

## **PROVIDER ROLE**

State-wide, AlohaCare provides medical and behavioral health services through a network of contracted physicians and providers that is over 3,000 strong and which provides the full range of QUEST covered benefits. AlohaCare's provider network has been developed and continues to grow to meet the diverse medical and behavioral health needs of our members. Providers, who meet the service delivery needs of AlohaCare, maintain an active license and/or certification to practice in Hawaii, and remain in good standing within their profession may apply to AlohaCare for network participation and begin the credentialing process.

AlohaCare's network includes a broad range of PCPs, specialists, facility, ancillary and other providers through which members can access the full range of QUEST benefits. From facilities that provide acute inpatient hospital services for medical, surgical, maternity/newborn care and behavioral health care; long term care and hospice; outpatient hospital services, radiology, laboratory and other diagnostic services; to practitioners and providers who serve as PCPs, provide specialty care or ancillary services, AlohaCare's provider network is able to provide for and meet the medical, behavioral health and pharmaceutical care needs of our members.

### **AlohaCare's Responsibility to Our Providers**

A key component of our relationship with our providers is centered on our responsibility to be a good partner. As our partners in the delivery of timely and medically appropriate health care to our members, AlohaCare has a responsibility to its network of providers to:

- Seek provider input to improve the quality of care for AlohaCare members,
- Seek provider input to improve the quality of provider relations with AlohaCare,
- Keep providers informed of any changes in AlohaCare's policies and procedures that may affect the provider network,
- Provide a dispute resolution/arbitration process for disagreements regarding contracts and a grievance/appeal process for other disagreements,
- Not discriminate against the participation, reimbursement, or indemnification of any provider who is acting within the scope of his/her license or certification under applicable State law, solely on the basis of that license or certification,
- Not discriminate against particular providers who serve high-risk populations or specialize in conditions that require costly treatment,
- Not control, direct, supervise nor intervene in any way in the rendering of medical and other health services by the provider,
- Process claims timely and accurately in accordance with contract requirements,
- Provide access to accurate eligibility information telephonically or electronically to allow eligibility verification, and
- Maintain a grievance and appeal program.

## **Provider Responsibilities**

### **All AlohaCare network providers have responsibilities to:**

- Verify member eligibility, current PCP assignment and TPL coverage on the date of service (via AlohaCare On-Line or by calling Customer Service).
- Successfully complete AlohaCare's initial credentialing process, as well as subsequent recredentialing processes.
- Maintain an accessible office environment conducive to the regulations and standards of the Americans with Disabilities Act (ADA), including the provision of assistance with interpreter (oral or sign), assistive listening devices, or other acceptable means of alternate communication for language or hearing impaired individuals.
- Schedule appointments in compliance with the AlohaCare appointment accessibility standards.
- Maintain medical record documentation which records all medical services provided to AlohaCare patients.
- Ensure confidentiality of patient information in compliance with State and Federal regulations.
- Notify AlohaCare's case management staff of potentially high risk and complex cases, so staff can assist in the coordination of resources to ensure cost effective and appropriate care for the member.
- Providers shall notify the Plan if, in the opinion of the provider and as defined by the Plan or the Hawaii Department of Human Services, a covered member meets the criteria for the following designations:
  - Members with Disability: The provider will assist in and support the Plan's effort to identify, coordinate, manage and/or transition the care of members who have a disability.
  - Members Requiring Long Term Care: The provider will assist in and support the Plan's effort to identify, coordinate, manage and/or transition the care of members who are in need of long term care services.
  - Members with Serious Mental Illness/Seriously Emotionally and Behaviorally Disturbed (SMI/SEBD): The provider will assist in and support the Plan's effort to identify, coordinate, manage and/or transition the care of members that have a SMI/SEBD.
- Submit all claims/encounters to AlohaCare within required timeframes (within 120 days of date of service or within 150 days of date of service if claim involves a third party payer), with accurate and valid ICD-9 diagnosis and CPT/HCPCS codes.
- Bill and collect surcharges, co-payments and share of cost from members only as set forth in the provider agreement and in the "Billing and Reimbursement" section of the Provider Manual.
- Cooperate with all AlohaCare Quality Improvement initiatives, complaint or grievance inquiries, compliance investigations, fraud and abuse investigations, and other state or federal reviews, including providing copies of medical records when requested.

- Agree to allow access upon reasonable notice, during regular business hours, to members' records for the purposes of quality improvement, complaint/grievance/appeal investigations, compliance investigations, fraud and abuse investigations, and other state or federal reviews.
- Comply with all applicable Federal and State laws prohibiting discrimination against any recipient or employee on the grounds of race, color, sex, national origin, age, mental or physical handicap and not use any policy or practice that has the effect of discriminating on the basis of race, color or national origin.
- Comply with AlohaCare's medical service guidelines, policies and procedures, contractual agreements, and guidelines set forth in this *Provider Manual*.
- Comply with the federal physician self-referral law, 42 C.F.R. Part 411, subpart J, as applicable, which generally prohibits a physician from making a referral for designated health services to an entity with which the physician or a member of the physician's immediate family has a financial relationship unless statutory or regulatory exception applies.
- In the event of termination of provider agreement, the provider shall continue to provide, coordinate or assist in the transition of care until AlohaCare makes reasonable and medically appropriate arrangements for the assumption of such covered services by another provider.
- In the event that provider refuses to provide any covered service based on moral or religious objections, the provider shall notify the covered member who requires such service(s) and make arrangements to refer the member to another participating provider who will provide the service.

### **Role of the Primary Care Provider (PCP)**

At the core of AlohaCare's provider network is the Primary Care Providers (PCP). AlohaCare believes in fully supporting the PCP in his or her role as the central coordinator of care required by an AlohaCare member. As such, the PCP is responsible for assessing the member's health care needs and provides/directs the services to meet these needs in all realms of care (case management, care coordination with specialists, delivery of primary care services, etc.).

AlohaCare's Primary Care Provider (PCP) panel includes Family Practice physicians, General Practice physicians, Internal Medicine physicians, Pediatricians, OB/GYNs, Family or Pediatric Nurse Practitioners, Certified Nurse Midwives and Physician Assistants.

### **PCP Responsibilities**

As the key provider for AlohaCare members, the PCP has the following additional responsibilities:

- Provide primary care services to AlohaCare members, and coordinate all medically necessary care with other providers.
- Complete an initial history and physical assessment on all assigned AlohaCare members no later than the third office visit.
- Maintain continuity of care for patients by coordinating all care, referrals, and follow-up treatment of the patient.
- Honor member requests for second opinion, when reasonable, and coordinate referral and prior authorization requests that may be required.

- Refer members, as needed, to an AlohaCare network specialist and manage and coordinate the member's specialty care to avoid duplicated, unnecessary or fragmented care.
- Communicate AlohaCare's utilization review decision to the member.
- Provide preventive health services, ongoing health maintenance, and disease prevention services according to established guidelines.
- Provide timely provision and documentation of Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) screening and related services for members under the age of 21.
- Maintain member referral information.
- If applicable, and where contractually stated, maintain hospital admitting privileges at a licensed acute care hospital within the service area or have a written agreement on file with AlohaCare utilizing another AlohaCare provider for admission and treatment privileges.
- Identify backup coverage when unavailable during regular office hours (i.e., out of town or on vacation) and provide written notice to AlohaCare of the coverage arrangements including the name of the covering provider and the dates of coverage. The backup provider need not be an AlohaCare participating provider. The use of a covering provider who is not participating with AlohaCare is subject to approval, and at minimum the provider must be eligible for participation in the Hawaii Medicaid program.
  - When making coverage arrangements, please ensure that covering provider understands the payment arrangement under which he/she will be reimbursed for submitted claims while providing coverage (if you are a capitated provider and the covering provider submits a claim for a capitated service, the claim will be processed and reimbursed as a capitated encounter and the covering provider will look to you for reimbursement; if you are a fee-for-service provider the covering provider will be paid fee-for-service).
  - All covering providers who are not a part of AlohaCare's network of participating providers will be required to complete and submit a one-page profile to the provider network department. See Forms/Tables/Lists section of this manual for the Provider Profile.
- Provide telephone access 24-hours per day, seven days per week. Answering machine or answering service must indicate how to contact you or your on-call provider in a medical emergency, and should not direct the AlohaCare member to go to the Emergency Room for non-emergent care.
- Follow AlohaCare's policies when referring members to specialists or other providers (refer to the "Medical Referrals, Prior Authorization and Notification Process" section located in Section 5, Utilization Management/Medical Management of the provider manual).
- Comply with federal and state law regarding advance directives for adult patients and at a minimum maintain written policies regarding patient's rights to make decisions about medical care, require documentation in patient's medical record, not discriminate against a patient because of patient's decision to execute or not execute an advance directive and provide staff education on issue concerning advance directives.

### **Primary Care Services**

This list of procedures represents the scope of services defined as primary care. Not all codes are reimbursable. Reimbursement will be based on the terms of your provider agreement.

**See Forms/Tables/Lists section of this manual for the Primary Care Services list (Section 14, page 1-9).**

### **PCP Patient Capacity**

PCPs may define the number of AlohaCare members they wish to have assigned to their care and may request a change in member load by submitting written notification to AlohaCare requesting an increase or decrease in member capacity. The request shall become effective immediately upon review and approval by AlohaCare.

AlohaCare will monitor patient capacity of its PCP network, to ensure that there is acceptable access to medical services for AlohaCare members. Such monitoring may include:

- The total number of AlohaCare members assigned to the practice
- The total number of QUEST, QUEST-Net and QUEST-ACE patients assigned to the practice
- The total number of commercially-based patients assigned to the practice
- The total number of private-pay patients treated at the practice

In addition to the overall volume of patients seen on an average weekly or monthly basis, AlohaCare may factor in the number of health care professionals (physicians and mid-level providers) utilized within the PCP office.

### **Requesting PCP Re-Assignment**

At times, it may be necessary for a PCP to request a member re-assignment to another PCP. PCPs may request member re-assignment for a variety of reasons, including but not limited to: abusive, disruptive or dangerous behavior toward office personnel; noncompliance with treatment recommendations; repeated failure to keep or cancel scheduled appointments; family continuity.

The PCP must send a certified letter to member informing him or her of the intent to terminate the relationship and that care will be extended for 15 days, to allow time to find another provider. The PCP will provide emergency care during those 15 days or until a new provider is identified. A copy of the certified letter and any additional specific details of the problem must be faxed or mailed to the AlohaCare Customer Service Manager. In cases of extremely serious or dangerous situations, the PCP should call AlohaCare and request expedited consideration.

AlohaCare's Customer Service Manager will assist the member in selecting another PCP and will notify the member by phone or in writing of the new PCP assignment. A new member ID card will be sent to the member with the new PCP indicated.

The member's failure to exercise the option of choosing a new PCP shall result in the Customer Service Department automatically assigning the member to another PCP by the end of the 15 day period. The new PCP will be contacted to obtain his or her approval for the member assignment. The member will be notified by phone or in writing of the new PCP assignment and a new ID card will be sent to the member, with the new PCP indicated. Copies of all correspondence are retained by the Customer Service Department.

### **Specialist & Ancillary Provider**

To ensure the timely provisions of comprehensive and medically necessary specialty health care to AlohaCare members, Specialist and Ancillary providers fill an integral role in the AlohaCare network.

In most situations, members access specialty care services by referral from the member's PCP. To facilitate the provision of health care and promote timely processing of claims, specialty care and ancillary providers are asked to observe the following additional responsibilities:

- Comply with AlohaCare's prior authorization and referral policies for non-PCP services (see "Medical Referrals, Prior Authorization and Notification" section of this manual).
- Coordinate the member's care with the PCP, and provide the specialty or ancillary care which was approved. As a standard of care, AlohaCare expects the specialist to report findings, as well as recommendations for additional care, in writing to the PCP as soon as possible after the visit. If additional care is recommended in the form of visits, testing, or surgery, the specialist will follow AlohaCare's Prior Authorization/Referral policies (see "Medical Referrals, Prior Authorization and Notification" section of this manual).
- Identify backup coverage for AlohaCare members in active treatment when you are unavailable during regular office hours (i.e., out of town or on vacation) and provide written notice to AlohaCare of the coverage arrangements including the name of the covering provider and the dates of coverage. The backup provider need not be an AlohaCare participating provider. The use of a covering provider who is not participating with AlohaCare is subject to approval, and at minimum the provider must be eligible for participation in Medicaid programs.
- When making coverage arrangements, please ensure that covering provider understands the payment arrangement under which he/she will be reimbursed for submitted claims while providing coverage (if you are a capitated provider and the covering provider submits a claim for a capitated service, the claim will be processed and reimbursed as a capitated encounter and the covering provider will look to you for reimbursement; if you are a fee-for-service provider the covering provider will be paid fee-for-service).
- All covering providers who are not a part of AlohaCare's network of participating providers will be required to complete and submit a one-page profile to the provider network department. See Forms/Tables/Lists section of this manual for the Provider Profile.
- Include the notification or prior authorization number on the claim form to ensure timely processing and payment if a notification or prior authorization is required for the service billed (see "Medical Referrals, Prior Authorization and Notification" section of this manual).

### **Credentialing/Recredentialing**

The purpose of credentialing is to ensure that AlohaCare members receive medical and behavioral health care from qualified practitioners. Practitioner credentialing is a quality initiative that assures providers have met appropriate levels of education, training, certification and licensing and are qualified to deliver medical care to members.

AlohaCare has established procedures to credential health care practitioners interested in joining our network. The credentialing process, which is based on NCQA a nationally recognized accreditation guideline, includes initial credentialing, recredentialing, delegated credentialing, site visits/medical record reviews, and credentialing file maintenance. All network practitioners must be credentialed before providing services to AlohaCare members. All practitioners must complete a credentialing application containing information pertinent to evaluating the practitioner's ability to provide quality care. Verification of information shall be from recognized monitoring agencies. In addition, an office site review and medical record review will be conducted by AlohaCare for specific provider categories prior to the AlohaCare Credentials Committee rendering a credentialing decision.

**AlohaCare credentialing policy:**

1. AlohaCare will ensure that practitioner credentialing/recredentialing is conducted in a non-discriminatory manner. AlohaCare will not discriminate against any provider requesting network participation on the basis of the applicant's race, ethnic/national identity, gender, age, sexual orientation, or the type of diagnoses or procedures the practitioner specializes in. However, AlohaCare has the sole right and responsibility to determine network need based on existing access and availability standards, participation criteria, and other business and contractual requirements of the Plan subject to market or geographic needs. If a need does not exist, AlohaCare reserves the right not to accept the application. In the event that an applicant practitioner does not meet participation criteria, the application will not be considered.
2. The credentialing process verifies that providers have the legal authority, training, experience and facilities required to provide appropriate care to AlohaCare members. The information obtained from the provider is verified through a primary source as recognized by accrediting bodies to ensure that the information is accurate and current.
3. Explicit minimum criteria for provider participation with AlohaCare are delineated and each provider's file contains sufficient documentation that the criteria are evaluated in the credentialing process.
4. AlohaCare will notify providers about information obtained during the Plan's credentialing process that varies substantially from the information provided to the Plan by the provider.
5. In accordance with AlohaCare policies concerning information practices and confidentiality, the information gathered shall be treated in a confidential manner and the disclosure of such information shall be limited to those parties mandated to receive such information by law.
6. All providers must be credentialed within a 180-day time frame. This time frame begins with the date of signature of the application and/or the most recent attestation form and ends on the date of action by the AlohaCare Credentials Committee.
7. Recredentialing of providers occurs every 2 years (24 months from the date of the last credentialing approval) and shall focus on verification of specific credentialing information, and additional components including member complaints and quality issues. The provider must continue to meet AlohaCare standards in all areas.
8. AlohaCare is solely responsible for making initial credentialing and recredentialing decisions based on the approval of the practitioner by the AlohaCare Credentials Committee.

- Providers will be notified of the credentialing or recredentialing decision rendered by the AlohaCare Credentials Committee within 60 calendar days of the committee's decision. In certain cases, provisional credentialing may be granted for a maximum of 60 days. AlohaCare continues to process credentialing for provisionally credentialed providers and will ensure that final credentialing is completed within 180 days of signing a credentialing application.

**Medical Records Requirements** (for PCPs, Specialists, and Ancillary Providers for Credentialing and Ongoing QI Reviews)

For credentialing purposes, the guidelines require that prior to rendering an initial credentialing decision for each new PCP (defined as Family Practitioners, General Practitioners, Internal Medicine, Pediatricians, and some OB/GYN providers who contract as a PCP), OB/GYN specialists or high volume Behavioral Health provider applicant, an assessment of medical record-keeping practices and an onsite visit be performed for each of the provider's service locations that did not undergo such an evaluation in the past.

The value of organized, accurate, detailed and comprehensive patient medical records is a fundamental part of delivering and documenting quality, timely and medically necessary patient care. In support of this and to conform to guidelines established under the NCQA and URAC-based AlohaCare credentialing policy, an evaluation of a practitioner's medical record keeping practices is a necessary component of initial credentialing activities for PCPs, OB/GYN specialists and high volume Behavioral Health providers. For the purposes of credentialing reviews, AlohaCare considers high volume Behavioral Health providers to be any provider that practices in a clinical setting that offers an array of services that provide a continuum of care, i.e. outpatient and inpatient services.

Record reviews are also performed to evaluate AlohaCare quality initiatives. For example, pediatric and OB/GYN and PCP records are reviewed to assess EPSDT, Pregnancy Care and Preventive Health care criteria, respectively.

AlohaCare will hold its contracted providers to medical record keeping standards in accordance with contractual obligations and any State and Federal laws. Accordingly, AlohaCare has developed the following standards for provider documentation and maintenance of members' medical records. These standards are monitored through the AlohaCare review process.

**Medical Record Standards:**

1. Medical records are maintained in a current, detailed, organized, and comprehensive manner.
2. Medical records are systematically organized and legible, and reflect all aspects of patient care.
2. All medical records are maintained in a manner that permits effective professional medical review and medical audit processes
3. All medical records are maintained in a manner that facilitates an adequate system for follow-up treatment.
4. Medical records conform to good professional medical practice and permit effective quality assurance review. For each patient encounter, a complete, dated, signed progress note will be entered into the medical record that contains, at a minimum, the chief complaint or purpose of visit, objective findings, diagnosis or medical impression, and therapeutic plan.

5. Appropriate health management and continuity of care clearly are reflected in the medical records. Where appropriate, evidence of follow-up to previous encounters, hospital discharge summaries, referrals and referral results, and documentation of emergency encounters and follow-up are recorded. For patients 12 years and older, appropriate notations concerning the use of tobacco, alcohol, and other substances should be documented.
6. All medical records must be maintained and accessible to AlohaCare, its representatives, and the representatives of the Med-QUEST Division. Upon reasonable notice and during provider's regular business hours, AlohaCare, Department of Health Services (DHS) and any applicable state or federal agencies or their designees shall have the right to inspect, review and make copies of all records maintained by the provider with respect to all services rendered and payments received by the provider from all sources for Covered Services rendered to members during the term of their agreement with AlohaCare. AlohaCare, DHS and any applicable state or federal agencies or their designees shall have the right to conduct periodic audits of such records for quality reviews, fraud and abuse investigations, or other purposes that may be delineated in state or federal regulations. In accordance with HIPAA requirements, the provider will make requested medical records available to the aforementioned without patient consent.
7. The medical record of a member is the property of the provider who generates the record. Members are entitled to a copy of their records. When members change PCPs, their medical records or copies of the medical records will be forwarded to the new PCP within 10 days of the receipt of a member request. Providers make the medical records of AlohaCare patients available to requesting hospitals, specialists, and new PCPs at no charge to the AlohaCare member.
8. All medical records are maintained in such a manner that ensures confidentiality. Access to a member's medical record must be restricted only to individuals directly involved in the member's treatment or monitoring of the quality of care, or by other individuals specifically authorized or permitted by law to have such access.
9. Medical records are preserved and maintained for a minimum of 7 years from the last date of entry in the records. For minors, providers will preserve and maintain all medical records during the period of minority plus a minimum of 7 years after the age of majority.
10. As part of the medical record standards, providers who facilitate the transfer of a member's medical records (or copies) to a newly assigned PCP, must do so within seven (7) business days from receipt of the request.

**Medical Records should contain the following components:**

- All pages contain patient ID
- There is personal/demographical data to include name, address, age, next of kin, date of birth, and home and work phone numbers, marital status and employment, if applicable.
- All entries are legible, signed and dated
- The provider is identified on each entry
- Allergies/adverse reactions/NKDA are adequately displayed/consistently recorded
- Current medications are noted/listed and updated appropriately
- Medical record is systematically organized and entries are legible by someone other than the writer (second reviewer will examine any record judged to be illegible, by the initial reviewer)

- There is an appropriate past medical history that is easily identified and includes serious accidents, hospitalizations, operations and illnesses. For children, past medical history relates to prenatal care and birth
- Pediatric medical records must include a completed immunization record or documentation that immunizations are up-to-date.
- The chief complaint or purpose of the visit is documented
- A physical examination, appropriate to the patient's condition, is documented
- Diagnoses or clinical impressions are documented
- There is a documented treatment plan, and appropriate laboratory and other studies have been ordered, working diagnosis(es) consistent of findings,
- There is documentation of treatments, therapies, prescribed regimens, procedures, and tests with results
- Documentation concerning follow up care, telephone calls or visits as well as unresolved concerns from previous visits are addressed in subsequent visits
- Hospitalizations and/or emergency room visits
- All other aspects of patient care including ancillary services
- Recommendations and instructions to patient have been noted, including a date for return visit or other follow-up plan for each applicable encounter
- Reasons for and results of referrals are documented
- Consultant summaries, lab, and other imaging study results reflect provider review
- Documentation of the patient being given/offered advance directive information/instructions is provided for all members eighteen (18) years or older including mental health directive

For the purposes of initial credentialing, the medical record review is not a review of actual clinical documentation. Rather, it is a review of the components and forms used by the servicing provider to record a patient's clinical information. The medical records should allow for organized, comprehensive and detailed documentation of patient identification and demographics and clinical aspects of care. A copy of the AlohaCare Credentialing Medical Record Keeping Review Scoring Sheet is provided under the Forms/Tables/Lists section of this Provider Manual. AlohaCare staff also assesses how the practice ensures confidentiality of patient medical records. AlohaCare's benchmark for compliance with credentialing-related medical record reviews is 100%.

***See Forms/Tables/Lists section of this manual for the Credentialing Medical Record Keeping Review Scoring Sheet (Section 14, page 10).***

For quality review purposes not related to credentialing, AlohaCare clinical personnel are required to periodically review the medical charts for specific categories such as EPSDT, Maternity Care and Preventive Health. Prior to such a review occurring, AlohaCare's staff will contact the PCP's office to let the provider know which charts will be reviewed, and to establish a date and time for the review to occur.

For the clinical review, the provider is asked to select five medical records of his/her choice if he/she does not have any current AlohaCare members assigned. Providers are asked to “blind” the records for confidentiality purposes. For those providers with current AlohaCare membership, a random selection of ten members is made from claims/encounter data. A high volume PCPs, with greater than 400 members, a minimum of 20 records will be reviewed.

AlohaCare’s benchmark for compliance to clinical reviews is 80 percent. Providers who score 80 percent or better will be sent a letter indicating their results. All future reviews will be coordinated with any quality assurance/improvement needs or as quality of care issues arise.

AlohaCare will work with providers scoring below 80 percent and a follow-up review will be scheduled within eight months of notification of results. Providers not in compliance at the time of follow-up will be asked to submit a written action plan and are scheduled for a second follow-up review within six months. Providers electing not to submit a written action plan and/or not in compliance on the second follow-up review will be presented to the Credentials Committee and/or Quality Improvement Committee for consideration of remedial actions.

For serious deficiencies, the time interval for follow-up review and/or the number of follow-up reviews prior to referral to the AlohaCare Credentials Committee or the Clinical and Service Quality Improvement Committee may be reduced, at the Medical Director’s discretion.

### **Appointment and Accessibility Standards**

Ensuring that AlohaCare members have availability and access to timely medical care is a fundamental aspect of the AlohaCare QUEST plan. Adequate appointment availability ensures that PCPs are able to accommodate members, based on the urgency of the patient’s medical condition, in a timely manner as defined by AlohaCare’s policy on Appointment and Accessibility, or have an alternative provider who can render care in the event the primary provider is unavailable. Appointment availability is also one of the dimensions AlohaCare examines to determine network adequacy. AlohaCare will maintain accessibility to an adequate provider network, taking into account reasonable distance and travel times for members.

Monitoring of appointment and accessibility standards is done by reviewing complaints, conducting member satisfaction surveys as well as Appointment and Accessibility survey, performing office site reviews, conducting clinical reviews for quality of care, and reviewing medical records. AlohaCare will also conduct Secret Shopper Phone Calls that will be measured against the providers’ written responses from the Appointment and Accessibility survey. Through AlohaCare’s documentation and follow-up of member grievances, problems with long waits for appointment scheduling are identified. AlohaCare staff contact providers to determine if issues exist that prevent timely access to medical appointments. Based on the results of AlohaCare’s research, a corrective action is initiated when appointment standards are not consistently met. AlohaCare also evaluates whether accessibility barriers exist that may adversely affect appointment availability. If it is determined that barriers do exist, AlohaCare works collaboratively with the provider’s office to correct the problem.

Providers are required to meet the following appointment standards based on levels of care, as listed below:

#### **Primary Care Provider (PCP) and Specialist Appointments:**

- Immediate care (twenty-four [24] hours a day, seven [7] days a week) and without prior authorization for emergency medical situations;
- Appointments within twenty-four (24) hours for urgent care and for PCP pediatric sick visits;
- Appointments within seventy-two (72) hours for PCP adult sick visits;
- Appointments within twenty-one (21) days for PCPs (routine visits for adults and children); and
- Appointments within six (6) weeks for visits with a specialist or for non-emergency hospital stays

**Maternity, Initial Prenatal Care Appointments:**

- First trimester: within 14 days
- Second trimester: within seven days
- Third trimester: within three days
- High Risk OB: within three days of identification of high risk

**Behavioral Health:**

- Emergency: immediately, 24-hours per day, seven days per week
- Urgent: within 24 Hours
- Routine non-urgent: within six weeks

Providers must assure that emergency services are available seven days a week, 24-hours a day. This may be done through the use of recorded messages, answering service, or backup coverage. Backup coverage must be arranged when the provider is not available during regular hours (i.e., out of town or on vacation). The backup provider need not be an AlohaCare participating provider. The use of a covering provider who is not participating with AlohaCare is subject to approval prior to the provider's leave of absence/vacation. At a minimum, the covering provider must be eligible for participation in the Hawaii Medicaid program. To ensure timely claims processing and payment (if applicable), AlohaCare must be informed regarding alternative coverage.

**Reporting Requirements**

All providers are required to adhere to the following reporting requirements:

- Submit claims/encounters to AlohaCare in an accurate and timely manner. Timely claim submissions means that:
  - Claims (either hard-copy or electronic) are submitted within 120 days of the last date of service or
  - Claims with TPL involvement are submitted, with the primary carrier's Explanation of Benefits (EOB) within 150 days of the last date of service on the claim.

- Notify AlohaCare if an AlohaCare member is or may be eligible for long term care, disability, Serious Mentally Ill (SMI) or Support for Emotional and Behavioral Development (SEBD) designations;
- Notify AlohaCare if an AlohaCare member has had a qualifying circumstance that may affect their QUEST membership;
- Notify AlohaCare when a member has other insurance or third party liability (TPL). As a Medicaid-based program, the QUEST program is always deemed as the payer of last resort. AlohaCare is contractually bound to pursue other existing primary payers prior to paying a claim;
- Notify AlohaCare when your AlohaCare member is diagnosed as pregnant. AlohaCare will, in turn, notify Med-QUEST to ensure, to the extent possible, that the member's QUEST benefits continue;
- Notify AlohaCare of a newborn. AlohaCare will, in turn, notify Med-QUEST to ensure timely enrollment of the newborn into the QUEST plan;
- Notify AlohaCare when you are going to be away and ensure that coverage arrangements have been made;
- Notify AlohaCare if you have objections to performing any health services that are within the scope of your responsibilities and make arrangements via the AlohaCare referral or prior authorization process for members to receive those services from another provider;
- Notify AlohaCare if you are involved in a malpractice or other action that has bearing on your ability to provide health services or impact the scope of your practice;
- Notify AlohaCare of other circumstances as stipulated in your Provider Agreement with AlohaCare.

## **MARKETING GUIDELINES**

**AlohaCare is subject to QUEST communication and marketing guidelines.**

- All member-related communications are reviewed and approved by Med-QUEST before distribution to members.
- All member-related communications include a language block that is translated into a minimum of five (5) prevalent languages identified by Med-QUEST to ensure that members know how to request a translated copy or obtain an oral interpretation of the written information from AlohaCare. The languages are:
  - English
  - Chinese (Mandarin)
  - Korean
  - Ilocano
  - Tagalog
- Providers who develop their own educational or marketing materials for distribution to QUEST members must first receive approval from AlohaCare and the State of Hawaii Med-QUEST Division if the materials relate to the QUEST Program itself.
- Providers must allow equal access to all QUEST plans to display QUEST Plan-related marketing materials (such as a provider's participation in the network of a specific QUEST health plan).

## **FRAUD AND ABUSE**

As a Medicaid Managed Care Organization, AlohaCare is required by state and federal law to have a formal Fraud and Abuse Program. This program addresses the prevention, detection, and reporting of fraudulent and abusive situations. Such situations include, but are not limited to: the abuse, neglect, or exploitation of any individual receiving or providing QUEST-eligible services; and the loss, theft, misappropriation or overpayment of state and federal Medicaid funds

**Fraud** is an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/her or some other person. It includes any act that constitutes fraud under applicable federal or state law.

**Abuse** means practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

### **Common Types of Provider Fraud and Abuse**

- Billing for services not provided
- Charging members for "no show" or canceled appointment fees, except where allowed for QUEST-Net or QUEST-ACE adult members
- Providing substandard or low quality care
- Ordering and/or billing for unnecessary services

- Poor or incomplete documentation for services billed

**Common Types of Member Fraud and Abuse**

- Authorizing another person to use the member's ID card
- Failure to report other TPL coverage
- Seeking non-emergent care through the Emergency Room
- Misrepresenting facts concerning a medical condition to obtain higher doses and or unnecessary drugs.

Providers are required to participate in AlohaCare's Fraud and Abuse Program and report instances of suspected fraud and abuse about a member, another provider or provider group, facility or supplier to the AlohaCare Compliance Officer. Anonymous submissions can be accepted and ample detail should be provided to ensure that an appropriate and effective investigation can ensue. Reports of suspected fraud and abuse are confidential and should be sent to:

AlohaCare  
Attention: Compliance Officer  
1357 Kapi'olani Boulevard, Suite 1250  
Honolulu, HI 96814

AlohaCare has takes many measures to detect false claim submissions and prevent incorrect payments. Current methods used to avoid fraudulent payments include, but are not limited to:

- Automated edits in the claim system to deny duplicate claims
- Member identity validation by matching the AlohaCare ID number and birth date as provided by Med-QUEST to what is submitted on the claim form
- Review of claims for unbundling of services
- Random verification with members as to whether billed services were furnished
- Review of outlier facility claims against the medical record to determine covered services, and that services were ordered and documented as billed

Under our QUEST contract with the State of Hawaii, AlohaCare is required to report all incidents of suspected fraud and abuse to the state Medicaid agency within thirty (30) days of discovery.

Penalties for false claim submission may include fines of \$5,000 but not more than \$10,000 plus three times the amount of damages for all federal violations and state claims only if the claim amount is \$5,000 or more. For claims under \$5,000, violators will be required to pay interest at the maximum legal rate on the excess amounts and \$1,000 for each fraudulent claim.

Any person or entity with evidence of fraud may file a “qui tam” (whistleblower) lawsuit on behalf of the government. Under these provisions, this person, or persons, may be eligible to receive between 15 and 30 percent of Federal and State proceeds recovered. The federal and state law prohibits retaliation against anyone who in “good faith” reports and/or participates in an investigation of a false claim violation. Anyone who feels they have been unlawfully retaliated against should contact the state or federal government immediately.

### **ALOHACARE ONLINE**

Providers with internet capability may access AlohaCare member, claims, and prior authorization information for their own members, 24 hours a day, 7 days a week, through our secure application, AlohaCare Online.

You must register with AlohaCare to gain access to AlohaCare Online. Please contact Provider Relations or Customer Service and we will set you up for this helpful resource.

### **ELECTRONIC FUND TRANSFERS**

Electronic Fund Transfers (EFT) is available for those providers who choose to have payments automatically deposited into their bank account. If interested, please see the Forms/Tables/Lists Section of the Manual. We will also need a deposit slip or canceled check (which includes the bank routing number) to set the process up and verify account information.

**See Forms/Tables/Lists Section of the Manual for the Electronic Fund Transfer form (Section 14, page 11).**