PROVIDER TRAINING
2020
ALOHACARE
OVERVIEW

- Our Mission
- About AlohaCare and Our Plans
- Model of Care and Neighborhood Model
- Unable to reach (UTR) Program
- Prior Authorizations and Referral Information
- Claims Filing Guidelines
- Provider Roles and Responsibilities
- Cultural Competency
- Member Rights and Responsibilities
- 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 ALOHA CARE

- Local, non-profit health plan
- Founded in 1994 by Hawaii’s Community Health Centers
- Provides Medicaid and Medicare coverage
- Over 65,000 members statewide
- Over 260 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
OUR PLANS - MEDICARE

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 MODEL OF CARE
OUR CARE MODEL

Our Care Model:

- Organizes care according to the member needs and integrates care across Medicaid and Medicare
- Addresses long-term service needs and coordinates needs across medical, behavioral and social services
- Proactively identifies members at risk for future episodes allowing us to intervene to avoid or prevent escalation

Our previous Care Model was:

- Different for QI Medicaid and SNP Medicare
- Originally developed to serve families and children
- Reactive vs proactive
CARE MODEL FEATURES

Every member has access to a care manager!

We take data from claims, surveys, assessments and risk scores to stratify our members into one of the following risk levels:

- **Low Risk** – minor/no health issues, are low utilizers, and need general assistance with benefits, referrals, transportation
  - Assigned to a non-licensed, telephonic Care Navigator.

- **Medium Risk** – moderate/chronic health issues, be on multiple medications, and see multiple providers
  - Assigned to a licensed (RN or LPN), telephonic Care Coordinator

- **High Risk** – higher ER utilization, multiple conditions or medications, and/or in need of Home and Community Based Services, or Long Term Services and Supports
  - Assigned to a licensed (RN or LCSW) Service Coordinator and services are conducted Face-to-Face
CARE MODEL OVERVIEW

Claims
Assessments
Risk Scores

LOW RISK
Telephonic Navigator
(non-licensed)

MODERATE RISK
Telephonic Care Coordination
(licensed)

HIGH RISK
Field Based Service Coordination
(licensed)

Risk Stratification
Top 5%
HOW TO CONNECT TO CARE TEAMS

Both providers and members can contact our care management team by calling (808)973-0712, and selecting Option 1.

You will be able to directly speak to the member’s Lead Care Manager.
NEIGHBORHOOD MODEL

As part of our Care Model, we have changed the way we assign our staff to assist members with their needs.

- Teams are now assigned to specific neighborhoods/zip codes. This allows for:
  - Familiarity with community and resources
  - Better rapport with members
  - Familiarity with members in homeless shelters
  - Familiarity and better rapport with providers

- Our Neighborhoods
  - Big Island- 2 neighborhoods (Hilo, Kona)
  - Kauai- 1 neighborhood (Kauai County)
  - Oahu- 4 neighborhoods (Leeward, North, South, Central)
  - Maui- 1 neighborhood (Maui County)
    - Includes Lanai and Molokai
UNABLE TO REACH (UTR) PROGRAM

- AlohaCare launched our UTR initiative to actively search for members we have not been able to reach.

- Incorrect or missing information from enrollment files received creates a challenge for AlohaCare to engage our members.

- Members who are not connected to a PCP tend to have higher ER visits, increased acute episodes and higher inpatient hospitalizations.
UTR ACTIVITIES

We have staff dedicated by island working with providers, and community partners to find and connect with members to establish primary care.

Some of the ways we research to find our members:

- Member notes - research the notes in our clinical and claims systems looking for mention of a new address or phone number
- Claims - review the member's information submitted on claims from various providers
- Authorization Forms - review prior authorization requests looking to identify new or updated member information
- State/Federal Resources - review CMS and DHS files in attempts to locate members.
PRIOR AUTHORIZATIONS AND REFERRALS
PRIOR AUTHORIZATIONS

AlohaCare simplified our prior authorization process which resulted in a 49% reduction of commonly used procedure codes from our authorization list.

Providers now have access to AlohaCare’s Prior Authorization Lookup Tool:

- Look up authorization requirements by code or category
- Get timely and accurate information
- Allows exporting capabilities into your billing or practice management system.

This enhancement can be accessed by going to our website www.alohacare.org.
PRIOR AUTHORIZATION
LOOK-UP TOOL

SERVICES REQUIRING PRIOR AUTHORIZATION

DISCLAIMER:
Please note that all prior authorization information listed here are for services effective 1/1/2018.

AlohaCare provides the most up-to-date prior authorization information in the Services Requiring Prior Authorization Tool. However, use of the tool does NOT guarantee payment. Payment of claims is dependent on eligibility, covered benefits, provider contracts, correct coding and billing practices. For specific details, please refer to the AlohaCare Provider Manual. If you are uncertain whether a prior authorization is needed, please contact AlohaCare Provider Services at 973-1650 or toll-free at 1-800-434-1002.

All services rendered by an out-of-network provider continue to require prior authorization from AlohaCare.

SEARCH BY OPTIONS LISTED BELOW

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>ALL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type</td>
<td>ALL</td>
</tr>
<tr>
<td>Category</td>
<td>ALL</td>
</tr>
</tbody>
</table>

SEARCH BY CODE

<table>
<thead>
<tr>
<th>Line of Business</th>
<th>ALL</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT/HCPCS Code</td>
<td></td>
</tr>
</tbody>
</table>

Partial code is not allowed, it must be exact.

Reset Search

ALOHA CARE
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

- Medical prior authorizations are processed within 14 business days for standard requests, and 72 hours for expedited requests
- Retail Pharmacy prior authorizations are processed within 24 hours

How to Submit a Prior Authorization

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

AlohaCare does not require a referral notification when you refer an AlohaCare member to other in-network providers.

- This means that you -- primary care provider or specialist -- may refer AlohaCare members to in-network providers without having to submit referral paperwork to AlohaCare. If you are a specialist, your office does not need 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.

- Prior Authorization requirements still apply for any off-island travel for medical services or to out-of-network providers. In either case, medical necessity needs to be apparent.
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
  - Exceptions to the filing deadlines will be granted only for unusual circumstances. Please resubmit the claim with a letter attached detailing the reasons for the filing delay.

- AlohaCare accepts claim submissions (and resubmissions) both via Electronic Data Interchange (EDI) and hardcopy

- Hard copy claims must be submitted on the original red and white CMS 1500/UB04 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) 751-3271 www.administep.com
  - Change Healthcare (866) 871-3813 www.changehealthcare.com
  - Gateway/Trizetto (800) 969-3666 www.gatewayedi.com
  - Claim Remedi (866)633-4626 www.claimremedi.com
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

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
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
ROLES AND RESPONSIBILITIES

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.

Some exceptions are 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
- 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
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 10 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>

**Please reference the QI Provider Manual for further information**
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
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

- Over utilization, under utilization, or misuse if 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

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

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

Member Grievance Timeframes

- Filing: members may file at any time after the event or incident occurred
- Acknowledgement: within 5 business days from date of receipt
- Determination: within 30 calendar days from date of receipt

Member Appeal Timeframes

- Filing: within 30 calendar days from date of decision
- Acknowledgement: within 5 business days from date of receipt
- Determination: within 30 calendar days from receipt

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 and Appeals Division
  AlohaCare Grievance and Appeals Division
  1357 Kapiolani Blvd., Ste. 1250
  Honolulu, HI 96814

- Fax: (808) 873-2140

- Should you have further questions regarding our G&A process, please contact Customer Service: (808) 973-0712 Toll-Free 1-877-973-0712
PROVIDER RESOURCES AND TOOLS
PROVIDER RESOURCES AND TOOLS

AlohaCare’s website is a hub of information aimed at keeping our provider’s informed. Visit www.alohacare.org and select the Provider Tab to find:

**FORMS**
- Provider applications
- AC online registration
- Electronic Funds Transfer (EFT)
- Address update/change form
- Prior authorizations forms

**PLAN PUBLICATIONS**
- Provider manuals
- Medical policies
- Provider newsletters and advisories
- Cultural Competency Plan
- Plan formularies (QI, SNP)

**RESOURCES**
- Providers training
- PA Look Up Tool
- Special Needs Plan – Model of Care
- Drug finder
- Provider directories (QI, SNP)
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 HEDIS and 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
CONTACT US TODAY!

AlohaCare’s Customer Service team can assist you with:
- Member eligibility and benefits
- Billing, payment and claims
- Prior authorization status
  And more!
Call us at (808) 973-0712
or toll free 1 (877) 973-0712
PROVIDER SERVICES LEADERSHIP TEAM

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MAHALO!

ALOHA CARE