



## Member and Provider Survey Results on Behavioral Health Services

‘OHANA HEALTH PLAN APPRECIATES ALL THAT YOU DO IN PROVIDING QUALITY CARE AND SERVICES FOR OUR MEMBERS.

We conduct annual surveys to assess member experiences and perceptions with their provider and health plan using a survey program called CAHPS® (Medical focused survey for adults and children) and BH ECHO® (Behavioral Health service focused survey for adults). This feedback helps us improve our quality and member experience.

The BH Echo survey includes adults who briefly received a behavioral health screening or assessment at their Primary Care Provider (PCP) visits. This includes visits for their regular treatment.








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### Join the Conversation on Social Media

Join our digital and social communities for up-to-date information on how we're working with you and others to help our members live better, healthier lives.



# Member and Provider Survey Results on Behavioral Health Services Continued

Here are some of the results of the BH ECHO<sup>®</sup> survey:



## Members were *Satisfied/Very Satisfied* (responded *Usually or Always*) in the following areas of the services you have provided:

- ✓ Getting Treatment Quickly – Able to access treatment as soon as they wanted.
- ✓ How Well Clinicians Communicate – Listened to them carefully and they were involved in their treatment and counseling as much as they wanted
- ✓ Informed about Treatment Options – Given information about different kinds of counseling or treatment that are available



## Areas where patients felt that more attention was needed:

- ✓ To provide more information about what they can do to manage their condition
- ✓ To improve overall rating of counseling and treatment
- ✓ To improve waiting time - from the time they check in until the time they see you has been longer than 30 minutes

This year, 'Ohana Health Plan will focus on improving the survey participation rate, sharing the results and expanding access for behavioral health services further through telehealth service in our network.

Thanks to you, patients with better care experiences often have better health outcomes by adhering to treatment plans.<sup>[1]</sup> **We value your partnership and look forward to working together to provide the best care possible for your patients, our members.**

Resources:

Stewart M A. Effective physician-patient communication and health outcomes: a review. CMAJ. 1995. Retrieved from: <https://pubmed.ncbi.nlm.nih.gov/7728691/>



## Getting Needed Care

Access to medical care, including primary care, specialist appointments and appointment access, are key elements of quality care.

**Each year, CAHPS® surveys patients and asks questions like:**

- In the last 6 months, how often was it easy to get appointments with specialists?
- In the last 6 months, how often was it easy to get the care, tests, or treatments you needed through your health plan?
- In the last 6 months, when you needed care right away, how often did you get care as soon as you thought you needed?
- In the last 6 months, not counting the times when you needed care right away, how often did you get an appointment for your health care at a doctor's office or clinic as soon as you thought you needed?
- In the last 6 months, how often did you see the doctor you were scheduled to see within 15 minutes of your appointment time?

**To ensure your patients are satisfied with their ease of access:**

- See members within access and availability standards
- Schedule appointments in a reasonable window for each request
- Follow up with members after referral to specialists to ensure care is coordinated
- Provide all information for specialists, tests and procedure authorizations and follow up as necessary
- Reduce time in the waiting room to no more than 15 minutes from appointment time

Remember to view the online Provider Bulletins regularly for important updates and notices. Provider bulletins are located at <https://www.ohanahealthplan.com/providers/news-and-education/bulletins.html>



## Coordination of Care

**HERE ARE MORE TIPS TO PROVIDE THE NEEDED CARE FOR YOUR PATIENTS:**

- ✓ Review medications with your patients.
- ✓ Remind your patients about annual flu shots and other immunizations.
- ✓ Call or contact your patients to remind them when it's time for preventive care services such as annual wellness exams, recommended cancer screenings and follow-up care for ongoing conditions such as hypertension and diabetes
- ✓ Offer to schedule specialist and lab appointments while your patients are in the office.
- ✓ Make sure your patients know you also are working with specialists on their care. Ensure you receive notes from specialists about the patient's care and reach out to specialists if you have not gotten consultation notes. Tell your patient the results of all test and procedures. Share decision making with patients to help them manage care. And please follow up on all authorizations requested for your patient.



## Immunizations & Well-Child Checkups

Immunizations and Well-Child Checkups Providers play a key role in establishing and maintaining a practice-wide commitment to communicating effectively about vaccines and maintaining high vaccination rates, including providing educational materials and making themselves available to answer questions.

Parents who are confused or have misperceptions about disease risk and safety may delay or refuse immunizations for their children.

A successful discussion about vaccines involves a two-way conversation with both parties sharing information and asking questions. These communication principles can help you connect with patients and their caretakers by encouraging open, honest and productive dialogue.

**Here are two ways you can lead this discussion:**

- 1** | Educate parents on how to prevent the spread of disease.
- 2** | Remind parents of the value of comprehensive well-child checkups and staying on schedule with immunizations.



**Remember, you may complete a comprehensive well-child checkup during a sick child visit or sports physical if the member is due for a checkup.**



## 2021 Medicaid Behavioral Health Bonus Program Announcement

At 'Ohana we understand that the provider-member relationship is a key component in ensuring superior healthcare and the satisfaction of our members. **Because 'Ohana recognizes these important partnerships, we have developed the 2021 Behavioral Health Bonus Program to reward eligible Behavioral Health practitioners for providing specific services listed in the table below.**

- Behavioral Health providers must submit a claim/encounter containing the requisite diagnosis and/or procedure codes to receive the bonus payment for eligible members.
- These bonus rewards are applicable to services rendered to members with 'Ohana Health Plan QUEST Integration. The services rendered to members enrolled in 'Ohana QUEST Integration coverage in conjunction with Medicare and/or CCS coverage will not be eligible for this bonus program.
- A follow-up visit with a mental health provider within 7 days after discharge. Do not include visits that occur on the date of discharge.
- Service must be rendered from January 8, 2021 to December 8, 2021.
- All claims/encounters must be submitted by January 31, 2022, to be used in calculating the final payment.
- A one-time payment will be issued in 2022 after the end of the program year.
- 'Ohana may request medical records if unable to verify care using claim/encounter data.

### Measure and Bonus Amount:

Measure	Amount
Follow-up after Hospitalization for Mental Illness – 7 Days	\$30

### Instructions:

- 1 Schedule and conduct an exam with the member by December 8, 2021, to address the program measure(s).
- 2 Upon completion of the appointment, document care and diagnosis in the patient's medical record and submit the claim/encounter containing all relevant ICD 10, CPT and/or CPT II codes by January 31, 2022.



### Questions?

If you have questions about Behavioral Health Bonus Program, please contact your Provider Relations Representative, Quality Practice Advisor or call Provider Services at **1-888-846-4262** (TTY 711).

You can reach us Monday–Friday from 7:45 a.m. to 4:30 p.m. Hawai'i Standard Time (HST).

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## 2021 Medicaid Behavioral Health Bonus Program Announcement Continued

### Additional Conditions:

To be eligible to receive a bonus payment under this Program, Behavioral Health Providers must meet the following requirements and/or conditions:

1. All Providers must:
  - (a) Be in a participation Agreement with 'Ohana, either directly or indirectly through a Vendor, from the Effective Date and continually through the dates the bonus payments are made, and
  - (b) Be in compliance with their participation Agreement including the timely completion of required training or education as requested or required by 'Ohana.
2. Bonus payments are paid to the eligible 'Ohana Health Plan Quest Integration member's Behavioral Health Provider of record at the end of the applicable measurement periods as defined by the HEDIS® specifications. Bonus rewards are not applicable to services rendered to members who are enrolled in Medicare and/or CCS coverage in conjunction with 'Ohana QUEST Integration coverage.
3. Any bonus payments earned through this Program will be in addition to the compensation arrangement set forth in your participation Agreement, as well as any other 'Ohana bonus program in which you may participate. At 'Ohana's discretion, Providers who have a contractual or other quality bonus arrangement with 'Ohana either directly or through an IPA/Vendor may be excluded from participation in this Program.
4. The terms and conditions of the participation Agreement, except for appeal and dispute rights and processes, are incorporated into this Program, including without limitation, all audit rights of 'Ohana, and the Provider agrees that 'Ohana or any state or federal agency may audit his/her/its records and information.
5. The Program is discretionary and subject to modification due to changes in government healthcare program requirements, or otherwise. 'Ohana will determine if the requirements are satisfied and payments will be made solely at 'Ohana's discretion. There is no right to appeal any decision made in connection with the Program. If the Program is revised, 'Ohana will send a notice to Provider by email or other means of notice permitted under the participation Agreement.
6. 'Ohana reserves the right to withhold the payment of any bonus that may have otherwise been paid to a Provider to the extent that such Provider has received or retained an overpayment (any money to which the Provider is not entitled, including, but not limited to, Fraud, Waste or Abuse) from 'Ohana, or 'Ohana's Eligible Member. In the event 'Ohana determines a Provider has been overpaid, 'Ohana may offset any bonus payment that may have otherwise been paid to the Provider against overpayment.
7. Only one bonus payment will be made for a specific HEDIS® member-measure combination. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
8. 'Ohana shall make no specific payment, directly or indirectly under a provider bonus program, to a Provider as an inducement to reduce or limit medically necessary services to an enrollee, and this Program does not contain provisions that provide bonuses, monetary or otherwise, for withholding medically necessary care. All services should be rendered in accordance with professional medical standards.



## 2021 Medicaid OB/GYN Incentive Program Announcement

At 'Ohana we understand that the provider-member relationship is a key component in ensuring superior healthcare and the satisfaction of our members. **Because 'Ohana recognizes these important partnerships, we have developed the 2021 OB/GYN Incentive Program to reward eligible OB/GYN practitioners for providing specific services listed in the table below.**

- OB/GYN providers must submit a claim/encounter containing the requisite diagnosis and/or procedure codes to receive the bonus payment for eligible members
- Services must be rendered to eligible members by December 31, 2021.
- All claims/encounters must be submitted by Jan. 31, 2022, to be used in calculating the final payment
- A one-time payment will be issued in 2022 after the end of the program year.
- 'Ohana may request medical records if unable to verify care using claim/encounter data.

### Measure and Bonus Amount:

Measure	Amount
Postpartum Visit	\$40
Prenatal Visit (Timeliness)	\$40

### Instructions:

- 1 Schedule and conduct an exam with the member by December 31, 2021, to address the program measure(s).
- 2 Upon completion of the examination, document care and diagnosis in the patient's medical record and submit the claim/encounter containing all relevant ICD 10, CPT and/or CPT II codes by Jan. 31, 2022.



### Questions?

If you have questions about OB/GYN Incentive Program, please contact your Provider Relations Representative, Quality Practice Advisor or call Provider Services at **1-888-846-4262 (TTY 711)**.

You can reach us Monday–Friday from 7:45 a.m. to 4:30 p.m. HST

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## 2021 Medicaid OB/GYN Incentive Program Announcement Continued

### Additional Conditions:

To be eligible to receive a bonus payment under this Program, OB/GYN Providers must meet the following requirements and/or conditions:

1. All Providers must:
  - (a) be in a participation Agreement with 'Ohana, either directly or indirectly through a Vendor, from the Effective Date and continually through the dates the bonus payments are made, and
  - (b) be in compliance with their participation Agreement including the timely completion of required training or education as requested or required by 'Ohana.
2. Bonus payments are paid to the Eligible Member's OB/GYN Provider of record at the end of the applicable measurement periods as defined by the HEDIS® specifications.
3. Any bonus payments earned through this Program will be in addition to the compensation arrangement set forth in your participation Agreement, as well as any other 'Ohana incentive program in which you may participate. At 'Ohana's discretion, Providers who have a contractual or other quality incentive arrangement with 'Ohana either directly or through an IPA/Vendor may be excluded from participation in this Program.
4. The terms and conditions of the participation Agreement, except for appeal and dispute rights and processes, are incorporated into this Program, including without limitation, all audit rights of 'Ohana, and the Provider agrees that 'Ohana or any state or federal agency may audit his/her/its records and information.
5. The Program is discretionary and subject to modification due to changes in government healthcare program requirements, or otherwise. 'Ohana will determine if the requirements are satisfied and payments will be made solely at 'Ohana's discretion. There is no right to appeal any decision made in connection with the Program. If the Program is revised, 'Ohana will send a notice to Provider by email or other means of notice permitted under the participation Agreement.
6. 'Ohana reserves the right to withhold the payment of any bonus that may have otherwise been paid to a Provider to the extent that such Provider has received or retained an overpayment (any money to which the Provider is not entitled, including, but not limited to, Fraud, Waste or Abuse) from 'Ohana, or 'Ohana's Eligible Member. In the event 'Ohana determines a Provider has been overpaid, 'Ohana may offset any bonus payment that may have otherwise been paid to the Provider against overpayment.
7. Only one bonus payment will be made for a specific HEDIS® member-measure combination. HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).
8. 'Ohana shall make no specific payment, directly or indirectly under a provider incentive program, to a Provider as an inducement to reduce or limit medically necessary services to an enrollee, and this Program does not contain provisions that provide incentives, monetary or otherwise, for withholding medically necessary care. All services should be rendered in accordance with professional medical standards.





## 2021 Medicaid Partnership for Quality (P4Q) Program Announcement

At 'Ohana Health Plan, we understand that the provider-member relationship is a key component in ensuring superior health care and the satisfaction of our members. **Because 'Ohana recognizes these important partnerships, we have developed the 2021 P4Q Program to reward primary care providers (PCPs) for submitting documentation for HEDIS Measures (ICD 10, CPT, CPT II, NDC).**

In order to help you maximize gap closures, 'Ohana pays \$0.01 for certain CPT II codes to allow you to bill without receiving a non-payable code denial. Using CPT II codes for certain preventive care services and test results makes it easier for you to share data with 'Ohana quickly and efficiently.

### HEDIS Bonus Amounts:

Measure	Amount
Cervical Cancer Screen	\$25
Childhood Immunization Status (Combo 10)	\$50
Diabetes HbA1c <8	\$30
Diabetes HbA1c Test	\$20
Well Child 15 Months Visits (6 or more visits)	\$50
Well Child 3-6 Years Old Visit	\$50
Well Child 12-21 Years Old Visit	\$30

This announcement is subject to all of the terms and conditions of the Partnership for Quality Information Guide.

### The program leverages your existing workflow as follows:

- 1 Schedule and conduct comprehensive patient exams.
- 2 Use the HEDIS® reports as guides to close care gaps.
- 3 Submit a claim/encounter containing all appropriate diagnostic and procedure codes and document in the patient's medical record.



### Questions?

If you have questions about our P4Q Program, please contact your Provider Relations Representative, Quality Practice Advisor, or call Provider Service at **1-888-846-4262 (TTY 711)**. The hours are Monday–Friday, from 7:45 a.m. to 4:30 p.m. HST

You can find more information in the Other Resources box after logging in at <https://provider.wellcare.com/ohanacare>.

**Thank you for working with us to deliver quality healthcare to our members.**

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).



## Annual CAHPS® Survey – What Matters Most to Your Patients

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) is an annual survey mailed to an anonymous select sample of our health plan members. The purpose is to assess member experience with their providers and health plan to improve the quality of care provided. This survey focuses on asking your patients whether or how often they experienced critical aspects of health care, including communication with their doctors, understanding how to take their medications, and the coordination of their healthcare needs. **We hope you will encourage your patients to participate if selected.**

**The pharmacy team can affect the member experience, whether we interact with members directly or not, by ensuring that we address the following items that are addressed in the annual CAHPS survey:**

- ✓ Assist members in understanding and accessing their pharmacy benefits (i.e. what medications are/are not covered),
- ✓ Identify (and mitigate) barriers to members obtaining and taking their medications.
- ✓ Ensuring appropriate communications with providers and health plans occur to complete the processing of timely authorizations

**These factors are important for our members (your patients) to take their medications on time but also to ensure adherence of their medication regimen(s).**



**We value and appreciate the excellent care you provide to our members and look forward to partnering with you.**

Source: Centers for Medicare & Medicaid Services. Consumer Assessment of Healthcare Providers & Systems (CAHPS). <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS>

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).



# How to Improve Patient Satisfaction and CAHPS Scores, Part 1 of 3

## WHAT IS THE CAHPS?

The Consumer Assessment of Healthcare Providers and Systems (CAHPS®) survey asks patients to evaluate their health care experiences. 'Ohana conducts an annual CAHPS survey, which asks members to rate experiences with their health care providers and plans. As an 'Ohana provider, you can provide a positive experience on key aspects of their care; we've provided some examples of best practice tips to help with each section.

Know What You Are Being Rated On	What This Means:	Tips to Increase Patient Satisfaction:
<b>Getting Needed Care</b>	<ul style="list-style-type: none"> <li>• Ease of getting care, tests, or treatment needed</li> <li>• Obtained appointment with specialist as soon as needed</li> </ul>	<ul style="list-style-type: none"> <li>• Help patients by coordinating care for tests or treatments, and schedule specialists appointments, or advise when additional care is needed to allow time to obtain appointments.</li> </ul>
<b>Getting Care Quickly</b>	<ul style="list-style-type: none"> <li>• Obtained needed care right away</li> <li>• Obtained appointment for care as soon as needed</li> <li>• How often were you seen by the provider within 15 minutes of your appointment time?</li> </ul>	<ul style="list-style-type: none"> <li>• Educate your patients on how and where to get care after office hours.</li> <li>• Do you have on-call staff? Let your patients know who they are.</li> </ul>
<b>How Well Doctors Communicate</b>	<ul style="list-style-type: none"> <li>• Doctor explained things in an understandable way</li> <li>• Doctor listened carefully</li> <li>• Doctor showed respect</li> <li>• Child's doctor spent enough time with your child</li> </ul>	<ul style="list-style-type: none"> <li>• The simple act of sitting down while talking to patients can have a profound effect.</li> <li>• Ask your patients what is important to them; this helps to increase their satisfaction with your care.</li> </ul>
<b>Shared Decision Making</b>	<ul style="list-style-type: none"> <li>• Doctor/health care provider talked about reasons you might want your child to take a medicine</li> <li>• Doctor/health care provider talked about reasons you might not want your child to take a medicine</li> <li>• Doctor/health care provider asked you what you thought was best for your child when starting or stopping a prescription medicine.</li> </ul>	<ul style="list-style-type: none"> <li>• Use of office staff other than physicians to distribute decision aids could help more patients learn about the medical decisions they are facing or simply to address medications</li> <li>• Decision making tools and quick reference guide are available at: <a href="http://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/tools/index.html">www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/tools/index.html</a></li> <li>• Ask your patients, "What should I know about you that may not be on your medical chart?"</li> </ul>

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## How to Improve Patient Satisfaction and CAHPS Scores, Part 1 of 3 Continued

Know What You Are Being Rated On	What This Means:	Tips to Increase Patient Satisfaction:
<b>Coordination of Care</b>	<ul style="list-style-type: none"> <li>In the last 6 months, did your personal doctor seem informed and up-to-date about the care you got from other health providers?</li> </ul>	<ul style="list-style-type: none"> <li>Your office staff should offer to help your patients schedule and coordinate care between providers.</li> </ul>
<b>Rating of Personal Doctor</b>	<ul style="list-style-type: none"> <li>Using any number from 0 to 10, where 0 is the worst personal doctor possible and 10 is the best personal doctor possible, what number would you use to rate your personal doctor?</li> </ul>	<ul style="list-style-type: none"> <li>Studies have shown that patients feel better about their doctor when they ask their patients, “What’s important to you?”</li> </ul>
<b>Rating of Specialist</b>	<ul style="list-style-type: none"> <li>Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that specialist?</li> </ul>	<ul style="list-style-type: none"> <li>Help your members value their visit to the specialists, be informed of their visit and their advice.</li> </ul>

### Knowledge is Power.



Make sure both you and your medical team know the questions your practice is being rated on. For more information and research on ways to improve patient satisfaction, see “*Flipping Health Care: From ‘What’s the Matter’ to ‘What Matters to You?’*” You can access the article and video at the websites below.

#### Sources and References:

[www.ihl.org/Topics/WhatMatters/Pages/default.aspx](http://www.ihl.org/Topics/WhatMatters/Pages/default.aspx) Christina Gunther-Murphy-What Matters Office Practice Setting IHI  
[www.ihl.org/resources/Pages/AudioandVideo/WIHIWhatMatters.aspx](http://www.ihl.org/resources/Pages/AudioandVideo/WIHIWhatMatters.aspx)  
 2016 Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey



## 2020 Hospital Survey Outcomes:

### IMPORTANCE OF PATIENT CARE IN OUR FACILITIES AND CARE AFTER DISCHARGE

Sharing clinical information in timely, useful and confidential manner across healthcare network when patients transition between different levels of care is an example of excellent quality care as defined by National Committee for Quality Assurance (NCQA). Inter-provider and facility collaborations foster informed treatment decisions and compatible courses of treatment, which greatly increases the chances for positive outcomes.

We have administered a hospital safety survey to explore ways of improving coordination and continuity of care when patients discharge from the facilities within our network.



**Out of 24 facilities, we have received 20 responses (83% response rate)**



#### Here are the things that most of our facilities are excellent at:

- Almost all of the facilities who responded to the survey in our network identify patient's PCP prior to discharge.
- Most of the facilities notify PCP of admissions within 24 hours or during patient/member stay.
- All facilities require handoff communication between ICU and regular units for continuity of care.



#### Here are the areas with opportunity for growth:

- To notify the member's PCP when patients are discharged to another level of care.
- To notify both PCPs and BH Specialists when member is discharged from behavioral
- To schedule patient's follow up appointment with the patient's BH provider prior to discharge.



**Thanks to you, patients with better discharge planning minimize readmissions and often have better health outcomes by adhering to treatment plans. We value your partnership and look forward to working together to provide the best care possible for your patients, our members.**

#### Sources and References:

Prusaczyk B., Kripalani S., and Dhand A. Networks of hospital discharge planning teams and readmissions. Epub. 2018. Retrieved from: [Networks of hospital discharge planning teams and readmissions - PubMed \(nih.gov\)](#)



## ‘Ohana Health Plan Members Achieve Better Outcomes When Primary Care and Behavioral Health Providers Collaborate

Clinicians sharing relevant clinical information in a timely, useful and confidential manner is an example of excellent quality care as defined by the National Committee for Quality Assurance (NCQA). Inter-provider collaboration fosters informed treatment decisions and compatible courses of treatment, which greatly increases the chances for positive health outcomes.

Many ‘Ohana Health Plan members have co-existing physical and behavioral health conditions. **As a general guide, Primary Care Providers and**

### **Behavioral Health Providers should exchange relevant clinical information at these times:**

- ✓ At the point of PCP referral, and after the BH provider completes the initial evaluation
- ✓ Whenever there is a significant change in the patient's health or treatment plan
- ✓ At the point that a patient discontinues care
- ✓ When a patient has an inpatient hospital admission
- ✓ Annually, if none of the above apply



## Attention Deficit and Hyperactivity Disorder Medication Management

Are you treating a child with Attention Deficit Hyperactivity Disorder (ADHD) or Attention Deficit Disorder (ADD)? To promote good health care outcomes, ‘Ohana Health Plan asks that you provide our members with follow-up care as recommended by the National Committee for Quality Assurance (NCQA).

Current NCQA guidelines recommend that patients 6–12 years of age have at least three follow-up care visits within a 10-month period after ADHD medication is first dispensed. The first of the follow-up visits should occur within the first 30 days.

If you would like further details regarding NCQA recommendations, please do not hesitate to contact our Customer Service team at **1-888-846-4262**.



## Referring Members to Behavioral Health Services



**A recent Surgeon General's report estimates that up to 15 percent of the U.S. population may need behavioral health (BH) care in any given year, and that a large percentage of these individuals will go undiagnosed or undertreated.**

Many individuals identify their primary care physician (PCP) as the provider they would most likely consult for a mental health problem. While many BH conditions, including depression, anxiety, and attention deficit hyperactivity disorder can be effectively managed and treated in the primary care setting, more complicated BH conditions may require the involvement of a BH specialist.

### **Below are some clinical situations that might warrant BH specialist consultation:**

- ▶ Your patient is having suicidal or homicidal thoughts.
- ▶ Your patient is displaying psychotic symptoms
- ▶ Your patient has a history of multiple BH related inpatient admissions or emergency department visits
- ▶ Your patient has received multiple BH diagnoses, or has a co-existing substance use or personality disorder
- ▶ Your patient is unresponsive to first-line BH therapeutic interventions.



Please contact our Customer Service team at **1-888-846-4262** if you would like assistance with referring your patient to a BH provider.



## Providers Love Our Live Chat!

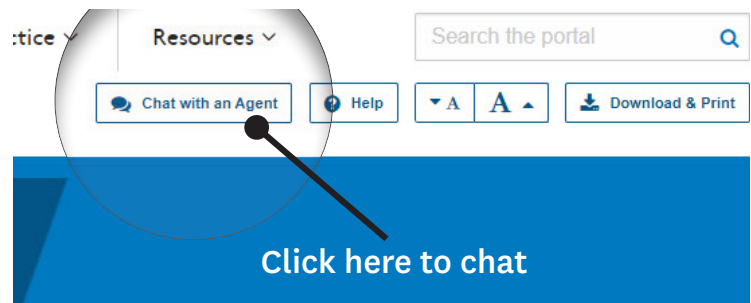
INCREASINGLY, PROVIDERS ARE CHOOSING TO CHAT WITH A LIVE AGENT ON THE PROVIDER PORTAL.

### Providers are talking — about the live-chat feature on our Provider Portal, that is!

So far in 2021, live chats with our agents have increased at an unprecedented rate. As of the third quarter, more than 10 percent of our inbound interactions happened via live chat, as opposed to traditional phone calls.

That's because live chat is **the easiest and fastest way** to get access to basic status updates on a member's eligibility, claims, or authorizations. In addition, our live-chat agents are able to help with complex, on-the-spot inquiries. This means less time waiting on hold to speak to an agent on the phone. Best of all, live chat has the highest score for first contact resolution among all of our communication channels.

The next time you or someone in your office has a question, remember that live chat is just a click away:



### Need Access?

If you'd like to learn more about the Provider Portal and its features, or would like to request access for you and your office, email **AWSEscalations@WellCare.com**. We're here to answer any questions you have about live chat and more!





## ‘Ohana’s Provider Portal Has New Live-Chat Offerings

CHECK OUT ALL THE NEW WAYS PROVIDERS CAN EASILY ACCESS IMMEDIATE ASSISTANCE

**Providers will now have more options to easily access help thanks to the new Chat offers that are now available on the Provider Portal!**

Live-Chat agents are trained to quickly – and accurately – answer your questions.

### New Live-Chat Offers on the Provider Portal:



Provider Home Page



Claim Main Page



Care Management  
Home Page  
(Authorizations)



Claims Appeals &  
Disputes Page



If you would like more information on Live-Chat on the Provider Portal, please contact your provider representative.



## 'Ohana New Benefits 2021

PLEASE BE ADVISED THAT EFFECTIVE JULY 1, 2021 'OHANA HEALTH PLAN IS OFFERING THE BELOW BENEFITS

### Asthma Program

- **Hypoallergenic Bedding** - Eligible members with asthma can get hypoallergenic bedding (Mattress casings and Pillow casings).
- **Carpet Cleaning** - Covers the cost of 2 carpet cleanings per calendar year, for qualified members with a diagnosis of asthma
- **HEPA Filter Vacuum Cleaner** - Provides a HEPA vacuum cleaner at no cost to qualified members with a diagnosis of asthma.
- **Allergy Mask** – Provides an allergy mask to protect against air pollution

### Pain Management Program

This program is to help qualified members manage chronic pain; and alternative to opioids. Prior authorization is required by a Health Coordinator or a referral from a PCP or treating physician, limitations apply.

- **Chiropractic** - For manipulation of the spine by a licensed chiropractor to treat, pain. Limitations apply
- **Acupuncture** - For pain management. For stimulating certain points on the body, most often with a needle penetrating the skin, to alleviate pain or to help treat various health conditions. Limitations apply

- **Massage Therapy** - Manual manipulation of soft body tissues (muscle, connective tissue, tendons and ligaments) to help manage pain. Limitations apply

### Traditional Healer

This benefit covers all traditional healing (Native American and Spanish/Mexican healers). Members will receive up to \$250.00 per calendar year **(this benefit is reimbursement only)**.

### Ambulatory Blood Pressure Monitoring

This benefit is for qualified members at-risk with hypertension can receive a blood pressure cuff to self-monitor

### Cell Phone ConnectionsPlus Program

'Ohana will provide eligible members with free smart phones and data through our ConnectionsPlus Program.

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## ‘Ohana New Benefits 2021 Continued

### Caregiver Package

Provides package to caregivers with phone numbers, keepsake bag, caregiver educational materials, caregiver journal, and information regarding support groups.

### Weight Watchers

‘Ohana offers a 6 -month membership benefit to qualify members. The program’s goal is to support healthy lifestyles and improve health outcomes.

### Social Call Program

This program links local community-based volunteers to qualify members that are able to facilitate ongoing calls with those who would like more social contact, creating meaningful connections.



## Community Care Services (CCS)

### Cell Phone ConnectionsPlus Program

‘Ohana will provide eligible members with free smart phones and data through our ConnectionsPlus Program.



## Updating Provider Directory Information

**WE RELY ON OUR PROVIDER NETWORK TO ADVISE US OF DEMOGRAPHIC CHANGES SO WE CAN KEEP OUR INFORMATION CURRENT.**

To ensure our members and Provider Relations staff have up-to-date provider information, please give us advance notice of changes you make to your office phone number, office address or panel status (open/closed). Thirty-day advance notice is recommended.



### **New Phone Number, Office Address or Change in Panel Status:**



**Mail:**

'Ohana Health Plan  
ATTN: Provider Operations  
949 Kamokila Blvd., Suite 350  
Kapolei, HI 96707



**Fax:**

**1-866-788-9910**

Thank you for helping us maintain up-to-date directory information for your practice.



## Provider Formulary Updates

### **Medicaid:**

There have been updates to the QUEST Integration Preferred Drug List (PDL).

Visit [www.ohanahealthplan.com/providers/medicaid/pharmacy.html](https://www.ohanahealthplan.com/providers/medicaid/pharmacy.html) to view the current PDL and pharmacy updates. You can also refer to the *Provider Manual* available at [www.ohanahealthplan.com/provider/medicaid/resources](https://www.ohanahealthplan.com/provider/medicaid/resources) to view more information on 'Ohana's pharmacy Utilization Management (UM) policies/procedures.

### **Community Care Services:**

Visit <https://www.ohanahealthplan.com/providers/medicaid/community-care-services/pharmacy.html> to view the current PDL and pharmacy updates. You can also refer to the *Provider Manual* available at <https://www.ohanahealthplan.com/providers/medicaid/community-care-services.html> to view more information on 'Ohana's pharmacy UM policies and procedures.



## Electronic Funds Transfer (EFT) Through PaySpan®

### FIVE REASONS TO SIGN UP TODAY FOR EFT:

- 1** **You** control your banking information.
- 2** **No** waiting in line at the bank.
- 3** **No** lost, stolen, or stale-dated checks.
- 4** Immediate availability of funds - **no** bank holds!
- 5** **No** interrupting your busy schedule to deposit a check.

Setup is easy and takes about five minutes to complete. Please visit [www.payspanhealth.com/nps](http://www.payspanhealth.com/nps) or call your Provider Relations representative or PaySpan at **1-877-331-7154** with any questions. We will only deposit into your account, **not** take payments out.



## Access to Staff

If you have questions about the utilization management program, please call Customer Service at **1-888-846-4262**. TTY users call **711**. Language services are offered.

You may also review the Utilization Management Program section of your Provider Manual. You may call to ask for materials in a different format. This includes other languages, large print and audio. There is no charge for this.



## Provider Resources

### Provider News – Provider Portal

Remember to check messages regularly to receive new and updated information. Access the secure portal using the Secure Login area on our home page. You will see Messages from 'Ohana on the right. Provider Homepage – <https://www.ohanahealthplan.com/providers.html>.

**Remember, you can check the status of authorizations and/or submit them online. You can also chat with us online instead of calling.**

### Resources and Tools

You can find guidelines, key forms and other helpful resources from the homepage as well. You may request hard copies of documents by contacting your Provider Relations representative.

Refer to our *Quick Reference Guide* for detailed information on areas including Claims, Appeals and Pharmacy.

These are located at <https://www.ohanahealthplan.com/providers.html>, select *Medicaid Resources*.

### Additional Criteria Available

Please remember that all Clinical Guidelines detailing medical necessity criteria for several medical procedures, devices and tests are available at <https://www.ohanahealthplan.com/providers.html>, click on *Tools*.

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## We're Just a Phone Call or Click Away

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**Medicaid:**  
**1-888-846-4262**



<https://www.ohanahealthplan.com/>