‘Ohana CCS ... Your Behavioral Health Plan

‘Ohana CCS is a managed behavioral health care plan for Medicaid members who are eligible for more behavioral health services than regular Medicaid offers. Many people now get their health benefits through managed care. Managed care plans like ‘Ohana CCS are contracted by the Department of Human Services to provide behavioral health services statewide. In this way, we meet the needs of the members and ensure members receive necessary and effective care. We work with doctors, licensed clinical staff, specialists, hospitals, labs and other health care facilities that are part of our provider network. These providers give our members the behavioral health care services they need. As a member, you may select a Case Manager/Agency. Your Case Manager/Agency will work with you to make sure you get your treatment. (You’ll find more about Case Managers/Agencies later in this booklet.)

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

As you work with everyone at ‘Ohana CCS, you will see that we put you and your family first, so you get better behavioral health care. Our members are our priority. We make every effort to make sure you get the care you need to stay healthy.

This handbook will tell you more about your benefits and how your behavioral health plan works. Please read it and keep it in a safe place. We hope it will answer most of your questions. For additional help, please call Customer Service toll-free at 1-888-846-4262 (TTY 1-877-247-6272). You can reach us Monday through Friday from 7:45 a.m. to 4:30 p.m. Hawai‘i Standard Time (HST). We have friendly staff trained to answer all of your questions. You can also visit us on the web at www.ohanahealthplan.com.

We wish you good health!
We’re on Facebook and Twitter. Come get social with us on the web today!

@OhanaKokua @OhanaHealthPlan
www.facebook.com/OhanaHealthPlan
AE should provide job number AND hard copy for Language Block.

Place 14 pt PDF into file.
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We’re Here to Help

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

Help From ‘Ohana CCS Customer Service

You can call Customer Service toll-free Monday through Friday from 7:45 a.m. to 4:30 p.m. HST. Call with questions about:

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

Customer Service Toll-Free Phone Number
1-888-846-4262 (TTY 1-877-247-6272)

You can also contact Customer Service by writing to:

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

We Care About Your Privacy!

When you call Customer Service, we need to verify your identity. We do this to protect your privacy. To make changes or access information, you will need to verify your:

- First and last name
- Date of birth
- Address (mailing or residence)
**Our Service Area**

‘Ohana serves the following areas:

- Kaua‘i
- O‘ahu
- Moloka‘i
- Maui
- Lāna‘i
- Hawai‘i

If you do not speak English, we can help. We want you to know how to use your behavioral health care 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 1-877-247-6272.

**Help From Your Case Manager/Agency**

You can choose a Case Management Agency to coordinate your care. The Agency will assign you to a Case Manager. Your Case Manager will be your main connection to the plan. He or she will make sure you get timely care. Your Case Manager, along with the Agency, will also make sure you get the right care.
Within 10 days of becoming an ‘Ohana CCS member, a Care Coordinator will reach out to help you choose a Case Manager/Agency. You may also choose a Case Manager/Agency by calling Customer Service. We will choose one for you if you do not select one yourself.

It is important to build a partnership with your Case Management Agency. It gives them a chance to get to know your needs. They can help you:

- Arrange services
- Get help with a provider
- Coordinate care with your provider
- Find answers to your questions about things like your benefits, behavioral health care or medicines

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

You will have face-to-face visits with your Case Manager to help ensure your needs are being met. You will get details about how often these meetings will happen. (You’ll find more about Case Managers and Agencies later in this booklet.)

Sometimes, you may want to call a nurse for urgent behavioral health questions. You can call our 24-Hour Nurse Advice Line at 1-800-919-8807. You can reach them any time, even after business hours, on holidays or on weekends. A nurse will help by phone at these times. The nurse may be able to answer many of your questions and help you when you are not feeling well. Please see the Nurse Advice Line section later in this handbook. If you are in crisis, you can also use the Crisis Line of Hawai‘i at 832-3100 for O‘ahu or 1-800-753-6879 for neighbor islands.

### Other Important Phone Numbers

<table>
<thead>
<tr>
<th>Who To Call For Help</th>
<th>Toll-Free Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Crisis Line of Hawai‘i</td>
<td>O‘ahu: 832-3100</td>
</tr>
<tr>
<td></td>
<td>Neighbor Islands: 1-800-753-6879</td>
</tr>
<tr>
<td>24-Hour Nurse Advice/Hotline</td>
<td>1-800-919-8807</td>
</tr>
<tr>
<td>Who To Call For Help</td>
<td>Toll-Free Phone Number</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-----------------------------------------</td>
</tr>
<tr>
<td>TTY</td>
<td>1-877-247-6272</td>
</tr>
<tr>
<td>Transportation Requests (IntelliRide)</td>
<td>1-866-790-8858</td>
</tr>
<tr>
<td>Transportation Ride Assist Line (IntelliRide)</td>
<td>1-866-481-9699</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>1-888-846-4262 (TTY 1-877-247-6272)</td>
</tr>
<tr>
<td>Hawai‘i Med-QUEST Division</td>
<td>1-800-316-8005</td>
</tr>
<tr>
<td>‘Ohana Customer Service</td>
<td>1-888-846-4262 (TTY 1-877-247-6272)</td>
</tr>
</tbody>
</table>

**Visit our Website to Stay Informed**

Remember to visit our website often. You can get updated information on:

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

Plus, you can print a temporary ‘Ohana ID card, and update your address and phone number when you log in to our secure portal. Visit [www.ohanahealthplan.com](http://www.ohanahealthplan.com) today!
Ombudsman Program

The Hawai‘i Department of Human Services (DHS) oversees the Medicaid Ombudsman Program. This program allows Hilopa‘a, an independent reviewer, to look into concerns about Medicaid health plans. Their findings can help plans reach these goals:

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

The Ombudsman program is available to all members. You can learn more by contacting the Hilopa‘a Family to Family Health Information Center. You can visit their website at www.hilopaa.org. You can also call, email or fax them using the contact information below:

<table>
<thead>
<tr>
<th>Island</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>O‘ahu</td>
<td>1-808-791-3467</td>
</tr>
<tr>
<td>Hawai‘i</td>
<td>1-808-333-3053</td>
</tr>
<tr>
<td>Maui and Lāna‘i</td>
<td>1-808-270-1536</td>
</tr>
<tr>
<td>Moloka‘i</td>
<td>1-808-660-0063</td>
</tr>
<tr>
<td>Kaua‘i</td>
<td>1-808-240-0485</td>
</tr>
</tbody>
</table>

Email (general information): info@hilopaa.org
Email (Medicaid questions): ombudsman@hilopaa.org

O‘ahu fax: 1-808-531-3595
The ‘Ohana CCS Dictionary

<table>
<thead>
<tr>
<th>Advance Directive: A legal paper that tells your doctor and family how you wish to be cared for when you are ill and need care to prolong life. It goes into effect when you are so ill that you cannot make decisions for yourself.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeal: Requests you make when you do not agree with our decision to deny, cut back or end a service. Someone who represents you can also ask for an appeal.</td>
</tr>
<tr>
<td>Behavioral Health Provider: Case Managers, agencies, doctors, licensed clinical staff, specialists, hospitals, labs, pharmacies and other health care facilities that are part of our provider network. The providers in our network give you the care services offered by Medicaid and coordinate your behavioral health care needs.</td>
</tr>
<tr>
<td>Benefits: Health care we cover.</td>
</tr>
<tr>
<td>Case Manager: Your Case Management Agency will assign you a Case Manager. The Case Manager from that agency will help you coordinate your behavioral health needs. They help you get the care you need.</td>
</tr>
<tr>
<td>Case Management Agency: The Case Management Agency oversees the Case Managers within their organization.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td><strong>Disenrollment</strong>:</td>
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<tr>
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<tr>
<td><strong>Emergency</strong>:</td>
</tr>
<tr>
<td><strong>Generic Drug</strong>:</td>
</tr>
<tr>
<td><strong>Grievance</strong>:</td>
</tr>
<tr>
<td><strong>Health Maintenance Organization (HMO)</strong>:</td>
</tr>
<tr>
<td><strong>Inpatient</strong>:</td>
</tr>
<tr>
<td><strong>Managed Care Plan</strong>:</td>
</tr>
<tr>
<td><strong>Medically Necessary Services</strong>:</td>
</tr>
<tr>
<td><strong>Medicare</strong>:</td>
</tr>
<tr>
<td><strong>Med-QUEST Division (MQD):</strong> A division of the State Department of Human Services. It administers the Medicaid programs, including QUEST Integration and CCS.</td>
</tr>
<tr>
<td>---</td>
</tr>
<tr>
<td><strong>Member:</strong> A person who has joined our plan.</td>
</tr>
<tr>
<td><strong>‘Ohana CCS ID Card:</strong> An ID card that shows you are a member of our plan.</td>
</tr>
<tr>
<td><strong>Outpatient:</strong> A person who gets health treatment, usually at a hospital, but does not need to stay overnight.</td>
</tr>
<tr>
<td><strong>Over-the-Counter Drugs:</strong> Drugs that are not behind the drugstore counter and do not require a doctor’s order.</td>
</tr>
<tr>
<td><strong>Pharmacy Network:</strong> A group of drugstores that members can use.</td>
</tr>
<tr>
<td><strong>Post-Stabilization:</strong> Follow-up care after you leave the hospital to make sure you get better.</td>
</tr>
<tr>
<td><strong>Preferred Drug List (PDL):</strong> Medicines approved by the Pharmacy and Therapeutics (P&amp;T) Committee, which consists of ‘Ohana CCS doctors and pharmacists. These drugs are safe and cost less. You can find more information about the list and the medications we cover in the <em>Prescription Drug Services</em> section of this handbook.</td>
</tr>
<tr>
<td><strong>Prescription Medicine:</strong> A drug for which your doctor writes an order.</td>
</tr>
<tr>
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</tr>
<tr>
<td><strong>Primary Care Provider (PCP):</strong> Your personal doctor or Advanced Practice Registered Nurse. They manage all your medical health care needs.</td>
</tr>
<tr>
<td><strong>Prior Authorization:</strong> When we have to OK treatment or medicines before you receive them.</td>
</tr>
<tr>
<td><strong>Providers:</strong> Those who work with the plan to give health care to members. They include Case Managers, agencies, licensed clinical staff, doctors, hospitals, pharmacies, labs and others.</td>
</tr>
<tr>
<td><strong>QUEST Integration:</strong> A managed care program. It provides health care benefits, including acute and long-term care services to eligible individuals, families, and children under the Medicaid state plan.</td>
</tr>
<tr>
<td><strong>Referral:</strong> When your Case Manager/Agency sends you to see another health provider.</td>
</tr>
<tr>
<td><strong>Specialist:</strong> A doctor who focuses on a specific field of medicine.</td>
</tr>
<tr>
<td><strong>Treatment:</strong> The care you get from doctors and facilities.</td>
</tr>
</tbody>
</table>
Medicare Basics

Medicare is a federal insurance program that pays for certain health care expenses. It’s available to U.S. citizens 65 years of age or older and some people with disabilities under 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 the option to choose from a package of health care plans
- **Medicare Part D** – covers prescription drugs for people on Medicare
How to Get the Most from Your Plan

Here are a couple of important things to remember as you get started with ‘Ohana CCS.

Check your ID card and put it in a safe place

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

You will need your ‘Ohana CCS ID card each time you get behavioral health services. This means that you need your card when you:

• See your Case Manager/Agency or health provider
• Go to an emergency room, urgent care facility or a hospital for behavioral health services
• Pick up prescriptions from the pharmacy
• Have mental health exams done

Call ‘Ohana CCS Customer Service as soon as possible if:

• You have not received your card yet
• Any of the information on your card is wrong
• You lose your card
Choose your Case Management Agency

You will need to choose a Case Management Agency. You may have done this already. You can call Customer Service to select a Case Manager/Agency. You can ask for information about the Case Manager/Agency such as their background and qualifications.

You may choose a Case Manager/Agency by calling Customer Service within 10 days of becoming an ‘Ohana member. We will choose one for you if you do not select one yourself.

Get to know your Case Manager and Agency

The Case Management Agency you choose will connect you with a Case Manager to schedule a face-to-face behavioral health assessment within 30 days. Your Case Manager/Agency will help coordinate your benefits to meet your behavioral health care needs. Their goal is to help you get the care you need.

You can reach your Case Manager/Agency by calling his or her office. Your Case Manager’s/Agency’s name and telephone number should be printed on your ‘Ohana CCS ID card. It is important to build a partnership with your Case Management Agency. It
gives them a chance to get to know your needs and help you get needed care. You are allowed to change your Case Management Agency three times per 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 request a new Case Manager.

You also have the option to change your Case Management Agency. To do this, you can call Customer Service. The approved changes will become effective the first day of the following month. You are allowed to change your Case Management Agency up to three times per year.

We will send you a new ‘Ohana CCS ID card after we make the change. Please continue to use your old card to receive services until your new card arrives in the mail. Once you receive your new ‘Ohana CCS ID card, verify that the information is correct. Then destroy the old ‘Ohana CCS ID card.

Where you can find a list of our Case Managers/Agencies:

- Look in your Provider Directory
- Visit our website at [www.ohanahealthplan.com](http://www.ohanahealthplan.com)
- Call Customer Service

**How to get services before choosing or being assigned a Case Manager/Agency**

Once you join ‘Ohana CCS, you may get services before you have a Case Manager/Agency. Select a provider who is a part of our network to give you the care you need. You can see a list of providers on the web at [www.ohanahealthplan.com](http://www.ohanahealthplan.com).

Call to set up an appointment and tell them you are an ‘Ohana CCS member. Show them your welcome letter when you arrive for your visit. Your welcome letter includes your member ID number and offers proof of your membership with ‘Ohana CCS.

You can also call Customer Service. They will help you get the services you need until your ID card arrives with information about your Case Manager/Agency.
Get to know your 24-Hour Nurse Advice Line

Our 24-Hour Nurse Advice Line is offered at no cost to you. You can call the line 24 hours a day, 7 days a week. It is available every day of the year. Call toll-free 1-800-919-8807. Call any time you need health advice.

A nurse is there to help. You may call the Nurse Advice Line before you call a doctor or go to the hospital.

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

In an emergency

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

Call us, tell us

Do you have questions? Call us. We can get translators for all languages. We have materials available in Ilocano, Chinese (traditional), Korean, Vietnamese, large print, audio tapes and Braille. Sign language services are also available for hearing-impaired members. All of these services are available at no cost. Call toll-free 1-888-846-4262 (TTY 1-877-247-6272) weekdays from 7:45 a.m. to 4:30 p.m. HST. You may leave a non-urgent message after hours. We will return your call within one business day. You may also contact Customer Service by writing to:

‘Ohana CCS Customer Service
949 Kamokila Boulevard
3rd Floor, Suite 350
Kapolei, HI 96707
It’s also important for you to tell us if there’s a major change in your life. For example, if you:

- Change your name and/or address
- Get married or divorced
- Experience the death of a spouse or child
- Get health insurance from another company

‘Ohana CCS members have certain rights and responsibilities

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

The State has certain rules in place to make sure you are able to get to your appointments in a timely manner. (This is also called “access to care.”)

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

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

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

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

You shouldn’t have to wait more than 45 minutes once you have arrived at your scheduled appointment. If you’re having trouble getting care, call us. We can help make appointments for you too.
Your Health Plan
Covered Services

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

Behavioral Health Services, Coverage and Limits

<table>
<thead>
<tr>
<th>Services</th>
<th>Coverage and Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and Chemical Dependency Services</td>
<td>All medically necessary services</td>
</tr>
<tr>
<td>Crisis Services</td>
<td>• 24 hours a day, 7 days a week emergency/crisis intervention</td>
</tr>
<tr>
<td></td>
<td>• Crisis hotline</td>
</tr>
<tr>
<td></td>
<td>• Crisis residential services</td>
</tr>
<tr>
<td></td>
<td>• Crisis stabilization</td>
</tr>
<tr>
<td></td>
<td>• Mobile crisis response</td>
</tr>
<tr>
<td>Outpatient Services to include:</td>
<td>• Continuous treatment teams</td>
</tr>
<tr>
<td></td>
<td>• Family/collateral therapeutic support and education</td>
</tr>
<tr>
<td></td>
<td>• Individual/group therapy and counseling</td>
</tr>
<tr>
<td></td>
<td>• Screening, registration and referral</td>
</tr>
<tr>
<td></td>
<td>• Treatment/service planning</td>
</tr>
<tr>
<td></td>
<td>• Other medically necessary therapeutic services</td>
</tr>
<tr>
<td>Services</td>
<td>Coverage and Limits</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Diagnostics                      | • Other medically necessary behavioral health diagnostic services to include labs  
• Psychiatric or psychological evaluation and treatment (including neuropsychological evaluation)  
• Psychological testing  
• Psychosocial history  
• Screening for and monitoring treatment of substance use and mental illness |
| Emergency Department (ED Services) | • Any covered inpatient and outpatient services given by a qualified provider; these services are needed to evaluate or stabilize an emergency medical condition  
• An emergency medical condition must be a result of serious mental illness (SMI) or serious and persistent mental illness (SPMI) diagnosis. The health plan may not deny payment for these services when a representative from the health plan instructed the member to seek services. |
| Inpatient Psychiatric Hospitalization (24 hours) | • Ancillary services  
• 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 |
<table>
<thead>
<tr>
<th>Services</th>
<th>Coverage and Limits</th>
</tr>
</thead>
</table>
| Intensive Case Management      | • Case assessment
• Case planning (service planning, care planning)
• Coordination with member’s health plan and PCP
• Ongoing monitoring and service coordination
• Outreach                        |
| Medication Management          | • Medication counseling and education
• Medication evaluation
• Psychotropic medications        |
<p>| Methadone Management Services  | Includes the provision of methadone or suitable alternative (i.e., LAAM or buprenorphine) as well as outpatient counseling services |</p>
<table>
<thead>
<tr>
<th>Services</th>
<th>Coverage and Limits</th>
</tr>
</thead>
</table>
| **Out-of-State and Off-Island Coverage**     | Provides for any medically necessary covered services that are prearranged when not available on your island or in Hawai‘i. This includes:  
  • Referrals to an out-of-state or off-island specialist or facility  
  • Transportation to and from the referral destination  
  • Lodging & meals  
  • Member attendant (if authorized)  
  May require prior authorization |
| **Partial Hospitalization or Intensive Outpatient Hospitalization, including:** | • Diagnostic tests  
  • Medical supplies  
  • Medication management  
  • Prescribed drugs  
  • Therapeutic services including individual, family and group therapy, and aftercare  
  • Other medically necessary services |
<p>| <strong>Peer Specialist</strong>                          | Support from behavioral health peers                                                                                                                |</p>
<table>
<thead>
<tr>
<th>Services</th>
<th>Coverage and Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescription Drugs</td>
<td>The plan covers behavioral health drugs listed on our Preferred Drug List (PDL). This list will also have drugs that may have limits such as prior authorization, quantity limits, step therapy, age limits or gender limits. Alternate drugs may be covered with a prior authorization.</td>
</tr>
</tbody>
</table>
| Psychosocial Rehabilitation/Clubhouse Services | • Day treatment  
• Intensive day treatment  
• Residential treatment services  
• Social/recreational therapy services  
• Work assessment service |
<p>| Representative Payee           | Budgeting services                                                                                                                                 |</p>
<table>
<thead>
<tr>
<th>Services</th>
<th>Coverage and Limits</th>
</tr>
</thead>
</table>
| **Supportive Employment Services** | • Pre-employment service  
• Work assessment service                                              |
<p>| <strong>Supportive Housing</strong>          | Case management help to find and maintain housing                     |
| <strong>Therapeutic Living Supports</strong> | Includes specialized residential treatment facilities                |</p>
<table>
<thead>
<tr>
<th>Services</th>
<th>Coverage and Limits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation</td>
<td>Provides for both emergency and non-emergency ground and air services to and from medically necessary provider appointments for members who:</td>
</tr>
<tr>
<td></td>
<td>• Have no means of transportation</td>
</tr>
<tr>
<td></td>
<td>• Live in areas not served by public transportation</td>
</tr>
<tr>
<td></td>
<td>• Cannot access public transportation due to a mental condition</td>
</tr>
<tr>
<td></td>
<td>• Do not live in a community care foster family home, adult residential care home, expanded adult residential care home or domiciliary home</td>
</tr>
<tr>
<td></td>
<td>Transportation is not provided to day programs that are not medically necessary.</td>
</tr>
<tr>
<td></td>
<td>Authorization is required for any ground transportation to a location greater than 50 miles from pick-up location. May require prior authorization.</td>
</tr>
<tr>
<td>Urgent Care Services</td>
<td>Covered as medically necessary. No prior authorization is required.</td>
</tr>
<tr>
<td>Other Services</td>
<td>• Maintenance of member’s medical assistance eligibility</td>
</tr>
<tr>
<td></td>
<td>• Other medically necessary practitioner services provided by licensed and/or certified health care providers</td>
</tr>
<tr>
<td></td>
<td>• Other medically necessary therapeutic services, including services that would prevent hospitalization</td>
</tr>
</tbody>
</table>
Receiving Non-Covered Services

You can still get a service that is not covered. However, you will have to pay the provider directly. It is required that you and your provider 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.

<table>
<thead>
<tr>
<th>Services Not Covered by ‘Ohana CCS and Med-QUEST Division</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Behavioral health care in a foreign country</td>
</tr>
<tr>
<td>• Cosmetic procedures</td>
</tr>
<tr>
<td>• Investigational and experimental procedures</td>
</tr>
<tr>
<td>• Services that are not for the treatment of a behavioral health condition</td>
</tr>
</tbody>
</table>
Prescription Drug Services

Prescriptions and Pharmacy Access

How do I get a prescription?
Prescriptions must be written by a plan doctor.

Which drugstores will fill my prescription?
Prescriptions must be filled at a drug store in our network. A list of these drugstores is in the pharmacy section of your Provider Directory and at www.ohanahealthplan.com. You may also be able to get your prescriptions by ‘Ohana CCS’s mail-order service. Contact Customer Service to find out about this program.

What is the process for getting a prescription filled?
Show your ‘Ohana CCS ID card when you give your prescription to the pharmacist. There is no co-pay for prescribed medications for Medicaid-only members. There may be a co-pay if you have other insurance coverage such as Medicare.

Preferred Drug List

What medicines does ‘Ohana CCS pay for?
‘Ohana CCS pays for medicines on our Preferred Drug List (PDL). Doctors and pharmacists decide which drugs should be on this list. Your doctor or provider will use the list when prescribing drugs for your behavioral health needs. Some drugs will require approval through a Coverage Determination Request (CDR) that your doctor will handle. (CDRs are for drugs that require prior authorization and those not listed on the PDL.) The PDL will also have drugs that may have limits such as prior authorization, quantity limits, step therapy, age limits or gender limits. If you would like to see the list, it is on our website. Go to www.ohanahealthplan.com.

Be sure to take all health care ID cards with you when you get a prescription filled. These include your Medicare, QUEST Integration and CCS ID cards.
Are there medicines ‘Ohana CCS will not pay for?
The plan does not pay for medicines to treat medical conditions not related to your behavioral health care, including:

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

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

Are generic drugs as good as brand-name drugs?
Yes. Generic drugs work the same as brand drugs. They have the same active ingredients as brand drugs.

Direct Member Reimbursement

What is a medication Direct Member Reimbursement?
Sometimes you may pay for medications out-of-pocket at a retail drug store. This can happen if you forgot to show your CCS ID card. After such a purchase, you have 36 months to send us a claim form and your receipts to recover your costs. This is called Direct Member Reimbursement, or DMR. To get a copy of the claim form, call Customer Service toll-free at 1-888-846-4262 (TTY 1-877-247-6272). You can reach us Monday through Friday from 7:45 a.m. to 4:30 p.m. HST. You can also go online to www.ohanahealthplan.com.

Where do I send my DMR request?
Send the form to:

‘Ohana CCS Health Plan
Reimbursement Department
P.O. Box 31577
Tampa, FL 33631-3577
What do I need to include with each DMR request for approval?

- A completed, signed DMR form
- A detailed prescription receipt (handwritten receipts will not be accepted) or pharmacy printout with the following information: member name, pharmacy name, physician name, drug name, drug strength, quantity dispensed, a day’s supply and the amount you paid
- A cash register receipt that shows the date the prescription was paid for and what amount was paid

All the above information must be included. Otherwise, the DMR will be denied. You will be able to send in your request again with the missing information.

How much will I get back?

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

How long should I expect to wait for my reimbursement?

It usually takes four to six weeks from the date you mail in the DMR form. Be sure that your form is complete and has all the information. Otherwise, your request may be delayed or denied. Formulary guidelines will apply to all reimbursement requests.

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

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

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

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

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

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

Bus service will be used:

- If your physical condition allows it (you are able to walk on your own or use a wheelchair)
- If you live less than a half mile from a bus stop

AND

- If your destination is no more than a half mile from a bus stop
- If you live on Oʻahu, you may be able to ride TheHandi-Van. This service is for persons with disabilities unable to ride the bus. TheHandi-Van service will be used:
  - If your physical condition does not allow you to ride a bus

AND

- 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 Avenue, Suite 835, Honolulu, HI 96814-1613.

The center is open Monday through Friday from 8 a.m. to 5 p.m. HST. Please call 1-808-538-0033 for more information or to schedule an in-person interview.
Questions?

- What if your medical provider says you are unable to ride the bus or TheHandi-Van?
- What if these services aren’t available in your area?

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

Also talk with your provider about ongoing appointments. He or she can request NET for you.

3 steps for using your transportation benefit

1. Schedule a ride by calling Intelliride toll-free. The number is 1-866-790-8858. Customer Service can also help.

2. Call at least 2 business days (48 hours) before your appointment. You can schedule a ride as long as 30 days before your appointment.

3. Be ready at least 15 minutes before your pick-up time.

NET service reminders

- NET services are for medical appointments like doctor visits. They’re not for trips to the pharmacy, community events or other non-medical trips.
- If you ask for a ride less than 48 hours ahead of time, we’ll get you one if we decide it’s for an urgent reason. We may ask you to reschedule if it’s not urgent.

Call right away to cancel or reschedule a ride – at least one hour before your pick-up time. This helps give better service for everyone.

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

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

We can help you get outpatient mental health or substance abuse treatment. Call your Case Manager/Agency or Customer Service to find out more. Our staff is happy to help you. We will give you names of providers near you. You may choose from these names to set up an appointment.

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 the nearest emergency room. Do this even if the emergency room is not in our service area.

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

Behavioral Health Limitations and Exclusions

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

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

Services from Providers That Are Not in Our Network

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

Services That Require Prior Authorization/Precertification

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

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

- Substance abuse treatment
- Psychosocial rehabilitation to include Clubhouse
- Supportive housing
- Specialized residential treatment
- Most mental health tests done by your Case Manager/Agency or health provider
- Investigational and experimental procedures and treatments
- Non-emergency hospital services
- Peer Specialists

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

Utilization Management Program

We have a utilization management (UM) program that 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 care while you are getting it to see if you need to keep getting it or if other care would better meet your needs
- **Transitional care** – we help you with the change when you leave a hospital by making sure that you have services in place before you go home
- **Retrospective reviews** – we check to see if you needed the care you got, after you received it

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

There may be times when we say we are unable to cover services or care that your provider asks for. This may be due to benefit limitations or lack of medical health necessity. These decisions may be made by our licensed clinical staff, who are nurses and doctors.

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

To learn more about our UM program, you may contact Customer Service toll-free at 1-888-846-4262. TTY users may call 1-877-247-6272.

In a retrospective review, your provider will not bill you for covered services you have received that we decide were not medically necessary.

If the health plan objects to providing a service on moral or religious grounds, we will notify you within 90 days after adopting the policy.

How to Get After-Hours Care

If you get sick or hurt, and it is not an emergency, call your Case Manager/Agency and you will be told how to get care. If you can’t reach them, you can go to an urgent care center.
Emergency Services

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

What to do in an emergency

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

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

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

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

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

The ER doctor will decide if your visit is an emergency. If it is not, you get the choice to stay. If you stay when it is not an emergency, you may have to pay for the care.

You can also call the 24-hour Nurse Advice Line toll-free at 1-800-919-8807.
You don’t need prior approval for emergency services or follow-up care. This is true whether it’s within or outside our Hawai‘i network. Emergency care outside the United States is not covered.

**Post-stabilization services**

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

This care must be done to maintain, improve or solve your medical condition. When you have a question or are unsure about your care, you may contact your behavioral health provider directly. If the provider’s office is closed, you may also contact the 24-hour Nurse Advice Line at 1-800-919-8807.

We will 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 precertification for this. However, this care must be needed to maintain, improve or solve your emergency medical condition.

**Out-of-area emergency care**

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

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

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

**What to Do if You Are in Crisis**

You have 24-hour crisis services. Contact your assigned Case Manager/Agency or the Crisis Line of Hawai‘i at 1-808-832-3100 on O‘ahu or toll-free from the neighbor islands at 1-800-753-6879.
Out-of-State and Off-Island Coverage

We cover any medically necessary covered services that are not available in the state or island where you live. If you or your provider decides that you need a service out-of-state or off-island, and is not available in our plan, just contact us. We will work with you to try to obtain the service locally. We will provide these services out-of-state or off-island if we are not able to 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 make a decision within 14 days. We may need more time to make this decision. If so, we will then take up to 14 more days. You or your doctor can ask us for a fast decision (a decision made within three business days). 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 health care services while you are out of the ‘Ohana service area, and it is not an emergency, call Customer Service. Call toll-free 1-888-846-4262 (TTY 1-877-247-6272). We will help arrange the care you need and ensure you get approval before receiving services.

Transition of Care

‘Ohana CCS Health Plan is here to help. If you are new to ‘Ohana CCS or your Case Manager/Agency or provider is no longer participating with ‘Ohana CCS, we can work with you and your provider to continue offering services as we transition you to a participating provider.

If you are leaving ‘Ohana CCS, we can help with your transition. Please call Customer Service or your Case Manager/Agency to help arrange the care you need.
Advance Directives

Your Care Is Your Decision

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

Advance Directives Help You Make Your Wishes Known

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

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

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

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

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

Where can I get an advance directives form?

You can call a lawyer or your local legal aid office. You can also ask your provider or call Customer Service. Call toll-free at 1-888-846-4262 (TTY 1-877-247-6272).

How can I learn more about advance directives?

Customer Service can help you learn more. Call toll-free at 1-888-846-4262 (TTY 1-877-247-6272). A representative will help you sign up for a free educational session. You can also ask your provider for more information.
Can I change my advance directive?

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

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

You should give copies to your Case Manager/Agency and health care 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. Don’t just put these forms away and forget about them.

Do my caregivers have to follow my advance directives?

Yes, as long as your advance directives follow state law. A caregiver may not follow your wishes if they go against his or her 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, health care facilities are not required to implement an advance directive if there is an institution-wide conscientious objection and state law allows such an objection.

What happens if my wishes aren’t followed?

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

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

Phone: 1-808-692-7227
Fax: 1-808-586-4444
Member Grievance and Appeal Procedures

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

This section will explain how you can express your concerns.

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

Grievances

What is a grievance?

A grievance is when you call or write to express 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 act
- Unclean provider offices
- Not getting the information you need

How do I file a grievance?

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

You must tell us that you agree to have someone else act on your behalf during the grievance process. Call Customer Service toll-free at 1-888-846-4262 (TTY 1-877-247-6272). You may also fax your grievance to 1-866-388-1769.
Or write to:

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

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

MQD Grievance Review

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

Med-QUEST Division
Health Care Services Branch
P.O. Box 700190
Kapolei, HI 96709-0190

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

Someone will review the grievance and respond within 90 days of getting it.

Appeals

What is an appeal?

An appeal is a request you can make when you do not agree with our decision about the health care you are getting and/or our timeliness. You can request an appeal when any
of the following actions occur:

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

You will get a letter from us when any of these actions occur. This is called a “Notice of Action.” You can file an appeal if you do not agree with our decision.

How do I file an appeal?

You must file your appeal within 30 days from the date you receive your Notice of Action. You can file by calling or writing to us. If you file by calling, you must follow up with a written, signed appeal. If needed, we can help you file your appeal.

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

Call Customer Service toll-free at 1-888-846-4262 (TTY 1-877-247-6272). Or write to us at:

| For appeal requests for medical services:  |
| ‘Ohana Health Plan  |
| Attn: Appeals Department  |
| P.O. Box 31368  |
| Tampa, FL 33631-3368 |

| For appeal requests for pharmacy medications:  |
| ‘Ohana Health Plan  |
| Attn: Pharmacy Medication Appeals Department  |
| P.O. Box 31398  |
| Tampa, FL 33631-3398 |

Fax to: 1-866-201-0657

Fax to: 1-888-865-6531
We will send you a letter within five business days of receiving your appeal. This letter will let you know we received it. We will then review your appeal and send you a letter within 30 days telling you of our decision. You or someone you choose to act for you can review all of the information we used to make the decision during or after the review of the appeal.

**What if I need an expedited (fast) appeal?**

You or your doctor can ask for a fast appeal. We will give you a fast appeal if your provider says waiting could seriously harm your health. You may ask for a fast appeal without a doctor’s help. We will decide if you need a fast decision. You or your provider must call or fax us to ask for a fast appeal. Call toll-free 1-888-846-4262 (TTY 1-877-247-6272). 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 three business days.

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 written notice
- Inform you verbally and in writing that you may file a grievance about the denial of the expedited process

**What if I would like to submit additional information?**

You or someone appealing for you may give us more information. You may do this throughout the appeal review process. Your time to submit additional information for an expedited appeal is limited due to the short processing time frame.

You can also ask us for up to 14 more days to give us more information. 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 send you a written notice. The notice will also tell you when the review will be completed.

**What if I do not like an appeal decision?**

You may not like the appeal decision we make. If so, you can ask for State Administrative Hearing. Someone you choose to act for you can also ask for one. You must do this within 30 days of receiving the appeal decision letter. The letter will tell you how to file
for a State Administrative Hearing with the Administrative Appeals office. You can only ask for a DHS Administrative Hearing after you have gone through our complete appeals process. To do so, send your request to the address below.

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

You may also have the right to ask for an expedited (fast) State Administrative Hearing. You may only do this when you asked for, or ‘Ohana provided, a fast appeal review. If the fast appeal is denied, you or someone you choose to act for you can ask for the hearing. You must do this within 30 business days of receiving the appeal decision letter. The letter will tell you how to file an appeal. To do so, send your request to the address above.

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:

- You request that we continue your services.
- Your appeal or request for State Administrative Hearing is filed in a timely manner, defined as on or before the later of the following:
  - Within 10 days of the date we mailed you the notice of action
  - The date we planned to stop or reduce your service(s)
- Your appeal or request for State Administrative Hearing involves an action we are taking to stop, suspend or reduce services we had already approved.
- The services were ordered by an authorized provider.
- The original time period covered by the approval we gave has not ended yet.

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

Enrollment

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

- QUEST Integration Health Plans
- Patients being released from Hawai‘i State Hospital
- People who contact ‘Ohana CCS through Hawai‘i DOH, AMHD and CAMHD
- Inmates being released from jail
- Young adults 19 years old being released from juvenile detention
- People who contact ‘Ohana CCS for the first time on their own or through crisis services

Reinstatement

If you lose your Medicaid eligibility but get it back within six months, the state may reinstate you as a member of ‘Ohana CCS. Call ‘Ohana Customer Service toll-free at 1-888-846-4262 (TTY 1-877-247-6272) to request to be reinstated with ‘Ohana CCS.

Disenrollment

Med-QUEST Division makes all eligibility decisions. You may lose your ‘Ohana CCS membership if you:

- No longer qualify based on the behavioral health assistance eligibility criteria
- Voluntarily leave the program
- Are sent to prison
- Enter the Hawai‘i State Hospital
- Try to enroll in the program by using false information
- Do not make contact with your Case Manager for 4 consecutive months or longer
You cannot be disenrolled from the plan for these reasons:

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

Our Service Area

‘Ohana CCS serves the following islands:

- Kaua‘i
- O‘ahu
- Moloka‘i
- Maui
- Lāna‘i
- Hawai‘i

If you move, call ‘Ohana CCS Customer Service. You will want to pick a Case Manager/Agency near your new home. If you move out of our service area, you should call MQD for further information about how your move may impact your behavioral health coverage. The toll-free number is 1-800-316-8005.

Plan Structure, Operations and Provider Incentive Programs

The people of ‘Ohana Health Plan are 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. Anytime you need help, call us toll-free at 1-888-846-4262 (TTY 1-877-247-6272). And you can always stop by one of our offices on O‘ahu, Maui or the Big Island.

‘Ohana CCS also works with your Case Manager/Agency and health care providers to make sure you get the right care at the right time. This includes preventive care. We’ll sometimes offer your doctors incentives, or bonuses. We do this to encourage them to keep you on track with your wellness visits throughout the year. If you have any questions about this, Customer Service can help to answer them.

How Our Providers Are Paid

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

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

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

The review of new technology is done in the following areas:

• Behavioral health procedures
• Medical devices
• Medical procedures
• Pharmaceuticals

To learn more, call Customer Service.

Quality and Member Satisfaction Information

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

Fraud, Waste and Abuse

Billions of dollars are lost to health care fraud every year. What is health care fraud, waste and abuse? It’s when false information is given on purpose. This can be done by a member or provider. This false information can lead to someone getting a service or benefit that is not allowed. It can also lead to a provider receiving payment for services that were not performed.

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 actually performed
• Falsifying a patient’s diagnosis to justify tests, surgeries or other procedures that are not medically necessary
• Filing claims for services or medications not received
• Forging or altering bills or receipts
• Misrepresenting procedures performed to obtain payment for services that are not covered
• Over-billing the plan
• Using someone else’s ‘Ohana CCS ID card to get services
• Obtaining medications and then selling the medications to someone else
• Requesting and receiving transportation services to go somewhere other than to a medical appointment

If you know that fraud, waste or abuse has occurred, tell us. If you think that fraud, waste or abuse has occurred, tell us. We will be able to determine if something is fraud, waste or abuse. Call our 24-hour Fraud Hotline. The toll-free number is 1-866-678-8355. It is private and you may leave a message without leaving your name. If you do leave your phone number, we will call you back. We’ll do this to be sure our information is complete and accurate. You can also report fraud on our website. Submitting a report through the web is private too. Go to www.ohanahealthplan.com.
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.
• To have the protections listed in the Patients’ Bill of Rights and Responsibilities Act (HRS Chapter 432E).
• To know the names and titles of the providers who take care of you.
• To be treated with respect.
• To be treated with dignity.
• To privacy.
• To decide with your provider on the care you get.
• To talk about the care you need as it is related to your health conditions. This includes the choices and risks involved, regardless of the cost or benefit coverage. You must get this information in a way you understand.
• To know about your health care 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.
• To request to amend or correct your behavioral health records.
• To have your records kept private.
• To make your health care wishes known by using advance directives.
• To have input in the plan’s member rights and responsibilities.
• To use these rights no matter your sex, age, race, ethnicity, income, education or religion.
• To have all plan employees honor your rights.
• To get health care services that are accessible, comparable in amount, duration and scope to those provided under Medicaid Fee for Service and are sufficient in amount, duration and scope to reasonably be expected to achieve the purpose for which the services are furnished.
• To get appropriate services that are not denied or cut back just because of diagnosis, type of illness or mental health condition.
• To get all information in a way that you can easily understand, in alternative formats and in a manner that takes into consideration your special needs.
• To get help in understanding the rules and benefits of the plan.
• To get verbal interpretation services at no cost. This is for all non-English languages, not just those that are most common.
• To be told that verbal interpretation is available to you, and how to get this service.
• To get information about:
  - The basic features of managed care.
  - Who may or may not join the program.
  - The plan’s responsibilities for coordination of care in a timely manner in order to make an informed choice (potential members).
• To get a complete description of your right to leave the plan.
• To get a notice of any major change in benefits. You must get this at least 30 days before the change is to go into effect.
• To get full information about emergency and after-hours services.
• To get the plan’s policy on referrals for specialty care and other benefits that are not provided by the member’s Case Manager/Agency or health care provider.
• To have all these rights apply to the person you legally appoint to make decisions about your health care.
• To freely exercise your rights, including those related to filing a grievance or appeal, and that the exercise of these rights will not adversely affect the way you are treated.
• To receive a second opinion at no cost to the member.
• To receive services out of network if the health plan is unable to provide them in network for as long as the health plan is unable to provide them in network and not pay more than he or she would have if services were provided in network.
• To receive services according to the appointment waiting time standards.
• To receive services in a culturally competent manner.
• To receive services in a coordinated manner.
• To have your privacy protected.
• To be included in care plan development.
• To have access to providers contracted with the health plan.
• To have direct access to specialists (if you have a special health care 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 health care provider that furnishes the services; and payments of covered services furnished under a contract, referral or other arrangement to the extent that those payments are in excess of the amount the member would owe if the health plan provided the services directly.
• To only be responsible for cost-sharing as described by your plan.
• To be provided with written notice of any significant change related to member rights, responsibilities and procedures at least 30 days before the intended effective date of the change.

**Member Responsibilities**

You also have responsibilities as a member:

• To give information that the plan and its providers need to give care.
• To follow plans and instructions for care that you have agreed on with your Case Manager/Agency or health care provider.
• To understand your health problems.
• To help set treatment goals that you and your Case Manager/Agency or health care 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 health care through your Case Manager/Agency or health care provider.
• To get a referral from your Case Manager/Agency or health care provider for specialty care.
• To cooperate with the people providing your health care.
• 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 health care 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 1-888-846-4262 (TTY 1-877-247-6272).
Add NOTES pages at end of Handbook.
Number of NOTES pages will be determined by total amount of pages (guts).

Example: If the total book needs to be divisible by 8...
92 total - 4 (cover) = 88 (guts) ÷ 8 = 11... perfect!
94 total - 4 (cover) = 90 (guts) ÷ 8 = 11.25... In this case, add 6 NOTES pages
So, 94 total + 6 NOTES pages = 100 total - 4 (cover) = 96 ÷ 8 = 12... perfect!
Add NOTES pages at end of Handbook.
Number of NOTES pages will be determined by total amount of pages (guts).

Example: If the total book needs to be divisible by 8...
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March 2016

For HI ONLY - Moving forward, Social Media information is going to be added on the back cover.

Wave goes to .5 margins (Wave/swoosh is THIN version, scale percentage X and Y both at 91.85%)

Use guides for text - Left .6875 Right 7.6875

Wave and Image are 7.375 W

Phone numbers, website, tracking info, VIN and job number should be 14pts - See Master Page M-

Text Samples of Styles

For MO, NJ and HI, add state code under copyright line.