OVERVIEW

- Our Mission
- About AlohaCare and Our Plans
- Provider Roles and Responsibilities
- Cultural Competency
- Member Rights and Responsibilities
- Service Coordination
- Prior Authorizations and Referral Information
- Claims
- Fraud Waste and Abuse
- Grievance and Appeals
- Resources and Tools
OUR MISSION

Our mission is to serve individuals and communities in the true spirit of aloha by ensuring and advocating access to quality health care for all.

This is accomplished with emphasis on prevention and primary care through community health centers that founded us and continue to guide us as well as with others that share our commitment.
ABOUT ALOHACARE

- Local, non-profit health plan
- Founded in 1994 by Hawaii’s Community Health Centers
- Provides Medicaid and Medicare coverage
- Over 70,000 members statewide
- Over 230 employees
- Offices in Honolulu, Hilo, Kona, Wailuku, Lihue
OUR PLANS - MEDICAID

AlohaCare QUEST Integration

Our health plan assists members in receiving the highest quality of health care in the right setting and at the time that they need the care.

QUEST Integration Covered Services

- Preventative Care
- Pregnancy and Maternity Care
- Inpatient/Outpatient Care
- Emergency and Preventative Services
- Behavioral Health Services
- Vision Care
- Prescription Drug Coverage
- Long Term Services and Supports
AlohaCare Advantage Plus (Medicare SNP)

- AlohaCare Advantage Plus (HMO SNP) is a Medicare Advantage Prescription Drug Plan for Medicare beneficiaries who also have full benefit Medicaid coverage.

- This plan offers our additional benefits beyond Original Medicare, but is available only to beneficiaries who have Medicare and full benefit Medicaid coverage. This is called a Special Needs Plan (SNP).
# OUR MEMBERSHIP

<table>
<thead>
<tr>
<th>ISLAND</th>
<th>QUEST INTEGRATION</th>
<th>MEDICARE (SNP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hawaii Island</td>
<td>13,175</td>
<td>229</td>
</tr>
<tr>
<td>Kauai</td>
<td>5,924</td>
<td>81</td>
</tr>
<tr>
<td>Lanai</td>
<td>525</td>
<td>11</td>
</tr>
<tr>
<td>Maui</td>
<td>9,543</td>
<td>124</td>
</tr>
<tr>
<td>Molokai</td>
<td>2,315</td>
<td>26</td>
</tr>
<tr>
<td>Oahu</td>
<td>38,174</td>
<td>760</td>
</tr>
</tbody>
</table>

*As of August 30th 2017*
PROVIDER
ROLES AND RESPONSIBILITIES
PROVIDER ROLES AND RESPONSIBILITIES

- Provide and maintain continuity of care
- Assure emergency services are available 24 hours a day/7 days a week
- Have backup coverage available during regular hours
- Schedule appointments in compliance with the AlohaCare appointment accessibility standards
- Provide culturally competent care based on an individual’s background, ethnicity, cultural beliefs and language preference
PROVIDER ROLES AND RESPONSIBILITIES

Direct Member Billing

In accordance with the Hawaii QUEST Integration Program guidelines, providers cannot bill or make any attempt to collect payment for covered services or no-show fees, directly or through a collection agency, from a person claiming to be a QUEST Integration eligible member except in the following circumstances:

- The Individual was not eligible for QUEST Integration Program on date of service
- Non-covered services were performed. The provider must inform the member of the non-covered status of the service and that the member is responsible for the cost prior to rendering services
- QUEST Integration Adult members can be billed for services exceeding benefit limitations
- Member self-referral to an out-of-network specialist or other provider without following Plan procedure
- Member had primary coverage through a prepaid benefits plan (examples include: HMSA Health Plan Hawaii, Kaiser Health Plan) but did not go to a primary payer’s designated facility for treatment
- Med QUEST determines member has a share in the cost of health care or support services
- In cases where a member is retro-enrolled and made payment directly to a provider, AlohaCare will work with the member and provider to ensure that the member is reimbursed.

Please note that if plan procedures are not followed resulting in nonpayment, the provider may not bill the member.
PROVIDER SUBMISSION OF CHANGES

It is essential that you keep us informed of updates that affect your practice to keep provider network directories up-to-date. This will help us to stay compliant with CMS standards and will give patients the most accurate information about your practice. What we are looking for:

- Open panel status (accepting/not accepting members)
- Employed practitioners (new hires)
- Practitioners leaving (no longer employed)
- Office hours
- Appointment phone/fax numbers
- Practice locations
- Pay to Information
- ADA access
- Website (if applicable)
- Any other changes that affect your ability to see patients
APPOINTMENT AND AVAILABILITY

Providers are required to meet the following appointment standards based on the type of service:

<table>
<thead>
<tr>
<th>PCP and Specialists</th>
<th>Behavioral Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within 24 hours for urgent care and PCP pediatric sick visits</td>
<td>Within 48 hours for urgent care</td>
</tr>
<tr>
<td>Within 72 hours for PCP adult sick visits</td>
<td>Within 6 hours for non-life threatening emergency</td>
</tr>
<tr>
<td>Within 21 days for PCP routine visits (adults and children)</td>
<td>Within 21 days for routine visits (adults and children)</td>
</tr>
<tr>
<td>Within 4 weeks for specialist or non-emergency hospital stays</td>
<td></td>
</tr>
</tbody>
</table>
AMERICANS WITH DISABILITY ACT (ADA)

- Providers are responsible for maintaining an accessible office environment conducive to the regulations and standards of the Americans with Disabilities Act (ADA).

- This includes 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.

- If access to alternative communication is needed, please contact AlohaCare. These services are provided free to our members.
CULTURAL COMPETENCY

Providers are expected to provide all health care services in a culturally competent manner to all members, including those with limited English proficiency and diverse backgrounds.

We want to ensure our members:

- Have an opportunity to select a doctor who can speak their primary language.
- Understand their condition(s), the recommended treatment(s), and the effect of the treatment on their condition, including side effects.
- Receive improved services, care and health outcomes by eliminating errors, misunderstanding and access issues due to cultural differences.
MEMBER RIGHTS AND RESPONSIBILITIES
MEMBER RIGHTS

- Access to care
- Respect and dignity
- Identity of who is providing care
- Privacy and confidentiality
- Information
- Communication
- File grievance and appeals
- Refuse treatment (as permitted by law)
- Consent
- Seek a second opinion
- Be informed
- Freedom from restraint or seclusion
- Free from payment
- To make suggestions or comments
MEMBER RESPONSIBILITIES

- To select a PCP
- To know the name of their PCP
- To report other medical insurance
- To be compliant with instructions
- To treat others with respect and dignity
- To keep appointments
- To provide immunization records to their PCP
- To be responsible
- To report suspected fraud and abuse
- To make medical wishes known (via an advanced health care directive)
- To share health information
SERVICE COORDINATION
SERVICE COORDINATION

- Service Coordination is a program to address the complex needs of our members requiring intensive care management.

- Members enrolled in our Service Coordination program will have a dedicated nurse or social worker assigned as their single point of contact with AlohaCare.

- The Service Coordinator will perform an assessment and work with the member and providers to determine what services are necessary.

- The Service Coordinator will coordinate all activities being performed to meet the member’s needs, monitor goals, and follow up on urgent problems.
AVAILABLE SERVICES

Additional services are available for those members who meet certain criteria. The Service Coordinator will determine which services are necessary based on the assessment.

Some of these additional services are:

<table>
<thead>
<tr>
<th>Adult day health</th>
<th>“At-risk” Services</th>
<th>Counseling and training</th>
<th>Home maintenance</th>
<th>Non-medical transportation</th>
<th>Residential care services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult day care</td>
<td>Community Care Management Agency services</td>
<td>Environmental accessibility adaptations</td>
<td>Institutional services</td>
<td>Personal assistance services</td>
<td>Respite care</td>
</tr>
<tr>
<td>Assisted living services</td>
<td>Community Care Foster Family Home services</td>
<td>Home delivered meals</td>
<td>Moving assistance</td>
<td>Personal emergency response systems</td>
<td>Specialized medical equipment and supplies</td>
</tr>
</tbody>
</table>
REFERRAL TO SERVICE COORDINATION

Members may be referred into Service Coordination programs through a variety of ways including the following:

- Identification through a Member Survey
- Direct member referral
- Referral by the member’s family or representative
- AlohaCare’s internal departments
- Primary Care Provider (PCP) or other involved health care providers

*If you would like to refer a member into the Service Coordination program, contact AlohaCare or utilize the Service Coordination referral form located on our website.*
PRIOR AUTHORIZATIONS
AND REFERRALS
PRIOR AUTHORIZATIONS

AlohaCare requires prior authorization for certain services and drugs for our members. The review ensures that the services are covered health interventions and meet the definition of medical necessity.

AlohaCare has multiple prior authorization forms depending on the services requested. Some of these forms are:

- **Request for Prior Authorization (RAN) Form**: Used to request authorization for services/procedures, or request for travel. This form is also used to request interpretive services and provide OB/Prenatal notifications. This form can also be used to request for out-of-network services when necessary.

- **QI Prescription Drug Standard PA Request Form**: Used to request coverage for drugs that are not included on our formulary or require prior authorization.

- **Request for Applied Behavioral Analysis (ABA) Services**: Used by Autism providers to request ABA services.

For a complete listing of prior authorization forms, please visit our website
PRIOR AUTHORIZATIONS

Prior Authorization Timeframes

- Prior authorizations are processed within 14 business days for standard requests, and 72 hours for expedited requests

How to Submit a Prior Authorization

- Providers may fax the RAN form to 973-0676 or toll-free at 1-888-667-0680
- Submit electronically via our Provider Web Portal (AC Online) at www.alohacare.org
PRIOR AUTHORIZATIONS

We are pleased to announce the simplification and reduction of codes requiring Prior Authorization for providers, effective January 1, 2018. This policy change alleviates the administrative burden of the prior authorization requirement by removing nearly 49% of commonly used procedure codes from our authorization list.

Providers will have access to AlohaCare’s Prior Authorization Lookup Tool to get timely and accurate information around codes that do and do not require authorizations. This enhancement will be available to all providers by going to our website www.alohacare.org starting November 6, 2017.

The tool also allows exporting capabilities into your billing or practice management system.

The new process applies to AlohaCare’s QUEST Integration (Medicaid) and AlohaCare Advantage Plus (Medicare Special Needs Plan) lines of business.
REFERRAL PROCESS

We are pleased to announce the elimination of Referral Notifications when you refer an AlohaCare member to other in-network providers, effective August 1, 2017.

This means that you -- primary care provider or specialist -- may refer AlohaCare members to in network providers without having to submit a referral paperwork to AlohaCare. If you are a specialist, your office no longer needs a referral notification number for payment of services. As is usual and customary, any referring provider should continue to document the medical necessity for the referral.

What has not changed is the Prior Authorization for any off-island travel or authorization to out-of-network providers. In either case, medical necessity needs to be apparent.

This new policy applies to AlohaCare’s QUEST Integration/ABD (Medicaid) and AlohaCare Advantage Plus (Medicare Special Needs Plan).

For further information, please refer to the “AlohaCare Change in Referral Process” Provider Advisory which is available in your packet, and can also be found on our website.
CLAIMS FILING GUIDELINES
CLAIMS FILING GUIDELINES

All encounters for AlohaCare members must be submitted as a claim, regardless of whether the services are covered under a capitation or fee-for-service payment arrangement. All claims must contain required information and all data must be consistent and valid.

- Claims must be submitted within 1 year from date of service
- Hard copy claims must be submitted on the original red and white CMS 1500/UB04 forms
- AlohaCare accepts claim submissions (and resubmissions) both via hardcopy and Electronic Data Interchange (EDI)
CLAIMS FILING GUIDELINES

Hardcopy Claims

- Paper claims must be printed with a font size between 10 and 12.

- All submissions must be on original claim forms; no copied or scanned forms are accepted for claim submission or resubmissions.

- All attachments must identify the patient’s name, Health Insurance Claim number (HICN), date of service and other pertinent information.

Please see Appendix A of our Provider Manual for additional information regarding requirements and helpful tips on the CMS 1500 claim and the CMS 1450 (UB-04) forms.
CLAIMS FILING GUIDELINES

EDI Claims

- EDI allows for faster claim payment and reduction of paperwork
- This service is available to providers who meet the following requirements:
  - You own your own billing software which is capable of submitting data files or use a third-party billing service that can process and submit your claims for you
  - Complete a HIPAA Transaction Set Form. The HIPAA Transaction Set Form is available on our website
- Providers must use approved AlohaCare vendors
  - Legacy/Administep (888) 751-8271 www.administep.com
  - RelayHealth (866) 735-2963 www.relayhealth.com
  - Gateway/Trizetto (800) 969-3666 www.gatewayedi.com
  - Claim Remedi (866) 633-4626 www.claimremedi.com
Claims Processing for EPSDT Services (Child PCP's)

- Early Periodic Screening, Diagnostic, and Treatment (EPSDT) claims must include an EPSDT exam form (8015, 8015A, & 8016)

- It is important to submit both the EP modifier along with the EPSDT exam form to ensure proper processing and payment

- AlohaCare recommends that EPSDT claims resubmissions be filed with a copy of the EPSDT exam form

*Please see Section 9 of our Provider Manual under EPSDT Claims Processing for further guidelines*
FRAUD, WASTE, AND ABUSE
FRAUD, WASTE, AND ABUSE

Fraud

- Intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to him/herself or some other person. It includes any act that constitutes fraud under the applicable Federal and State law.

Waste

- Overutilization, underutilization, or misuse of resources and typically is not a criminal or intentional act.

Abuse

- Provider practices that are inconsistent with sound fiscal, business or medical practices and result in unnecessary cost to the Medicaid/Medicare programs or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care.
FRAUD, WASTE, AND ABUSE

Common Types of Fraud, Waste, and Abuse

| Provider billing for services not provided | Provider falsifying information to justify payment | Pharmacy providing less than prescribed quantity, but billing for the fully prescribed amount |
| Pharmacy altering the prescription without the prescriber’s permission | Member letting another person use their ID card | Member selling or giving someone else supplies, equipment or drugs paid for by AlohaCare |

Please report to AlohaCare as soon as you become aware of any potential situations!

AlohaCare Compliance Hotline 1-855-973-1852
GRIEVANCE AND APPEALS
## PROVIDER GRIEVANCE AND APPEALS

### Provider Grievance

Providers may file a grievance with AlohaCare if they are unhappy with any aspect of AlohaCare’s operations activities, or behavior pertaining to issues such as:

- Eligibility and enrollment
- Member issues
- Health Plan issues
- Issues related to the availability and quality of care
- Any issue not resolved to the provider’s satisfaction

### Provider Appeal

Providers may file an appeal with regard to an adverse decision made by AlohaCare pertaining to issues such as:

- Denial of prior authorization for health services or prescription drugs
- Denial of a claim for services performed
- Denial of payment for a prescription drug
PROVIDER G&A TIMEFRAMES

Provider Grievance Timeframes

- **Filing**: no later than 60 calendar days after the event or incident occurred
  - NOTE: If the grievance is in regards to claims processing, provider has 365 days from the date of service to file the grievance
- **Acknowledgement**: within 10 calendar days from date of receipt
- **Determination**: within 30 calendar days from date of receipt

Provider Appeal Timeframes

- **Filing**: within 30 calendar days from date of decision
- **Acknowledgement**: within 10 calendar days from receipt
- **Determination**: within 60 calendar days from date of receipt
MEMBER GRIEVANCE AND APPEALS

Member Grievance

Members or their representative may file a grievance if they are dissatisfied with issues such as:

- AlohaCare’s or provider’s operations or activities
- AlohaCare’s or provider’s failure to respect their rights
- AlohaCare’s or provider’s staff behavior

Member Appeal

Members or their representative may file an appeal if they are dissatisfied with issues such as:

- Denial or limited prior authorization of a requested service
- Reduction, suspension, or termination of a previously authorized service
- Denial, in whole or in part, of payment for a service
### MEMBER G&A TIMEFRAMES

<table>
<thead>
<tr>
<th>Member Grievance Timeframes</th>
<th>Member Appeal Timeframes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Filing:</strong> members may file at any time after the event or incident occurred</td>
<td><strong>Filing:</strong> within 30 calendar days from date of decision</td>
</tr>
<tr>
<td><strong>Acknowledgement:</strong> within 5 business days from date of receipt</td>
<td><strong>Acknowledgement:</strong> within 5 business days from date of receipt</td>
</tr>
<tr>
<td><strong>Determination:</strong> within 30 calendar days from date of receipt</td>
<td><strong>Determination:</strong> within 30 calendar days from receipt</td>
</tr>
</tbody>
</table>

AlohaCare may grant a 14 day extension for an appeal if additional information is required to make a determination.

Expedited appeal determinations are made within 72 hours from the date of receipt.

If AlohaCare’s disposition of the appeal does not meet the satisfaction or expectations of the member, the member has the right to request a Grievance Review from the State **within thirty 30 calendar days** of the AlohaCare’s decision date.
HOW TO SUBMIT G&A

All grievance and appeals may be submitted to AlohaCare by:

- Mailing the written requests to AlohaCare’s Grievance Coordinator
  AlohaCare Grievance Coordinator
  1357 Kapiolani Blvd Ste 1250
  Honolulu, HI 96814

- Fax: (808) 873-2140

- Contacting Customer Service: (808) 973-0712 Toll-Free 1-877-973-0712

- Logging in to your AC Online account (providers only)
PROVIDER RESOURCES AND TOOLS
AlohaCare’s website is a hub of information aimed at keeping our provider’s informed. Visit [www.alohacare.org](http://www.alohacare.org) and select the Provider Tab to find:

<table>
<thead>
<tr>
<th>FORMS</th>
<th>PLAN PUBLICATIONS</th>
<th>RESOURCES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider applications</td>
<td>Provider manuals</td>
<td>Providers training</td>
</tr>
<tr>
<td>AC online registration</td>
<td>Provider newsletters and advisories</td>
<td>Special Needs Plan – Model of Care</td>
</tr>
<tr>
<td>Electronic Funds Transfer (EFT)</td>
<td>Cultural Competency Plan</td>
<td>Drug finder</td>
</tr>
<tr>
<td>Address update/change form</td>
<td></td>
<td>Provider directory</td>
</tr>
<tr>
<td>Prior authorizations forms</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

AlohaCare is for a healthy Hawaii.
AlohaCare's medical policies provide guidance on our coverage benefits. Our medical policies can be located on our website. Some examples of our medical policies are:

- **ABA** - addresses the coverage of Applied Behavior Analysis (ABA) for treatment for members with Autism Spectrum Disorder (ASD).

- **Telehealth** - the use of telecommunications services and information technology to deliver medical diagnostic, monitoring, and therapeutic services from one site to another.

- **Genetic Testing** - examines the genetic information contained within cells and can help a physician determine if a person has a genetic disorder, is a carrier of a genetic disease, or has a predisposition to develop a genetic disorder.
AC ONLINE
SECURE PROVIDER PORTAL

AC Online is a web portal designed just for you! At www.alohacare.org you can log in and gain access to invaluable patient information, 24 hours a day, 7 days a week. The web portal allows you to view:

- Member eligibility
- PCP information – view assigned members, access Gaps in Care reports
- Claims status and history
- Third Party Liability (TPL) or other insurance
- Submit requests for authorizations
- View member prescription and cost share information
ALOHACARE PROVIDER SERVICES LEADERSHIP TEAM

If you have any questions with regard to our presentation, you may contact your Provider Services Representatives directly

Ruffy Arellano
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(808) 973-6393 rellano@alohacare.org

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MAHALO!