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Overview

‘Ohana Health Plan Inc. (the Plan) will make information available to members of the role of the primary care physician (PCP), how to obtain care, what to do in an emergency or urgent medical situation as well as their rights and responsibilities. The Plan will convey this information through various methods including a member handbook.

Member Handbook

‘Ohana will mail all newly enrolled members a member handbook within 10 calendar days of receiving the notice of enrollment from the state. The Plan will mail all enrolled members a member handbook at least annually thereafter.

Enrollment

Membership enrollment in the Plan is voluntary as members may select other CMOs or may be randomly assigned to a CMO by the state.

The Plan accepts all individuals without restrictions and does not discriminate against individuals on the basis of religion, gender, race, color or national origin and will not use any policy or practice that has the effect of discriminating on the basis of religion, gender, race, color or national origin or on the basis of health, health status, pre-existing condition or need for health care services.

Upon enrollment in the Plan, members are provided with the following:

- Terms and conditions of enrollment;
- Description of covered services;
- Information about PCPs, such as location, telephone number and office hours;
- Information regarding “Out-of-Plan” emergency services;
- Grievance and disenrollment procedures;



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- “Over-the-Counter” brochure, if applicable.

Member Identification Cards

Member identification cards are intended to identify Plan members and facilitate their interactions with physicians and other health care providers. Information found on the member identification card may include the member’s name, identification number, PCP’s name and telephone number, third-party liability information, EPSDT eligibility indicator, health plan contact information and claims submission address.

‘Ohana will mail member ID cards to all new members within 10 days of their selecting a PCP or the Plan auto-assigning a PCP. The plan will re-issue a member ID card within 10 days of notice if a member reports a lost card or there is any change that results in a change to the information on the member ID card.

Possession of the member identification card does not guarantee eligibility or coverage. The physician or provider is responsible for ascertaining the current eligibility of the cardholder.

Eligibility Verification

A member’s eligibility status can change at any time. Therefore, all providers should consider requesting and copying a member’s identification card, along with additional proof of identification like a photo ID, and file them in the patient’s medical record.

Providers may do one of the following to verify eligibility:

Access the ‘Ohana Web site at .

- Access ‘Ohana’s Interactive Voice Response (IVR) system. You will need your Provider ID number to access member eligibility.
- Contact the Customer Service department. The telephone number is found on the **Quick Reference Guide** of this manual.



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Verification is always based on the data available at the time of the request, and because subsequent changes in eligibility may not yet be available, verification of eligibility is not a guarantee of coverage or payment. See your Provider Agreement for additional details.

Member Rights and Responsibilities

Plan members, adults and children, have specific rights and responsibilities. These are included in the member handbook.

‘Ohana members have the right:

- To get information about the plan, its services and its providers.
- To get information about their rights and responsibilities.
- To know the names and titles of the providers that take care of them.
- To be treated with respect.
- To be treated with dignity.
- To privacy.
- To decide with their provider on the care they get.
- To talk about the care they need for particular health conditions. This includes the choices and risks involved, regardless of the cost or benefit coverage. They must get this information in a way they understand.
- To know about their health care needs after they get out of the hospital or leave a provider’s office.
- To participate in decisions regarding his or her healthcare, including the right to refuse treatment.



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- To not take part in any medical research.
- To complain about the plan or the care it provides. And to know that if they do, it will not affect how they are treated.
- To be free from any form of restraint or seclusion as a means of force, discipline, convenience or retaliation.
- To request and receive a copy of his or her medical records pursuant to 45 CFR Parts 160 and 164, subparts A and E, and request to amend or correct the record as specified in 45 CFR § § 164.524 and 164.526.
- To have all records and medical and personal information remain confidential.
- To make their health care wishes known by using advance directives.
- To have input in the plan's member rights.
- To use these rights no matter their sex, age, race, ethnicity, income, education or religion.
- To have all plan employees honor their rights.
- To get health care services that are accessible, comparable in amount, duration and scope to those provided under Medicaid FFS 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 service that is not denied or cut back just because of diagnosis, type of illness or medical condition.
- To get all information in a way that they can easily understand, in alternative formats and in a manner that takes into consideration their special needs.



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- To have plan materials available in English, Ilocano, Tagalog, Mandarin Chinese and Korean languages, written at a 6th-Grade level.
- 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 them and how to get this service, at no cost.
- To have access to oral translation services, sign language and TTY/TDD services as needed.
- 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 their right to leave the plan at least once a year.
- To get a notice of any major change in benefits. They must get this at least 30 days before the change is to go into effect.
- To get full information about emergency and after-hours services.
- To get the plan's policy on referrals for specialty care and other benefits that are not provided by the member's PCP.
- To have all these rights apply to the person who they legally appoint to make decisions about

their health care.

- To freely exercise their rights, including those related to filing a grievance or appeal, and that the exercise of these rights will not adversely affect the way they are treated.
- To have direct access to a women's health specialist within the network.
- To receive a second opinion, at no cost.
- 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 they 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 their privacy protected.
- To be included in care plan development.
- To have direct access to specialists (if they have a special healthcare need).
- To not have services arbitrarily denied or reduced in amount, duration or scope solely because of diagnosis, type of illness or condition.
- To choose between institutional care and HCBS (if determined cost-neutral by the health plan).
- To receive a description of cost-sharing responsibilities, if any.

- To not be held liable for:
 - The Plan's debts in the event of insolvency;
 - The covered services provided to the member by the health plan for which the DHS does not pay the Plan; or
 - Covered services provided to the member for which the DHS or the Plan does not pay the health care provider that furnishes the services; and
 - Payments of covered services furnished under a contract, referral or other arrangement to the extent that those payments are in excess of the amount the member would owe if the Plan provided the services directly.
- To only be responsible for cost sharing as described by their Plan.

Members also have certain responsibilities. These include the responsibility:

- To give information that the Plan and its providers need to give care.
- To follow plans and instructions for care that they have agreed on with your PCP.
- To understand their health problems.
- To help set treatment goals that they and their PCP agree to.
- To read the member handbook to understand how the Plan works.
- To always carry their member ID card.
- To always carry their Medicaid card.



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- To show their ID cards to each provider.
- To notify 'Ohana if they lose their member ID card.
- To schedule appointments for all non-emergency care through their PCP.
- To get a referral from their PCP for specialty care.
- To cooperate with the people providing their health care.
- To be on time for appointments.
- To notify the provider's office if they 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 they take, what they are for and how to take them properly.
- To make sure their PCP has copies of all of their previous medical records.
- To let the plan know within 48 hours, or as soon as possible, if they are admitted to the hospital or get emergency room care.
- To call 'Ohana to get information or get their questions answered. The telephone number is found on the **Quick Reference Guide** of this manual.



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Medical Necessity

Members will be informed that Medically necessary services are those that are:

- Appropriate and consistent with the diagnosis of the treating provider and the omission of which could adversely affect the eligible member's medical condition.
- Compatible with the standards of acceptable medical practice in the community.
- Provided in a safe, appropriate and cost-effective setting given the nature of the diagnosis and the severity of the symptoms.
- Not provided solely for the convenience of the member or the convenience of the health care provider or hospital.
- Not primarily custodial care unless custodial care is a covered service or benefit under the members evidence of coverage.

Emergency Services

An emergency medical condition shall not be defined or limited based on a list of diagnoses or symptoms. An emergency medical condition is a medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following:

- Placing the physical or mental health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily functions;
- Serious dysfunction of any bodily organ or part;



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- Serious harm to self or others due to an alcohol or drug abuse Emergency; or
- Injury to self or bodily harm to others.

The Plan shall base coverage decisions for emergency services on the severity of the symptoms at the time of presentation and shall cover emergency services when the presenting symptoms are of sufficient severity to constitute an emergency medical condition in the judgment of a prudent layperson. Once the member's condition is stabilized, the Plan may require prior authorization for hospital admission or follow-up care.

Primary Care Providers

Primary Care Providers, or PCPs, have the responsibility of supervising, coordinating and providing initial and primary care to the member, for initiating referrals and maintaining the continuity of member care. A Primary Care Provider or PCP, is a provider licensed in Hawai'i who is:

- 1) 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; or
- 2) an advanced practice registered nurse with prescriptive authority (APRN-Rx) who:
 - a. Is a registered professional nurse who is authorized by the State to practice as a nurse practitioner in accordance with State law;
 - b. Is certified as a nurse practitioner by a recognized national certifying body that has established standards for a nurse practitioner; and
 - c. Possesses a master's degree in nursing.

The Plan allows specialists or other healthcare



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practitioners to serve as PCPs *for members with chronic conditions*, provided:

- The member has selected a specialist with whom he or she has a historical relationship as PCP; and
- The specialist agrees, in writing, to assume responsibility as PCP.
- The Plan also allows a clinic to serve as a PCP as long as the clinic is appropriately staffed to carry out PCP functions and so long as the clinic agrees, in writing, to assume the responsibilities of a PCP.

Assignment of Primary Care Providers

All Plan members are offered freedom of choice in selecting a PCP. PCPs are routinely those physicians who practice in the areas of family practice, general practice, obstetrics/gynecology, pediatrics, geriatrics or internal medicine or nurse practitioners certified (NP-C) who specialize in family practice or pediatrics. All Plan members must choose a PCP or they will be assigned to a PCP within the Plan's network.

To ensure quality and continuity of care, the PCP is responsible for arranging all of the member's health care needs, from providing primary care services, to coordinating referrals to specialists and providers of ancillary or hospital services.

The health plan shall immediately transfer a member to another PCP, health plan, or provider if the member's health or safety is in jeopardy.

Changing Primary Care Providers

Members may change their PCP selection at any time by calling the Customer Service department. If the change is requested on or prior to the 10th of the month, the new PCP will become effective the same month of the request. Should the request be made after the 10th of the month, the change will take effect on the following month. The Customer Service telephone



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number is found on the **Quick Reference Guide** of this manual.

Women's Health Specialists

The Plan will provide female members with direct in-network access to a women's health specialist for covered care necessary to provide her routine and preventive health care services. Women's routine and necessary health care services include, but are not limited to, breast cancer screening (clinical breast exam), Pap smears and pelvic exams. This direct, in-network access is in addition to the member's designated source of primary care if the PCP is not a women's health specialist.

Hearing Impaired, Interpreter and Sign Language Services

Providers should note that 'Ohana will provide alternate methods of communication for written member information, including translation into English, Ilocano, Tagalog, Mandarin Chinese and Korean. 'Ohana supports member special needs (i.e., visual impairment, limited reading proficiency) through both oral and written accommodations. You may contact our Customer Service department at the number listed on the **Quick Reference Guide** of this manual to lead your patients to these and other services.

Members may contact Customer Service to:

- Request ID cards.
- Change PCPs.
- Request Personal Care Items.
- Find a list of doctors in the Plan.
- Find a list of drug stores in the Plan.