'ohana health plan™

Hawaii
Member Handbook

COMMUNITY CARE SERVICES (CCS)

ohanahealthplan.com

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OH25-061 CCS MHB

ʻOhana Community Care Services (CCS)...

YOUR BEHAVIORAL HEALTH PLAN

ʻOhana CCS is a managed behavioral healthcare plan for Medicaid members who qualify for more behavioral health services than regular Medicaid offers. ʻOhana 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 can find out more about Case Management later in this booklet.

ʻOhana CCS is your managed *behavioral* healthcare plan. You get your medical healthcare through your QUEST (Medicaid) healthcare plan. Be sure to carry both ID cards with you so you can get care when you need it.

ʻOhana CCS puts you and your family first. We do this so you get better behavioral healthcare. We want to 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 and 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 your questions. You can also visit us at **ohanahealthplan.com/ccs**.

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

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We’re Here to Help

We're Here to Help

Call Customer Service or your Case Manager / Agency when you need help.

Help from ʻOhana 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 ʻOhana 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:
ʻOhana CCS Customer Service
820 Mililani Street
Suite 200
Honolulu, HI 96813

We Care about Your Privacy!

ʻOhana 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 ʻOhana 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 ʻOhana CCS Offices
ʻOhana CCS – Big Island Office 88 Kanoelehua Ave Suite A105 Hilo, HI 96720

Our Service Area

'Ohana CCS serves the following areas:

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

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 toll-free at **1-866-401-7540** (TTY: **711**). 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:

- Help with food or 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 toll-free at **1-866-401-7540** (TTY: **711**). 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 information about Case Managers and Agencies later in this booklet.

Sometimes, you may want to call a nurse about urgent behavioral health questions. You can call our 24-hour Nurse Advice Line at **1-800-919-8807**. Our Nurse Line is available any time and is here if you need help after business hours or on holidays or 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 ʻOhana Health Plan CCS 24/7 hotline toll-free at 1-866-401-7540 (TTY: 711) if you need assistance. In addition, the Hawaii CARES crisis line is available 24/7.

- Call **1-808-832-3100** for Oahu or **1-800-753-6879** for Neighbor Islands.
- Visit **hicares.hawaii.gov**.
- Call / Text / Chat: **988**.

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** Call / Text / Chat: **988**
24-Hour Nurse Advice Line	**1-800-919-8807**
TTY	**711**
Transportation Requests (Transdev Health Solutions)	**1-866-790-8858**
Transportation ride assistance line (Transdev Health Solutions)	**1-866-481-9699**
Pharmacy	**1-866-401-7540** (TTY: **711**)
Hawaii Med-QUEST Division	**1-800-316-8005**
24-hour toll-free ʻOhana 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.

In our secure 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 findings can help health plans:

- Make sure you have access to care.
- Promote quality of your care.
- Make 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 healthcare, recognized under State law relating to provision of healthcare 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.
6. The State determines that other circumstances warrant out-of-network treatment.

Appeal: A request to change an adverse decision that was made by ‘Ohana CCS. A member or the authorized representative of a member may appeal any adverse decision.

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 ʻOhana 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 individual, the health of the individual or their 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.

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, the member's representative, or a provider on behalf of a member about any matter other than an adverse benefit determination.

Words/Phrases

Habilitative / Habilitation Services: Healthcare 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 healthcare 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 Necessity: 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 healthcare 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 healthcare experts hired by ʻOhana 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.

ʻOhana 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 healthcare 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 ʻOhana 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 healthcare 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.

c. A physician's assistant recognized by the State Board of Medical Examiners as a licensed physician assistant.

Words/Phrases

Preauthorization: A decision by health insurers or plans that a healthcare 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 healthcare, 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 (Medicaid): QUEST (Medicaid) is the QUEST Integration managed care program that provides healthcare 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: Healthcare 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).

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 healthcare.

Words/Phrases

Treatment: The care you get from doctors and facilities.

Third Party Liability (TPL): Any person, institution, corporation, insurance company, or 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 ages 65 or older. It is also available for some people with disabilities younger than age 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 sometimes 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.

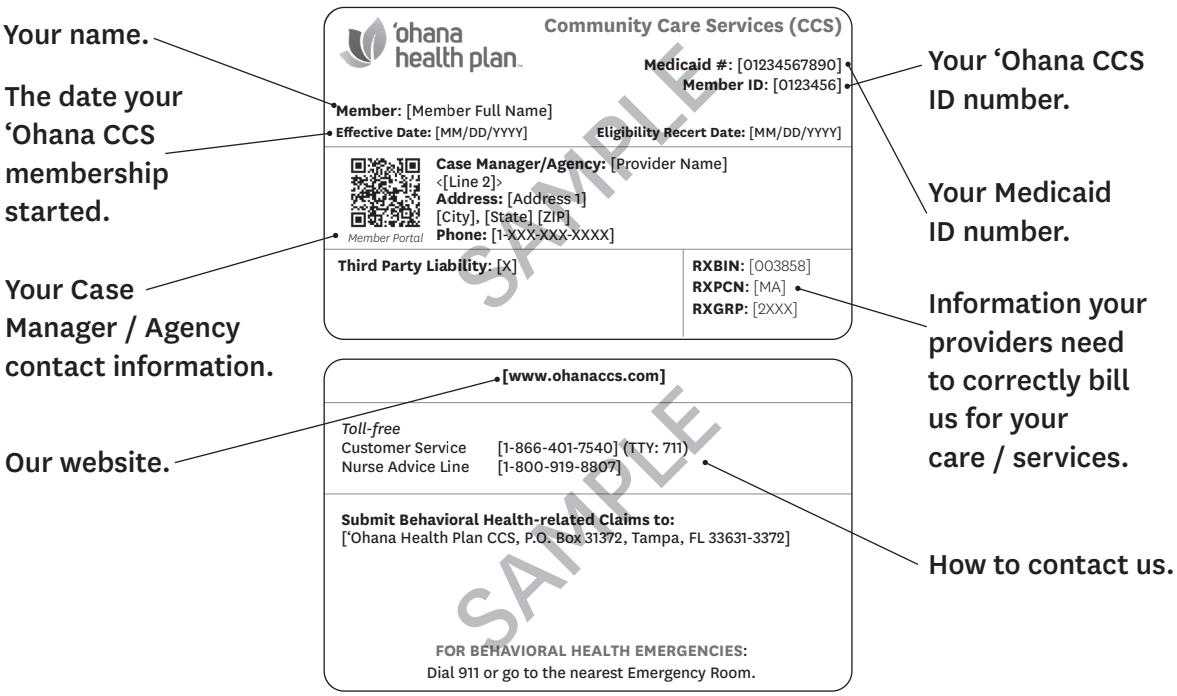
Check Your ID Card and Put it in a Safe Place

You should have received your ‘Ohana CCS member ID card in the mail. Keep this card and your QUEST (Medicaid) card with you at all times. You will need to show 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:
  - An emergency room.
  - An urgent care center.
  - A 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.



Choose Your Case Management Agency

Now that you are enrolled in CCS, ʻOhana CCS will contact you to choose a Case Management Agency. You can also call Customer Service toll-free at **1-866-401-7540** (TTY: **711**) to choose a Case Manager / Agency. Customer Service can give you details about each Case Manager / Agency, including background and qualifications. If we do not hear from you or 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. Your Case Manager 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. In addition, they will connect 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 are printed on your ʻOhana 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 each 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, call Customer Service toll-free at **1-866-401-7540** (TTY: **711**). The changes will take effect on the first day of the next month. You may change your Case Management Agency up to three times each calendar year.

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

You can get a list of our Case Management Agencies:

- Through your provider directory.
- At **ohanahealthplan.com/ccs**.
- 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. Call any time you need health advice. The toll-free number is **1-800-919-8807**.

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 Case 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 to get emergency care. It also gives examples of emergencies.

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

Call Us, Tell Us

Do you have questions? Call us. We can get translators for all languages. We have materials in Ilocano, Chinese (traditional), Korean, Vietnamese, large print, audio tapes, and Braille. Members with hearing impairments can get sign language services. These services are 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.

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. You must let us know if you:

- Change your name and/or address.
- Get married or divorced.
- Get health insurance from another company.
- Change your address.
- Have a change in income.
- Have any legal encumbrances: conditional release, jail diversion, released on conditions and mental health court, or receiving services from DOH-AMHD.
- Are institutionalized, imprisoned, or are placed in a 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 for your healthcare services. We will also coordinate benefits with any other coverage that you may have. This is called Third Party Liability (TPL).

In addition, ‘Ohana CCS will provide our members with copies of 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 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 24-48 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. These providers give Medicaid-covered behavioral health services that you are entitled to.

We will tell you how to get the following information about any provider:

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

Behavioral Health Services, Coverage and Limits

Services	Coverage and Limits
Community Integration Services (CIS)	Case Management can help you find and maintain housing. Covered for members who are homeless or at risk of becoming homeless. Members will be assessed to see if they meet eligibility criteria. Services are divided into three categories: **1. Pre-Tenancy Services** • Identify eligible individuals. • Provide screenings / assessments. • Develop housing support plan. • Search for housing. • Prep and submit applications. • Identify resources / costs for start-up needs. • Identify equipment, technology, and other modifications needed. • Ensure housing is safe. • Assist with moving. • Create individualized housing crisis plan. • Help with skill and acquisition development. • Develop independent living skills / financial literacy.

Services	Coverage and Limits
Community Integration Services (CIS) (continued)	**2. Tenancy Services** · Individual housing and tenancy sustaining services. · Community transition services (CTS). · Early identification / intervention for negative behaviors. · Education / training on the roles and responsibilities of tenant / landlord. · Coaching on development. · Maintenance of relationships between landlords / property managers. · Dispute resolution with landlords / neighbors. · Advocate and link with advocacy groups to help prevent eviction. · Housing recertification process. · Updating / maintaining housing support and crisis plans. · Development of daily living skills and maintaining residence skills to sustain residency. · Service care coordination. · Housing crisis management. · Training / education. · Financial literacy. · Relationship building and maintenance. **3. Other Housing & Tenancy Services** · Job skills training / employment activities. · Peer supports. · Non-medical transportation. · Support groups. · Caregiver or family support. · Outreach services. · Health management. · Counseling and therapies. · Service assessments. · Service plan development. · Independent living skills and financial literacy. · Equipment, technology, and other modifications. · Home management. · Other supplemental services as needed.

Services	Coverage and Limits
Crisis Services	• 24 hours a day, seven days a week emergency / crisis intervention. • Crisis hotline. • Crisis residential services. • Crisis stabilization. • Mobile crisis response.
Behavioral Health Outpatient Services	• Continuous treatment teams. • Family / collateral therapeutic support and education. • Individual / group therapy and counseling. • Treatment / service planning. • Other medically necessary therapeutic services.
Diagnostic Services	• Psychiatric or psychological evaluation and treatment, including neuropsychological evaluation. • Psychological testing. • Psychosocial history. • Screening for and monitoring treatment of mental illness and substance use, including substance use disorders (SUDs). • Other medically necessary behavioral health diagnostic services, including labs.
Emergency Department (ED) Services	• 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	• 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.

Services	Coverage and Limits
Inpatient Psychiatric Hospitalization (24 hours)	• Diagnostic services. • Medical supplies, equipment, and drugs. • Nursing care. • Other medically necessary services. • Other practitioner services as needed. • Physical, occupational, speech, and language therapy. • Post-stabilization services. • Psychiatric services. • Room and board.
Intensive Case Management	• Case assessment. • Case planning (service planning, care planning). • Coordination with member's health plan and primary care provider (PCP). • Ongoing monitoring and care coordination. • Outreach.
Medication Management	• Medication counseling and education. • Medication evaluation. • Psychotropic medications.
Medication Assisted Treatment (MAT)	• Includes the provision of methadone or buprenorphine products and related outpatient counseling services for opioid use disorder.
Out-of-State and Off-Island Coverage	**Provides for any medically necessary covered services that are prearranged when not available on your island or in Hawaii. Required prior authorization. Coverage includes:** • Referrals to an out-of-state or off-island specialist or facility. • Transportation to and from the referral destination. • Lodging & meals. • Member attendant (if authorized).

Services	Coverage and Limits
Partial Hospitalization or Intensive Outpatient Hospitalization	• Diagnostic tests. • Medical supplies. • Medication management. • Prescribed drugs. • Therapeutic services including individual, family, and group therapy, and aftercare. • Other medically necessary services.
Peer Specialist	Support from behavioral health peers.
Prescription Drugs	The plan covers behavioral health drugs listed on our 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 prior authorization.
Psychosocial Rehabilitation/ Clubhouse Services	• Day treatment. • Intensive day treatment. • Residential treatment services. • Social / recreational therapy services. • Work assessment service.
Representative Payee	Financial management services.

Services	Coverage and Limits
Substance Use Disorder (SUD) Services	‘Ohana CCS coordinates with Department of Health Alcohol and Drug Abuse Division (DOH-ADAD) to help our members with SUD by linking members with the ADAD specialists within our provider network. For help accessing these providers for SUD treatment, please work with your CCS Case Manager or call Customer Service toll-free at **1-866-401-7540** (TTY: **711**). **You also can access ADAD providers and SUD treatment 24/7 by calling Hawaii CARES:** · Oahu: **1-808-832-3100**. · Neighbor Islands: **1-800-753-6879** · Call / Text / Chat: **988**. **All medically necessary services include:** · Residential treatment. · Intensive outpatient treatment.
Supportive Employment Services	· Discovery – pre-employment service. · Work assessment service. · Job coaching.
Telehealth Services	**Services may include, but are not limited to:** · Real-time video conferencing. · Secure interactive and non-interactive web communication. · 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 (in combination or individually). · Getting medication by filling out an online form. If you get in-person care that needs prior authorization, you will need prior authorization to get the same care through telehealth. Providers will tell you if they offer telehealth services. Your provider will bill the plan for these services.

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

When you follow plan rules, you should not be billed for covered services, as there are no copayments. If you get a bill, do not wait! Call Customer Service toll-free at **1-866-401-7540** (TTY: **711**). 'Ohana CCS will look into this for you.

Getting Non-Covered Services

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

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

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

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

Prescription Drug Services

Prescriptions and Pharmacy Access

How do I get a prescription?

We recommend going to a participating ʻOhana provider, but you can get a valid prescription from any active and licensed prescriber who is not on the Office of Inspector General (OIG) exclusion list.

Which pharmacies can fill my prescription?

Prescriptions must be filled at a pharmacy in our network, which are listed in the provider directory. You can download a copy of our directory on our website or search the online version at **findaprovider.ohanahealthplan.com**. You may also be able to get your prescriptions through mail order / home delivery. Call Customer Service toll-free at **1-866-401-7540** (TTY: **711**) to learn more.

How do I get a prescription filled?

Bring all of your insurance ID cards to the pharmacy (e.g. CCS, QUEST [Medicaid], Medicare, etc.). There should be no copays for drugs covered by QUEST (Medicaid) or CCS (Medicaid). You may be responsible for copays for drugs covered by other insurance, like Medicare Part D.

Preferred Drug List

What medicines does ʻOhana CCS pay for?

ʻOhana pays for medicines listed on our formulary, or preferred drug list (PDL), for your behavioral health only. Providers and pharmacists decide which drugs should be on the PDL.

Some drugs require approval from ʻOhana first. You, your provider, or an appointed representative can ask us for approval. This applies to drugs that need prior authorization or step therapy, have quantity or age limits, and drugs not listed on the formulary.

You can view or download a copy of the PDL at **ohanahealthplan.com/members/medicaid/community-care-services/pharmacy-services.html**. You can also call Customer Service toll-free at **1-866-401-7540** (TTY: **711**) if you would like a printed PDL mailed to you.

What medicines does CCS not cover?

Your CCS benefit does not cover medicines not related to your behavioral health. For example:

- Drugs for pain management.
- Drugs covered by your Medicaid or Medicare plan.

Can I get any medicine I want?

'Ohana will cover all medicines that are medically necessary for your behavioral health. Some drugs require approval from 'Ohana first. You, your provider, or an appointed representative can ask us for approval. This applies to drugs that need prior authorization or step therapy, have quantity or age limits, and drugs not listed on the formulary. Call Customer Service toll-free at **1-866-401-7540** (TTY: **711**) with any questions. In some cases, you must try another drug before we approve the one you originally asked for. We may not approve the drug you asked for if you do not try the preferred 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 the brand name drugs.

Pharmacy Lock-In

What is the 'Ohana 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 want to protect you from potentially dangerous drug interactions.

The 'Ohana Pharmacy Lock-In Program can 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 Pharmacy Lock-In Program, you can file an appeal with us. See the *Member Grievance and Appeals Procedures* section in this handbook for more information.

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 for the 'Ohana Pharmacy Lock-In Program. It is a voluntary service. For questions or to begin working with a care team, please call us toll-free at **1-866-401-7540** (TTY: **711**).

Pharmacy Direct Member Reimbursement (DMR)

What is a DMR?

Sometimes you may pay for medications out of pocket at a pharmacy. This can happen if you forget to show your insurance ID card(s). After such a purchase, you have 12 months to send us a claim form and your receipts to recover your costs. This is called pharmacy direct member reimbursement (DMR). To get a copy of the Member Pharmacy Reimbursement 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 reimbursement request?

- A completed, signed Member Pharmacy Reimbursement Claim Form.
- A detailed prescription receipt (handwritten receipts are not accepted) or pharmacy printout with the following information:
  - Member name.
  - Pharmacy name.
  - Physician name.
  - Drug name.
  - Drug strength.
  - Quantity dispensed.
  - A day's supply.
  - 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, the request will be denied. If needed, you can send in your request again with the missing information.

How much will I get back?

If approved, we will mail you a check for the plan-contracted price, which may not be the retail price.

How long should I expect to wait for my reimbursement?

Processing can take up to 30 days from the date we get your Member Pharmacy Reimbursement Claim Form. Be sure your form is complete with all the needed information. Otherwise, your request may be delayed or denied. Formulary guidelines apply to all reimbursement requests.

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

If you do 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 other ways 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).
- You live less than a half mile from a bus stop.
- 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).
- You live more than a half mile from a bus stop.
- Your destination is more than a half mile from a bus stop.

TheHandi-Van service will be used if:

- You live on Oahu.
- 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 located 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?

If your provider says you are unable to ride the bus or TheHandi-Van, or if you have neither service in your area, we will work with you to find another way to get you where you need to go. Call us toll-free at **1-866-401-7540** (TTY: **711**). Be sure to talk with your provider about any ongoing appointments. They can request NET for you as well.

Three steps for using your transportation benefit

1. Schedule a ride by calling Transdev Health Solutions toll-free at **1-866-790-8858**. ʻOhana 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 Transdev Health Solutions 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.

Non-Emergency Transportation (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.

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

This helps us give better service to everyone.

If you have a grievance about NET, please call ʻOhana Customer Service or Transdev Health Solutions toll-free at **1-866-790-8858** to tell us about your experience.

Mileage reimbursement

We now offer mileage reimbursement! This means we will pay you back for the distance you travel to an appointment. 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 Transdev Health Solutions toll-free at **1-866-790-8858**.

Behavioral Health Services

How to Select or Change Behavioral Health Providers

ʻOhana CCS members may choose an in-network behavioral health provider or change their provider at any time. No referral is necessary. Call Customer Service toll-free at **1-866-401-7540** (TTY: **711**) or go to **ohanahealthplan.com/ccs** for a list of participating behavioral health providers. You may also ask your Case Manager for help 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 ʻOhana 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 get emergency services. Once you are stable, plans will be made to transfer you to a Medicaid facility. We will tell you if the use of certain network specialists is restricted.

Behavioral Health Limitations and Exclusions

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

Hospital Services

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

We need to approve the services listed below before you can get them. This is called prior authorization. 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 also give you information on how to make an appeals and your right to a DHS hearing if you disagree with our decision.

These services need 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.

This list may change. Go to **ohanahealthplan.com/ccs** or call Customer Service toll-free at **1-866-401-7540** (TTY: **711**) for the most up-to-date list of services that need prior authorization.

‘Ohana is committed to responding to standard requests for prior authorization within, at most, seven calendar days. We or your health provider may need more time to make this decision. If so, we will ask to take up to 14 more days. If the provider indicates, or if ‘Ohana determines, that the standard time frame could seriously jeopardize your life or health, ‘Ohana will make an expedited (fast) authorization decision within 72 hours of the request. For continued care (concurrent) reviews, we will give you a decision within 72 hours of the request. A written notice of the reason for the decision to extend the time frame will be sent along with your right to file a grievance if you disagree with the decision.

Utilization Management Program

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

- **Prospective reviews:** Before you get care, we check to see if you need it.
- **Concurrent reviews:** We look at the care you are receiving to see if you need to keep getting that care or if other care would better meet your needs.

- **Transitional care:** We help you when you leave a hospital by making sure that you have services in place before you go home.
- **Retrospective reviews:** We check to see if you needed the care you got.
- **Care coordination:** The UM team works together with an interdisciplinary team to ensure effective care coordination. We help to improve the overall safety, efficiency, and effectiveness of your healthcare delivery by collaborating with the appropriate teams to identify needs and barriers.
- **Pharmacy management:** We help to make sure the medications you are taking are safe and appropriate for your condition.
- **Prospective drug utilization review (ProDUR):** We check for problems with your medication before you get it.
- **Retrospective drug utilization review (RetroDUR):** We check for problems with your medication after you get it.
- **Preferred drug list (PDL):** We cover many commonly prescribed medications.
- **Clinical programs:** We build programs to improve the quality of your health.

We do these reviews to measure the behavioral healthcare and services you receive. We want to make sure the services you get match your ʻOhana CCS health plan coverage. We also 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 speak to UM staff, to learn more about our UM program, or to discuss UM issues, 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 will 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, call our 24-hour Customer Service line toll-free 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 12 for definitions). We will give you the names of providers near you. To find emergency and post-stabilization service providers, call Customer Service toll-free at **1-866-401-7540** (TTY: **711**), check your provider directory, or visit our website at **ohanahealthplan.com/ccs**.

Below is a list of hospitals with emergency service providers.

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 Waianuenue 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	Kealakekua	HI	96750	Hawaii	**1-808-322-9311**
Queens North Hawaii Community Hospital	67-1125 Mamalahoa Hwy	Kamuela	HI	96743	Hawaii	**1-808-885-4444**
Kauai Veterans Memorial Hospital	4643 Waimea Canyon Dr	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**

Facility Name	Address	City	State	Zip Code	Island	Phone Number
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	**1-808-691-6800**

For a full list of emergency service providers, please call Customer Service toll-free at **1-866-401-7540** (TTY: **711**), 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 street address, city, county, or ZIP Code and click "Select your plan."
3. Select a network from the drop-down menu. Choose ʻOhana Community Care Services (CCS).
4. Click "Continue."
5. Select how you want to search:
    a. Search by specialty, facility / group name, provider name, or NPI. For example, you can type in "social worker" to look for providers in that specialty or you can enter a specific provider's name. When you have entered the needed information, click "Search."
    b. Search using the category search tiles. Click on one of the boxes for:
        i. Medical professionals.
        ii. Medical facilities.
        iii. Behavioral health.
        iv. Pharmacy & medical supplies.

c. From the right side of the screen, click any of our popular searches links:

i. Primary care.

ii. Clinic or urgent care.

iii. Pediatrics (babies, children).

iv. Dental professionals.

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. You can also call, text, or chat 988. Some examples of emergencies / crises are:

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

A behavioral health emergency is when a lack of immediate attention could result in:

- Serious jeopardy to 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 ʻOhana CCS ID card. Let your Case Manager / Agency know as soon as you can when you at the hospital. Let them know if you got care in an emergency room. We will pay for follow-up care to emergency treatment (called *post-stabilization care*).

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 your 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

If you have an emergency while traveling within the United States, go to a hospital. Show your ʻOhana 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 to be paid back (called *reimbursement*).

If you get sick or hurt while out of the ʻOhana CCS service area and it is not an emergency, call your Case Manager / Agency.

Behavioral health services outside of the United States 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. Call CCS Customer Service toll-free at **1-866-401-7540** (TTY: **711**) or your assigned Case Manager / Agency. You may also call Hawaii CARES at **1-808-832-3100** on Oahu or toll-free from Neighbor Islands at **1-800-753-6879**. Or call, text, or chat **988**.

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 get 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 ʻOhana CCS service area, and it is not an emergency, call Customer Service toll-free at **1-866-401-7540** (TTY: **711**). We will help arrange the care you need and ensure you get approval before you get services.

Transition of Care

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

We can also help if you are leaving ʻOhana CCS. Please call Customer Service toll-free at **1-866-401-7540** (TTY: **711**) or your Case Manager / Agency to help you get the care you need.

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

Your QUEST (Medicaid) plan has an Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program. It provides needed care to members younger than 21 years of age. Please reach out to your QUEST (Medicaid) plan to learn more.

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 advance directives laws, 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 get.

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?

Call a lawyer or your local legal aid office. You can also ask your provider for help. Or call Customer Service 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 your wishes 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: 1-808-692-7420
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 get. 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 also has rules for filing grievances 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 give them permission 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 if you speak another language. You can also call Customer Service toll-free at **1-866-401-7540** (TTY: **711**) if you need help to file your grievance.

Within five business days of getting your grievance, we will mail you a letter telling you that we got it. We will make a decision within 30 calendar days.

The time frame for standard grievances may be extended by up to 14 calendar days if:

- The member asks for an extension.
- The plan shows that more information is needed and the delay is in the member's best interest.
- The time frame is extended for a reason other than at the member's request.

The plan must explain the delay to the member:

- Orally by close of business on the day the decision is made to extend the time frame.
- In writing within two calendar days of the decision to extend.

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 got 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 415
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 asked 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 got.
- 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 got 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 to file your appeal. Your provider or someone else you choose can help file an appeal if you give them your written permission. They can also discuss your appeal with us on your behalf. Call Customer Service toll-free at **1-866-401-7540** (TTY: **711**). Or write to us at:

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

We will send you a letter within five business days of getting your appeal. This letter will let you know that we got 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 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.

Can an appeal be extended?

You can also ask us for up to 14 more days to give us more information for standard and fast appeals. We may also ask for 14 more days if we feel more information is needed and it is in your best interest. If we ask for the extra days, we will try to give you oral notice of the extension and 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 file 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 getting 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 have completed our 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 a lawyer, a relative, a friend, or another representative 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 ʻOhana CCS provided, a fast appeal review. You or your 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 got 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 got 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 latter 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.
- 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 got 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 (Medicaid) medical assistance program and diagnosed as having certain mental health conditions may be referred to ʻOhana CCS, your plan for behavioral health services. QUEST (Medicaid) stays as your plan for medical services. Med-QUEST Division makes final eligibility decisions for ʻOhana CCS members. Referrals come from:

- QUEST (Medicaid) 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 of age or older) being discharged from the Hawaii Youth Correctional Facility.
- People who contact ʻOhana CCS for the first time on their own or through crisis services.

Reinstatement

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

Disenrollment

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

- If you no longer qualify based on the behavioral health eligibility criteria.
- If you voluntarily leave the program.
- If you lose your Medicaid eligibility.
- If you are sent to prison.
- If you enter the Hawaii State Hospital.
- If you are currently enrolled in a long-term care facility / intermediate care facility.
- If you transfer to a long-term care nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF-ID).
- If you are legally encumbered (conditional release, jail diversion, released on conditions and mental health court, or getting services from DOH-AMHD) and/or enrolled in the AMHD program.
- 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 death.
- If you are sent out of state or waitlisted for medical treatment by DHS or ʻOhana CCS and DHS or the QI Health Plan will assume responsibility for your behavioral healthcare needs.

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 ʻOhana CCS

Our Service Area

ʻOhana CCS serves the following islands:

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

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

Plan Structure, Operations and Provider Incentive Programs

ʻOhana 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 ʻOhana 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.

ʻOhana 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 toll-free at **1-866-401-7540** (TTY: **711**) if you have any questions or want more information about the provider incentive program.

How Our Providers Are Paid

ʻOhana CCS works hard to give you the care you need. We work with many providers. You may ask how our providers 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 toll-free at **1-866-401-7540** (TTY: **711**) for more information.

Behavioral Health Services Direct Member Reimbursement

Behavioral health service member reimbursement 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/ccs**. 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**

FOLLOW THESE INSTRUCTIONS CAREFULLY. For the reimbursement of behavioral health services, you need to:

A. Complete 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. 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. Provide proof of payment, such as:

- 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 new technology in these areas:

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

To learn more, call Customer Service toll-free at **1-866-401-7540** (TTY: **711**).

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 our Member Newsletter. Call Customer Service toll-free at **1-866-401-7540** (TTY: **711**) 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 a 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, to get medical assistance or benefits. You may be held liable for repaying the value of the benefits you got and be subject to penalties under the law.

We must report suspected 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.
- Getting 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 or 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/ccs**.

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.

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

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

**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.*

***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 is 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**).

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