

Hawaii Member Handbook

COMMUNITY CARE SERVICES (CCS)



[OhanaHealthPlan.com](https://www.OhanaHealthPlan.com)



‘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, seven days a week. Our friendly staff can answer all of your questions. You can also visit us at **ohanahealthplan.com**.

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



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Table of Contents

‘Ohana Community Care Services (CCS)... Your Behavioral Health Plan.....	1
We’re Here to Help.....	10
Help from ‘Ohana CCS Customer Service.....	10
We Care about Your Privacy!.....	10
Our Service Area.....	10
Help from Your Case Manager/Agency	11
Other Important Phone Numbers	12
Visit Our Website to Stay Informed	12
Ombudsman Program.....	13
The ‘Ohana CCS Dictionary	14
Medicare Basics.....	21
Getting Started With Us.....	24
How to Get The Most From Your Plan	24
Check Your ID Card and Put It in a Safe Place	24
Choose Your Case Management Agency	25
Get to Know Your Case Manager and Agency	25
Changing Your Case Manager/Agency	25
Get to Know Your 24-Hour Nurse Advice Line.....	25
In an Emergency	26
Call Us, Tell Us.....	26
‘Ohana CCS Coordination of Benefits	26
‘Ohana CCS Members Have Certain Rights and Responsibilities.....	27
Making Appointments.....	27
Your Health Plan	29
Covered Services	30
Behavioral Health Services, Coverage and Limits.....	30
Receiving Non-Covered Services	37
Prescription Drug Services	37
Prescriptions and Pharmacy Access.....	37
How do I get a prescription?.....	37
Which drugstores will fill my prescription?	37
What is the process for getting a prescription filled?.....	37



Pharmacy Lock-In 37
What is the Pharmacy Lock-In Program? 37

Preferred Drug List..... 38
What medicines does ‘Ohana CCS pay for? 38
Are there medicines ‘Ohana CCS will not pay for? 38
Can I get any medicine I want? 38
Are generic drugs as good as brand-name drugs?..... 38

Pharmacy Direct Member Reimbursement..... 39
What is a Pharmacy Direct Member Reimbursement (DMR)?..... 39
Where do I send my DMR request? 39
What do I need to include with each DMR request for approval? 39
How much will I get back?..... 39
How long should I expect to wait for my reimbursement? 40
What if I don’t like the decision that was made? 40

Telehealth Services 40

Transportation..... 40
Questions?..... 41
Three Steps for Using your Transportation Benefit 41
NET Service Reminders..... 42
Mileage Reimbursement 42

Behavioral Health Services 42
How to Select or Change Behavioral Health Providers 42
What to Do in an Emergency or if You Are Out of Our Service Area 42
Behavioral Health Limitations and Exclusions 42

Hospital Services 43
Services from Providers that Are Not in Our Network..... 43
Services that Require Prior Authorization/Precertification 43
Utilization Management Program 43
How to Get After-Hours Care..... 44
Emergency Services 44
What to Do in an Emergency..... 46
Post-Stabilization Services 47



Out-of-Area Emergency Care	47
What to Do if You Are in Crisis.....	47
Out-of-State and Off-Island Coverage	47
Transition of Care.....	48
EPSDT (Early and Periodic Screening, Diagnostic and Treatment) Services	48
Advance Directives.....	48
Your Care Is Your Decision	48
Advance Directives Help You Make Your Wishes Known	48
Where can I get an advance directive form?.....	49
How can I learn more about advance directives?.....	49
Can I change my advance directive?	49
What should I do with my forms after filling them out?	49
Do my caregivers have to follow my advance directive?.....	49
What happens if my wishes aren't followed?.....	49
Member Grievance and Appeal Procedures	50
Grievances.....	50
What is a grievance?	50
When can I file a grievance?	50
How do I file a grievance?.....	50
State Grievance Review.....	51
Appeals.....	51
What is an appeal?.....	51
How do I file an appeal?	52
What if I need an expedited (fast) appeal?	52
What if I would like to submit additional information?.....	53
What if I do not like an appeal decision?.....	53
What happens with my behavioral health benefits (services) during the appeal or State Administrative Hearing process?.....	53
Important Member Information	55
Enrollment Information.....	56
Enrollment.....	56
Reinstatement.....	56
Disenrollment.....	56



Important Information about ‘Ohana CCS..... 57

- Our Service Area..... 57
- Plan Structure, Operations and Provider Incentive Programs 57
- How Our Providers Are Paid..... 57
- Behavioral Health Services Direct Member Reimbursement 57
- Evaluation of New Technology..... 59
- Quality and Member Satisfaction Information 59
- Fraud, Waste and Abuse 59
- Digital Health Records..... 60

Member Rights and Responsibilities 60

- Member Rights 60
- Member Responsibilities..... 63



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, seven days a week with questions about:

- Benefits.
- Replacing a lost or stolen 'Ohana CCS 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
820 Mililani Street
Suite 200
Honolulu, HI 96813

We Care about Your Privacy!

'Ohana CCS 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 CCS. 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 'Ohana CCS Offices
<p>'Ohana CCS – Big Island Office</p> <p>88 Kanoelehua Ave</p> <p>Suite A105</p> <p>Hilo, HI 96720</p>

Our Service Area

'Ohana CCS serves the following areas:

- Kauai
- Maui
- Hawaii
- Oahu
- Lanai



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 arrange 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 reach out 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 arrange 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 in-person 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 also 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 call the 'Ohana Health Plan CCS 24/7 hotline at **1-866-401-7540** (TTY: **711**) if you need assistance. The crisis line of Hawaii is also available 24/7. Call Hawaii CARES at **1-808-832-3100** for Oahu or **1-800-753-6879** for Neighbor Islands.



Other Important Phone Numbers

Who to Call For Help	Toll-Free Phone Number
Hawaii CARES	Oahu: 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)
Hawaii Med-QUEST Division	1-800-316-8005
24-Hour 'Ohana CCS Customer Service	1-866-401-7540 (TTY: 711)

Visit Our Website to Stay Informed

Remember to go to our website often at ohanahealthplan.com. 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, in our Member Portal, you can order and view your 'Ohana CCS ID card. You can also update your address and phone number. Log in at ohanaccs.com/login/member today!



Ombudsman Program

The Hawaii Department of Human Services (DHS) oversees the Medicaid Ombudsman Program. This program allows Koan Risk Solutions, an independent reviewer, to look at concerns about Medicaid health plans. Their website is 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.

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 himedicaidombudsman.com. You can also call, email, or fax them. Their contact information is below:

Island	Phone Number
Oahu	1-808-746-3324
Hawaii	1-888-488-7988
Maui and Lanai	1-888-488-7988
Molokai	1-888-488-7988
Kauai	1-888-488-7988
Pharmacy	1-888-488-7988
Email: hiombudsman@koanrisksolutions.com	TTY: 711
Oahu fax: 1-808-356-1645	



The 'Ohana CCS Dictionary

Words/Phrases

Advance Directive: A written instruction, such as a living will or durable power of attorney for health care, recognized under State law relating to provision of health care when the individual is incapacitated.

Adverse Benefit Determination:

Any one of the following:

- a. The denial or restriction of a requested service, including the type or level or service;
- b. The reduction, suspension, or termination of a previously authorized service;
- c. The denial, in whole or part, of payment for a service;
- d. The failure to provide services in a timely manner, as defined in Section 8.1;
- e. The failure of 'Ohana CCS to act within prescribed timeframes;
- f. For a rural area member or for islands with 'Ohana CCS or limited providers, the denial of a member's request to obtain services outside the network:
 1. From any other provider (in terms of training, experience, and specialization) not available within the network;
 2. From a provider not part of a network that is the main source of a service to the member, provided that the provider is given the same opportunity to become a participating provider as other similar providers;
 3. If the provider does not choose to join the network or does not meet the qualifications, the member is given a choice of participating providers and is transitioned to a participating provider within sixty (60) calendar days;
 4. Because 'Ohana CCS or provider does not provide the service because of moral or religious objections;
 5. Because the member's provider determines that the member needs related services that would subject the member to unnecessary risk if received separately and not all related services are available within the network; and
 6. The State determines that other circumstances warrant out-of-network treatment.

Appeal: A review by 'Ohana CCS of an adverse benefit determination.



Words/Phrases

Behavioral Health Provider: The full continuum of services from screening to specialty treatment services to support individuals who have mental health and substance use needs, including those with mild to moderate conditions, emotional disturbance, mental illness, or substance use conditions.

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.

Copayment (Copay): The amount that you must pay, usually a fixed amount of the cost of a service.

Covered Services: Those services and benefits to which you are entitled to under Hawaii's Medicaid programs.

Cultural Competency: A set of interpersonal skills that allows individuals to 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. This requires a willingness and ability to draw on community-based values, traditions and customs, to devise strategies to better meet culturally diverse member needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications and other supports.

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

Durable Medical Equipment: Medical equipment that is ordered by a doctor for use in the home.

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



Words/Phrases

Emergency Medical Condition: The sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms, substance abuse) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of emergency services or immediate medical attention to result in:

- a. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- b. Serious impairment to body functions;
- c. Serious dysfunction of any bodily functions;
- d. Serious harm to self or others due to an alcohol or drug abuse emergency;
- e. Injury to self or bodily harm to others; or
- f. With respect to a pregnant woman who is having contractions:
 1. That there is inadequate time to affect a safe transfer to another hospital before delivery; or
 2. That transfer may pose a threat to the health or safety of the woman or her unborn child.

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

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

Emergency Services: Covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition that is found to exist using a prudent layperson standard.

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

Fraud: An intentional deception or misrepresentation made by an individual with the knowledge that the deception could result in some unauthorized benefit to that individual or some other individual. It includes any act that constitutes fraud under applicable Federal or State law.

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

Grievance: An expression of dissatisfaction from a member, member's representative, or provider on behalf of a member about any matter other than an adverse benefit determination.



Words/Phrases

Habilitative/Habilitation Services: Health care services that help keep, learn or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

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*).

Home Healthcare: Limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, durable medical equipment (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.

Hospice Services: Services to provide comfort and support for members in the last stages of a terminal illness and their families.

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

Hospitalization: Care in a hospital 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: A comprehensive approach to the provision of health care that combines clinical services and administrative procedures within an integrated, coordinated system to provide timely access to primary care and other necessary services in a cost-effective manner.



Words/Phrases

Medical Necessary: Means those procedures and services, as determined by the department, which are considered to be necessary and for which payment will be made. Medically necessary health interventions (services, procedures, drugs, supplies, and equipment) must be used for a medical condition. There shall be sufficient evidence to draw conclusions about the intervention's effects on health outcomes. The evidence shall demonstrate that the intervention can be expected to produce its intended effects on health outcomes. The intervention's beneficial effects on health outcomes shall outweigh its expected harmful effects. The intervention shall be the most cost-effective method available to address the medical condition. Sufficient evidence is provided when evidence is sufficient to draw conclusions, if it is peer-reviewed, is well-controlled, directly or indirectly relates the intervention to health outcomes, and is reproducible both within and outside of research settings.

Medicare: The health care insurance program for the aged and disabled administered by the Social Security Administration under Title XVIII of the Social Security Act.

Med-QUEST Division (MQD): The offices of the State of Hawaii, Department of Human Services, which oversees, administers, determines eligibility, and provides medical assistance and services for State residents.

Member: An individual who meets all eligibility requirements for Community Care Services (CCS), and for whom all applicable expenditure shares have been paid.

Network: A group of doctors, hospitals, pharmacies, and other health care experts hired by 'Ohana CCS to take care of its members

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.



Words/Phrases

Participating Provider: A provider who has a contract with health insurers or plans to provide services.

Plan: A benefit provided by employers, unions or other group sponsors to pay for health care services.

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.

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.

Premium: The amount paid for health insurance every month.

Prescription Drugs: Drugs and medications that, by law, require a prescription.

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

Primary Care Provider (PCP): A practitioner selected by the beneficiary or member, to manage the utilization of health care services, who is licensed in Hawaii and is:

- a. A physician, either an M.D. (Doctor of Medicine) or a D.O. (doctor of osteopathy), and must generally be a family practitioner, general practitioner, general internist, pediatrician or obstetrician-gynecologist (for women, especially pregnant women) or geriatrician;
- b. An advanced practice registered nurse with prescriptive authority. PCPs have the responsibility for supervising, coordinating and providing initial and primary care to enrolled individuals and for initiating referrals and maintaining the continuity of their care; or
- c. A physician's assistant recognized by the State Board of Medical Examiners as a licensed physician assistant.



Words/Phrases

Prior Authorization: A decision by health insurers or plans that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Health insurance or plans may require preauthorization for certain services prior to members receiving them, except in an emergency. Preauthorization does not guarantee the health insurer or plan will cover the cost.

Provider: Any licensed or certified person or public or private institution, agency or business concern authorized by the DHS to provide health care, service or supplies to individuals receiving medical assistance.

Physician Services: Services provided by an individual licensed under state law to practice medicine or osteopathy.

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

QUEST Integration (QI): QUEST Integration is the managed care program that provides health care benefits, including long-term services and supports, to individuals, families, and children, both non-aged, blind, or disabled (non-ABD) individuals and ABD individuals, with household income up to a specified federal poverty level (FPL).

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

Rehabilitative/Rehabilitation Services: Health care services that help keep, regain, or improve skills and functioning for daily living that have been lost or impaired because of illness, injury, or disability. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Care: A level of care that includes services that can only be performed safely and correctly by a licensed nurse (either a registered nurse or a licensed practical nurse).



Words/Phrases

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

Treatment: The care you get from doctors and facilities.

Third Party Liability (TPL): Any person, institution, corporation, insurance company, public, private or governmental entity who is or may be liable in contract, tort or otherwise by law or equity to pay all or part of the medical cost of injury, disease or disability of a member to Medicaid.

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 costs. It is available to U.S. citizens and permanent residents aged 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 'Ohana CCS.

Check Your ID Card and Put It in a Safe Place

You should have received your 'Ohana 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; or
 - Hospital.
- Pick up prescriptions from the pharmacy.
- Have mental health exams.

Call 'Ohana 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.

The diagram shows two parts of the ID card. The top part is the member information section, and the bottom part is the contact information section. Callouts point to specific fields with labels:

- Your name:** Points to the Member Name field.
- The date your 'Ohana CCS membership started:** Points to the Effective Date field.
- Your Case Manager/Agency contact information:** Points to the Case Manager/Agency name and phone number.
- Our website:** Points to the website URL.
- Your 'Ohana CCS ID number:** Points to the Member ID field.
- Your Medicaid ID number:** Points to the Medicaid # field.
- Information your providers need to correctly bill for your care/ services:** Points to the RXBIN, RXPCN, and RXGRP fields.
- How to contact us:** Points to the Customer Services and Nurse Advice Line phone numbers.

Member Information Section:

ohana health plan. Community Care Services (CCS)

Member: <Member Name>¹⁵
 Member ID: <123456>⁴ Medicaid #: <543210>⁹⁶
 Effective Date: <XX/XX/XXXX>⁴³
 Eligibility Recert Date: <XX/XX/XXXX>¹¹⁸
 Case Manager/Agency: <Case Manager or Agency Name>¹⁶ Third Party Liability: <X>¹¹⁷
 <Phy Add1>²⁶ RXBIN: <XXXXXX>⁵⁶
 <Phy Add2>²⁷ RXPCN: <XXXXXX>⁵⁸
 <Phy City, State, Zip>²⁸⁻³⁰ RXGRP: <XXXXXX>⁵⁷
 Phone: <1-555-555-1234>³¹

Contact Information Section:

<www.ohanaccs.com>¹²¹
 <Ohana Health Plan CCS>
 <820 Mililani Street, Suite 200 Honolulu, HI 96813>¹²⁵

Customer Services: <1-866-401-7540>⁵¹ / TTY: <711>⁵⁰
 Nurse Advice Line: <1-800-919-8807>⁷⁶

If you have a behavioral health emergency, call 911 or go to the nearest emergency room.

Mail behavioral health-related claims to:
 <Ohana Health Plan CCS P.O. Box 31372 Tampa, FL 33631-3372>⁵⁴

For non-emergencies you can call your 'Ohana CCS case manager/agency or our 24-hour toll-free Customer Service line.



Choose Your Case Management Agency

Now that you are enrolled in CCS, 'Ohana CCS 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 details about each Case Manager / Agency, including 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 an in-person 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:

- Through your Provider Directory.
- At **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, seven days a week through the entire 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 available 24 hours a day, seven days a week for your care management needs. You can call toll-free at **1-866-401-7540** (TTY: **711**).



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.

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, seven days a week. We will return your call within one business day.

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



You can also write to Customer Service at:

‘Ohana CCS Customer Service
820 Mililani Street
Suite 200
Honolulu, HI 96813

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.
- Change your address.
- Change in income.
- Legal encumbrances, conditional release, jail diversion, released on conditions, mental health court, or receiving services from DOH-AMHD.
- Institutionalization, imprisonment, long-term care facility, or 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 CCS Coordination of Benefits

‘Ohana CCS will let DHS know if you have any other health insurance plan or program that may be responsible for paying 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 CCS will provide our members any notices issued by the Hawaii 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

To make an appointment for behavioral health services, you can use our ‘Ohana CCS Provider Directory to choose a suitable network provider in your area. 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 an 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, seven 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 four weeks.
- Get follow-up care after a hospital stay as needed.

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 and 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
- Residency completion
- Professional qualifications
- Board certification status
- Specialty

Behavioral Health Services, Coverage and Limits

Services	Coverage and Limits
<p>Community Integration Services (CIS)</p>	<p>Case management helps to find and maintain housing.</p> <p>Pre-Tenancy Services</p> <ol style="list-style-type: none"> 1. Identify eligible individuals. 2. Provide screening/assessments. 3. Develop housing support plan. 4. Search for housing. 5. Prep and submit applications. 6. Identify resources/costs for start-up needs. 7. Identify equipment, technology, and other modifications needed. 8. Ensure housing is safe. 9. Assist with moving. 10. Create individualized housing crisis plan. 11. Help with skill and acquisition development. 12. Develop independent living skills/financial literacy.



Services	Coverage and Limits
<p>Community Integration Services (CIS) (continued)</p>	<p>Tenancy Services</p> <ol style="list-style-type: none"> 1. Individual Housing and Tenancy Sustaining Services. 2. Community Transition Services (CTS). <p>Other Housing & Tenancy Services</p> <ol style="list-style-type: none"> 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. 14. Other supplemental services as needed.
<p>Crisis Services</p>	<ul style="list-style-type: none"> • 24 hours a day, seven days a week emergency/crisis intervention. • Crisis hotline. • Crisis residential services. • Crisis stabilization. • Mobile crisis response.
<p>Behavioral Health Outpatient Services</p>	<ul style="list-style-type: none"> • Continuous treatment teams. • Family/collateral therapeutic support and education. • Individual/group therapy and counseling. • Treatment/service planning. • Other medically necessary therapeutic services.



Services	Coverage and Limits
Diagnostic Services	<ul style="list-style-type: none">• Psychiatric or psychological evaluation and treatment, including neuropsychological evaluation.• Psychological testing.• Psychosocial history.• Screening for and monitoring treatment of mental illness and substance use, including substance use disorders (SUDs).• Other medically necessary behavioral health diagnostic services to include labs.
Emergency Department (ED) Services	<ul style="list-style-type: none">• Any covered inpatient and outpatient services given by a qualified provider. These services are needed to assess 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.
Emergency Inpatient Care	<ul style="list-style-type: none">• In communities (excluding Oahu) where a psychiatric facility is not readily available, emergency inpatient service of up to 48 hours may be provided at the closest licensed general hospital.• On Oahu, an emergency exists only when all authorized psychiatric facilities are filled, and no beds are available. Patients determined by the attending physician to require inpatient care beyond the 48-hour period are to be transferred to an authorized psychiatric facility.
Inpatient Psychiatric Hospitalization (24 hours)	<ul style="list-style-type: none">• 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.



Services	Coverage and Limits
<p>Intensive Case Management</p>	<ul style="list-style-type: none"> • 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.
<p>Medication Management</p>	<ul style="list-style-type: none"> • Medication counseling and education. • Medication evaluation. • Psychotropic medications.
<p>Medication Assisted Treatment (MAT)</p>	<ul style="list-style-type: none"> • Includes the provision of methadone or buprenorphine products and related outpatient counseling services for Opioid Use Disorder.
<p>Out-of-State and Off-Island Coverage</p>	<p>Provides for any medically necessary covered services that are prearranged when not available on your island or in Hawaii. This includes:</p> <ul style="list-style-type: none"> • 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). <p>Requires prior authorization.</p>
<p>Partial Hospitalization or Intensive Outpatient Hospitalization</p>	<ul style="list-style-type: none"> • Diagnostic tests. • Medical supplies. • Medication management. • Prescribed drugs. • Therapeutic services including individual, family and group therapy, and aftercare. • Other medically necessary services.



Services	Coverage and Limits
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.
Psychosocial Rehabilitation/ Clubhouse Services	<ul style="list-style-type: none"> • 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	<p>‘Ohana CCS coordinates with Department of Health Alcohol and Drug Abuse Division (DOH-ADAD) to help our members with SUDs by linking members with the ADAD specialists within our Provider Network.</p> <p>For help accessing these providers for SUD treatment, please work with your CCS case manager or contact our Customer Service toll-free at 1-866-401-7540 (TTY: 711).</p> <p>You also can access ADAD providers and SUD treatment 24/7 by calling Hawaii CARES:</p> <p>Oahu: 1-808-832-3100 Neighbor Islands: 1-800-753-6879</p> <p>All medically necessary services include:</p> <ul style="list-style-type: none"> • Residential treatment. • Intensive outpatient treatment.



Services	Coverage and Limits
<p>Supportive Employment Services</p>	<ul style="list-style-type: none"> • Discovery – pre-employment service. • Work assessment service. • Job coaching.
<p>Telehealth Services</p>	<p>Services may include, but are not limited to:</p> <ul style="list-style-type: none"> • Real-time video conferencing. • Secure interactive and non-interactive web communication. • Secure transfer of your medical records. Your provider can use high-quality images and lab reports for your care. <p>Services not covered include:</p> <ul style="list-style-type: none"> • Standard phone calls, faxes, or email — in combination or individually. • Getting medication by filling out an online form. <p>If you get in-person care that needs prior approval, you will need prior approval to get the same care through telehealth.</p> <p>Providers will tell you if they offer telehealth services.</p> <p>Your provider will bill the plan for these services.</p>



Services	Coverage and Limits
Transportation	<p>Provides for both emergency and non-emergency ground and air services to and from medically necessary provider appointments for members who:</p> <ul style="list-style-type: none">• 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:<ul style="list-style-type: none">– Community care foster family home;– Adult residential care home;– Expanded adult residential care home; or– Domiciliary home. <p>Transportation to a pharmacy is covered when a member is unable to access needed medications due to transportation, and no viable alternative is available.</p> <p>Transportation is not provided to day programs that are not medically necessary.</p> <p>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.</p> <p>Transportation to the Hawaii State Hospital is not covered.</p>
Urgent Care Services	Covered as medically necessary. No prior authorization is required.
Other Services	<ul style="list-style-type: none">• 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.



When you follow plan rules, you should not be billed for covered services.

If you get a bill, do not wait! Call Customer Service at 1-866-401-7540 (TTY: 711). 'Ohana CCS will look into this for you.

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 'Ohana 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 provider.

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 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 copay for prescribed medications for Medicaid-only members. There may be a copay if you have other insurance coverage such as Medicare.

Pharmacy Lock-In

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

What is the Pharmacy Lock-In Program?

Seeing many different providers for your care can be dangerous if each provider gives you similar drugs without knowing what the other providers are prescribing. We are committed to you having a clear understanding of these possible dangers and protecting you from that.



If we see 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 provider 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 provider and pharmacy know. However, if you do not want to be in the 'Ohana CCS Pharmacy 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 provider is in our network.

There is no cost; this is a voluntary service. For questions about our 'Ohana CCS Pharmacy 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). Providers and pharmacists decide which drugs should be on this list. Your provider will use this list when prescribing drugs for your behavioral health needs. Some drugs will require approval through a Coverage Determination Request (CDR). Your provider will handle 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 **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 providers order for you may be covered if they are on the PDL (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-name drugs. They have the same active ingredients as brand-name drugs.



Pharmacy Direct Member Reimbursement

What is a Pharmacy 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 12 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, seven days a week. You can also go to **ohanahealthplan.com**.

Where do I send my DMR request?



Send the form to:

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

What do I need to include with each Pharmacy Member Reimbursement 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 four to six weeks from the date you mail in the DMR form. Be sure that your form is completed with all the needed 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 provider 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 provider 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 **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 Oahu, 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).
- If you live less than a half mile from a bus stop.
- 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).
- If you live more than a half mile from a bus stop.
- If your destination is more than a half mile from a bus stop.

TheHandi-Van service will be used:

- If you live on Oahu.
- If your physical condition does not allow you to ride the bus.
- 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 through 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.

Three 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.

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** after your appointment. NET services will arrive within 60 minutes. Please allow for this time. Let them know exactly where to pick you up. This will help 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** to tell us about your experience.

Mileage Reimbursement

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

Behavioral Health Services

How to Select or Change Behavioral Health Providers

‘Ohana CCS 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 **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.

**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.**



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 services listed below 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 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 received.

We do these reviews to measure the behavioral healthcare and services you receive. We want to make sure the services you receive match your 'Ohana 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 ensure our reviews are based only on the suitability 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: **711**).

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

If we object 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** (TTY: **711**).

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

Emergency Services

Emergency services are for very serious conditions that must be treated right away. They may include inpatient and outpatient services (see page 46 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.

Facility Name	Address	City	State	Zip Code	Island	Phone Number
Hale Hoola Hamakua	45-547 Plumeria St	Honokaa	HI	96727	Hawaii	1-808-932-4100
Hilo Benioff Medical Center	1190 Waiuanuenue Ave	Hilo	HI	96720	Hawaii	1-808-932-3000
Kau Hospital	1 Kamani St	Pahala	HI	96777	Hawaii	1-808-932-4200
Kohala Hospital	54-383 Hospital Rd	Kapaau	HI	96755	Hawaii	1-808-889-6211
Kona Community Hospital	79-1019 Haukapila St	Kealahou	HI	96750	Hawaii	1-808-322-9311



Facility Name	Address	City	State	Zip Code	Island	Phone Number
Queens North Hawaii Community Hospital	67-1125 Mamalahoa Hwy	Kamuela	HI	96743	Hawaii	1-808-885-4444
Kauai Veterans Memorial Hospital	4643 Waimea Canyon Rd	Waimea	HI	96796	Kauai	1-808-338-9431
Samuel Mahelona Memorial Hospital	4800 Kawaihau Rd	Kapaa	HI	96746	Kauai	1-808-822-4961
Wilcox Memorial Hospital	3-3420 Kuhio Hwy	Lihue	HI	96766	Kauai	1-808-245-1100
Lanai Community Hospital	628 Seventh St	Lanai City	HI	96763	Lanai	1-808-565-8450
Kula Hospital	100 Keokea Pl	Kula	HI	96790	Maui	1-808-878-1221
Maui Memorial Medical	221 Mahalani St	Wailuku	HI	96793	Maui	1-808-244-9056
Molokai General Hospital	280 Home Olu Pl	Kaunakakai	HI	96748	Molokai	1-808-553-5331
Adventist Health Castle	640 Ulukahiki St	Kailua	HI	96734	Oahu	1-808-263-5500
Kahuku Medical Center	56-117 Pualalea St	Kahuku	HI	96731	Oahu	1-808-293-9221
Kapiolani Medical Center For Women And Children	1319 Punahou St	Honolulu	HI	96826	Oahu	1-808-983-6000
Kuakini Medical Center	347 N Kuakini St	Honolulu	HI	96817	Oahu	1-808-536-2236
Pali Momi Medical Center	98-1079 Moanalua Rd	Aiea	HI	96701	Oahu	1-808-486-6000
Straub Clinic Hospital	888 S King St	Honolulu	HI	96813	Oahu	1-808-522-4000
The Queens Medical Center	91-2141 Fort Weaver Rd	Ewa Beach	HI	96706	Oahu	1-808-691-3000
The Queens Medical Center	1301 Punchbowl St	Honolulu	HI	96813	Oahu	1-808-691-1000
The Queens Medical Center	128 Lehua St	Wahiawa	HI	96786	Oahu	1-808-621-8411



For a full list of emergency service providers, please Call Customer Service, check your Provider Directory, or visit our website at **ohanahealthplan.com**.

To use the “Find a Provider / Pharmacy” tool on our website, go to ohanahealthplan.com and follow these directions:

1. Click “Find a Provider / Pharmacy.”
2. Enter your zip code.
3. Select “Medicaid” as your coverage and plan, and press “Continue.”
4. Select your plan. Choose either:
 - a. ‘Ohana Community Care Services (CCS); or
 - b. ‘Ohana QUEST Integration.
5. Select where you want to search:
 - a. You may choose city and state, island, zip code, or address;
 - b. Then set the distance from your location that you would like to search.
6. Select what you're looking for:
 - a. Type in the specialty, urgent care, emergency care, etc.
7. Click “Go to Results.”

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 don’t require prior authorization. Go to the nearest hospital emergency room right away. Call Hawaii CARES at 1-808-832-3100 for Oahu, 1-800-753-6879 for Neighbor Islands, or your Case Manager/Agency. Some examples of emergencies/crises are:

- Feeling like you'll hurt yourself or others.
- Feeling suicidal.
- Feeling unsafe.

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

- Serious jeopardy of the physical or mental health of the individual.
- 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 physical or mental health or safety of a pregnant person or their unborn child.

When you get to the emergency room, you must show your ‘Ohana CCS ID card. Let your Case Manager/Agency know as soon as you can when you are at the hospital. Let them know if you received care in an emergency room. 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 Hawaii 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** (TTY: **711**), or contact your assigned Case Manager/Agency. You may also call Hawaii CARES at **1-808-832-3100** on Oahu 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, 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 provider 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 'Ohana CCS 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 ensure you get approval before you receive services.

Transition of Care

'Ohana CCS Health Plan is here to help. If you are new to 'Ohana CCS or your Case Manager/Agency or provider no longer participates with 'Ohana 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 'Ohana 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 plan has an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program. 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 Hawaii Uniform Health Care Decisions Act says you have a right to refuse medical treatment. This law also lets you tell your provider 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 of advance directives. One is a living will. The other is a durable power of attorney for healthcare decisions.

A living will 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 provider.

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 CCS does not place limits on your advance directives. 'Ohana CCS 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 it covers 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 Grievance and Appeal 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: 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 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
820 Mililani Street
Suite 200
Honolulu, HI 96813**



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. It 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 from the date that you received 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



Oahu: 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, stop, or terminate services you have been getting that we already approved.
- If we do not pay in full or in part for 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	
<p>For appeal requests for medical services:</p> <p>‘Ohana CCS Attn: Appeals Department P.O. Box 31368 Tampa, FL 33631-3368</p>	<p>For appeal requests for pharmacy medications:</p> <p>‘Ohana CCS Attn: Pharmacy Medication Appeals Department P.O. Box 31398 Tampa, FL 33631-3398</p>
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 provider 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 provider’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 is in your best interest. If we ask for the extra days, we will try to give you oral notice of the extension and will send you a written notice within two days. The notice will also tell you when the review will be completed. It will tell you that 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 Hawaii 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 also have the right to ask for an expedited (fast) State Administrative Hearing. You may only do this when you asked for, or 'Ohana CCS provided, a fast appeal review. You or your chosen representative 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 fast 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 'Ohana CCS, your plan for behavioral health services. QUEST Integration stays as your plan for medical services. Med-QUEST Division makes final eligibility decisions for 'Ohana CCS members. Referrals come from:

- QUEST Integration Health Plans.
- Hawaii 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 a correctional facility).
- DHS for young adults (18 years old or older) being discharged from the Hawaii Youth Correctional Facility.
- People who contact 'Ohana 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 'Ohana CCS. Call 'Ohana CCS Customer Service toll-free at **1-866-401-7540** (TTY: **711**) to ask to be reinstated with 'Ohana CCS.

Disenrollment

Med-QUEST Division makes all eligibility decisions. You may lose your 'Ohana 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 Hawaii State Hospital.
- If you try to enroll in the program by using false information.
- If you move to another state.
- If you do not contact 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 CCS 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:

- Pre-existing 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 'Ohana CCS

Our Service Area

'Ohana CCS serves the following islands:

- Kauai
- Molokai
- Lanai
- Oahu
- Maui
- Hawaii

Call 'Ohana 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

'Ohana CCS 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 'Ohana CCS, call us toll-free at **1-866-401-7540** (TTY: **711**). You can always stop by one of our offices on Oahu or the Big Island.

'Ohana CCS also works with your Case Manager/Agency and healthcare providers to ensure you get the right care at the right time. This includes preventive care. We will sometimes offer your providers 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

'Ohana 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.

Behavioral Health Services Direct Member Reimbursement

What is a Behavioral Health Service Member Reimbursement? **This is for eligible out-of-pocket behavioral health expenses.** After such an expense, you have 12 months from the date of the service to send us a member reimbursement claim form and receipts to recover your costs.

To get a copy of the member reimbursement claim form, call Customer Service toll-free at **1-866-401-7540**



(TTY: **711**). You can also visit **ohanahealthplan.com**. The behavioral health reimbursement claim form is located under the “More Helpful Documents” section. Please submit one form per member.

Mail the form to:

‘Ohana Health Plan
CCS Member Reimbursement
P.O. Box 31381
Tampa, FL 33631-3381

Email the form to: **Memberreimbursements@Wellcare.com**

Or fax form and required documents to: **1-813-283-3284**

For the reimbursement of behavioral health services, FOLLOW THESE INSTRUCTIONS CAREFULLY:

A. Completion of the CCS Member Reimbursement claim form:

- Print your name and Member ID number as shown on your ‘Ohana ID Card.
- Provide your mailing address and telephone number.
- Describe why you are asking for reimbursement.
- Provide the date of service for which you are requesting reimbursement. This is the date the service was given. List separately each date of service or admission date for inpatient / hospital stays.
- Print the name of the doctor, provider, or facility that provided the service.
- Provide a brief description of the service that was provided.
- List the amount requested for the individual service line.
- Add all individual lines together and provide the total amount requested for the reimbursement of all services.

B. Each itemized bill MUST include all the following information:

- Date of each service.
- Location of each behavioral health service, such as a doctor’s office, independent laboratory, outpatient hospital, inpatient hospital, or the patient’s home.
- Description of each behavioral health service provided.
- Charge for EACH service.
- Doctor or Provider’s name and address. A bill will often show the names of several doctors or providers. IT IS VERY IMPORTANT THAT YOU IDENTIFY THE ONE WHO TREATED YOU. Simply circle their name on the bill.

C. Proof of payment documentation:

- Copy of canceled check (front and back).
- Credit card statement showing provider as paid.
- Invoice / statement from doctor or provider showing their name, address, and telephone number.

What if I my behavioral health services reimbursement claim is denied?

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



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/or 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/or 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 ensure our information is complete and accurate. You can also report fraud on our website. This is private too. Go to **ohanahealthplan.com**.

You can also send a report in writing to:



‘Ohana CCS
Attn: Special Investigations Unit
PO Box 31407
Tampa, FL 33631-3407

Digital Health Records

What are My Options for Managing My Digital Health Records?

In 2021, a new federal rule made it easier for members* to manage their digital health records. This rule is called the Interoperability and Patient Access rule (CMS-9115-F) and makes it easier to get your health records when you need it most.

You now have full access to your health records on your mobile device, **at no charge**. This allows you to manage your health better and know what resources are available to you.

**Beginning in 2022, the Payer-to-Payer Data Exchange portion of this rule allows former and current members to request that their health records go with them as they switch health plans. For more information about this rule, visit the Payer-to-Payer Data Exchange section found on the web page below.*

The new rule makes it easy to find information** on:

- Claims (paid and denied)
- Pharmacy drug coverage
- Specific parts of your clinical information
- Healthcare providers

***You can get information for dates of service on or after Jan. 1, 2016.*

For more info, please visit: **ohanahealthplan.com/members/medicaid/community-care-services/benefits/interoperability-and-patient-access.html**

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 openly about the appropriate and medically needed treatment options regarding your care as it relates to your health conditions. This includes the choices and risks involved, regardless of the cost or benefit coverage.
- 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 and give suggestions about 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 goes 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 to know that the exercising 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 the member 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 more than 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 changes related to member rights, responsibilities, and procedures at least 30 days before the intended effective date of the change.
- To receive information in accordance with information requirements (42 CFR §§ 438.10).
- To have direct access to a reproductive health specialist within the network.
- To 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

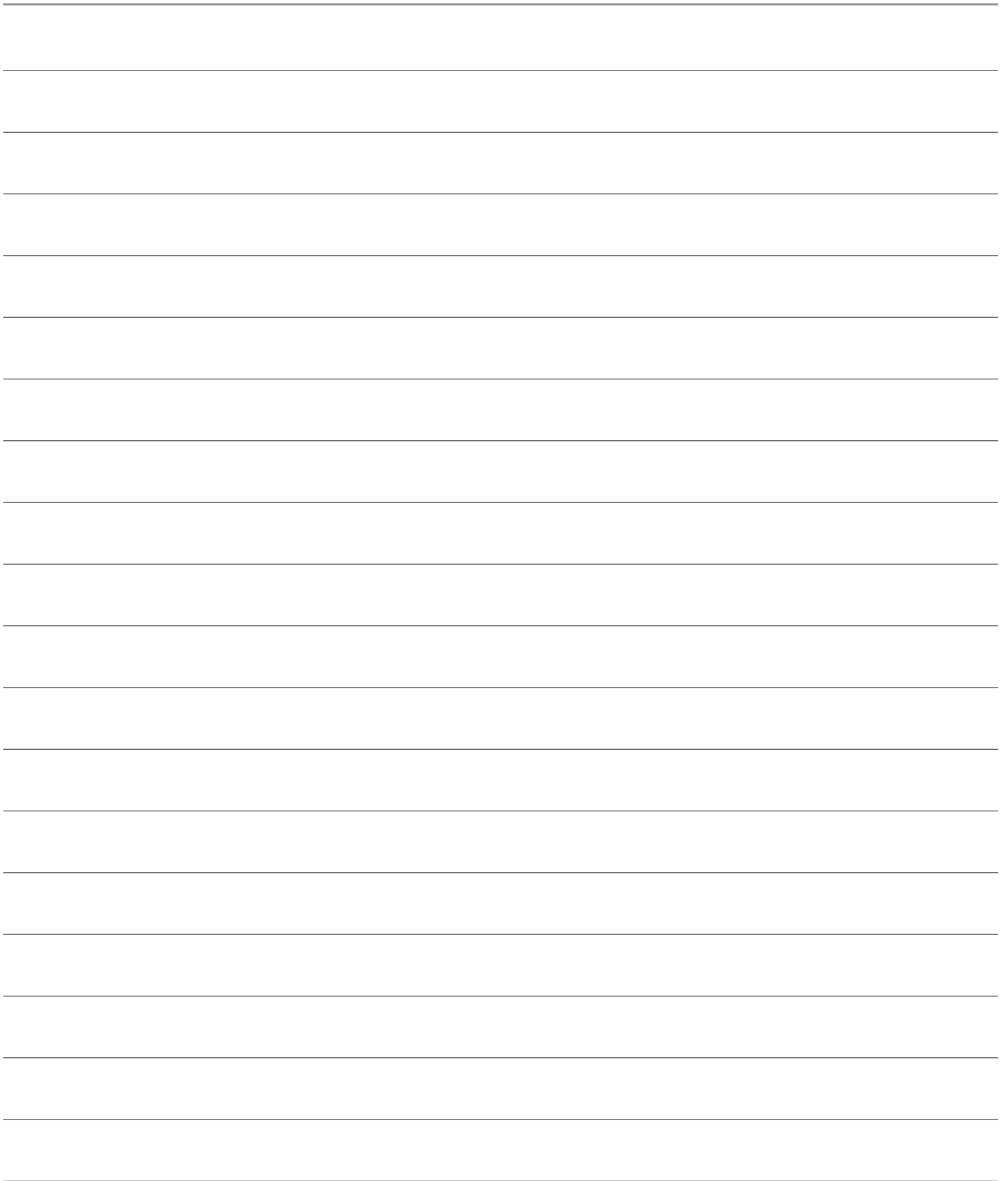
You also have responsibilities as a member:

- To give information that the plan and its providers need to give you 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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