transportation Help Line toll-free at **1-866-481-9699** to make arrangements after your appointment. They will arrive within 60 minutes. Please allow for this time. Let them know exactly where to pick you up. This helps the driver find you.

We want to hear from you. If you have a grievance about NET, please call Customer Service or call IntelliRide toll-free at **1-866-790-8858** and tell us about your experience.

Mileage Reimbursement

We now offer mileage reimbursement! If you are interested in having a family member or friend brings you to behavioral health appointments, call for more details. The program is easy. Call IntelliRide toll-free at **1-866-790-8858**.

Behavioral Health Services

How to Select or Change Behavioral Health Providers

'Ohana members may choose an in-network behavioral health provider and change at any time. No referral is necessary. You may call Customer Service or go to **www.ohanahealthplan.com** for a list of participating behavioral health providers. You may also ask your case manager for help in changing your provider.

What to Do in an Emergency or if You Are Out of Our Service Area

First, decide if it is a true mental health emergency. Do you think that you are a danger to yourself or others? If you think you are, call **911**. Or go to the nearest emergency room. Do this even if the emergency room is not in our service area.

If you need emergency care outside our service area, please tell us. Just call the number on your 'Ohana CCS ID card. You should also call your Case Manager/Agency if you can. Call your Case Manager/Agency again within 24 to 48 hours after you receive emergency services. Once you are stable, plans will be made to transfer you to a Medicaid facility. We will tell you if the use of certain network specialists is restricted.

Behavioral Health Limitations and Exclusions

We will not cover services if they are not medically necessary.

Hospital Services

We can help you get any needed behavioral health services such as a behavioral health hospitalization. Emergency services do not require any authorization. See the *Emergency Services* section for more details. For outpatient or inpatient services, your health provider will ask for a prior authorization.

Services from Providers that Are Not in Our Network

There may be times when the healthcare you need is not available from the providers in our network. If you need care from someone not on our provider list, your Case Manager/Agency will work with the health plan to arrange care for you. Prior authorization may be needed.

Services that Require Prior Authorization/Precertification

We need to approve the following services before you can get them. This is called prior authorization or precertification. Your Case Manager/Agency or health provider will contact us to ask for this. If we do not approve the services, we will let you know. We will give you information about the appeals process and your right to a DHS hearing if you disagree with our decision.

This list may change. You can go to www.ohanahealthplan.com or call Customer Service for the most up-to-date list of services that require a prior authorization:

- Substance use disorder treatment
- Psychosocial rehabilitation to include Clubhouse
- Community Integration Services
- Investigational and experimental procedures and treatments
- Non-emergency hospital services
- Peer Specialists
- Supportive employment

We will make a decision within 14 days. We or your health provider may need more time to make this decision. If so, we will then take up to 14 more days. You or your health provider can ask us for a faster decision (a decision made within 72 hours) for urgent requests. You may ask for an urgent request if waiting for a decision could put your life or health in danger.

Utilization Management Program

We have a utilization management (UM) program. It seeks to make sure you get the right care at the right place and at the right time. Our UM program includes:

- **Prospective reviews** – Before you get care, we check to see if you need it
- **Concurrent reviews** – We look at the care you are receiving to see if you need to keep getting that care or if other care would better meet your needs
- **Transitional care** – We help you when you leave a hospital by making sure that you have services in place before you go home
- **Retrospective reviews** – We check to see if you needed the care you got, after you received it

We do these reviews to measure the behavioral healthcare and services you receive. We want to make sure the services you receive match your ʻOhana CCS health plan coverage. We check to see if the care and services are provided at the right place and at the right time. Then we decide how much coverage we can provide according to your benefits. We also decide on how to pay those who give you the care.

There may be times when we say we cannot cover services or care that your provider requests. This may be due to benefit limitations or lack of medical necessity. These decisions may be made by our licensed clinical staff. They are nurses, doctors, and licensed behavioral health clinicians.

We make sure our reviews are based only on the appropriateness of care and your benefit coverage. We do not give financial rewards to those who make these decisions.

To access UM staff or learn more about our UM program, you may call Customer Service toll-free at **1-866-401-7540**. **TTY** users may call **711**.

Your provider will not bill you for covered services you have received that we decide were not medically necessary.

If the health plan objects to providing a service on moral or religious grounds, we will let you know within 30 days after adopting the policy. We also let you know how to contact DHS. They will give you information on how and where to get the services that you need.

How to Get After-Hours Care

If you get sick or hurt, and it is not an emergency, call your Case Manager/Agency. They will tell you how to get care. If you cannot reach them, you can contact our 24-hour CCS customer service line at **1-866-401-7540**.

You can also call the 24-hour Nurse Advice Line toll-free at **1-800-919-8807**.

Emergency Services

Emergency services are for a very serious condition that must be treated right away. They may include inpatient and outpatient services (see next page for definition). We will give you names of providers near you. Call Customer Service, check your Provider Directory or visit our website to find emergency and post-stabilization service settings.

What to do in an emergency

Call 911 in an emergency. Call an ambulance if you do not have 911 services in your area. Emergency services do not require prior authorization. Go to the nearest hospital emergency room right away. Call the Crisis Line of Hawai'i: 1-808-832-3100 (for O'ahu); 1-800-753-6879 (Neighbor Islands); or your Case Manager/Agency. Some examples of emergencies/crises are:

- Feel like hurting yourself or others
- Feeling suicidal
- Feeling unsafe

A behavioral health emergency is when the lack of immediate attention results in:

- Placing the physical or mental health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious harm to yourself or others due to a substance use disorder emergency
- Injury to yourself or bodily harm to others
- A threat to the health or safety of a pregnant woman or her unborn child

When you get to the emergency room (ER), you must show your 'Ohana CCS ID card. Let your Case Manager/Agency know as soon as you can when you are in the hospital. Let them know if you received care in an ER. We will pay for follow-up care to emergency treatment (post-stabilization).

You do not need prior approval for emergency services or follow-up care. This is true whether it is within or outside our Hawai'i network. Emergency care outside the United States is not covered.

Post-stabilization services

It is important that you see your behavioral health provider for follow-up care after you leave the hospital to make sure you get better. This is important to your full recovery. It is also important to get care until your condition is stable. This is called post-stabilization care.

This care must be done to maintain, improve or solve your medical condition. When you have a question or are not sure about your care, you may contact your Case Manager or behavioral health provider directly. You may also contact the 24-hour Nurse Advice Line at **1-800-919-8807** if the provider's office is closed.

We pay for care you get after your emergency room care until you are stable or can be safely transferred to an in-network provider. You do not need prior authorization for this. However, this care must be needed to maintain, improve or solve your emergency medical condition.

Out-of-area emergency care

What should you do if you have an emergency while traveling within the United States? Go to a hospital. Show your 'Ohana CCS ID card. Then call your Case Manager/Agency as soon as you can. Ask the hospital staff to call us. If you have to pay for care you get while you are out of the service area, write to our Claims Department. They need copies of your medical reports and the bills. They also need proof of payment. You have up to one year from the date of service to ask for reimbursement.

What should you do if you get sick or hurt while out of the 'Ohana CCS service area and it is not an emergency? Call your Case Manager/Agency.

Behavioral health services in a foreign country are not covered. You need to pay for these services yourself.

What to Do if You Are in Crisis

You have 24-hour crisis services. Contact our CCS Customer Service line at **1-866-401-7540**, or contact your assigned Case Manager/Agency. You may also call the Crisis Line of Hawai'i at **1-808-832-3100** on O'ahu or toll-free from the Neighbor Islands at **1-800-753-6879**.

Out-of-State and Off-Island Coverage

We cover any medically necessary covered services that are not available in the state or island where you live. If you or your provider decides that you need a service out-of- state or off-island, and it is not available in our plan, just contact us. We will work with you to try to obtain the service locally. We will provide these services out-of-state or off-island if we cannot find a plan provider.

This includes:

- Referrals to an out-of-state or off-island specialist or facility
- Transportation to and from the referral destination for an off-island or out-of-state destination
- Lodging and meals for you and any needed attendant (if medically necessary)

We will work with you to try to get the service locally. We will decide within 14 days. We may need more time to make this decision. If so, we will then take up to 14 more days. You or your doctor can ask us for a fast decision (a decision made within 72 hours). You may ask for this if waiting for an approval could put your life or health in danger. Sometimes we will need more time to make a fast decision. This can mean up to 14 more business days for us to make a decision or give approval.

If you need behavioral healthcare services while you are out of the ʻOhana service area, and it is not an emergency, call Customer Service. Call toll-free at **1-866-401-7540 (TTY 711)**. We will help arrange the care you need and make sure you get approval before you receive services.

Transition of Care

ʻOhana CCS Health Plan is here to help. If you are new to ʻOhana CCS or your Case Manager/Agency or provider no longer participates with ʻOhana CCS, we can work with you and your provider. This is so you keep getting services as we transition you to a participating provider.

We can help you if you are leaving ʻOhana CCS. Please call Customer Service or your Case Manager/Agency to help you get the care you need.

EPSDT (Early and Periodic Screening, Diagnostic and Treatment) Services

Your QUEST Integration has an EPSDT program. It stands for Early and Periodic Screening, Diagnostic and Treatment. It provides needed care for members younger than the age of 21. Please reach out to your QUEST Integration plan for information and assistance.

Advance Directives

Your Care Is Your Decision

The Hawai'i Uniform Health Care Decisions Act says you have a right to refuse medical treatment. This law also lets you tell your doctor what kinds of treatment you do or do not want in the future. This includes life-prolonging care. As your health plan, we have a responsibility to tell you about advance directives. If there is a change to an advance directives law, we will let you know no later than 90 days after the change is made.

Advance Directives Help You Make Your Wishes Known

An advance directive is a legal document. It tells providers what type of care you want to get (or not get) if you are not able to tell them yourself. Whether or not you have an advance directive will not affect the type of care you receive.

There are two types. One is a living will. The other is a durable power of attorney for healthcare decisions.

An individual instruction tells what type of care you want if you cannot make decisions yourself. It is used when you cannot make your wishes known to your doctor.

A durable power of attorney for healthcare decisions names the person you want to make choices for you. It will be used if you are not able to make choices for yourself. It will also be used if you cannot tell your provider about the care you want.

'Ohana does not place limits on your advance directives. 'Ohana does not discriminate against its members by requiring or not requiring advance directives as a condition of care.

Where can I get an advance directive form?

You can call a lawyer or your local legal aid office. You can also ask your provider or call Customer Service. Call toll-free at **1-866-401-7540 (TTY 711)**.

How can I learn more about advance directives?

Customer Service can help you learn more. Call toll-free at **1-866-401-7540 (TTY 711)**. They will help you sign up for a free educational session. You can also ask your provider for more information.

Can I change my advance directive?

Yes. You can change your advance directive whenever you want. You may want to contact your local legal aid office for help. It is a good idea to look over your advance directive from time to time. Make sure it still says what you want and that they cover all areas of care.

What should I do with my forms after filling them out?

You should give copies to your Case Manager/Agency and healthcare facility to put into your medical record. Give one to a trusted family member or friend. Keep a copy with your personal papers. You may want to give one to your lawyer or clergy person. Be sure to tell your family or friends – persons close to you – about what you have done. Do not just put these forms away and forget about them.

Do my caregivers have to follow my advance directive?

Yes, as long as your advance directive follows state law. A caregiver may not follow your wishes if they go against their conscience. (This means it is possible that a specific treatment or medication you list in your advance directive may be denied to you because the provider cannot in good conscience authorize it.) If so, they will help you find someone else who will follow your wishes. In addition, healthcare facilities are not required to implement an advance directive if there is an institution-wide conscientious objection and state law allows such an objection.

What happens if my wishes aren't followed?

Other than for conscience reasons, your wishes should be followed. Any reports of non-compliance can be filed with the DOH Office of Health Care Assurance:

Department of Health (DOH) Office of Health Care Assurance
Medicare Section
601 Kamokila Blvd., Suite 395
Kapolei, HI 96707

Phone: **1-808-692-7227**
Fax: **1-808-586-4444**

Member Grievances and Appeals Procedures

We want you to let us know right away if you have any questions, concerns or problems with your covered services or the care you receive.

This section will explain how you can express your concerns.

There are two types of concerns. They are called grievances and appeals. Federal law allows you to make a grievance if you have any problems with the plan. The state has also helped to set the rules for filing a grievance and what we must do when we get one. If you file a grievance or an appeal, we must be fair. We cannot disenroll you or treat you differently because you filed a grievance.

Grievances

What is a grievance?

A grievance is when you call or write to tell us about your dissatisfaction with a provider, the plan or a service. Grievances may include:

- Quality-of-care issues
- Wait times during provider visits
- The way your providers or others, such as provider or health plan staff act
- Unclean provider offices
- Not getting the information you need
- Cultural Needs

When can I file a grievance?

You can file a grievance at any time.

How do I file a grievance?

You or another person can file a grievance by calling or writing to us. Your Case Manager/ Agency or health provider can also file a grievance for you if you authorize them to do so.

You must tell us that you agree to have someone else act on your behalf during the grievance process. Call Customer Service toll-free at **1-866-401-7540 (TTY 711)**. You may also fax your grievance to **1-866-388-1769**.

Or write to:

‘Ohana CCS Health Plan
Attn: Grievance Department
949 Kamokila Blvd.
3rd Floor, Suite 350
Kapolei, HI 96707

We can help you if you speak another language. You can also call Customer Service if you need help to file your grievance. Within five business days of getting your grievance, we will mail you a letter telling you we received it. We will make a decision within 30 calendar days.

We may need additional time to resolve your grievance. This is called an extension. We may take up to 14 more days, and we will notify you in writing within two days of our decision to extend your grievance. If you disagree with our decision to extend your grievance. You have the right file a grievance.

State Grievance Review

You can also ask for a state grievance review. This must be done within 30 calendar days of when you receive your grievance response letter from us. To ask for this review, call or write to the MQD at:

Med-QUEST Division
Health Care Services Branch
601 Kamokila Blvd., Suite 506A
Kapolei, HI 96709-0190

O‘ahu: **1-808-692-8094**
(TTY 1-808-692-7182)
Neighbor Islands: **1-800-316-8005** toll-free
(TTY 1-800-603-1201)

Someone will review the grievance and respond within 90 calendar days of getting it. This decision is final.

Appeals

What is an appeal?

An appeal is a review of an adverse benefit determination. You can ask for an appeal when you do not agree with our decision about the healthcare you are getting and/or our timeliness. You can ask for an appeal when any of these actions occur:

- If we deny or limit a service request your healthcare provider asks us to approve
- If we reduce or stop or terminate services you have been getting that we already approved
- If we do not pay in whole or in part for the behavioral healthcare services you get
- If we fail to give services in the required time frame
- If we fail to give you a decision on an appeal you already filed in the required time frame
- If we fail to give you resolution on a grievance in the required time frame
- If we do not agree to let you see a healthcare provider that is not in our network and you live in a rural area or in an area with limited providers
- If you want to dispute your financial liability

You will get a letter from us when any of these actions occur. This is called a Notice of Adverse Benefit Determination. You can file an appeal if you do not agree with our decision. There is only one level of appeal with the Plan.

How do I file an appeal?

You must file your appeal within 60 calendar days from the date you receive your Notice of Adverse Benefit Determination. You can file by calling or writing to us. We can help you file your appeal if needed.

You can also get help from others. But we must have your written or verbal consent for this. Your provider or someone else you choose can help file an appeal. They can also discuss your appeal with us on your behalf.

Call Customer Service toll-free at **1-866-401-7540 (TTY 711)**. Or write to us at:

Send Your Written Appeals Here	
For appeal requests for medical services: 'Ohana Health Plan Attn: Appeals Department P.O. Box 31368 Tampa, FL 33631-3368	**For appeal requests for pharmacy medications:** 'Ohana Health Plan Attn: Pharmacy Medication Appeals Department P.O. Box 31398 Tampa, FL 33631-3398
Fax to: **1-866-201-0657**	Fax to: **1-888-865-6531**

We will send you a letter within five business days of getting your appeal. This letter will let you know we received it. We will then review your appeal and send you a letter within 30 calendar days for standard appeals telling you of our decision.

You or someone you choose to act for you can review your appeal file. You can review all documents and records received, and any new or additional information considered and/or relied upon. You can look at all of the information we used to make the decision during or before the appeal decision is made as well as after the review of the appeal. You can ask for this additional information free of charge.

What if I need an expedited (fast) appeal?

You or your doctor can ask for a fast appeal. We will give you a fast appeal if your provider says waiting could seriously harm your health. You may ask for a fast appeal without a doctor's help. We will decide if you need a fast decision. You or your provider may call or fax us to ask for a fast appeal. Call toll-free at **1-866-401-7540 (TTY 711)**. If your request was filed verbally, written notice is not needed. For fast appeals, we will call you when we make a decision. We will also send a letter with the appeal decision within 72 hours.

If you ask for a fast appeal and we decide that one is not needed, we will:

- Transfer the appeal to the time frame for standard resolution
- Make reasonable efforts to try to call you
- Follow up within two days with a written notice
- Inform you verbally and in writing that you may file a grievance about the denial of the fast appeal

What if I would like to submit additional information?

You or someone appealing for you may give us more information and present evidence. You can give us this additional information in person and/or in writing. You may do this throughout the appeal review process. Your time to submit more information for a fast appeal is limited due to the short processing time frame.

You can also ask us for up to 14 more days to give us more information for standard and fast appeals. We may also ask for 14 more days if we feel more information is needed and it is in your best interest. If we ask for the extra days, we will try to give you oral notice of the extension and within two days we will send you a written notice. The notice will also tell you when the review will be completed. It will tell you have the right to a grievance if you disagree with the extension.

What if I do not like an appeal decision?

You may not like the appeal decision we make. If so, you can ask for a State Administrative Hearing. Someone you choose to act for you can also ask for one. You must do this within 120 calendar days of receiving the appeal decision letter. The letter will tell you how to file for a State Administrative Hearing with the Administrative Appeals office. You can only ask for a DHS Administrative Hearing after you completed our complete appeals process. To do so, send your request to the address below.

State of Hawai'i Department of Human Services
Administrative Appeals Office
P.O. Box 339
Honolulu, HI 96809-0339

At the State Administrative Hearing, you may represent yourself. However, you may also use legal counsel, a relative, a friend or other spokesperson to act for you. The state will make a decision within 90 calendar days from the date the request was filed.

You may also have the right to ask for an expedited (fast) State Administrative Hearing. You may only do this when you asked for, or 'Ohana provided, a fast appeal review. You or someone you choose to act for you can ask for the hearing if we denied the fast appeal. You must do this within 120 calendar days of the Final Appeal Determination. The letter will tell you how to file an appeal. To do so, send your request to the address above. The State will make a decision within 72 hours from when they received your request.

What happens with my behavioral health benefits (services) during the appeal or State Administrative Hearing process?

We will continue your services if ALL of the following happen:

- An appeal was requested within 60 calendar days from the date you receive your Notice of Adverse Benefit Determination letter.
- Your appeal or request for a State Administrative Hearing involves an action we are taking to stop or reduce services we had already approved.
- The services were ordered by an authorized provider.
- The original time frame covered by the approval we gave has not ended yet.
- You request that we continue your services in a timely manner, defined as on or before the later of the following:
  - Within 10 calendar days of the date we mailed you the Notice of Adverse Benefit Determination Letter; or
  - The date we planned to stop or reduce your service(s)

We will continue your benefits until:

- You withdraw your request for the appeal or State Administrative Hearing;
- You do not ask for an appeal or State Administrative Hearing and continuation of benefits within 10 calendar days from when the plan mails a Notice of Adverse Benefit Determination; or
- A State Administrative Hearing decision is unfavorable to you.

If our decision on your appeal or the state decision (if you asked for a State Administrative Hearing) is to deny the services, we may ask you to pay for the services you received while waiting for the decision.

If the plan or the state changes the decision to deny, limit or delay services that were not provided while the appeal or State Administrative Hearing was pending, the plan shall authorize or provide the service promptly and as expeditiously as your health requires but no later than 72 hours from the date reversing the determination is received.

Important Member Information

Enrollment Information

Enrollment

People covered under QUEST Integration medical assistance program and diagnosed as having certain mental health conditions may be referred to ʻOhana CCS, your plan for behavioral health services. QUEST Integration stays as your plan for medical services. Med-QUEST Division makes final eligibility decisions for ʻOhana CCS members. Referrals come from:

- QUEST Integration Health Plans
- Hawaiʻi State Hospital for people who are being discharged
- DOH-AMHD, DOH-CAMHD or DOH-DDD
- Department of Public Safety for people who are being discharged from their correctional facility.
- DHS for young adults (18 years old or older) being discharged from the Hawaii Youth Correctional Facility
- People who contact ʻOhana CCS for the first time on their own or through crisis services

Reinstatement

If you lose your Medicaid eligibility but get it back within six months, the state may reinstate you as a member of ʻOhana CCS. Call ʻOhana Customer Service toll-free at **1-866-401-7540 (TTY 711)** to ask to be reinstated with ʻOhana CCS.

Disenrollment

Med-QUEST Division makes all eligibility decisions. You may lose your ʻOhana CCS membership:

- If you no longer qualify based on the behavioral health eligibility criteria
- If you voluntarily leave the program
- If you lose your Medicaid eligibility
- If you are sent to prison

- If you enter the Hawai'i State Hospital
- If you try to enroll in the program by using false information
- If you move to another state
- If you do not make contact with your Case Manager for three months or longer
- If there is documentation of your refusal of services
- Upon the death of the Member
- If you are sent out of state for medical treatment by DHS or 'Ohana and DHS or the QI Health Plan will assume responsibility for the behavioral healthcare needs for you

You cannot be disenrolled from the plan for these reasons:

- Preexisting behavioral health conditions
- Missed appointments
- Changes in health status
- Utilization of behavioral health services
- Diminished mental capacity
- Uncooperative or disruptive behavior resulting from your special needs (except where the member's continued enrollment in the health plan seriously impairs the health plan's ability to furnish services to either the member or other members)

Important Information about ʻOhana CCS

Our Service Area

ʻOhana CCS serves the following islands:

- Kauaʻi
- Molokaʻi
- Lanaʻi
- Oʻahu
- Maui
- Hawaiʻi

Call ʻOhana CCS Customer Service if you move. You will want to pick a Case Manager/Agency near your new home. If you move out of our service area, call MQD to learn more about how your move may affect your behavioral health coverage. The toll-free number is **1-800-316-8005**.

Plan Structure, Operations and Provider Incentive Programs

ʻOhana Health Plan is dedicated to helping you get the most out of your health plan. Our Case Managers and Customer Service representatives can help you get the care you need. If you need information on the structure and operations of ʻOhana Health Plan, call us toll-free at **1-866-401-7540 (TTY 711)**. You can always stop by one of our offices on Oʻahu, Maui or the Big Island.

ʻOhana CCS also works with your Case Manager/Agency and healthcare providers to make sure you get the right care at the right time. This includes preventive care. We will sometimes offer your doctors incentives, or bonuses. We do this to encourage them to keep you on track with your wellness visits throughout the year. Call Customer Service if you have any questions or want more information about the provider incentive program..

How Our Providers Are Paid

ʻOhana CCS works hard to give you the care you need. We work with many providers. You may ask how they are paid and if the way they are paid will affect how they use referrals. You may also ask if it will affect other services you may need. Call Customer Service for more information.

Evaluation of New Technology

We look at new technology every year. We also look at the ways we use the technology we have. We review the findings to:

- Determine how new technology can be included in member benefits
- Make sure members have fair access to safe and effective care
- Make sure we are aware of changes in the industry

We review of new technology in these areas:

- Behavioral health procedures
- Medical procedures
- Pharmaceuticals
- Medical devices

To learn more, call Customer Service.

Quality and Member Satisfaction Information

You can ask about how the plan has performed. You can also ask if our members are satisfied. You can give us ideas for how we can improve. We give you highlights of areas that we are working on each year in the Member Newsletter. Call Customer Service to get more information or a copy of the newsletter.

Fraud, Waste and Abuse

Billions of dollars are lost to healthcare fraud every year. What is healthcare fraud, waste and abuse? It's when false information is given on purpose. This can be done by a member or provider. This false information can lead to someone getting a service or benefit that is not allowed. It can also lead to a provider getting paid for services that were not performed. We do not tolerate fraud, waste and abuse. It is a crime to lie, misrepresent facts, withhold information, or arrange for someone to knowingly lie or misrepresent facts on your behalf, in order to receive medical assistance or benefits. You may be held liable for repaying the value of benefits you received and be subject to penalties under the law.

We are required to report suspected member or provider fraud, waste and abuse to the MED-QUEST Division.

Here are some other examples of fraud, waste and abuse:

- Billing for a more expensive service than what was actually given
- Billing more than once for the same service
- Billing for services not performed
- Falsifying a patient's diagnosis to justify tests, surgeries or other procedures that are not medically necessary
- Filing claims for services or medications not received
- Forging or altering bills or receipts
- Misrepresenting procedures performed to obtain payment for services that are not covered
- Over-billing the plan
- Using someone else's 'Ohana CCS ID card to get services
- Obtaining medications and then selling them to someone else
- Asking for and getting transportation services to go somewhere other than to a medical appointment

Tell us if you know that fraud, waste or abuse has occurred. Tell us if you think that fraud, waste or abuse has occurred. We will determine if something is fraud, waste or abuse. Call our 24-hour Fraud Hotline at **1-866-685-8664**. It is private. You may leave a message without leaving your name. We will call you back if you leave your phone number. We will do this to be sure our information is complete and accurate. You can also report fraud on our website. This is private too. Go to **www.ohanahealthplan.com**.

You can also send a report in writing to:

'Ohana Health Plan
Attn: Special Investigations Unit
PO Box 31407
Tampa, FL 33631-3407

Member Rights and Responsibilities

Member Rights

As an 'Ohana CCS member, you have the right:

- To get information about the plan, its services, its practitioners and its providers.
- To get information about your rights and responsibilities as required by 42 CRF §§ 438.10.
- To have the protections listed in the Patients' Bill of Rights and Responsibilities Act (HRS Chapter 432E).
- To know the names and titles of the providers who take care of you.
- To be treated with respect.
- To be treated with dignity.
- To privacy.
- To decide with your provider on the care you get.
- To talk about the care you need as it is related to your health conditions. This includes the choices and risks involved, regardless of the cost or benefit coverage. You must get this information in a way you understand.
- To know about your healthcare needs after you get out of the hospital or leave a provider's office.
- To refuse care, as long as you agree to be responsible for your decision.
- To not take part in any medical research.
- To file a grievance and/or an appeal about the plan or the care it provides. And to know that if you do, it will not affect how you are treated .
- To be free from any form of restraint or seclusion as a means of force, discipline, convenience or retaliation.
- To request and get a copy of your behavioral health records pursuant to 45 CFR Parts 160 and 164, subparts A and E
- To request to amend or correct your behavioral health records as specified in 45 CFR §§ 164.524 and 164.526
- To have your records kept private.
- To make your healthcare wishes known by using advance directives.

- To have input in the plan's member rights and responsibilities.
- To use these rights no matter your sex, age, race, ethnicity, income, education or religion.
- To have all plan employees honor your rights.
- To get healthcare services that are accessible, comparable in amount, duration and scope to those provided under Medicaid Fee-for-Service and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.
- To get appropriate services that are not denied or cut back just because of diagnosis, type of illness or mental health condition.
- To get all information in a way that you can easily understand, in alternative formats and in a manner that takes into consideration your special needs.
- To get help in understanding the rules and benefits of the plan.
- To get verbal interpretation services at no cost. This is for all non-English languages, not just those that are most common.
- To be told that verbal interpretation is available to you, and how to get this service.
- To get information about:
  - The basic features of managed care.
  - Who may or may not join the program.
  - The plan's responsibilities for coordination of care in a timely manner in order to make an informed choice (potential members).
- To get a complete description of your right to leave the plan.
- To get a notice of any major change in benefits. You must get this at least 30 days before the change is to go into effect.
- To get full information about emergency and after-hours services.
- To get the plan's policy on referrals for specialty care and other benefits that are not provided by the member's Case Manager/Agency or healthcare provider.
- To have all these rights apply to the person you legally appoint to make decisions about your healthcare.
- To freely exercise your rights, including those related to filing a grievance or appeal, and that the exercise of these rights will not adversely affect the way you are treated.
- To receive a second opinion at no cost to the member.

- To receive services out of network if the health plan is unable to provide them in network for as long as the health plan is unable to provide them in network and not pay more than he or she would have if services were provided in network.
- To receive services according to the appointment waiting time standards.
- To receive services in a culturally competent manner.
- To receive services in a coordinated manner.
- To have your privacy protected.
- To be included in care plan development.
- To have access to providers contracted with the health plan.
- To have direct access to specialists (if you have a special healthcare need).
- To be informed regarding the restrictions on freedom of choice among network providers.
- To not have services arbitrarily denied or reduced in amount, duration or scope solely because of diagnosis, type of illness or condition.
- To receive a description of cost-sharing responsibilities, if any.
- To not be held liable for:
  - The health plan's debts in the event of insolvency.
  - The covered services provided to the member by the health plan for which Med-QUEST Division does not pay the health plan.
  - Covered services provided to the member for which Med-QUEST Division or the health plan does not pay the healthcare provider that furnishes the services; and payments of covered services furnished under a contract, referral or other arrangement to the extent that those payments are in excess of the amount the member would owe if the health plan provided the services directly.
- To only be responsible for cost-sharing as described by your plan in accordance with 42 CFR Section 447.50.
- To be provided with written notice of any significant change related to member rights, responsibilities and procedures at least 30 days before the intended effective date of the change.
- Receive information in accordance with information requirements (42 CFR §§ 438.10).
- Have direct access to a women's health specialist within the network.
- Be furnished healthcare services in accordance with requirements for timely access and medically necessary coordinated care (42 CFR §§ 438.206 through 42 CFR §§ 438.210).

Member Responsibilities

You also have responsibilities as a member:

- To give information that the plan and its providers need to give care.
- To follow plans and instructions for care that you have agreed on with your Case Manager/Agency or healthcare provider.
- To understand your health problems.
- To help set treatment goals that you and your Case Manager/Agency or healthcare provider agree to.
- To read the Member Handbook to understand how the plan works.
- To always carry your ‘Ohana CCS member ID card.
- To always carry your Medicaid card.
- To show your ID cards to each provider.
- To notify ‘Ohana CCS if you lose your member ID card.
- To schedule appointments for all non-emergency behavioral healthcare through your Case Manager/Agency or healthcare provider.
- To get a referral from your Case Manager/Agency or healthcare provider for specialty care.
- To cooperate with the people providing your healthcare.
- To be on time for appointments.
- To notify the provider’s office if you need to cancel or change an appointment.
- To respect the rights of all providers.
- To respect the property of all providers.
- To respect the rights of other patients.
- To not be disruptive in any provider’s office.
- To know the medicines you take, what they are for, and how to take them the right way.
- To help your Case Manager/Agency or healthcare provider obtain copies of all of your previous health records.
- To let the plan know within 48 hours, or as soon as possible, if you are admitted to the hospital or get emergency room care.
- To call ‘Ohana CCS to get information or get your questions answered. Call Customer Service toll-free at **1-866-401-7540 (TTY 711)**.

1-866-401-7540
(TTY 711)

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