QUEST (Medicaid) Member Handbook

Your introduction to Kaiser Permanente

KAISER PERMANENTE® thrive

NONDISCRIMINATION NOTICE

Kaiser Permanente complies with applicable Federal civil rights laws and does not discriminate, exclude people, or treat people differently or less favorably because of:

- Race
- Color
- National Origin (including limited English proficiency and primary language)
- Age
- Disability
- Sex

Kaiser Permanente provides free aids and services to people with disabilities to communicate effectively with us, such as:

- Qualified sign language interpreters
- Written information in other formats (large print, audio, braille, accessible electronic formats, other formats)

Kaiser Permanente provides free language services to people whose primary language is not English, such as:

- Qualified interpreters
- Information written in other languages

If you need these services, contact **808-432-5330**, toll-free **1-800-651-2237** or by TTY **711**

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way, you can file a grievance with: Kaiser Civil Rights Coordinator, 711 Kapiolani Blvd., Honolulu, HI 96813. Phone: **808-432-5330** or toll-free **1-800-651-2237;** TTY: **711;** Fax: **808-432-5300;** Email: civil-rights-coordinator@kp.org.

You can file a grievance in person or by mail or fax. If you need help filing a grievance, the Kaiser Permanente Civil Rights Coordinator is available to help you.

This notice is available at Noticehttps://healthy.kaiserpermanente.org/hawaii/language-assistance/nondiscrimination-notice/medicaid

You can also file a grievance with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at:

U.S. Department of Health and Human Services, 200 Independence Avenue, SW Room 509F, HHH Building, Washington, D.C. 20201; **1-800-368-1019**,**1-800-537-7697** (TDD) Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

HELP IN YOUR LANGUAGE

(English) Do you need help in another language? Language assistance services including appropriate auxiliary aids and services, free of charge, are available to you. Call **1-800-651-2237** to tell us which language you speak. (TTY: **711**).
(Cantonese) 您需要其他语言帮助吗？我们免费为您提供语言援助服务，包括适当的辅助工具和服务。请致电**1-800-651-2237**告知我们您说什么语言。 (TTY: **711**).
(Chuukese) En mi nit aninis non pwan och fosun fonu? Mi kawor aninisin fosun fonu me ekoch pisekin aninis, ese kamo, mi kawor ngonuk. Kekeri **1-800-651-2237** ka ereni kich meni fosun fonu ke kan fos non. (TTY: **711**).
(French) Avez-vous besoin d'aide dans une autre langue ? Des services d'assistance linguistique comprenant des aides et services auxiliaires appropriés, gratuits, sont à votre disposition. Appelez le **1-800-651-2237** pour nous dire quelle langue vous parlez. (TTY: **711**).
(German) Benötigen Sie Hilfe in einer anderen Sprache? Die Sprachassistenz mit entsprechenden Hilfsmitteln und Dienstleistungen steht Ihnen kostenfrei zur Verfügung. Rufen Sie **1-800-651-2237** an, um uns mitzuteilen, welche Sprache Sie sprechen. (TTY: **711**).
(Hawaiian) Loa'a iā 'oe nā lawelawe kōkua 'ōlelo me nā kōkua kōkua a me nā lawelawe me ka uku 'ole. Kāhea **1-800-651-2237** oe ia la kaua a e ha`ina `oe ia la maua mea `olelo o na `aina `e. (TTY: **711**).
(Ilocano) Kasapulam kadi ti tulong iti sabali a pagsasao? Dagiti serbisio a tulong iti pagsasao agraman dagiti maitutop a kanayonan a tulong ken serbisio, a libre, ket mabalin a mausar para kenka. Tawagan ti **1-800-651-2237** tapno maibagam kadakami no ania a pagsasao ti pagsasaom. (TTY: **711**).
(Japanese) 他の言語でのサポートが必要ですか？適切な補助機器やサービスを含む言語支援サービスが無料で提供されます。**1-800-651-2237**にお電話いただき、使用される言語をお知らせください。（TTY：**711**）。
(Korean) 다른 언어로 도움이 필요하신가요? 언어 지원 서비스는 필요에 따라 보조 기기 및 서비스를 포함하여 무료로 제공됩니다. 도움이 필요한 언어를 알려주시려면**1-800-651-2237**로 전화해 주세요. （TTY：**711**）.
(Mandarin) 您需要其他語言的幫助嗎？您可獲得免費語言協助服務，包括適當的輔助器材和服務。致電 **1-800-651-2237** 告訴我們您說哪種語言。(TTY:**711**).
(Marshallese) Kwōj ke aikuj jipañ ilo kajin ko jet? Ro rej ropajikin jipañ eok ikijjien kajin im jerbal ko jet repojakin jerbal ippaṃ ilo ejjeḷọk oṇaer. Kūr tok **1-800-651-2237** ñan kaaroñ tok kōm kōn kajin eo aṃ. (TTY: **711**).
(Samoan) O lo'o e mana'omia se fesoasoani i se isi gagana? O auaunaga fesoasoani i le gagana, e aofia ai meafaigaluega talafeagai ma auaunaga, e leai ni totogi, o lo'o avanoa mo oe. Fa'amalie atu i le **1-800-651-2237** ma ta'u mai i matou le gagana e te tautala ai. (TTY: **711**).
(Spanish) ¿Necesita ayuda en otro idioma? Tiene a su disposición servicios de asistencia lingüística que incluyen ayudas y servicios auxiliares adecuados y gratuitos. Llame al **1-800-651-2237** para que nos indique el idioma que habla. (TTY: **711**).
(Tagalog) Kailangan mo ba ng tulong sa ibang wika? Available sa iyo ang mga serbisyo ng tulong sa wika kabilang ang mga naaangkop na karagdagang tulong at serbisyo, nang walang bayad. Tumawag sa **1-800-651-2237** para sabihin sa amin kung aling wika ang sinasalita mo. (TTY: **711**).

(Tongan) ‘Oku ke toe fiema’u ha tokoni ‘i ha lea kehe? ‘Oku ‘i ai ha sevesi tokoni fakatonu lea pea mo ha naunau me’a fanongo, ‘oku ta’etotongi, mo faingamalie kiate koe. Taa **1-800-651-2237** pea talamai ‘a e lea ‘oku ke faka’aonga’i. (TTY:**711**).
(Vietnamese) Bạn có cần trợ giúp bằng ngôn ngữ khác không? Bạn có thể sử dụng các dịch vụ hỗ trợ ngôn ngữ miễn phí, bao gồm các dịch vụ và phương tiện hỗ trợ phù hợp. Xin gọi **1-800-651-2237** để cho chúng tôi biết ngôn ngữ bạn nói. (TTY: **711**).
(Visayan) Nanginahanglan ka ba og tabang sa laing pinulongan? Ang mga serbisyo sa tabang sa pinulongan lakip ang angay nga mga auxiliary nga mga himan ug serbisyo, libre, anaa kanimo. Tawag sa **1-800-651-2237** aron isulti kanamo kung unsang pinulongan ang imong ginasulti. (TTY: **711**).

Contents

Information in this handbook is current as of the date of publication. This handbook provides general information, not medical advice.

Important Telephone Numbers

Medical care

Emergency ambulance **Call 911**

Kaiser Permanente clinics - Oahu

Moanalua Medical Center **808-432-0000**
Behavioral Health Services **808-432-7600**
Hawaii Kai Clinic **1-833-833-3333**
Honolulu Medical Office **1-833-833-3333**
Kahuku Clinic..... **1-833-833-3333**
Kailua Clinic..... **1-833-833-3333**
Koolau Medical Office..... **1-833-833-3333**
Mapunapuna Medical Office..... **1-833-833-3333**
Waipio Medical Office **1-833-833-3333**
West Oahu Medical Office at Kapolei **1-833-833-3333**

Kaiser Permanente clinics - Maui

Behavioral Health Services **1-888-945-7600**
Kihei Clinic **1-833-833-3333**
Lahaina Clinic **1-833-833-3333**
Maui Lani Medical Office **1-833-833-3333**
Maui Lani Elua Clinic..... **1-833-833-3333**
Wailuku Medical Office..... **1-833-833-3333**

Kaiser Permanente emergency facilities

Moanalua Medical Center **808-432-0000**
Maui Memorial Medical Center.....**808-244-9056**

Other emergency facilities

Adventist Health Castle.....808-263-5500
Kapiolani Medical Center 808-983-6000
Pali Momi Medical Center 808-486-6000
Kuakini Medical Center.....808-536-2236
Straub Clinic & Hospital.....808-522-4000
The Queen's Medical Center 808-538-9011
Waianae Coast Comprehensive Health...808-696-7081
Hilo Medical Center.....808-974-6800
Kona Community Hospital 808-322-4413
North Hawaii Community Hospital.....808-885-4444
West Kauai Medical Center 808-338-9431
Samuel Mahelona Memorial Hospital.....808-822-4961
Wilcox Memorial Hospital.....808-245-1010
Molokai General Hospital..... 808-553-5331
Lanai Community Hospital 808-565-6411

Medical advice

24/7 advice..... **1-833-833-3333**
TTY **711**

Poison Control Center

1-800-222-1222 (toll-free) 24 hours a day, 7 days a week

Help for QUEST members

Kaiser Permanente QUEST Program **808-432-5330**/**1-800-651-2237** (toll-free)

Kaiser Permanente

Transportation Services.....(refer to page 22)

State of Hawaii

DHS Med-QUEST Division

Med-QUEST Service Centers 1-800-316-8005

711 Hawaii Relay Service is available for deaf, hard of hearing, and speech impaired.

Welcome

Welcome to the Kaiser Permanente QUEST (Medicaid) Program. Thank you for choosing us. We want to help you stay healthy. We are also here to serve you when you're sick or injured. This handbook tells you how to use the many services that can help you get the most out of life.

Our philosophy and goals — caring for the whole you

Families just like yours have relied on Kaiser Permanente for quality health care since 1958. At Kaiser Permanente, we want to help you get healthy and stay healthy. We will work with you to help you feel good — mind, body, and spirit.

Managed care

QUEST is a managed care program of the State of Hawaii Department of Human Services, and Kaiser Permanente is one of the participating health plans. As a managed care plan, we provide your medical and behavioral health benefits by coordinating care through our three parts: Kaiser Foundation Health Plan, Inc.; Kaiser Foundation Hospitals; and Hawaii Permanente Medical Group, Inc. (HPMG). We work together to give you the medical care you need, when you need it, in the way that is cost effective. This is called "managed care."

We provide each Member with a Primary Care Provider (PCP) who checks your medical and behavioral health needs and provides/directs the services to meet those needs. We have many doctors and other medical staff who are the best at what they do.

We have our own clinics on Oahu and Maui. On Oahu, we have our own hospital, the Moanalua Medical Center. On Maui, our doctors are part of the staff of the community hospitals. We also use other doctors and hospitals in urgent or emergency situations. They must meet our standards. We check their licenses, credentials, and professional performance. We want to give you excellent care and service.

It is important to remember that you must receive all your care from Kaiser Permanente doctors. We are responsible to provide and arrange your care. If you need a service that we can't provide, your Kaiser Permanente doctor may refer you to another doctor or hospital. Kaiser Permanente will only pay for services we approved according to your QUEST plan benefits unless it was an emergency. If you go to doctors outside of Kaiser Permanente without approval, you will have to pay them for your care.

QUEST at Kaiser Permanente

QUEST Call Center

Our QUEST Call Center can help you find information or medical services. Call us at **808-432-5330** or toll free at **1-800-651-2237**. We are open from 7:45 a.m. to 4:30 p.m., Monday through Friday, except state holidays. After normal business hours, you may leave a message on the voice mailbox and someone will call you back as soon as possible, but no later than 4:30 p.m. the following business day. Members who are deaf, hard of hearing, or speech impaired may call **711** (TTY).

The QUEST Call Center representative can help you with the following:

- How to request a Kaiser Permanente identification card
- How to access an interpreter and sign language services at no charge
- How to obtain information in alternative languages and formats at no charge
- Complaints or compliments
- Claim forms
- Our clinics and hospitals on the U.S. mainland
- Address changes
- Advance Health Care Directive information and forms
- Professional qualifications of Kaiser Permanente primary care and specialty doctors
- How we review new medical technology
- How to request an Appointment of Representative form to assign a representative who you want to have access to your medical information
- Request a paper copy of Member Handbook free of charge
- Request a paper copy of the Kaiser Permanente directory, *Caring for You: Physicians and Locations Directory* free of charge

Deaf, hearing impaired, or have difficulty with speech?

To reach us by TTY, call the relay service at **711**. If you need an interpreter for an appointment, tell us when you make the appointment. We offer interpreter services, including sign language, at no charge.

If you need information in a different language or format (including large print or Braille), call the QUEST Call Center at **808-432-5330** or toll free at **1-800-651-2237** for assistance.

Enrolling and disenrolling

Enrolling. Each QUEST Member chooses a medical plan. The Department of Human Services (DHS) enrolls you in the plan. To enroll in Kaiser Permanente, you must live on Oahu or Maui. If you move to another island, DHS will ask you to choose another plan.

Changing plans. QUEST Members can change plans every year during a plan change period. DHS will tell you the plan change period and which plans you can choose.

Disenrolling from QUEST. Only DHS can end your enrollment in the QUEST program. If you want to disenroll, contact the Med-QUEST Division of DHS.

Eligibility for other programs. If your QUEST plan is ending, you may be able to get help from another state program. Ask your eligibility worker. You can also check out other Kaiser Permanente plans. For more information about Kaiser Permanente plans, contact the Customer Service Center.

Auto-Assignment. DHS will auto-assign new Members into a Health Plan using set rules and procedures. This happens when a new Member has not actively selected a Health Plan within the DHS-specified timeframe. Also, a new Member will be auto assigned to a primary care clinic if a primary care provider is not chosen within 10 days of enrollment.

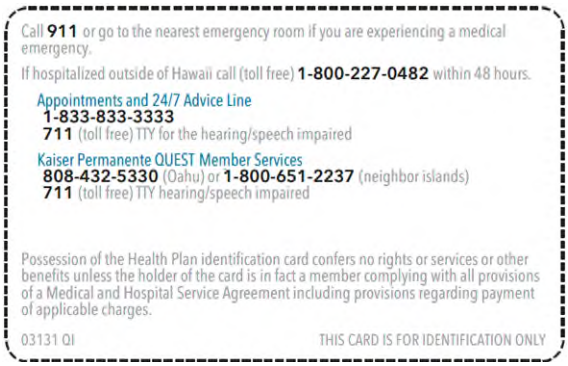
Questions about cost sharing?

You may have to share in the cost of your health care services. This is based on Medicaid financial eligibility. Your State of Hawaii Medicaid eligibility worker will figure the amount of your cost share and let us know. If you have a cost share, you must pay this to your provider every month. Your health coordinator will work with you to determine which service provider you will pay your cost share to each month. For more information, call the QUEST Call Center at **808-432-5330** or toll free at **1-800-651-2237**. Members who are deaf, hard of hearing, or speech impaired may call **711** (TTY).

How to get medical care

Your Kaiser Permanente identification (ID) card

We will be mailing you one ID card:



Your Kaiser Permanente identification card includes the following information:

- Your Kaiser Permanente Member identification number
- Your name
- Effective date of your Kaiser Permanente QUEST coverage
- Primary clinic name and telephone number
- Third-party liability (TPL) information (not Kaiser Permanente insurance)
- QUEST Call Center telephone number
- After-hours advice line telephone number

How to use your ID card:
Show us your Kaiser Permanente identification (ID) card and your photo ID when you need medical care, when you pick up your medicine, or when you have a medical emergency.

If you don't have your card you can still get help. We have all your information in our computer to provide you with the care you need. If you need to replace a lost or worn ID card, call the QUEST Call Center at **808-432-5330** or toll free at **1-800-651-2237**. Members who are deaf, hard of hearing, or speech impaired may call **711** (TTY). You may use your ID card only while you are a Kaiser Permanente member. Do not let anyone else use your Kaiser Permanente ID card.

Make your care personal

Good health care begins with a connection with your primary care provider (PCP), who will be your main doctor. You will choose your PCP. Your PCP is in charge of your medical care. He or she treats you, refers you to specialists when needed, and connects you to all our services. Your PCP will work with you to help you meet your health goals.

How to choose your doctor

Step 1: Select the clinic you plan to use the most. Members usually choose a clinic that is closest to home or work. See our directory or visit **kp.org/locations** to find the facility nearest you.

Step 2: Decide what kind of doctor is best for you and your family. You may choose a doctor from one of the three primary care specialties. NOTE: Some clinics do not have all three primary care specialties.

- **Family Medicine:** Health care for persons of all ages. Family medicine doctors can care for the whole family.
- **Pediatrics:** Health care for children. These doctors focus on child development and general medical care for children up to age 21.
- **Internal Medicine:** General and specialized medical care for adults. Internal medicine doctors diagnose and treat a wide variety of illnesses.

Step 3: Find out more about our doctors. There are several ways to do this:

- **Physician biography cards** at reception counters in the clinics
- **Our physician directory, *Caring for You: Physicians and Locations***
- **Our website, kp.org/medicalstaff**, where you can find information about our practitioners, including name, address, telephone numbers, professional qualifications, specialty, medical school attended, residency completion, and board certification status.

Step 4: Call your clinic to let them know which doctor you want as your primary care provider (PCP). You must choose a PCP within 10 calendar days of receiving this packet. If you don't choose a PCP, we will assign you to the clinic nearest your home. The clinic doctors will act as your PCP. You may change your clinic/PCP at any time.

NOTE for Medicare members: QUEST Members who also have Kaiser Permanente's Senior Advantage plan are not required to choose a PCP. Members with Medicare fee-for-service must choose a PCP, but the PCP does not have to be in Kaiser Permanente's provider network.

How our providers are paid

Most of your care is by Hawaii Permanente Medical Group (HPMG) providers, who work as a group and use their skills and experience to help you. Kaiser Permanente also works with other providers to care for you. You may ask how they are paid. You may also ask if their payment affects referrals or services that you need. For more information, call QUEST Call Center at **808-432-5330** or toll free at **1-800-651-2237**. Members who are deaf, hard of hearing, or speech impaired may call **711** (TTY).

An important reminder: Your benefits apply only at Kaiser Permanente

As a Kaiser Permanente QUEST member, you may get medical care outside of Kaiser Permanente's provider network, but Kaiser Permanente will NOT pay for other doctors or hospitals. The only exceptions are: (1) emergency care, (2) authorized referrals by Kaiser Permanente, (3) continuing medical care arranged by Kaiser Permanente, and (4) family planning services, and (5) prenatal services for pregnant Members who are in their second or third trimester and were receiving medically necessary prenatal services the day before enrollment in Kaiser Permanente QUEST.

(1) Emergency care. We will pay for emergency services covered by your health plan benefits. Kaiser Permanente will not deny payment for emergency services sought by a prudent layperson, even if emergency services are determined not needed and regardless if the provider is in- or out-of-network.

(2) Referrals. Your Kaiser Permanente doctor may refer you to an outside doctor or other provider for services we do not have. The services must be a covered benefit by your plan. There must be an approved, written referral from Kaiser Permanente before getting the services. Kaiser Permanente will arrange for the care and payment.

(3) Continuing medical care. Kaiser Permanente QUEST Members must live on the islands of Oahu or Maui. If you are visiting outside the islands of Oahu or Maui, and believe you will need non-emergent care, call our QUEST case management team before you leave home. Let us know about the care you think you will need so we can assess your needs and arrange for your approved medical care. If you do not get our approval first, we will not pay for services, except in an emergency. Call **808-432-5330** or toll free at **1-800-651-2237**. Members who are deaf, hard of hearing, or speech impaired may call **711** (TTY).

Medical care on the U.S. mainland

We will pay for emergency care provided in an emergency room anywhere in the United States (U.S.). For more information, see "Emergency and post-stabilization services" in the QUEST covered benefits section on page 26.

- Emergent care out of area is covered for all members
- Urgent care out of area is only covered for Members under age 21
- Routine care out of area is only covered for Members under age 21

For Members under age 21 who need medically necessary, non-emergency care in areas where there is no Kaiser Permanente facility, please contact QUEST Call Center at **808-432-5330** or toll free at **1-800-651-2237**.

Urgent care in Las Vegas

We contract with Concentra Urgent Care and Walgreens Healthcare Clinic to provide urgent care services to Members under 21 experiencing non-life-threatening health problems while visiting Las Vegas. When possible, call your doctor or after-hours advice nurse first to discuss your health situation. When visiting one of these urgent care clinics, present photo identification along with your Kaiser Permanente ID card. For more information on urgent care in Las Vegas, contact Member Services.

Care while traveling

Your plan will not cover services outside the U.S.

For 24/7 travel support anytime, anywhere, call the Kaiser Permanente Away from Home Travel Line* at **951-268-3900** or visit **kp.org/travel**.

Your prescriptions

Locations

Pharmacies are located in most of our Kaiser Permanente facilities and are open during regular business hours. You can get prescriptions filled and buy over-the-counter medications and supplies at our pharmacies.

In very limited instances, you may be able to use certain non-Kaiser Permanente pharmacies. To find out if you can fill your prescription at a non-Kaiser Permanente pharmacy, please call our QUEST Call Center at **808-432-5330**, toll free at **1-800-651-2237** or **711** by TTY. If you do not get our approval to use a non-Kaiser Permanente pharmacy, we will not pay for the pharmacy supplies or medicine.

Transfer your prescriptions

For help transferring your prescriptions, call our Care Transition Team at **808-643-5744** Monday through Friday, 9 a.m. to 5 p.m. Provide the name and phone number of your current pharmacy and our pharmacy team will take care of the rest.

Prescriptions

Save time by ordering most medications (new and refills) at **kp.org/pharmacycenter** or by calling **808-643-7979**. Most refills can be mailed to you at no extra charge. You can get a 90-day supply of refills.

Covered drugs

We use an approved list of drugs to make sure the most appropriate, safe, and effective prescription medications are available to you. This list is reviewed on a regular basis and includes generic, brand name, specialty drugs, and some over-the-counter medicines.

Drugs not covered

- Drugs for cosmetic uses
- Dental prescriptions (unless prescribed for a medical condition)
- Drugs used for reasons not approved by the FDA
- Plan-excluded prescription drugs

Contact us if you have pharmacy questions

Pharmacy Services
808-643-RxRx (**808-643-7979**)

Drug formulary

Kaiser Permanente Hawaii uses a drug formulary to help make sure that the most appropriate and effective prescription medications are available to you. The formulary is a list of medications that have been approved by our multidisciplinary Pharmacy and Therapeutics (P&T) Committee. Members of the P&T Committee may include Kaiser Permanente physicians, registered nurses, pharmacists, and physician assistants.

Our drug formulary allows us to choose drugs that are safe, effective, and a good value for you. We review our formulary regularly so we can compare new drugs and remove drugs that can be replaced by newer, more effective medications. The formulary also helps us restrict drugs that can be toxic or otherwise dangerous if misused. For a free copy of the formulary, please call our QUEST Call Center at **808-432-5330**, toll free at **1-800-651-2237** or **711** by TTY or visit **kp.org/formulary**.

Our drug formulary is considered a closed formulary, which means that medications on the list are usually covered under the prescription drug benefit. However, drugs on our formulary may not be automatically covered under your prescription drug benefit. If you would like to check on the coverage of a specific drug or have questions about any limitations on prescribing or access to drugs, please contact a pharmacist at any Kaiser Permanente pharmacy.

Non-formulary drugs are those that are not included on our drug formulary. These include new drugs that have not been reviewed yet, drugs that our clinicians and pharmacists have decided to leave off the formulary, or a different strength or dosage of a formulary drug that we don't carry in Kaiser Permanente pharmacies.

Non-formulary drugs are generally not covered under our prescription drug benefit. If formulary alternatives have failed and use of the non-formulary drug is medically necessary, your Kaiser Permanente doctor can request it.

Medicare Part D is a prescription drug benefit that is available to everyone who has Medicare. If you have Medicare Part D, most prescription drugs will be covered under your Medicare Part D plan and you will usually have a cost share to pay. If there are additional costs not covered by Medicare, your Kaiser Permanente QUEST plan may cover the rest and you pay nothing. If the drug is not covered by your Kaiser Permanente QUEST plan, you will need to pay for any costs not covered by Kaiser Permanente or not covered by your Medicare Part D prescription drug plan.

Understanding your medications

Kaiser Permanente pharmacists provide information and advice on prescription and over-the-counter medicines, as well as herbal supplements. You're encouraged to speak to your pharmacist whenever you have a concern about your medication. Some Kaiser Permanente pharmacists, known as clinical pharmacists, will work directly with you and your physician on complex drug therapies, such as blood thinners, or for medical conditions such as asthma, cancer, diabetes, hepatitis, kidney problems, high blood pressure, and high cholesterol. Clinical pharmacy services may be requested through your doctor.

Services to help you stay healthy

Your benefits at Kaiser Permanente include services to keep you healthy and to prevent serious medical problems. Children and adults of different ages have different needs. The doctor will order tests and exams that are best for your age and health condition. Helping you stay well is important to us. It's just as important as taking care of you when you are sick. Some healthy lifestyle habits can go a long way toward keeping you well and adding years to your life. These healthy habits include not smoking; eating a low-fat, high-fiber diet; wearing seatbelts; and getting regular exercise.

Services for adults

Preventive services are to keep you from getting sick. For adults, we cover physical exams, personal health appraisals, immunizations (shots), family planning, mammograms, and other tests.
Learn how to make good changes in your life. Learn how to control chronic conditions and how to give up unhealthy habits. Kaiser Permanente offers a variety of classes to help you. Only free classes are available to Kaiser Permanente QUEST members. For more information regarding the free classes, please call Kaiser Permanente's Prevention and Health Education Department at **808-432-2260** during weekdays from 8:30 am to 4:30 pm.

Services for Pediatrics and Adolescent Health

Regular medical visits are very important to keep your child as healthy as possible and reduce the spread of disease. Your child's regular visits, examinations, immunizations (shots), and screening tests are included in well-child care at no cost.

For Members under age 21 (including foster children and adopted children receiving subsidies), the QUEST program provides these preventative services under a program called Early and Periodic Screening, Diagnosis, and Treatment (EPSDT). Services provided complies with Sections 1902(a)(43) and 1905(r) of the Social Security Act and federal regulations at 42 CFR Part 441, Subpart B. EPSDT services include outreach and informing, screening, tracking, diagnostic, and treatment services. Your child will be examined periodically to check for any illness. Checkups are needed more often in the child's first years and less often as he or she grows older (see examination and vaccine schedule on page 16). Some children look healthy but have hidden health problems. Screening tests, such as blood tests, give the doctor information about your child's health. If any health problems are found, the doctor looks for the cause, makes a diagnosis, and orders treatment.

These medically necessary services, including behavioral therapy for children, are provided at no cost to you. The behavioral therapies include intensive behavioral therapy for children with autism spectrum disorder (ASD), including applied behavioral analysis (ABA) for the treatment of children with an ASD diagnosis.

Reminders of the next EPSDT appointment will be made by phone and email through kp.org.
Here is what to expect at your child's EPSDT checkups:

- Height, weight, and blood pressure checks
- Eye exams
- Hearing tests
- Lab tests
- Immunizations
- Screening for lead, tuberculosis (TB) and other conditions
- Mental and physical assessment
- Screening for behavioral health issues or substance abuse
- Review of medications (including fluoride and multivitamins)
- Dental screening and referral to dentist
- Health education and guidance about your child's health care
- Education and guidance for your child's growth and development
- Information regarding accessing care, such as appointments, advice nurse, or after-hours care

Use the schedule on the next page to remind you when to make appointments for your child. Let your child's health care provider know if your child is ill or taking medicines (such as steroids) that may suppress their immunity. This schedule may change based on your child's health care needs. Please check with your child's health care provider.

Physical exams are advised once yearly from age 2 – 6 years, then once every other year. More exams may be needed depending on your child's health care needs. Rotavirus vaccine for 2 and 4 months of ages only. TB risk assessment will be done with each physical exam starting from 2 years of age and annually up to 17 years of age. The TB skin test will only be done if the risk assessment is positive.

YOUR HEALTHY CHILD'S EXAMINATION AND VACCINE SCHEDULE

AGE	APPOINTMENT TYPE	VACCINE TYPE
2-3 days	Physical exam	Hepatitis B (HepB) administered at birth
2–3 weeks	Physical exam	Catch up immunizations if needed
2 months	Physical exam with shots	Diphtheria-Tetanus-acellular Pertussis (DTaP), Haemophilus Influenza B (Hib), Polio, Pneumococcal Conjugate Vaccine (PCV), HepB, Rotavirus
4 months	Physical exam with shots	DTaP, Hib, Polio, PCV, Rotavirus, Hep B if part of combo vaccination
6 months	Physical exam with shots	DTaP, Hib, Polio, PCV, HepB
9 months	Physical exam	Catch up immunizations if needed
12–13 months	Physical exam with shots	TB risk assessment if indicated at 12 months of age (TB skin test done if risk assessment positive), Hepatitis A, Measles-Mumps-Rubella (MMR), Varicella
15 months	Physical exam with shots	DTaP, Hib, PCV
18 months	Physical exam with shots	Hepatitis A
23–24 months	Physical exam	Catch up immunizations if needed
3 years	Physical exam with shots	MMR, Varicella
4 years	Physical exam with shots	DTaP, Polio
5 years	Physical exam with shots	DTaP, Polio (if not done at age 4 years)
6 years	Physical exam	Catch up immunizations if needed
7–13 years	Physical exam with shots	Physical done yearly. 9 years: Human Papillomavirus (HPV) series of two doses for both girls and boys; 11- 12 years: Tetanus-Diphtheria-acellular Pertussis (Tdap); Meningococcal
14–20 years	Physical exam with shots	Physical done yearly. Meningococcal booster. Catch up vaccines if needed
All persons ages 6 months and older should receive annual flu vaccination		

Appointments

It's important to call for an appointment so your doctor can set aside time for you. There are two kinds of appointments: same-day and future.

Same-day appointments. Same-day appointments are for when you are sick and need to see the doctor that day. For example, if you have a fever or rash, or if your child has an ear infection or becomes ill suddenly, you can call for a same-day appointment or schedule a same day appointment using **kp.org/appointments**. (You can also arrange to see the doctor the next day.) Kaiser

Permanente clinics have open access for same-day care. Call the clinic or call your doctor's nurse. If you don't have a doctor, or if your doctor isn't available, clinic staff will arrange for you to see another doctor.

Future appointments. Future appointments are scheduled in advance. They are for follow-up or for physical exams. To make a future appointment, call the clinic where your doctor works or schedule an appointment using **kp.org/appointments**.

As a Kaiser Permanente QUEST member, you have the right to get care in a timely manner:

- Immediate care without prior approval for emergencies
- Within 24 hours for urgent care
- Within 24 hours for PCP pediatric sick visits
- Within 72 hours for PCP adult sick visits
- Within 21 calendar days for PCP routine visits
- Within 21 calendar days for routine behavioral health visits
- Within 4 weeks for visits with a specialist
- Within 4 weeks for non-emergency hospital stays

When you call for an appointment, the clerk will ask for your name, Member identification number, birth date, phone number, and doctor's name.

If you need an interpreter during your visit to the doctor, tell the appointment clerk when you are making your appointment. We offer interpreter service at no cost.

Canceling an appointment. Sometimes you may be unable to come to a scheduled appointment. If this happens, please call to cancel at least 24 hours in advance. For Oahu cancellations, call **1-833-833-3333**. For Maui cancellations, call **1-833-833-3333**. You can also cancel your appointment using **kp.org/appointments**. By telling us, we can give your appointment time to someone else. If you do not show up for an appointment, your doctor cannot charge a "no show" fee.

Getting the medical care you need

Visit our member website at kp.org to find options to get care:
healthy.kaiserpermanente.org/hawaii/get-care

- **Online** (E-visit, Email, Video visit (scheduled), Video visit now, Self-care information)
- **Phone** (Phone appointment (scheduled), Phone visit now, 24/7 advice, Medication refills and advice)
- **In-person** (Doctor's office visit, Same-day care, Urgent Care, Mental health and wellness options, Specialty care visit, Care while traveling)

Self-referrals

Your medical care starts with your primary care provider (PCP). You can also make your own appointments, without a referral, for the following services:

- Dietician services
- Eye examinations for glasses and contact lenses
- Family medicine
- Gynecology
- Health coaching
- Health education
- Internal medicine
- Mental health and wellness
- Pediatrics
- Physical therapy
- Sports medicine
- Well woman exam

Your QUEST plan will cover self-referrals for the services listed above. If you self-refer to a service not listed above, you may have to pay for those services. You may also have to pay for services that are not covered under your QUEST plan benefit.

Maternity care and family planning

When you are pregnant, you want to know that you are getting the best possible care for you and your baby. We believe good care comes from a partnership between you and your health care provider. Our doctors, nurses, and other health care professionals work with you to keep you and your baby healthy, and to give you the information you need to make the best decisions for your growing family.

You can make your own appointments for maternity care and will have regular appointments with your personal physician or nurse practitioner. See the Kaiser Permanente directory, *Caring for You: Physicians and Locations*, for the nearest clinic with obstetrics/gynecology services, or check with your PCP. PCPs who specialize in family practice also provide these services.

You have access to the following advice and information:

- A 24-hour advice nurse is available by phone
- You may email your doctor with any questions or concerns
- Visit kp.org/maternity for access to hundreds of articles, tools, podcasts, and videos that will help you understand what's happening to your baby and how to best take care of your pregnancy
- Classes on childbirth, breastfeeding, infant CPR, and prenatal nutrition
- Tours of our birth centers

After your baby is born, he or she will get the best possible care through regular appointments with a pediatrician. Your baby's doctor will guide you through the necessary screening tests and immunizations and check that your baby is meeting important development milestones. Classes are available to learn about caring for your little one at home, and age-specific information is available online and through specific newsletters. Visit **kp.org/healthylifestyles**.

Family planning is important if you are sexually active and want to or don't want to have a baby now. Family planning services are listed in the QUEST covered benefits section. More than half of all pregnancies are unplanned. You don't have to wait until you have a period to start a birth control method. Talk with your health care provider to find out what method of birth control is the best option for you. Family planning services may be obtained from any provider. Kaiser Permanente does not require a referral before choosing a family planning provider.

Kaiser Permanente does not limit benefits for post-partum hospital stays to less than forty-eight (48) hours following a normal delivery or ninety-six (96) hours following a caesarean section, unless the attending provider, in consultation with the mother, makes the decision to discharge the mother or newborn child before that time. We do not require providers to obtain authorization before prescribing a length of stay up to forty-eight (48) or ninety-six (96) hours.

Kaiser Permanente does not:

- Provide monetary payments or rebates to mothers to encourage them to accept less than the minimum stays available under Newborns' and Mothers' Health Protection Act (NMHPA).
- Penalize, reduce, or limit the reimbursement of an attending provider because the provider provided care in a manner consistent with NMHPA; or
- Provide incentives, including monetary or otherwise, to an attending provider to induce the provider to provide care inconsistent with NMHPA.

Kaiser Permanente ensure appropriate perinatal care is provided to women and provides the following:

- Access to appropriate levels of care based on medical, behavioral, or social need, including emergency care
- Transfer and care of pregnant or post-partum women, newborns, and infants to tertiary care facilities when necessary
- Availability and accessibility of:
    - Appropriate outpatient and inpatient facilities capable of assessing, monitoring, and treating women with complex perinatal diagnoses; and
    - Obstetricians/gynecologists, including maternal fetal medicine specialists and neonatologists capable of treating the Members with complex perinatal diagnoses.
    - Perinatal care coordination for high-risk pregnant women provided through health coordination program.

Specialty care

Your PCP will need to give you a referral to see a specialty doctor for the first time. If you can't reach your PCP when you need a referral, please call us at **808-432-5330** or toll free at **1-800-651-2237**. We will help you get the care you need. Members with special health care needs can see a specialist with a standing referral or for an approved number of visits. If you asked for a referral and it has been denied you have the right to ask for a review. This is called an appeal. Please see the section in this handbook titled "Appeals."

Second opinions

Not sure about a medical decision? Kaiser Permanente will facilitate arrangements for a medically necessary second opinion. If the second opinion cannot be obtained from a Kaiser Permanente provider, arrangements will be made for a second opinion from an out-of-network provider. The authorized second opinion by an in- or out-of-network provider will be at no cost to you.

Hospitalization

Sometimes you may need to be in the hospital. The doctor will check your condition and decide. Or you and the doctor may plan ahead. For example, you may need elective surgery – surgery that can wait. The doctor will arrange it with you at the clinic or by telephone.

Your Kaiser Permanente doctor arranges your hospital care. You will be at Moanalua Medical Center on Oahu, Maui Memorial Medical Center on Maui, or another hospital that we designate. If you are at Moanalua Medical Center or Maui Memorial Medical Center, a Kaiser Permanente doctor who treats hospital patients will be in charge of your care. He or she will be in contact with your PCP. Because hospital specialists take care of hospital patients, PCPs can spend more time with their patients in the clinic.

Your doctors and hospital staff will work closely with you to plan your discharge from the hospital. Your doctor will determine the best place for you to get follow-up care. Other members of the health care team may help in planning. These may include your nurse, a clinical nurse specialist, a continuing care coordinator, or case managers.

After-hours care

If you're not feeling well and our offices are closed, call our 24/7 advice line at no cost. Registered nurses can provide advice when medically appropriate or direct you to the appropriate place for care. Please have your medical record number (on the front of your Kaiser Permanente ID card), or the medical record number of the person for whom you are calling.

24/7 Advice Line

1-833-833-3333
711 TTY for hearing/speech impaired
24 hours a day, 7 days a week

Urgent Care

If you need to receive non-emergent care outside of normal business hours, you don't have to go to the emergency department. You can visit these locations:

Honolulu Clinic
Monday–Friday, 8 a.m.–8 p.m.
Weekends and most holidays, 8 a.m. –5 p.m. Closed on Thanksgiving, Christmas, and New Year's Day. Please call **1-833-833-3333** for an appointment before your visit.

West Oahu Medical Office at Kapolei
Monday–Friday, 8 a.m.–8 p.m.
Weekends and most holidays, 8 a.m. –5 p.m. Closed on Thanksgiving, Christmas, and New Year's Day. Please call **1-833-833-3333** for an appointment before your visit.

Maui

Wailuku
Maui Lani Medical Office
Monday–Friday, 8 a.m.–8 p.m.
Weekends and most holidays, 8 a.m.–5 p.m.
Closed Christmas and New Year's Day

Hana
Hana Health
4590 Hana Highway
Monday – Wednesday, Friday, 7 a.m. – 6 p.m.
Thursday, 7 a.m.– noon: 2 - 6 p.m.
Saturday, 8 a.m.–6 p.m.
808-248-8294

Kahului
Minit Medical
Maui Marketplace
270 Dairy Rd., #239
Monday-Friday, 8 a.m.-7 p.m.
Saturday, 8 a.m.-6 p.m.
Sunday, 8 a.m.-4 p.m.
808-667-6161

Lahaina
Doctors on Call
Hyatt Regency Maui
200 Nohea Kai Dr., #100
Monday–Friday, 8 a.m.–5 p.m.
808-667-7676

Doctors on Call
Times Market Place / North Kaanapali
3350 Lower Honoapiilani Rd., Unit 211
Open every day, 8 a.m.–9 p.m.
808-667-7676

Minit Medical
Lahaina Gateway Shopping Center
305 Keawe St., Ste. 507
Monday–Saturday, 8 a.m.–6 p.m.
Sunday, 8 a.m.–4 p.m.
808-667-6161

Hawaii Poison Center

For medical problems related to poison or chemicals, call the Hawaii Poison Center at **1-800-222-1222.** Open 24 hours a day, 7 days a week.

Emergency services

- Emergent care is covered anywhere in the United States for all Members at any facility.
- If you think you're experiencing an emergency, go immediately to an emergency department.
- Emergency services do not require prior approval.
- If you need an ambulance, call **911**. Don't call Kaiser Permanente and waste precious time.
- Your emergency services are covered outside of Kaiser's network on an emergent basis until you are stabilized and when medically necessary.
- Screening examination services to determine whether an emergency medical condition exists are also covered.

Emergency conditions

- Emergency medical conditions need immediate medical attention to avoid serious threats to your body or health. These conditions might include but not limited to:
    - Severe pain
    - Suspected heart attack or stroke
    - Extreme difficulty in breathing
    - Bleeding that will not stop
    - Major burns
    - Seizures
    - Sudden onset of severe headache
    - Suspected poisoning

Your Kaiser Permanente plan defines an "Emergency Medical Condition" as an illness or injury that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Non-Kaiser Permanente facilities

If admitted to a non-Kaiser Permanente facility, you or a family Member must notify us within 48 hours after care begins (or as soon as reasonably possible) by calling the phone number on the back of your Kaiser Permanente Member ID card, or your claim for payment may be denied.

Emergency care is available 24 hours a day, 7 days a week at the following facilities:

Kaiser Permanente emergency facilities:

Kaiser Permanente Moanalua Medical Center
3288 Moanalua Road
Honolulu, HI 96819
808-432-0000

Maui Memorial Medical Center
221 Mahalani Street
Wailuku, HI 96793
808-244-9056

Other emergency facilities:

Adventist Health Castle
640 Ulukahiki Street
Kailua, HI 96734
808-263-5500

Hilo Medical Center
1190 Waianuenue Avenue
Hilo, HI 96720
808-974-6800

Kona Community Hospital
79-1019 Haukapila Street
Kealakekua, HI 96750
808-322-4413

North Hawaii Community Hospital
67-1125 Mamalahoa Highway
Kamuela, HI 96743
808-885-4444

Kapiolani Medical Center for
Women & Children
1319 Punahou Street
Honolulu, HI 96826
808-983-6000

West Kauai Medical Center
4643 Waimea Canyon Road
Waimea, HI 96796
808-338-9431

Kapiolani Medical Center at Pali Momi
98-1079 Moanalua Road
Pearl City, HI 96782
808-486-6000

Samuel Mahelona Memorial Hospital
4800 Kawaihao Road
Kapaa, HI 96746
808-822-4961

Kuakini Medical Center
347 Kuakini Street
Honolulu, HI 96817
808-536-2236

Wilcox Memorial Hospital
3420 Kuhio Highway
Kapaa, HI 96746
808-245-1100

Straub Clinic & Hospital
888 South King Street
Honolulu, HI 96814
808-522-4000

Molokai General Hospital
280A Puali Street
Kaunakakai, HI 96748
808-553-5331

The Queen's Medical Center
1301 Punchbowl Street
Honolulu, HI 96813
808-538-9011

Lanai Community Hospital
628 Seventh Street
Lanai City, HI 96763
808-565-6411

Wahiawa General Hospital
128 Lehua Street
Wahiawa, HI 96786
808-621-8411

Waianae Coast Comprehensive
Health Center
86-260 Farrington Highway
Waianae, HI 96792
808-696-7081

You have the right to use any hospital emergency room or other appropriate health care setting for emergency services. You are not limited to those listed above.

Ambulance

If you feel you have an emergency and need an ambulance, **call 911.** When it comes, tell them you are a Kaiser Permanente member. We pay for an ambulance in an emergency. If you have questions about the bill, please call our QUEST Call Center at **808-432-5330** or toll free at **1-800-651-2237**. Members who are deaf, hard of hearing, or speech impaired may call **711** (TTY).

We also pay if we call the ambulance to send you from the clinic to the hospital. We will not pay for an ambulance if it is not medically needed.

Non-Emergency Medical Transportation (NEMT)

When you have a non-emergency medical visit scheduled based on your Health Coordinator or Primary care provider (PCP) plan of care (POC), free transportation that best meets your needs should be the first option. Free transportation includes: your own vehicle; transportation provided by family, friends, volunteer services, and by the facility serving. If this is not an option, there are other options to consider.

The Handi-Van or the bus:

- Handi-Van.
- Bus pass if you meet the following eligibility:
    1. You live less than half (½) a mile from bus stop.
    2. Your appointment is less than half (1/2) a mile from bus stop.
    3. You are ambulatory or capable of using a wheelchair and handicap public transit is available.
    4. The number of trips required per month indicates a monthly bus pass is most cost-effective method of transportation.

Your PCP or Health Coordinator must determine other transportation is medically necessary to be covered by QUEST.

Other transportation guidelines:

- Providers of recurring appointments are encouraged to schedule transportation.
    1. For recurring appointment such as dialysis or adult day care, providers may make appointments in advance for the quarter.
    2. Providers shall schedule transportation appointments with the Kaiser Permanente NEMT vendors through Medical Transportation Management (MTM).
    3. Provider requests must specify mode of transportation as determined by your plan of care.
- Requires scheduling 48-hours advance notification for appointments.
    1. If you call in less than forty-eight (48) hours you may be asked to re-schedule the doctor's appointment unless it is urgent.

2. Requests for urgent care may be made with less than 48 hours-notice when you have a medical problem that is serious and requires medical attention within 24 hours but is not an immediate threat to your life or health.

- Ride-sharing is allowed as long as you do not have to travel more than thirty (30) minutes longer than if you had traveled directly.
- Ride-sharing will not be allowed when you exhibit signs and symptoms of a possible contagious illness such as coughing, fever, open lesions, etc.
- A companion is allowed only when it is determined medically necessary by the PCP or your Health Coordinator.
- General Excise Tax (GET) will not be paid separately since this is included as part of the NEMT and taxi meter rate structures.
- Side trips are not covered. Side trips include:
    1. Pharmacy with exception;
    2. Shopping;
    3. Visiting;
    4. Pick up or drop off for durable medical equipment or supplies;
    5. SSI Determination medical appointment or Medicaid eligibility; and
    6. Trips to classes, support groups, community events, etc., unless included as part of the member's plan of care.
- Pharmacy exception:
    1. Transportation for medication prescription pickup will only be allowed when there is a serious medical condition that requires the immediate administration of medication to prevent further or serious medical complications.
- You have a right to appeal this process.

Kaiser Permanente QUEST Health Plan has entered into an agreement with Medical Transportation Management (MTM) to be the new Transportation Coordinator for Kaiser Permanente Medicaid members on Oahu beginning November 1, 2022. We are dedicated to providing a smooth transition for you.

MTM's Contact Center is open Monday through Friday, 5 a.m. to 7 p.m. (HST) for routine appointments, and 24 hours a day, 7 days a week for urgent appointments. The Member Trip Reservation Line is: **1-855-735-1226** (TTY **711**).

MTM will follow the Med-QUEST policy for non-emergency medical transportation:

- Explore the availability of free transportation
- Require that Members not using TheHandi-Van or bus have a determination from their doctor or Health Coordinator for a medically necessary higher level of transportation

How to schedule your ride
You may call MTM to schedule Non-Emergency Medical Transportation on Oahu for appointments. Please schedule at least 3 business days before your appointment. It is also important to notify MTM of any cancellations or schedule changes as soon as you are aware of them.

Please have the following information when you call to schedule your ride:

- Member's name,
- Medical Record Number (MRN)
- birthdate,
- phone number,
- appointment date and time,
- pick up address,
- drop off destination and address,
- destination phone number, and
- time to be picked up to return home.

MTM's goal is to provide high-quality customer service and timely transportation to medical appointments.

Medication-Assisted Treatment

If you need Medication-Assisted Treatment (MAT) for Opioid Use Disorder (OUD) you have several ways to get care. You can talk to your primary care provider (PCP). Your PCP can then refer you for Referral Addiction Medicine. You are also able to talk to Behavioral Health for chemical dependency. After referral, providers will assess you to identify the appropriate level of care needed and you will receive services from internal providers or through Kaiser Permanente's contracted providers. You may also receive additional therapy services based on your medical needs to help with your treatment of OUD.

What does the plan cover?

QUEST health coordination

Kaiser Permanente offers a range of Long-Term Services and Supports (LTSS) for low-income seniors and people with disabilities. This includes in-home and community-based services for Members who need help in maintaining their independence, and nursing facility care for Members who require a higher level of support. Members who do not meet nursing facility level of care but are at risk of getting worse may also qualify for some LTSS services. LTSS services can be found on page 39 of the benefit grid.

You can receive services from LTSS providers if you qualify. All new Members will be mailed a survey that will help us identify if you have any special health care needs. If you identify a need, someone from the health coordination team will contact you. A Health and Functional Assessment and Health Action Plan will be developed based on your medical and social needs. The Health Action Plan will describe the type of service(s) needed, the frequency, intensity, and quantity of services, as well as who will provide services.

Our QUEST health coordination team (nurses, social workers, and paraprofessional staff) encourages you to become an active participant in your health care. They will work with you and your doctors to make sure you receive the care and service you need to get healthy and stay healthy. A few of the ways they can help you are:

- Explaining your health plan benefits
- Educating you on prevention services, chronic disease management, and other medical and behavioral health care services
- Instructing you on how to access an interpreter and sign language services at no charge
- Explaining how to obtain information in alternative languages and formats at no charge
- Helping you make and keep your appointments
- Helping you when you have no transportation to medical appointments
- Introducing you to other community agencies, if needed

Referrals to QUEST staff may be made by calling **808-432-5330**, **1-800-651-2237** (toll-free), or **711** (TTY).

Services, benefits, and copayments

The State of Hawaii decides what the covered services are. These are your Kaiser Permanente QUEST benefits.

There is no charge for covered services. If you choose to get services that are *not* covered, or if you get them somewhere else, you will have to pay for them, and your Kaiser Permanente QUEST plan will not cover those services. If you are unable to pay for the services that you agreed to pay for, you will not lose your QUEST eligibility.

If you have other insurance, such as Medicare, your QUEST plan will be the "payor of last resort." This means that your other insurance will pay first. If there are any costs left over, your QUEST plan will pay for covered services.

Some services are only covered if we approve them first. If we do not approve it, then you can't get it unless you pay for it. For example, when your Kaiser Permanente doctor orders medical equipment for you, the doctor will ask the health plan. If we approve, we will pay for it. Our decision has to be made by a health care professional who has appropriate clinical expertise in treating your condition or disease. We will tell you and your doctor if we did not approve or if we approved less than your doctor requested.

Not all benefits, exclusions, and limitations are listed here. For more information, call our QUEST Call Center at **808-432-5330** or toll free at **1-800-651-2237**.

Kaiser Permanente QUEST covered benefits and services

Service	Description
Primary and Acute Care Services (in alphabetical order)	
Community Palliative Care	Community Palliative Care is a special kind of medical help for people who are very sick. It is given outside of hospitals, like in homes or community centers. A serious illness is one that can be life-threatening and makes it hard to do everyday things, affects how good life feels, or makes it hard for people taking care of the sick person. Palliative care tries to make people feel better by reducing symptoms and stress. It can be given at any time during the illness, even if the person is still getting treatment to try to cure the illness.
Cornea Transplants and Bone Graft Services	Cornea transplants and bone graft services are covered when medically necessary.
Cognitive Rehabilitation Services	Services provided to cognitively impaired persons, most commonly those with traumatic brain injury, that assess and treat communication skills, cognitive and behavioral ability, and cognitive skills related to performing ADLs. Five cognitive skills areas: • Attention Skills - sustained, selective, alternating, and divided • Visual Processing Skills - acuity, oculomotor control, fields, visual attention, scanning, pattern recognition, visual memory, or perception • Information Processing Skills - auditory or other sensory processing skills, organizational skills, speed, and capacity of processing • Memory Skills - orientation, episodic, prospective, encoding, storage, consolidation, and recall • Executive Function Skills - self-awareness, goal setting, self-initiation, self-inhibition, planning and organization, self-monitoring, self-evaluation, flexible problem solving, and metacognition Approaches include: • Education • Process training • Strategy development and implementation • Functional application • Selected approaches should match the appropriate level of awareness of cognitive skills • Some techniques/strategies include: o Speech/language/communication o Neuropsychological assessment o Compensatory memory techniques o Executive functions strategies

Service	Description
	o Reading/writing skills retraining
Diagnostic Testing	Include, but is not limited to: • Screening and diagnostic radiology and imaging • Screening and diagnostic laboratory tests • Other screening or diagnostic radiology or laboratory services When Medically Necessary Prior approval is not required for laboratory, imaging, or diagnostic services. Prior approval is required for: • Magnetic resonance imaging • Magnetic resonance angiogram • Positron emission tomography • Reference lab tests that cannot be done in Hawaii and not specifically billable by clinical laboratories in Hawaii • Disease-specific new technology lab tests • Genetic tests • Psychological testing • Neuropsychological testing • Cognitive testing • Computerized tomography
Dialysis	Provided by: • Medicare-certified hospitals • Medicare-certified end stage renal disease (ESRD) providers Settings where you can receive dialysis include: • Hospital inpatient • Hospital outpatient • Non-hospital renal dialysis facility • Member's home Dialysis services include: • Equipment • Supplies • Diagnostic testing (including laboratory tests) • Drugs for dialysis treatment approved by Medicare when Medically Necessary • Hepatitis B surface antigen • Anti-HB testing for patients on hemodialysis

Service	Description

	• Intermittent peritoneal dialysis
	• Continuous ambulatory peritoneal dialysis (CAPD)
	• Alfa-Epoetin (EPO) provided during dialysis
	• Other drugs related to ESRD
	• Home dialysis equipment and supplies prescribed by physician
	• Physician services
	• Hospital stays for
	  • acute medical conditions requiring dialysis treatments
	  • a patient receiving chronic outpatient dialysis for an unrelated medical condition
	  • placement, replacement, or repair of the chronic dialysis route.

Durable Medical Equipment (DME) and Medical Supplies	Durable medical equipment needed to: • Reduce a medical disability • Restore or improve function Supplies for rent or purchase include: • Oxygen tanks and concentrators • Ventilators • Wheelchairs • Crutches and canes • Eyeglasses • Orthotic devices • Prosthetic devices • Hearing aids • Pacemakers • Medical supplies (surgical dressings, continence, and ostomy supplies) • Foot appliances (orthoses, prostheses) • Orthopedic shoes and casts • Ortho digital prostheses and casts • Other medically necessary durable medical equipment covered by the Hawaii Medicaid program Prior approval is required.
Emergency and Post-Stabilization Services	Services in an emergency room for emergent conditions. If the condition is considered non-emergent, you may have to pay for charges related to the visit. Kaiser Permanente will not deny payment for emergency services sought by a prudent layperson, even if emergency services are determined not needed and regardless if the provider is in- or out-of-network. You are also covered for care that keeps your condition stable after an emergency. Post-stabilization services include follow-up outpatient specialist care.

Service	Description
	If you receive post-stabilization services from a provider outside of Kaiser Permanente's network, we will not charge you more than if services were obtained through an in-network provider.
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services	Routine checkups for children and youth under the age of 21 included (but are not limited to): • Medical and behavioral health screening • Dental screening and referral to dentist • Diagnostic tests • Immunizations • Preventive care, etc. • Additional services to correct or amend defects of physical, mental/emotional, and conditions discovered as a result of EPSDT screens when Medically necessary.
Family Planning Services	Services for members who are sexually active and of childbearing age: • Education and counseling to make informed choices and understand contraceptive methods • Emergency contraception and counseling, as indicated • Follow up care and office visits (to help prevent unwanted pregnancies; to help plan the number of pregnancies; to help plan the time between pregnancies; or to confirm if you are pregnant) • Pregnancy testing • Family planning drugs, supplies, and devices to prevent unwanted pregnancy (to include FDA-approved contraceptive methods, sterilization procedures, and patient education and counseling for all individuals with reproductive capacity) • Diagnosis and treatment of sexually transmitted diseases You have the choice to get the above family planning services from Kaiser Permanente or from an out-of-network provider without a referral from us. Other family planning services available to you: • Office visits and diagnostic tests to diagnosis infertility • Sterilization. Services are voluntary and confidential to Members.
Fluoride Varnish	Application by a qualified primary care provider is covered for children between one and six years of age who have not received topical fluoride treatment by a dentist or qualified PCP within the past six months. Qualified PCPs include physicians and nurse practitioners. These qualified PCPs may delegate under direct supervision to a PA, RN, LPN, or certified medical assistant.

Service	Description
Habilitation Services	Habilitative services and devices develop, improve, or maintain skills and functioning for daily living to developmentally appropriate levels when medically necessary. Habilitative services and devices include: • Audiology services • Occupational therapy • Physical therapy • Speech-language therapy • Vision services • Augmentative communication devices • Reading devices • Visual aids Devices used as school-based services or used only for activities at school are not covered when not medically necessary. Does not include routine services listed in Vision Services on page 33.

<table>
<tr><th>Service</th><th>Description</th></tr>
<tr><td>Hearing Services</td><td>Services include:

Diagnostic services
Screening
Preventive care
Corrective services/equipment/supplies

<table>
<tr><th>Service</th><th>Age 3 years or younger</th><th>Age 4 years or older</th><th>Under age 21</th><th>Age 21 and older</th><th>Prior approva required</th></tr>
<tr><td>Initial Exam</td><td></td><td></td><td>One time a year</td><td>One time a year</td><td>No</td></tr>
<tr><td>Electroacoustic Exam</td><td>4 times per year</td><td>2 times per year</td><td></td><td></td><td></td></tr>
<tr><td>Fitting/ Orientation/ Hearing Aid Check</td><td></td><td></td><td>Two times every three years</td><td>One time every three years</td><td>Yes</td></tr>
<tr><td>Hearing aid devices (includes service/loss/ damage warranty, a trial or rental period</td><td></td><td></td><td>One hearing aid per ear every 24 months</td><td>One hearing aid per ear every 24 months</td><td>Yes</td></tr>
</table>
Services provided by or under the direction of an otorhinolaryngologist or an audiologist when medically necessary.</td></tr>
<tr><td>Home Health Services</td><td>Home health services are part-time or intermittent care for the Members who do not require hospital care provided under the direction of a physician in order to prevent re-hospitalization or institutionalization.

Services provided at your home by qualified home health agencies include by not limited to:

Skilled nursing
Home health aides
Medical supplies and DME
Therapeutic services (physical and occupational therapy)
Audiology and speech pathology
</td></tr>
<tr><td>Immunizations</td><td>Receive the following immunizations approved by CDC's Advisory Committee including but not limited to type of language:

Influenza
Diphtheria usually combined with Tetanus
Pneumococcal vaccine
Other vaccines as needed
</td></tr>
</table>

Service	Description
Inpatient Hospital Services for Medical, Surgical, Maternity/Newborn Care, and Rehabilitation	Includes the cost of room and board for inpatient stays. The services include: • Nursing care • Medical supplies, equipment, and drugs • Diagnostic services, physical therapy, occupational therapy, audiology and • Speech-language pathology services • Other services in this category When Medically Necessary.
Inpatient Hospital Maternity/Newborn Care Services	Women in good health with deliveries that are not complex may stay in the hospital for up to: • 48 hours after a natural birth • 96 hours after a cesarean section The patient and physician may agree to an early discharge.
Medical Services Related to Dental Needs	Kaiser Permanente covers dental services to treat medical conditions done in a medical facility like a hospital when medically necessary. Also includes: • Referrals • Follow-ups • Coordination • Provision of appropriate medical services related to dental needs (including but not limited to: • Emergency room treatment • Hospital stays • Ancillary inpatient services • Operating room services • Excision of tumors • Removal of cysts and neoplasms • Excision of bone tissue surgical incisions • Treatment of fractures (simple and compound) • Oral surgery to repair traumatic wounds surgical supplies • Blood transfusion services ambulatory surgical center services • X-rays • Laboratory services • Drugs • Physician examinations • Consultations • Second opinions • Sedation by physician anesthesiologist • Dental or medical services resulting from a dental condition that are provided in a medical facility (e.g., inpatient hospital and ambulatory surgical center).

Service	Description
	Includes: • Medical services for adults and children required as part of a dental treatment • Dental procedures by oral surgeons and physicians (primarily plastic surgeons, otolaryngologists, and general surgeons) • Services by a dentist or physician due to a medical emergency (for example, car accident, where the services are primarily medical) • Services in relation to oral or facial trauma, oral pathology. Includes, but not limited to infections of oral origin, cyst and tumor management, and craniofacial reconstructive surgery, as inpatient basis in an acute care hospital setting. Services in a private office or hospital-based outpatient clinic for services not medically necessary or provided by government-sponsored or subsidized dental clinics, and hospital-based outpatient dental clinics are not covered by Kaiser. Also see "Covered by Med-QUEST but not by Kaiser Permanente" at the end of this section.
Nutrition Counseling	Types of services for members include: • Diabetes Self-Management Education • Nutrition counseling for obesity • Nutrition counseling for other metabolic conditions (if medically necessary)
Other Practitioner Services	Other practitioner services by: • Certified nurse midwife services • Licensed APRN services • Family, pediatric, and psychiatric health specialists • Paraprofessionals including peer support specialists • Licensed or certified healthcare provider including: o Behavioral health providers (psychologists, marriage and family therapists, mental health counselors, and CSACs) When services are Medically Necessary
Outpatient Hospital Services	Outpatient hospital services to prevent, diagnose, or manage the pain of an illness or injury such as: • Family planning • Medical services related to dental needs • Imaging services • Laboratory studies • Oncology services • Diagnostic testing

Service	Description
	• Ambulatory surgery services • Physical therapy • Occupational therapy • Speech therapy • Blood storage and processing • Respiratory services • Audiology services • Cardiology services • Chemotherapy services • Radiation services • Surgeries performed in a freestanding ambulatory surgery center (ASC) or hospital ASC • Twenty-four (24) hours a day, seven (7) days per week, emergency services • Urgent care services • Medical supplies, equipment, and drugs Services when Medically Necessary.
Physician Services	Services provided by or under the direct supervision of physicians include: • Physical examinations • Screening examinations • EPSDT screenings for children and youth under age 21 Services when Medically Necessary and provided at locations including, but not limited to: • Physician's office • Clinic • Private home • Licensed hospital • Licensed skilled nursing or intermediate care facility or • Licensed or certified residential setting
Podiatry (foot and ankle) Services	Treatment of conditions of the foot and ankle such as: • Professional services, not involving surgery provided in an office or clinic • Diabetic foot care (inpatient and outpatient) not involving surgery • Diagnostic radiology procedures limited to ankle and below • Surgical procedures limited to ankle and below • Foot and ankle care for infection or injury in an office or outpatient clinic • Bunionectomies when the bunion is present with overlying skin ulceration or neuroma secondary to the bunion.
Pregnancy-Related Services for Pregnant	Services for the health of the woman and her fetus during the woman's pregnancy and up to sixty (60) days post-partum when Medically Necessary.

Service	Description
Women and Expectant Parents	Services provided for pregnancy and maternity care such as: • Prenatal care • Diagnostic tests (Radiology, laboratory, and other diagnostic tests) • Treatment of missed, threatened, incomplete abortions • Health education and screening for conditions that could make a pregnancy "high risk" • Fetal development • Labor and delivery of infant and post-partum care • Diagnostic ultrasound • Fetal stress and non-stress testing • Prenatal vitamins • Screening, diagnosis, and treatment for pregnancy-related conditions, to include SBIRT, screening for maternal depression, and access to necessary behavioral and substance use treatment or supports • Lactation counseling – up to six months* • Breast pump rental – up to six months* • Breast pump purchase – requires prior approval • Educational classes on childbirth, breastfeeding, and infant care • Counseling on healthy behaviors, to include prevention and harm reduction • Inpatient hospital services, physician services, other practitioner services, and any other services that impact pregnancy outcomes. • Inpatient and outpatient substance use treatment for pregnant and parenting women and their children. *May be extended with prior approval.
Prescription Drugs	Medications when Medically Necessary to optimize the Member's medical condition, including behavioral health prescription drugs for children receiving services from CAMHD. Includes: • Prescription drugs and certain over-the-counter drugs which are on the list of approved drugs and prescribed by your doctor who is licensed to prescribe • Medication management and counseling • Medications of non-pulmonary and latent tuberculosis not covered by DOH.
Preventive Services – Adult (21 years or older)	Includes: • AAA (abdominal aortic aneurysm) screening for those that meet criteria • Blood pressure • Breast cancer screening

Service	Description
	• Cervical cancer screening • Chemoprophylaxis • Colorectal cancer screening • Diabetes screening for those that meet criteria • Health education and counseling • Hepatitis C screening for those that meet criteria • Immunizations • Prostate cancer screening • Rubella serology or vaccine history • Total cholesterol measurements • Tuberculin skin testing • Weight/height measurements
Preventive Services – Children (Less than 21 years of age)	Includes: • Age-appropriate dental checkup and oral fluoride • Age-appropriate health education • EPSDT services • Hospital stay for normal, term, and healthy newborn • Immunizations • Newborn screening • Other age-appropriate laboratory screening tests • Screening to assess health status • Tuberculin skin testing For help finding a dentist, call Community Case Management Corporation (CCMC) at 808-792-1070 or toll-free at l-888-792-1070. CCMC can explain the covered dental benefits and help you find a dentist near you.
Preventive Services – Pregnant Women	Includes: • Diagnostic amniocentesis, diagnostic ultrasound, fetal stress, and non-stress • Diagnosis of premature labor • Health education and screening • Hospital stays • Prenatal laboratory screening tests • Prenatal visits • Prenatal vitamins, including folic acid
Radiology/Laboratory/ Other Diagnostic Services	Includes: • Diagnostic and therapeutic radiology and imaging • Screening and diagnostic laboratory test • Other medically necessary diagnostic or therapeutic service Services may require a prior approval.

Service	Description
Rehabilitation Services	Provided to patients who are expected to improve in a reasonable period of time with therapy provided by licensed physical therapist (PT), licensed occupational therapist registered (OTR), licensed audiologist, and licensed speech pathologist respectively. A PT assistant or a certified occupational therapy assistant may be utilized as long as they are working under the direct supervision of either a PT or OTR, respectively. Services include: • Physical therapy • Occupational therapy • Audiology • Speech-language pathology Services are limited to those who expect to improve in a reasonable period of time. Services for children under EPSDT have different requirements Prior approval is required for all rehabilitation services except for the initial evaluation.
Sleep Laboratory Services	Diagnosis and treatment of sleep disorders performed by sleep laboratories or sleep disorder centers. Sleep laboratory service providers accredited by the American Academy of Sleep Medicine.
Smoking Cessation Services	Services include: • At least four in-person sessions of at least ten (10) minutes each per quit attempt, including individual, group, or phone counseling. • Two (2) effective components of counseling, practical counseling (problem-solving/skills training), and social support delivered as part of the treatment, shall be emphasized. • Counseling services by licensed providers trained on this service. Including: physician, psychologist, clinical social worker in behavioral health, APRNs, Mental Health Counselors and Certified tobacco treatment specialists under supervision of a licensed provider. • Medications approved by the U.S. Food and Drug Administration (FDA) • No out-of-pocket cost or co-payment required for these services or medication No prior approval or step therapy is needed for treatment
Sterilizations and Hysterectomies	Sterilizations and Hysterectomies for both men and women when the following are met: • Age 21 years or older at time of consent • Mentally competent

Service	Description
	• Requires Sterilization Required Consent Form at least 30 calendar days before the procedure but not more than 180 days between the date of consent and date of sterilization (except for premature delivery or emergency abdominal surgery) • A Member may consent to be sterilized at the time of premature delivery or emergency abdominal surgery if at least 72 hours have passed since consent for sterilization was signed • For premature delivery, the informed consent shall be at least 30 days before the expected date of delivery. The expected date of delivery shall be provided on the consent form • An interpreter is provided when needed and arrangements for Members who are visually impaired, hearing impaired, or disabled made to communicate the required information. • Member is not institutionalized (in a prison, mental hospital, or other rehabilitative facility) • If the Member is incapacitated, then a court order is required, and the required amount of time shall pass pursuant to HRS §560:5-609. Hysterectomies not covered under the following: • For the purpose of making the Member permanently incapable of reproducing • There is more than one purpose for the hysterectomy, but the primary purpose is to make the Member permanently incapable of reproducing • It is performed for the purpose of cancer prophylaxis when not medically needed
Telehealth Services	Services include live consultations through video or web calls. These services are covered if referred by an in-network provider and if you have trouble getting to the provider. Telehealth services are not available from providers outside the USA.
Transportation Services	Services include emergency and non-emergency ground and air transportation. Transportation to and from medically necessary covered medical appointments for: • Members who have no means of transportation • Members who reside in areas not served by public transportation or who cannot access public transportation Transportation is also covered when your medical condition requires treatment that is not available in the area where you are. Travel services include: • Ground and air transportation • Lodging

Service	Description
	• Meals Prior approval is required. Includes travel services when medically necessary for the member and (if needed) one attendant. Also covered if you do not have access to specialty providers (including but not limited to psychiatrists and specialty physicians)
Urgent Care Services	Care for a medical condition that is serious but not life threatening and needs to be treated within 24 hours. Call any Kaiser Permanente clinic for an appointment. If the clinic is closed, call the after-hours advice line at **1-833-833-3333**, toll free at 1-800-467-3011, or **711** (TTY). Urgent care out of area is only covered for members under age 21.

Vision Services

Routine eye exams and glasses:

Service	Under age 21	Age 21 and older
Eye exam*	Once in 12 months	Once in 24 months
Visual aids** (Eyeglasses***, contact lens****, frames, other parts of glasses, fittings and adjustments)	One every 24 months	One every 24 months

*Additional visits may be allowed with prior approval when Medically Necessary.

**Visual aids must be prescribed by ophthalmologists or optometrists and covered when Medically Necessary. Individuals under forty (40) years of age require medical justification for bifocals.

***Replacement and new glasses with significant changes in prescription are covered within the benefit periods for both adults and children with prior approval.

****Contact lenses are only covered when Medical Necessity is established.

Dispensing of the visual aids begins anew after each twenty-four (24)-month period since the prior dispensing.

Also covered for all Members:

- Prescription lenses
- Cataract removal
- Prosthetic eyes
- Cornea (keratoplasty) transplants provided in accordance with the Hawaii Administrative Rules

Emergency eye medical-condition care covered for all members without prior approval.

Vision services not included:

- Orthoptic training
- Prescription fee
- Progress exams
- Radial keratotomy
- Visual training
- Lasik procedure

Service	Description
Other Facility Services	
Hospice Care	Provides care to terminally ill patients who are not expected to live more than six months. Hospice services will be covered in the home, nursing facility or inpatient settings. Children under the age of 21 can receive treatment to manage or cure disease while in hospice care.
Nursing Facility	Includes: • Skilled Nursing Facility (SNF) • Intermediate Care Facility (ICF) • Subacute level of care in a hospital
Behavioral Health Services	
Standard Behavioral Health Services (includes psychiatric services and substance abuse treatment services)	Includes: • Room and board • Nursing care • Medical supplies • Equipment • Medications • Medication management • Diagnostic services • Professional services • Medically necessary services • Substance abuse treatment services Use of triage lines or screening systems, telemedicine, e-visits, and/or other technological solutions covered when applicable. Covered for the involuntarily committed for evaluation and treatment when Medically Necessary. Not covered for Members receiving behavioral health services from the CCS program.
Ambulatory Mental Health Services	Includes: • 24-hour access line • Mobile crisis response • Crisis stabilization • Crisis management • Crisis residential services

Service	Description
	The psychiatric evaluation and treatment of Members criminally committed to ambulatory mental healthcare settings are covered by the state. Medical and standard behavioral health services for Members criminally committed to ambulatory mental healthcare settings may be billed to Kaiser.
Collaborative Care Model	Services provided by a primary care team consisting of a primary care provider and a care manager who works in collaboration with a psychiatric consultant, such as a psychiatrist.
Psychotropic Medications and Medication Management	Medications and medication management includes: • Evaluation, prescription maintenance of psychotropic medications • Medication management • Counseling • Education • Promotion of algorithms and guidelines
Inpatient Psychiatric Hospitalizations	Includes • Room/board • Nursing care • Medical supplies • Equipment • Medications and medication management • Diagnostic services • Psychiatric and other behavioral health practitioner services • Ancillary services • Other services When Medically Necessary.
Psychiatric or Psychological Evaluation and Treatment	Services to evaluate and provide treatment of behavioral health include: • Individual and group counseling and monitoring
Medically Necessary Alcohol and Chemical Dependency Services	Inpatient and outpatient substance abuse services. Provided in a setting accredited according to standards set by the Alcohol and Drug Abuse Division (ADAD) of the Hawaii State Department of Health.
Medication-Assisted Treatment (MAT)	Medications, in combination with counseling and behavioral therapies, to provide a whole-person approach to the treatment of SUDs. Medications approved by the FDA and are clinically driven and tailored to meet each patient's needs.
Parity in Mental Health and SUD	Services necessary for compliance with the requirement for parity in mental health and SUD benefits in 42 CFR Part 438, Subpart K.
SBIRT	Early intervention treatment services for persons with SUDs, and those at risk for developing a SUD.

Service	Description
Substance Use Disorder (SUD) Treatment	Inpatient and outpatient treatment when Medically Necessary. SUD treatment in a treatment setting accredited by the ADAD. Includes: • Medication approved by FDA for SUDs. • Methadone/Levomethadyl acetate services for acute opiate detoxification as well as maintenance.
Long-Term Services and Supports (LTSS)	
Members who are aged and disabled can receive care in an institution like a nursing facility or in community settings like Care Homes, Foster Homes, or a member's own home through Home and Community Based Services (HCBS). A special form called DHS 1147 - Level of Care (LOC) and At-Risk Evaluation Form is done to find out what kind of help they need. The form is completed at least once a year to see if their needs have changed. Members who live in their own home and are At-Risk can receive limited services that may include: • Meals delivered to their home • Personal Emergency Response System (PERS) • Help with personal care • Adult day care • Adult day health services • Private duty nursing To receive more LTSS services, a member must meet the Intermediate Care Facility (ICF) level of care and be approved by the State to receive long-term care benefits.	
Acute Waitlisted SNF/ICF	Skilled Nursing Facility (SNF), or Intermediate Care Facility (ICF) level of care services provided in an acute care hospital in an acute care hospital bed.
Adult Day Care Center (ADC)	Supportive care for four or more disabled adults. Including: • Observation/supervision by center staff • Coordination and use of behavioral, medical, and social care plans, and implementation of instructions listed in Health Action Plan. Also includes therapeutic, social, educational, and recreational activities. Performed by qualified and/or trained individuals only, including family members and professionals, such as an RN or LPN, from an authorized agency. Does not include medication administration, tube feedings, and other activities which require healthcare-related training.
Adult Day Health Center (ADH)	Organized day program with nursing oversight. Provided to adults with physical and/or mental conditions. The purpose is to help members to stay in the community as much as possible. Provided under supervision of RN.

Service	Description
	Members who require skilled nursing services, will have services provided by an RN or under the direct supervision of an RN. Services include: • Emergency care • Dietetic services • Occupational therapy • Physical therapy • Physician services • Pharmaceutical services • Psychiatric or psychological services • Recreational and social activities • Social services • Speech-language pathology • Transportation services.
Assisted Living Facility (ALF)	Services include: • Personal care • Supportive care (homemaker, chore, PCS, and meal preparation) • Nursing • Help with medication Payment for room and board is not allowed. Members receiving ALF services shall be receiving ongoing CCMA services.
Attendant Care	Hands-on care, both supportive and health-related in nature, provided to children. The service includes the Member supervision specific to the needs of a medically stable, physically disabled child. Includes: • Skilled or nursing care • Housekeeping activities • Supportive services for the absence, loss, diminution, or impairment of a physical or cognitive function. May be self-directed as personal assistant delegated services.
Community Care Management Agency (CCMA)	For members living in Community Care Foster Family Homes and other community settings, services by a CCMA include: • Nurse delegation to the caregiver • Identifying needed services, supplies, and equipment • Face-to-face monitoring • Use of the health action plan

Service	Description
	• Assisting the caregiver with undesired effects and/or changes in condition of members
Community Care Foster Family Home (CCFFH)	Services provided in a State-certified private home by a principal care provider who lives in the home. CCFFH may accept up to three adults each. Services include: • Personal and supportive care • Homemaker • Chores • Companion services • Nursing • Medication oversight (as permitted under state law)
Counseling and Training	Counseling and training serviced provided to the Members, families/caregivers, and professional and paraprofessional caregivers on behalf of the Member. Provided individually or in groups. Provided at the Member's home or an alternative site. Counseling and training activities include: • Member care training for members, families, and caregivers regarding the nature of the disease and the disease process • Methods of transmission and infection control measures • Biological, psychological care and special treatment needs/regimens • Employer training for consumer-directed services • Instruction about the treatment regimens • Use of equipment specified in the HAP • Employer skills updates as needed to safely maintain the individual and home • Crisis intervention • Supportive counseling • Family therapy • Suicide risk assessments and intervention • Death and Dying counseling • Anticipatory grief counseling • Substance Abuse Disorder counseling • Nutrition assessment and counseling on coping skills to deal with stress caused by member's deteriorating functional, medical, mental status
Companion Services	Non-medical care, supervision, and socialization prior approved by a service coordinator and documented in the health action plan.
Environmental Accessibility Adaptations (EAA)	Physical changes to the member's home required by the HAP, Medically Necessary to ensure the health, welfare, and safety of the member, allowing the

Service	Description
	member to stay at home as much as possible. Without these adaptations, the member would require institutionalization. Includes: • Installation of ramps and grab-bars • Widening of doorways • Modification of bathroom facilities • Installation of specialized electric and plumbing systems Window air conditioners may be installed when it is necessary for the health and safety of the Member. Not covered: Adaptations or improvements to the home that are of general utility and are not of direct medical or remedial benefit to the individual. Examples include carpeting, roof repair, central air conditioning, etc. Adaptations to the total square footage of the home are excluded from this benefit. All services shall be provided in accordance with applicable state or local building codes.
Home Delivered Meals	Home-delivered meals are provided to individuals who cannot prepare nutritionally-sound meals without help and need meal services to stay independent in the community and to prevent institutionalization. Home-delivered meals are nutritional and delivered to a member's home. Excludes residential or institutional settings. Two meals a day.
Home Maintenance	Services to maintain a safe, clean, and sanitary environment. Services not included as a part of personal assistance. Including: • Heavy-duty cleaning • Minor repairs to essential appliances (to stoves, refrigerators, and water heaters) • Fumigation or extermination services For individuals who cannot perform cleaning and minor repairs without assistance and are assessed, to need the services in order to prevent institutionalization.
Moving Assistance	May be provided in rare cases for members assessed by Heath Coordination team and found that the Member needs to move to a new home. For example: • Unsafe deteriorating home

Service	Description
	• Member is evicted from current home • Member is not able to afford home due to a rent increase • Wheelchair bound member living above the first floor of a multi-story building without elevator • Home is unable to support the Member's additional needs for equipment • Moving expenses include packing and moving of belongings
Non-Medical Transportation	Offered to enable individuals to gain access to community services, activities, and resources, specified by the HAP. Only when not included in the HCBS service being accessed. Members living in a residential care setting or a CCFFH are not eligible for this service. This does not replace medical transportation.
Nursing Facility (NF), Skilled Nursing Facility (SNF), or Intermediate Care Facility (ICF)	Services provided in a nursing facility licensed and certified to provide skilled nursing and rehabilitative services on a regular basis. Nursing facility members require assistance 24 hours a day with Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs) and need care provided by licensed nursing personnel and paramedical personnel on a regular, long-term basis. Services include skilled nursing, health-related care, and rehabilitative services on a regular basis in an inpatient facility. Services in a nursing facility include independent and group activities, meals and snacks, housekeeping and laundry services, nursing, and social work services, nutritional, monitoring, and, counseling, pharmaceutical services, and rehabilitative services.

Personal Assistance Service Level I (PA1)	For members who are not living with their family and may need help with their daily activities.
	May be self-directed by the member and include:
	• Companion services (meal prep, laundry, errands) – prior approval needed.
	• Homemaker/chore services including:
	  • Routine housecleaning such as sweeping, mopping, dusting, making beds, cleaning the toilet and shower or bathtub, taking out rubbish
	  • Care of clothing and linen by washing, drying, ironing, mending
	  • Shopping for household supplies and personal essentials (not including cost of supplies)
	  • Light yard work, such as mowing the lawn
	  • Simple home repairs, such as replacing light bulbs
	  • Preparing meals
	  • Escorting the member to clinics, physician office visits or other trips for the purpose of obtaining treatment or meeting needs established in the health action plan, when no other resource is available

Service	Description
	• Providing standby/minimal assistance or supervision of activities of daily living such as bathing, dressing, grooming, eating, ambulation/mobility and transfer • Reporting and/or documenting observations and services provided, including observation of member self- administered medications and treatments, as appropriate • Reporting to the assigned provider, supervisor or designee, observations about changes in the member's behavior, functioning, condition, or self-care/home management abilities that necessitate a change in service provided
Personal Assistance Service Level II (PA2)	For members needing: • Moderate to total assistance with activities of daily living and health maintenance activities May be self-directed and consist of the following • Personal hygiene and grooming, including bathing, skin care, oral hygiene, hair care, and dressing • Assistance with bowel and bladder care • Assistance with ambulation and mobility • Assistance with transfers • Assistance with medications, which are ordinarily self-administered when ordered by member's physician • Assistance with feeding, nutrition, meal preparation and other dietary activities • Assistance with exercise, positioning, and range of motion • Taking and recording vital signs, including blood pressure • Measuring and recording intake and output, when ordered • Collecting and testing specimens as directed • Special tasks of nursing care when delegated by a registered nurse, for members who have a medically stable condition and who require indirect nursing supervision as defined in Chapter 16-89, HAR • Proper utilization and maintenance of member's medical and adaptive equipment and supplies. Checking and reporting any equipment or supplies that need to be repaired or replenished • Reporting changes in the member's behavior, functioning, condition, or self-care abilities which necessitate more or less service • Maintaining documentation of observations and services provided • When personal assistance services Level II activities are the primary services, personal assistance services Level I activities identified on the health action plan, which are incidental to the care furnished or that are essential to the health and welfare of the member, rather than the member's family, may also be provided.

Service	Description
	Provided by Home Health Aide, Personal Care Aide, Certified Nurse Aide or Nurse Aide.
Personal Emergency Response Systems (PERS)	Electronic device with a 24-hour emergency assistance service that helps members get secure immediate help in an emotional, physical, or environmental emergency. Individually designed to meet the needs and capabilities of the Member and includes training, installation, repair, maintenance, and response needs. Access to PERS may be through an electronic device for Members at high risk of institutionalization to secure help in an emergency. Or the Member may wear a portable "help" button to allow for mobility. The response center is staffed by trained professionals. Allowable types of PERS items include: • 24-hour answering or paging • Beepers • Med-alert bracelets • Medication reminder services • Intercoms • Life lines • Fire/safety devices, such as fire extinguishers and rope ladders • Monitoring services • Light fixture adaptations (e.g., blinking lights, etc.) • Telephone adaptive devices not available from the telephone company • Other electronic devices or services designed for emergency assistance Limited to those individuals: • Living alone • Alone for significant parts of the day • Have no regular caregiver for extended periods of time • Who would otherwise require extensive routine supervision Only provided to Members residing in a non-licensed setting except for an ALF.
Residential Care Services or Type I or Type II Expanded Adult Residential Care Home (E-ARCH)	Services provided in a licensed private home by a principle care provider who lives in the home. Includes: • Personal care • Nursing • Homemaker

Service	Description
	• Chores • Companion services • Medication oversight (provided by a principle care provider who lives in the home) Residential care is furnished: • In a Type I E-ARCH, five or fewer residents provided that up to six residents may be allowed at the discretion of DHS to live in a Type I home with no more than three residents of whom may be NF LOC • In a Type II E-ARCH, six or more residents, where no more than 20 percent of the home's licensed capacity may be individuals meeting a NF LOC who receive these services in conjunction with residing in the home Members receiving residential care services shall be receiving ongoing CCMA services.
Respite Care	May be provided on a short-term basis to individuals unable to care for themselves. Respite may be provided hourly, daily, or overnight in the following locations: individual's home or place of residence; CCFFH; E-ARCH; Medicaid-certified NF; licensed respite day care facility; or other community care residential facility approved by the State.
Skilled (or Private Duty) Nursing	For members requiring ongoing nursing care at home or in the community, provided by licensed nurses. Services may be self-directed under personal assistance level II/delegated using nurse delegation procedures as outlined in HRS §457-7.5 and the Health Plan Manual.
Specialized Medical Equipment and Supplies (SMES)	Refers to the purchase, rental, lease, warranty costs, assessment costs, installation, repairs, and removal of devices, controls, or appliances, as specified in the health action plan that enable individuals to increase and/or maintain their abilities to perform ADL, or to perceive, control, participate in, or communicate in the environment in which they live. Services include but are not limited to: • Items necessary for life support • Specialized infant car seats • Modification of parent-owned motor vehicle to accommodate the child, e.g. wheelchair lifts • Intercoms for monitoring the child's room • Shower seat • Portable humidifiers • Electric utility bills specific to electrical life support devices (e.g., ventilator, oxygen concentrator)

Service	Description
	• Medical supplies • Heavy duty items including but not limited to patient lifts or beds that exceed $1,000 per month • Rental of equipment that exceeds $1,000 per month such as ventilators • Emergency back-up generators specific to electrical life support devices (ventilator, oxygen concentrator); and • Miscellaneous equipment such as customized wheelchairs, specialty orthotics, and bath equipment that exceeds $1,000 per month. Items reimbursed shall be in addition to any medical equipment and supplies furnished under the MSP and shall exclude those items which are not of direct medical or remedial benefit to the individual. Specialized medical equipment and supplies shall be recommended by the Member's PCP.
Subacute Facility Services	Members do not require acute care but need more intensive skilled nursing. Services provided in: • A licensed nursing facility • A licensed and certified hospital
Community Integration Services (CIS)	
To be eligible, you need to be eighteen (18) years of age or older to be eligible. Also, you must meet the following to qualify for CIS: 1. Be chronically homeless, or 2. Currently homeless and have one of the qualifying health conditions listed below, or 3. Living in an institution and cannot leave without stable housing and have one of the qualifying health conditions listed below, or 4. Living in public housing and at risk of being kicked out and have one of these qualifying health conditions: • A mental health disorder affecting one or more major life activities, or • Diagnosed with substance use disorder, or • Have a chronic physical or complex health needs, or • Go to the emergency department or inpatient hospital often. CIS is divided into three categories: (1) pre-tenancy services, (2) tenancy services, and (3) other housing and tenancy support services.	

Service	Description
Pre-tenancy services	Include: • Screening and assessments • Developing housing support assistance plan • Searching for housing • Preparing and submitting applications • Identifying needs for start-up • Identifying equipment, technology, and other changes needed • Reviewing safety of housing • Moving assistance • Housing crisis plan
Tenancy services	Include: • Identifying and assisting with behavioral management • Educating you about roles and responsibilities of tenant/landlord • Coaching you how to develop and maintain relationships with landlords/property managers • Teaching you how to resolve disagreement with your landlords/neighbors • Connecting you with supportive groups to help prevent you from being kicked out of your home • Housing recertification process • Updating/maintaining housing assistance and crisis plans • Developing skills for daily living and maintaining your home • Coordinating Service care • Managing housing crisis
Community Transition Services	Include: • Case Management Services: o Moving into stable housing o Assessing the unit's and Member's readiness for move-in o Assisting the Member in obtaining furniture and commodities • Housing Quality and Safety Improvement Services. o Repairs or remediation for issues such as mold or pest infestation if cost effective method of addressing occupant's health condition, as documented by a health care professional, and not covered under any other program. • Legal Assistance. o Connecting to expert community resources to address legal issues impacting housing and health, such as assistance with breaking a lease due to unhealthy living conditions. • Securing House Payments. o Provide a one-time payment for security deposit and/or first month's rent provided that such funding is not available through

Service	Description
	any other program. Once for each Member, except for State determined extraordinary circumstances such as a natural disaster.
Other Services	
Certification of Physical/Mental Impairment	Coverage for evaluations and re-evaluations of disabilities.
Advance Care Planning	Voluntary advance care planning services between a provider and the Member with or without completing relevant legal forms as described in 42 CFR §438.3.(j).
Hospice Care	A program that provides care to terminally ill patients who are not expected to live more than six months. A participating hospice provider shall meet Medicare requirements. Children under the age of twenty-one years may receive treatment to manage or cure their disease while concurrently receiving hospice services.

Value-Added Services

Service	Description	Eligibility
Inpatient Palliative Care	Palliative care focuses on providing total care to our members with chronic, potentially life limiting illness. The care focuses on the physical, spiritual, emotional, and social needs of the member and family. Our goal is to relieve suffering in all its manifestations. We provide this care through an interdisciplinary team including physician, nurse, social worker, and chaplain. Palliative care focuses on symptoms management and alleviating the stress and suffering of a chronic illness.	Members with life limiting illness in hospital setting. Prior Authorization required.
Medical Respite	When a member is discharging from the hospital and has lingering medical needs but does not have stable housing, Kaiser Permanente contracts with providers for medical respite housing which includes case management services.	Members with medical need for follow-up care and unstable housing. Prior Authorization required.
Aqua Therapy	We offer aqua or hydrotherapy to members in need of physical therapy during recovery from injury or to manage chronic pain when they cannot tolerate land-based physical therapy (PT) and meet medical necessity criteria. Aqua therapy takes place in a salt-water based, heated pool with expert physical therapists.	At physician discretion for members who cannot tolerate land-based PT. Prior Authorization required.
Remote Monitoring Technology	Kaiser Permanente provides blood pressure cuffs, pulse oximeters, and glucose monitors to some members with chronic conditions. In some cases, the devices are integrated with KPHC and automatically feed readings into the member's health record.	At physician discretion. Prior Authorization required.
Behavioral Health Self-care Apps	Kaiser Permanente offers members free access to: Calm and Headspace online behavioral health applications to help with mild-to-moderate depression, anxiety, and sleep issues. They are also high quality, secure, and confidential.	All Kaiser Permanente members **healthy.kaiserpermanente.org/hawaii/health-wellness/mental-health/tools-resources/digital**
Lifestyle Medicine Program	Kaiser Permanente's Lifestyle Medicine Program offers a wide variety of classes, coaching, and other resources to improve members' health and well-being. Classes range from weight loss, nutrition, and exercise to sleep hygiene, and unlimited attempts at smoking cessation. It also includes individual health coaching for all members.	All Kaiser Permanente members **kpinhawaii.org/our-services**

Covered by DHS Med-QUEST but not by Kaiser Permanente

Some services are not covered by your medical plan. You can get these services in other ways.

- **Dental care:** The DHS, not Kaiser Permanente, covers dental services. Some limitations and prior authorization may apply.

Dental Services are now available to eligible members over the age of 21. **Some limitations and prior authorization may apply.** Effective January 1, 2023, covered services include the following:

Services	Description and Limitation
Preventative Services	• **Comprehensive Oral Evaluation – Once every 5 years** • **Periodic screening examinations - 2 per year** • **Prophylaxis - 2 per year** • **Topical fluoride or fluoride varnish - 2 per year**
Diagnostic and Radiology Services	• **Bitewing x-rays - 2 per year** • **Full series x-rays – 1 every 5 years** • **Periapical x-rays** • **Biopsies of oral tissue**
Endodontic Therapy Services	• **Root canal therapy on permanent molars**
Restorative Services	• **Amalgams on primary and permanent posterior teeth** • **Composites on anterior and posterior teeth** • **Pin and/or post reinforcement** • **Cast cores** • **Recement inlays and crowns** • **Stainless steel crowns**
Oral Surgery	
Periodontal Therapy Services	• **Scaling and root planning – one every 24 months**
Prosthodontic Service	• **Complete Upper and Lower Dentures – one every 5 years** • **Partial Dentures – one every 5 years** • **Denture relines -- one every 2 years** • **Repairs**
Emergency and Palliative Treatment	• **Gingivectomy, for gingival hyperplasia** • **Other medically necessary emergency dental services**

For help finding a dentist, call Community Case Management Corporation (CCMC) at 808-792-1070 or toll-free at 1-888-792-1070. CCMC can explain the covered dental benefits and help you find a dentist near you..

- **Elective abortions or intentional termination of pregnancy (ITOP):** Intentional terminations of pregnancy (ITOP) are not covered by Kaiser Permanente. They are covered by the Med-QUEST Division (MQD). You will need authorization. Your provider shall contact MQD's Clinical Standards Office (CSO), on ITOP requests. MQD can also arrange transportation.

- **State of Hawaii Organ and Tissue Transplant (SHOTT) Program:** DHS provides transplants through the SHOTT program. Covered transplants must be non-experimental, non-investigational for the specific organ/tissue and specific medical condition being treated. These transplants may include liver, heart, heart-lung, lung, kidney, kidney-pancreas, and allogenic and autologous bone marrow transplants. In addition, children may be covered for transplants of the small bowel with or without liver. Children and adults must meet specific medical criteria as determined by the State and the SHOTT program contractor. We can help with a referral to the SHOTT Program when it is medically appropriate.

Services from other agencies in the community:

- **Early Intervention Program (EIP)** provides services for children 0 – 3 years of age with special needs. Services are provided in places where a child lives, learns, and grows. Parents and/or caregivers are coached on how to help their child succeed in their environment. Services covered include: Assistive Technology, occupational therapy, physical therapy, psychology services, special instruction, speech-language pathology, and vision services. For more information, call 808-594-0066.
- **Honolulu Community Action Program (HCAP) – Head Start**
  This is a federal program to help prepare children ages 3 – 5 years old for school. Some of the programs offered are part-day or full-day centers, home-based, Head Start DOE combined classrooms, and family activities. To apply, or for more information, call 808-847-2400.
- **Women, Infant and Children (WIC)** - This program helps low-income, nutritionally at-risk pregnant women, new moms, and children under age 5 with healthy foods, nutrition education, screening and referrals to other health, welfare, and social programs. Some of the healthy foods are milk, eggs, cheese, cereal, peanut butter, fruits, vegetables, and infant food. For more information, call 808-586-8175 on Oahu or 1-888-820-6425.
- **Tuberculosis Control Program:** This program is for the diagnosis, treatment, identification, prevention, and appropriate therapy of tuberculosis. For more information, call the Tuberculosis Control Branch at 808-832-5731.
- **Hansen's Disease Community Program:** This program is for patients with Hansen's Disease. The program provides treatment, education, assistance to family members and health care providers, and helps patients obtain services. For more information, call the Hansen's Disease Branch at 808-733-9831.

- **Community Care Services (CCS) Behavioral Health Program (provided by Ohana Health Plan)**: Adult Members eighteen (18) years or older with a diagnosis of serious mental illness (SMI) or serious and persistent mental illness (SPMI) may be eligible for additional behavioral health service from the CCS program. Specialized behavioral health services include inpatient and outpatient therapy, tests to monitor the member's response to therapy, and intensive case management. For more information, call 1-888-846-4262.
- **Services for Individuals with Developmental Disabilities/Intellectual Disabilities (DD/ID):** The DOH Developmental Disability Division (DOH/DDD) provides intermediate care facility/ID services to some individuals. Kaiser Permanente and DOH/DDD coordinate activities for people with DD/ID. For more information, call 808-586-5840.
- **Support for Emotional and Behavioral Development (SEBD) for children:** Behavioral health services are available for children/youth less than twenty-one (21) with diagnosis of emotional and behavioral development disorders. The Department of Health, through its Child and Adolescent Mental Health Division (CAMHD) SEBD program provides behavioral health services, including transportation, to children and adolescents ages 3 through 20 who need intensive behavioral health services. To find out more, call one of the Family Guidance Centers listed below.

Family Guidance Center	Address	Phone Number	Fax Number
Pearl City Office	Central Oahu Family Guidance Center (COFGC) 860 Fourth Street, 2nd Floor Pearl City, Hawaii 96782	808-453-5900	808-453-5940
Family Court Liaison Branch (FCLB)	Hawaii Youth Correctional Facility 42-470 Kalanianaole Hwy. Building 03 Kailua, Hawaii 96734	808-266-9922	808-266-9933
Honolulu	Honolulu Oahu Family Guidance Center (HOFGC) 3627 Kilauea Avenue, Room 401 Honolulu, Hawaii 96816	808-733-9393	808-733-9377
Leeward Oahu	Leeward Oahu Family Guidance Center (LOFGC) 601 Kamokila Blvd., Room 355 Kapolei, Hawaii 96707	808-692-7700	808-692-7712
Kaneohe Office	Central Oahu Family Guidance Center (COFGC) 45-691 Keaahala Road Kaneohe, Hawaii 96744	808-233-3770	808-233-5659
Maui	Maui Family Guidance Centers (MFGC) 270 Waiehu Beach Road, Suite 213 Wailuku, Hawaii 96793	808-243-1252	808-243-1254

Services that are typically NOT covered under the QUEST Program

- Personal care items such as shampoos, toothpaste, toothbrushes, mouth washes, denture cleansers, shoes, slippers, clothing, laundry services, baby oil, sanitary napkins, diapers for babies, soaps, lip balm, bandages, and contact lens solution
- Non-medical items such as books, telephones, beepers, radios, linens, clothing, television sets, computers, air conditioners, air purifiers, fans, household items, motor vehicles or furnishings
- Experimental and/or investigative services, procedures, drugs, devices, and treatments; drugs not approved by the Federal Drug Administration (FDA)
- Treatment of complications resulting from previous cosmetic, experimental or investigative services, or other services that are not covered
- Treatment of baldness, including hair transplants and topical medications, wigs, and hairpieces
- Treatment of persons confined to public institutions
- All medical and surgical procedures, therapies, supplies, drugs, and equipment for the treatment of sexual dysfunction or inadequacies
- Penile or testicular prostheses and related services
- Reversal of sterilization, in vitro fertilization, artificial insemination, sperm banking procedures, fertilization by artificial means, and all procedures and drugs to treat infertility or enhance fertilization
- Bereavement counseling, employment counseling, primal therapy, long-term character analysis, marathon group therapy, and/or consortium
- Routine foot care, treatment of flat feet
- Swimming lessons, summer camp, gym membership, and weight control classes
- Beds – lounge beds, bead beds, water beds, day beds, overbed tables, bed lifters, bed boards, bed side rails if not an integral part of a hospital bed
- Contact lenses for cosmetic purposes, bifocal contact lenses
- Oversized lenses, blended or progressive bifocal lenses, tinted or absorptive lenses (except for aphakia, albinism, glaucoma, medical photophobia) trifocal lenses (except as a specific job requirement), spare glasses
- Refractive eye surgery
- Physical exams and/or psychological evaluations as a requirement for employment or as a requirement for continuing employment (e.g., truck and taxi drivers' licensing)
- Physical exams and/or psychological evaluations as a requirement for drivers' licenses or for the purpose of securing life and other insurance policies or plans
- Organ transplants not meeting the guidelines established by the Medicaid program and organ transplants not specifically identified as benefits
- Biofeedback, acupuncture, chiropractic services, naturopathic services, faith healing, Christian Science services, hypnosis, massage treatment (by masseurs), and any other form of self-care or self-help training and any related diagnostic testing
- Ambulance wait time, physician wait time, standby services, telephone consultations, telephone calls, writing of prescriptions, stat charges
- Treatment of pulmonary tuberculosis that is covered by DOH

- Treatment of Hansen's Disease that is covered by DOH
- Topical application of oxygen
- Orthoptic training
- Travel medicine
- OPTIFAST programs and supplements, bariatric classes, and supplies

Comments, grievances, and appeals

We want you to be happy with your care at Kaiser Permanente. We welcome your comments, suggestions, and concerns. They will let us know what we're doing well and what we need to do better.

There are several ways to bring your comments to our attention.

- Talk with your doctor or the department supervisor.
- Fill out the "Let Us Hear From You!" form at the clinic.
- Call or write to the QUEST Call Center at **808-432-5330**, toll free at **1-800-651-2237**, or **711** (TTY).

Our address

Kaiser Foundation Health Plan, Inc.
Member Services Department
711 Kapiolani Blvd.
Honolulu, HI 96813

Grievances

If you are unhappy with Kaiser Permanente, you may file a grievance or have a representative or a provider file the grievance for you. You can ask anyone at Kaiser Permanente to send it to Member Services or you can mail it to: Member Services, Kaiser Permanente, **711** Kapiolani Boulevard, Honolulu, HI 96813. If you would like someone to help you write your grievance, or you want to file your grievance by telephone, call the QUEST Call Center at **808-432-5330**, toll free at **1-800-651-2237**, or **711** (TTY).

A letter will be sent to you within five business days to let you know that we have received your grievance. All comments, documents, records, and other information submitted by you or your representative is considered by the grievance decision makers. We will send it to the supervisor of the area you wrote or called about. That person will answer your grievance within 30 calendar days from when it was received.

If you got our answer, but you're still not satisfied, you may ask for a state grievance review from the State of Hawaii's Department of Human Services Med-QUEST Division. You must call or write to Med-QUEST within 30 days from the date on the grievance resolution letter issued from the health plan. If you do not do this, your complaint will be considered resolved.

To ask for a State grievance review, call DHS at 808-692-8094. Or mail request to:

Med-QUEST Division
Health Care Services Branch
PO Box 700190
Kapolei, HI 96709-0190

DHS will review your complaint. They will decide on it within 90 calendar days from the day the request for a grievance review is received. DHS's decision will be final.

Filing a claim

How to file a claim for payment

If you receive medical care outside of Kaiser Permanente, you may submit a claim with us. We review each claim to decide if we will pay. We look to see if your care was referred by us. We will see whether it was medically needed emergency care or urgent care. If we approve your claim, we will pay according to your plan benefits.

If you have questions relating to filing a claim, please contact the QUEST Call Center at **808-432-5330** or toll free at **1-800-651-2237**, or **711** (TTY). If you have questions about a claim already submitted, please call Claims Administration toll free at **1-877-875-3805**.

You may have someone file the claim for you. If you choose to do this, you must name this person in writing and state that he or she may file the claim for you. Both you and your representative must sign this statement unless the person is your attorney. When necessary, your representative will have access to medical information about you that relates to the request. If you prefer, you may call our QUEST Call Center at **808-432-5330** or toll free at **1-800-651-2237** to request a form.

Appeals

Did Kaiser Permanente health plan or your doctor refuse an item or service you asked for? If you do not agree with a decision that was made about the services you are getting, or want to get, you may ask for a review of an adverse benefit determination taken by Kaiser Permanente for your medical care. Some of the other reasons you may want to file an appeal are if we stopped care that we already approved; if you don't get care when you need it; if we don't give you an answer to a grievance or an appeal that you already filed by the time we're supposed to; or if we can't provide you with a medically necessary covered service within Kaiser Permanente and we don't authorize coverage for that service outside Kaiser Permanente. If you provide your written consent, providers may file an appeal on your behalf if we deny coverage of a service.

After you get a denial notice or Notice of Adverse Benefit Determination, you have 60 calendar days to make your appeal. You may make an appeal orally or in writing. You may ask us or someone else to help you write your appeal. If you would like help to write your appeal, call the QUEST Call Center at **808-432-5330**, toll free at **1-800-651-2237**, or **711** (TTY). You may also request an interpreter to help you through this process.

Only you or someone with your permission may make an appeal. If you're going to give someone else permission to make an appeal, you can let us know by sending us a letter or by calling **808-432-5330**, toll-free at **1-800-651-2237** or **711** (TTY). If you let us know by phone, you must also send a letter saying that you are giving someone your permission to make an appeal. Your letter must have the name of the person you are giving permission to and say that you are authorizing that person to file an appeal for you. You both must sign and date the letter. When necessary, your representative may have access to medical information about you that relates to the request.

Send your appeal to:

Kaiser Foundation Health Plan Inc.
Attn: Regional Appeals Office
711 Kapiolani Blvd.
Honolulu, HI 96813

You may fax your appeal to 808-432-5260 or send it by email at **KPHawaii.Appeals@kp.org**. You may also contact the QUEST Call Center at **808-432-5330**, toll free at **1-800-651-2237** or **711** (TTY).

We will write to you within five business days to say we got your appeal. You will have a chance to present evidence and to argue facts or law if you want to. You may do this in person or in writing. You or your representative may examine the case file. The case file may have medical records and any other papers and records that we will look at during the appeals process. You may give us written comments, papers, medical records, or other information to consider. We will review the case and give you a written decision no later than 30 calendar days of the initial grievance. We may take up to 14 more calendar days if you ask us to or if we need more information and it would be in your best interest if we had more time before deciding. If you didn't ask for the delay, we will make reasonable efforts to give prompt oral notice of the delay. We will also send you a letter to explain why we need extra time within 2 calendar days. Then we will inform you of your right to file a grievance if you disagree with our decision.

Expedited review

Sometimes we must review your appeal more quickly. You, or your Provider, or other authorized representative acting on your behalf with your written authorization, may file an expedited appeal orally or in writing. When we receive your appeal, we will decide if taking the regular amount of time to review it could mean a danger to your life, physical or mental health, or ability to attain, maintain, or regain maximum function. If we or the person who treats you finds that it could, we will use a faster process. We call it an expedited review of your appeal. It's the same as the regular one except:

- We make sure that the person who treats you won't be punished for helping you ask for the faster appeal
- You will have a limited time to present evidence and to argue facts or law if you want to. We will inform you ahead of time before the decision time for appeals.

- We must decide your appeal as fast as needed for your health condition. We can't take more than 72 hours from when we receive your appeal. We will make reasonable efforts to give you oral notice of the appeal decision.
- We will provide written notice of the decision which will include:
    - The results of the appeal process and the date it was completed
    - For appeals not decided wholly in your favor:
        - The right to request a State administrative hearing and clear instructions about how to access this process
        - The right to request an expedited State administrative hearing
        - The right to request to receive benefits while the hearing is pending, and how to make the request
        - A statement that the you may be held liable for the cost of those benefits if the hearing decision upholds our action.
- We may take up to 14 more calendar days if you, or your provider requests an extension, or if we need additional information and can show to the satisfaction of DHS upon DHS request for review, that there is a need for additional information that justifies the delay and demonstrates to DHS how the delay is in your best interest. For any extension you did not request, or if we denied the request for the expedited resolution of an appeal, we will:
    - Transfer the appeal to the time frame for standard resolution;
    - Make reasonable efforts to give prompt oral notice of the delay or denial;
    - Within two (2) days give written notice of the reason for the decision to extend the timeframe or deny a request for expedited resolution of an appeal;
    - Inform you orally and in writing that you may file a grievance with us for the delay or denial of the expedited process, if you disagree with that decision; and
    - Resolve the appeal as expeditiously as your health condition requires and no later than the date the extension expires
- We will notify DHS within 24 hours if an expedited appeal has been granted or if an expedited appeal time frame has been requested by you or your provider. If we need an extension of 14 calendar days, we will provide the reason to DHS. We will notify DHS within 24 hours, or as soon as possible from the time the expedited appeal is upheld. We will also let DHS know how we notified you of the expedited appeal decision.
- If we deny a request for expedited resolution of an appeal, we will transfer the appeal to the standard timeframe of no longer than thirty (30) days from the day we receive the appeal, with a possible fourteen (14) days extension.

External review

DHS administrative hearing

If you have gone through Kaiser Permanente's appeal process and are not happy with the decision, we made about your appeal you can ask DHS for an administrative hearing. Write to the Administrative Appeals Office (AAO) of DHS. The AAO must receive your letter within 120 calendar days from when you got Kaiser Permanente's notice of denial disposition about your appeal. Include information: any statements of fact or laws to support your request. Send your appeal to:

State of Hawaii Department of Human Services
Administrative Appeals Office
P.O. Box 339
Honolulu, HI 96809-0339

There is no cost to receive copies of the appeal file. You have the right to name someone to file the appeal for you. You must name that person in writing when you send your appeal. You may represent yourself at the hearing or you may have a lawyer, a relative, a friend, or someone else there to speak for you. You will receive a decision within 90 calendar days from the date they received your request. We must follow the decision of the DHS administrative hearing. You must go through Kaiser Permanente's appeal process first before asking for a DHS administrative hearing.

You or your approved representative, is considered to have used up Kaiser Permanente's grievance and appeal process if Kaiser Permanente does not follow the notice and timing requirements set by Med-QUEST Division of DHS. When this happens, you have the right to file for a State administrative hearing. Members must exhaust Kaiser Permanente's internal grievance and appeals system before accessing the State's administrative hearing system.

Expedited DHS administrative hearing

If you had an expedited review of your appeal with us, and it didn't go the way you wanted it to, then you may ask DHS for an expedited administrative hearing. You must submit your letter to the AAO within 120 calendar days of getting your answer from Kaiser Permanente about your appeal. An expedited administrative hearing needs to be reviewed and decided upon within three business days from when your request was filed. We will work with the State to ensure that the best results are provided for you and to ensure that the procedures comply with State and Federal regulations. When an expedited State administrative hearing is requested, we will submit information that was used to make the determination, for example, medical records, written documents to and from you, provider notes, etc. to DHS within 24 hours of the decision denying the expedited appeal.

Please send your request for an expedited State administrative hearing process to:

State of Hawaii Department of Human Services
Administrative Appeals Office
P.O. Box 339
Honolulu, HI 96809-0339

Receiving benefits during the appeals process or DHS administrative hearing

If we told you that we are going to reduce, delay or stop anything that we already approved, you have the right to still get those services during the appeals process or state administrative hearing process. For that to happen you or your authorized representative should request to continue your benefits during an Appeal or a State Administrative Hearing process in a timely manner. This means within 10 calendar days of getting the denial notice or Notice of Adverse Benefit Determination, or before the date that the service is going to be reduced, delayed, or stopped. The services you are asking to be continued must have been approved by an authorized provider within the time period covered by the original authorization.

If your benefits are continued during the appeal or administrative hearing process, it will be provided until one of the following happens:

- You withdraw your appeal
- You don't request a DHS administrative hearing within 10 calendar days of getting the denial notice or Notice of Adverse Benefit Determination from us
- The DHS administrative hearing does not decide in your favor

If Kaiser Permanente or DHS do not decide in your favor, you will have to pay for the services that you requested to be continued during the appeal process.

If you or your authorized representative requested to continue your benefits during an Appeal or a State Administrative Hearing process, we will continue your benefits if the following conditions are met:

- An appeal was requested within 60 calendar days following the date on the adverse benefit determination notice
- The appeal or request for State administrative hearing involves the termination, suspension, or reduction of a previously authorized services
- The services were ordered by an authorized provider
- The original authorization period has not expired
- You timely filed to request to continue your benefits on or before the later of the following:
    - Within 10 days of the Health Plan receiving the notice of adverse benefit determination; or
    - The intended effective date of the Health Plan's proposed adverse benefit determination.
- If the Health Plan continues or reinstates the Member's benefits while the appeal or State administrative hearing is pending, the Health Plan shall not discontinue the benefits until one of the following occurs:
        - The Member withdraws the appeal or request for a State administrative hearing
        - The Member does not request a State administrative hearing within ten (10)

days from when the Health Plan mails a notice of an adverse benefit determination
    - A State administrative hearing decision unfavorable to the Member is made
- If the final resolution of the appeal or State administrative hearing is adverse to the Member, that is, upholds the Health Plan's adverse benefit determination, the Health Plan may, consistent with the State's usual policy on recoveries and as specified in the Health Plan's contract, recover the cost of services furnished to the Member while the appeal and State administrative hearing were pending, to the extent that they were furnished solely because of the requirements of this section.
- If the Health Plan or the State reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, the Health Plan shall authorize or provide these disputed services promptly, and as expeditiously as the Member's health condition requires, but no later than seventy-two (72) hours from the date it receives notice reversing the determination.
- If the Health Plan or the State reverses a decision to deny authorization of services, and the Member received the disputed services while the appeal was pending, the Health Plan shall pay for those services.

Medicaid ombudsman program

The State of Hawaii Department of Human Services (DHS) oversees the Medicaid ombudsman program. Koan Risk Solutions is contracted with DHS to independently review concerns and complaints against Medicaid Health Plans as another resource for members. Visit the ombudsman website: www.himedicaidombudsman.com. To contact the Medicaid ombudsman office:

- Hours of Operation: 7:45am-4:30pm Monday-Friday (Excluding Hawaii State Holidays)
- Office Address:
  Koan Risk Solutions, Inc.
  1580 Makaloa Street #550
  Honolulu, HI 96814
- Phone: 1-808-746-3324; Toll Free: 1-844-488-7988
- Fax: 1-808-356-1645
- Email: hiombudsman@koanrisksolutions.com
  Deaf or Hard of Hearing may access text-telephone (TTY) captioned telephone or Braille TTY by dialing 1-877-447-5990 or 711.

General information

Online Services

KPQUEST.org
Want to know more about Kaiser Permanente QUEST? Log on to: **kpquest.org/home** to find out more about Kaiser Permanente QUEST membership benefits, drug formulary, providers, latest newsletters, and more.

kp.org
You can also keep track of your medical records by registering **on kp.org/registernow**. Once you are registered, visit My Health Manager to make appointments online, view most test results, email your doctor's office, order prescription refills, check past office visit information, and look up future appointments. You can also access free programs through **kp.org/healthylifestyles** to help you focus on being healthy.

Third-party liability (TPL)

Third-party liability means another person, organization, or program is responsible for all or part of the cost for your medical care at Kaiser Permanente.

If someone caused injury or sickness, you may receive money from him or her, or from insurance. It's called a "judgment" or "settlement." If we treated you for the problem, we have a right to get paid for the cost of medical care out of the judgment or settlement.

If you got hurt or sick from a motor vehicle accident, and we treated you, we have a right to get paid from the "no-fault" insurance.

It is important to tell us if another person, organization, or program is responsible for payment of the services provided to you.

Advance health care directive

At Kaiser Permanente Hawaii, we support your right to make decisions regarding your health care. We want to know how to manage your health care when you can no longer tell us. In fact, we encourage you to make these important decisions now, when you're healthy. With an advance health care directive, you can take charge of your health care and help ensure that your wishes will be respected.

By putting your wishes in writing, you can be sure that your family and health care team will know what to do if you become unable to make decisions for yourself. By clarifying your wishes when you're able to think clearly about them, you free your family from having to make difficult decisions for you. Your completed document(s) will be available 24 hours a day from Kaiser Permanente.

All staff and physicians shall make every reasonable effort to educate Members regarding advance health care directives, actively support the preparation and execution of written directives, and honor oral and written instructions in accordance with applicable law and organizational policy.

Although there are no institutional moral or religious objections put in place by Kaiser Permanente Hawaii, our health care providers may decline to comply with an individual's advance directive for reasons of conscience. In cases where an individual's advance directive is contrary to generally accepted standards of medical care, our health care providers and facilities may decline to comply with it. However, if the provider or facility refuses to comply, they must:

- Promptly inform the patient and any decision maker for the patient
- Provide continuing care until a transfer can be arranged
- Assist in the transfer of the patient to another health care provider or institution that is willing to comply with the instructions

If you want more information, or to request an Advance Health Care Directive forms packet, please contact our QUEST Call Center at **808-432-5330** (Oahu), **1-800-651-2237** (neighbor islands), or **711** (TTY).

Complaints concerning noncompliance with the advance directive requirements may be filed with the Hawaii State Department of Health, Office of Health Care Assurance, 601 Kamokila Blvd., Room 395, Kapolei, Hawaii 96707.

New medical technologies receive thorough review

Advances in science bring improved medical care. With new techniques patients can have better, sometimes longer, lives. But how do you know when something new is something better? We have a New Technologies Committee made up of doctors and scientists chosen from the national Kaiser Permanente system. They study medical advances. They make sure they are tested, safe, and helpful. We keep track of medical advances and how they fit the benefits we offer. We do that so we can give you up-to-date, effective, and efficient medical care. If you would like to know more about how we review medical technologies and our benefits, please call the QUEST Call Center **at 808-432-5330**, toll free at **1-800-651-2237**, or **711** (TTY).

Quality care at Kaiser Permanente

You can get a copy of our quality report. It tells how we are scored on the quality of the care and service we provide to our Members and the community. For a free copy of this year's report, please call our QUEST Call Center at **808-432-5330**, toll free at **1-800-651-2237**, or **711** (TTY). You can also see the report online at **kp.org/quality**.

Utilization management

Utilization management (UM) describes the different ways to make sure you receive the right care at the right time in the right place. Kaiser Permanente's UM program uses the advice and cooperation of practitioners and providers. It makes sure you get high-quality, cost-effective care. By giving you the medical care when you need it, we help you stay healthy. We also keep track of the services we provide and how they are working. Some of our UM activities are:

- Review of hospital admissions: We want to make sure your hospital stay is medically needed. We also want to be sure that you're getting the care you need. We use Medicare and InterQual guidelines. They are known throughout the U.S. and are widely used.
- Review of referred services: We may send you outside Kaiser Permanente for care. If we do, we want you to be treated the same as if we did the service ourselves. We will make sure you have a referral for medical need, and that you're enrolled in a Kaiser Permanente plan which covers the service. We will send you to a provider who meets our quality standards.
- Review of claims: Claims are bills or requests to pay for care you already got. We review them to be sure that you were enrolled in a Kaiser Permanente plan, the services were medically needed, and the service was approved. If we approve the claim, we pay based on what your plan covers.
- Case management for certain medical conditions: Case managers work with Members who have certain health problems. Examples are diabetes, asthma, HIV, and congestive heart failure. The case managers are nurses or other health professionals. They have had special training in one of these problems. They work with you, your family, and your doctor. They help you keep your health at the highest level possible.
- Clinical pharmacist services: Clinical pharmacists work in the clinic along with your doctor. They can talk with you to help you with your medicines. Just ask your doctor or clinic pharmacy staff.
- Care maps and clinical practice guidelines: Your doctor has some written tools which are based on clinical evidence of what type of treatment works. Your health care team can use them to best meet your medical needs. Examples of guidelines include the following:
    - **[Behavioral Health Guidelines**
        - Attention Deficit Hyperactivity Disorder (ADHD) Guideline
        - Depression Guideline
    - **Cancer Screening Guidelines**
        - Breast Cancer Screening
        - Cervical Cancer Screening
        - Colorectal Cancer Screening
        - Lung Cancer Screening
        - Prostate Cancer Screening
    - **Cardiovascular Health Guidelines**
        - Aspirin Recommendations
        - Blood Pressure Guideline
        - Cholesterol and Cardiovascular Risk Guideline
        - CKD: Treatment with SGLT-2 Inhibitors
        - Coronary Artery Disease (CAD) Guideline

    - Diabetes Guideline
    - Heart Failure Guideline
  - **Other Guideline Topics**
    - Asthma Guideline
    - Chronic Obstructive Pulmonary Disease (COPD) Guideline
    - HIV/STI Screening & Prevention
    - Management of Overweight and Obesity in Adults
    - Osteoporosis/Fracture Prevention Guideline]

If you are interested in learning more about these guidelines, call our QUEST Call Center:

- **808-432-5330** or **1-800-651-2237** (toll-free) or **711** (TTY)
- 7:45 a.m. to 4:30 p.m. Monday through Friday

Kaiser Permanente doctors and employees, as well as outside doctors, are part of making UM decisions. They care about the risks of not giving you the right services. They make decisions based on their knowledge that a service or item is medically needed and correct. They are not rewarded or paid for denying something that is asked for.

To ask anything about UM **during normal business hours,** call our QUEST Call Center:

- **808-432-5330** or **1-800-651-2237** (toll-free) or **711** (TTY)
- 7:45 a.m. to 4:30 p.m. Monday through Friday

After normal business hours, on weekends and on holidays, call**:**

- **808-432-7100** (Oahu)
- **1-800-227-0482** toll-free (all other locations) or **711** (TTY)

If you call after normal business hours, your message will go to our UM Team. They will call you back the next business day. You can also send them faxes at **808-432-7419**.

If, at any time, you feel you are not receiving an item or service you believe is medically necessary, you have the right to make a request for services or supplies you have not received or make a claim for payment of charges you have incurred. If you do not agree with our decision regarding your request, you have the right to request an appeal.

Patient safety

We know that a safe environment is a must when we're serving you. We are determined to provide it. We have an active patient safety program. We want to deserve your trust by having:

- Clinics and hospitals that are safe, secure, and clean
- Staff who have the knowledge and skills to do their jobs safely
- Systems that give the right information to the right people at the right time
- Programs that check and maintain buildings regularly for safety
- Processes to identify and manage hazards to ensure safety

- You and your family involved in our efforts to reduce errors, improve safety, and increase trust and respect

Your rights and responsibilities

Privacy information

Your privacy is important to us. Our doctors and staff must keep your information private. That's true whether it is spoken, written, or sent electronically. It's called "protected health information" (PHI). We have policies, procedures, and other safeguards to help protect your PHI. It's required by state and federal laws. We will release your PHI when you tell us to in writing. We will do so when the law requires it. And we will do so without your permission in some situations where the law allows it. One example is when our doctors and other professionals treat you. They may use and share your PHI in order to provide care. They don't need your permission. Another example is finding out who is responsible to pay for your medical care. Others are health care operations purposes. That includes measuring and improving quality, customer service, and making sure we comply with laws and rules

Our privacy policies and procedures tell about your right to see your PHI. They tell how you can correct or update it and get copies of it. The law requires us to track some kinds of disclosures of your PHI. You can ask us for a list of the disclosures that we tracked.

You can get a more complete explanation of our privacy policies. Please ask for a copy of our "Notice of Privacy Practices." You'll find it on our website at **kp.org/privacy** and in our clinics. You can get a copy by calling our QUEST Call Center. If you have questions or concerns about privacy, please call the QUEST Call Center. You can call them at **808-432-5330**, toll free at **1-800-651-2237**, or **711** (TTY).

Protecting you from health care fraud and abuse

Fraud and identity theft are growing problems. We want to protect you and your medical information. One way we do this is by checking your Kaiser Permanente ID card and photo ID when you come in for care.

At Kaiser Permanente we value our work and promise to do what is right. We train our staff and doctors to protect your privacy and help prevent fraud and identity theft. We pay close attention to our systems and operations. This helps us to find signs of wrong behavior. We will make corrections to our processes as needed.

If you see anyone wrongly using your information or our resources, call our QUEST Call Center at **808-432-5330**, toll free at **1-800-651-2237**, or **711** (TTY). For more information about how we're working to help protect you, visit **kp.org/protectingyou**.

Member rights and responsibilities

As a health care team, we treat each other, our members, and our community as part of our ‘ohana. We support each other to provide quality care. We are doing it for the health and well-being of our families and the community. We know how important your needs are. We try to exceed your expectations.

You are our partner in your health care. It’s important for you to share in making decisions about your care. By being willing to talk to your doctor and other health care practitioners about your health goals, you can help us give you the care that’s right for you.

Your rights

As a person using our services, you have specific rights. These rights are yours, regardless of your

- age
- cultural background
- gender
- gender identity
- sexual orientation
- financial status
- national origin
- race
- religion
- disability

You have a right to:

- Get information about us. Find out about our services. Find out who our health care practitioners and providers are. Find out about your rights and responsibilities.
- Get information about the people who give you health care. Find out their names. Find out their professional status and board certification.
- Be treated with consideration, compassion, and respect. That means we consider your dignity and treat you as a person. We think about your privacy when we give you treatment and care.
- Be free from neglect, exploitation, and verbal, mental, physical, and sexual abuse.
- Make decisions about your medical care. Make advance directives to have life-prolonging medical or surgical treatment given, ended, or stopped; to withhold resuscitative services; and for care at the end of life. You have the right to name another person to make health care decisions for you, to the extent allowed by law.
- Discuss all treatment options that are medically needed, regardless of what they cost or what your plan covers.
- Voice your grievances or appeals freely. Voice them without fear of discrimination or revenge. If you are not satisfied with how your grievance is handled, you may have us reconsider your grievance.
- Tell us how to improve this statement of rights and responsibilities.
- Be involved in planning your medical care. You may include your family in planning your care. You have the right to be told the risks, benefits, and consequences of your actions. You may refuse to take part in experimental research, investigation, and clinical trials.

- Choose or change your primary care provider or get a second opinion from another doctor at Kaiser Permanente at no charge. You also have the right to consult with a non-Plan doctor at your own expense.
- Have direct access to a practitioner of women's health services to ensure your ongoing care.
- Find out about your care. You have a right to talk it over with your doctor. Talk with your doctor about your medical condition. Discuss your diagnosis. Discuss what kind of treatment is available. You may discuss alternatives to treatment. You have a right to have these presented in a way that is appropriate to your condition and ability to understand.
- Have an interpreter for your language. You have a right to have an interpreter when needed to understand your care and services.
- Be involved in considering ethical issues. You have the right to contact our Bioethics Committee. Are there ethical, legal, or moral questions about your care? They can help to resolve them.
- Be told how Kaiser Permanente is related to other health care programs, providers, and schools.
- Be told about how we review new technologies. You have a right to know how we apply our benefits to them.
- Get medical information and education you need. This will let you play an active role in your health care.
- Give informed consent. We'll ask your permission before the start of any procedure or treatment.
- Give or withhold informed consent to produce or use recordings, films, or other images of you for purposes other than your care.
- Get fair and timely access to services. That means not just emergency care. It also includes medically needed services and treatment. It includes the things covered by your plan. We should not arbitrarily deny a service just because of your diagnosis, what kind of illness you have, or your condition. Nor should we reduce a service in amount, duration, or scope for those reasons alone.
- Receive services in a coordinated manner. Your PCP is in charge of your medical care. He or she treats you, refers you to specialists when needed, and connects you to all of our services. Your doctor will work with you to help you meet your health goals so that you can live well.
- Have us consider and respect your needs. We respect your cultural and spiritual needs. We respect your psychological and social needs.
- Have privacy and confidentiality for all discussion and records of your care. We will protect your confidentiality. You or a person you choose can ask for your medical records. You can see the records or get a copy. You can ask to amend or correct them, within the limits of the law. In addition, you have the right to limit, restrict or prevent disclosure of protected health information.
- Be treated in a safe, secure, and clean environment. Be free from physical and chemical restraints. Exception: these can only be used when ordered by a doctor, or in the case of an emergency. Even then, they can only be used when needed to protect you or others from injury.
- Get appropriate and effective pain management. Get it as an important part of your care plan.

- Get an explanation of your bill and benefits. You have this right regardless of how you pay. You have the right to know about our available services, referral procedures, and costs.
- Get other information and services. These are things required by various state or federal programs.
- When appropriate, be told about the outcomes of care. That includes outcomes that were not expected.
- Discuss "do not resuscitate" wishes or advance directive instructions for health care with your surgeon and anesthesiologist prior to an operative procedure when you wish to have the "do not resuscitate" honored in the event of a life-threatening emergency during an operative procedure.
- Medicaid patients receiving services, including in the Ambulatory Surgery Center, who wish to file a complaint or voice a concern may contact the Hawaii Medicaid Ombudsman, Koan Risk Solutions, Inc., email: hiombudsman@koanrisksolutions.com, 1-888-488-7988 (toll-free) or 808-746-3324 (Oahu). Medicare patients may contact the Medicare Beneficiary Ombudsman to get help with your Medicare-related questions or concerns, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. If your inquiry requires a response from the Medicare Beneficiary Ombudsman, a 1-800-MEDICARE representative can direct your inquiry to the Medicare Beneficiary Ombudsman as needed. For more information visit www.cms.gov/Center/Special-Topic/Ombudsman/Medicare-Beneficiary-Ombudsman-Home. The patient receiving services in the Ambulatory Surgery Center may also contact Accreditation Association for Ambulatory Health Care; 5250 Old Orchard Road, Suite 200, Skokie, IL 60077. Tel: 847-853-6060, or by email: info@aaahc.org.
- Be informed about 432E HRS Patient's Bill of Rights and Responsibilities.
- Be included in development of a service/treatment plan.
- Only be responsible for cost sharing in accordance with 42CFR Section 447.50.

Your responsibilities

As a partner in your health care, you have the following responsibilities:

- **Give us correct and complete information** about your health. Tell us about the medical conditions you have now. Tell us about the medical conditions you had in the past.
- **Follow the treatment plan.** You and your health care practitioner agreed on the plan. Tell them if you do not understand or cannot follow through with your treatment.
- **Understand your health problems.** As much as possible, work with the practitioner to come up with treatment goals you and they can agree on.
- **Tell us who you are.** Use your Kaiser Permanente identification card the way it's supposed to be used.
- **Cooperate with our staff.** Help us diagnose and treat your illness or condition properly.
- **Keep your appointments.** If you cannot keep them, cancel them in a timely manner.
- **Know your benefits.** Know your plan. Know your plan limits.

- **Sign a release form.** If you choose not to follow the recommended treatment or procedures, we will provide you with adequate information to make an informed decision and will ask you to sign a release form.
- **Realize the effects your lifestyle has on your health.** Understand that decisions you make in your daily life, such as smoking, can affect your health.
- **Be considerate of others.** Respect the rights and feelings of the staff. Respect the privacy of other patients.
- **Don't make a disturbance.** Don't disrupt our operations and administration. Cooperate with staff. That way we can continue what we're doing for other patients.
- **Follow all hospital, clinic, and health plan rules and regulations.** Respect hospital visiting hours.
- **Cooperate** in the proper processing of third-party payments.
- **Tell us** when you or your covered dependents change addresses.
- **Be responsible for your actions.** If you refuse treatment, do not follow instructions, and if your action or behavior interfere with facility and/or patient care, your care may be rescheduled. Should your medical condition change, the treatment plan may be modified.
- **For Ambulatory Surgery Center (ASC) patients:** Arrange for a responsible adult to take you home and stay with you for 24 hours, if required by your doctor.

Hospital patient rights and responsibilities

As a person using our services, you have specific rights. These rights are yours, regardless of your

- age
- cultural background
- gender
- gender identity
- sexual orientation
- financial status
- national origin
- race
- religion
- disability

As a patient in the Moanalua Medical Center you have the right to:

- **Know your rights and responsibilities.** We'll give you the information when you become a hospital patient.
- **Have proper discharge from the hospital or transfer to another.** This may be for your welfare. It may be for another patients' welfare. It may be for other causes as determined by your doctor. You have a right to have reasonable advance notice. You have a right to have

discharge planning. Qualified hospital staff will make sure you get the right care in the right place when you get out of the hospital.

- **Ask for a visit by clergy** at any time. You have a right to take part in social and religious activities. You may do this unless it harms the rights of other patients or would hurt your medical care.
- **Get and use your own clothes and things** as space permits. You may do this unless it harms the rights of other patients, violates our safety practices, or would hurt your medical care.
- **Give informed consent** before the start of any recording, films, or other images for purposes of nonpatient care.
- **Access protective and advocacy services.**
- **Get appropriate educational services.** You need these when a child or adolescent patient's treatment requires a significant absence from school.
- **Be protected from requests to perform services for Kaiser Foundation Hospital.** You don't need to do things that are not included for therapeutic purposes in your plan of care.
- **Be free from any form of restraint or seclusion as a means of coercion, discipline, convenience, or retaliation.** Federal regulations limit the use of restraints and seclusion.
- **Receive visitors of your choice** including a spouse, domestic partner, family member, or friend. All or certain visits may be excluded at your request or discretion of staff, physicians, or administration to allow for your and other's rights, safety, or well-being.

- **File a complaint in the hospital**, either verbally or in writing with the department manager or supervisor. If you are not satisfied with the response, please contact Hospital Administration. They are located on the first floor of the hospital. Or call the operator at 808-432-0000 and ask for them. If the concern cannot be resolved by the hospital, you may contact The Joint Commission by phone, mail, fax, or email. Phone: Toll free U.S., weekdays 8:30 a.m.–5 p.m. Central time, 1-800-994-6610. Mail: Office of Quality Monitoring, The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, IL 60181. Fax: 630-792-5636. Email: *complaint@jointcommission.org.*

As a QUEST member, you have the following additional rights and responsibilities.

You have a right:

- Not to pay for our debts if we go broke.
- Not to pay for services if the state doesn't pay us.
- Not to pay for covered services if we or the state do not pay the doctor or the person who gave you the service.
- To receive covered services outside of Kaiser Permanente (under a contract, referral, or other arrangement) if we are unable to provide the service for you and for as long as we are unable to provide it. You will not have to pay more than if we provided the services directly.
- To get direct access to a specialist through a standing referral for the same condition if the specialist treated you before and you have special health care needs. Special health care needs are determined by an appropriate health care professional.
- To receive information on available treatment options and alternatives in a way that you can easily understand and in a manner that takes into consideration your special needs.
- Freely exercise your rights, including those related to filing a grievance or appeal. Exercising those rights do not negatively affect the way we treat you.

- To receive all written materials in an easily understood language and format.
- To receive services according to appointment waiting time standards.
- To receive services in a culturally competent manner.
- To receive services in a coordinated manner.
- To access to behavioral health services that is no more restrictive than accessing medical services.
- To not have more restrictive financial requirements or treatment limitations for mental health or SUD benefits in any classification as applied to all medical/surgical benefits in the same classification, whether or not the benefits are provided by Kaiser Permanente.

You must tell DHS and Kaiser Permanente when there are any of these changes in your family:

- Death in the family (recipient, spouse, dependent)
- Birth
- Adoption
- Marriage
- Divorce
- Change in health condition (such as pregnancy or permanent disability)
- Change of address
- Institutionalization (such as nursing home, state mental health hospital or prison)

Also, you must notify Kaiser Permanente if:

- Some other person, organization or program needs to pay for your care (such as no-fault insurance for a car accident, or workers' compensation for an injury on the job)
- You will need continuing medical care while visiting another island
- You are going to be away from home for more than 90 calendar days

Please report the above information to Kaiser Permanente at **808-432-5330** or toll free at **1-800-651-2237** or **711** (TTY).

Definitions

Abuse –– Any practices that are inconsistent with sound fiscal, business, or medical practice and result in unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards or contractual obligations (including the terms of the RFP, contracts, and requirements of State and federal regulations) for healthcare in the managed care setting, including incidents or practices of providers that are inconsistent with accepted sound medical practices. It also includes Member practices that result in unnecessary cost to the Medicaid program.

Accountable Care Organization (ACO) – An entity comprised of healthcare providers responsible for coordinating patient care for a defined population with alignment of provider and payer incentives. An ACO model emphasizes value over volume of healthcare through value-based payments, quality improvement measures, and healthcare data analysis.

Activities of Daily Living (ADLs) – Activities a person performs on a daily basis, for self-care, such as:

- eating
- grooming
- bathing
- dressing
- toileting
- transferring

Acute Care – Short-term medical care usually in an acute care hospital, for individuals having an acute illness or injury.

Adult Group – Individuals who obtain Medicaid eligibility in accordance with Hawaii Administrative Rules Chapter 17-1718.

Adult Day Care Center – A licensed facility that is maintained and operated by an individual, organization, or agency for the purpose of providing regular care supportive care to four (4) or more disabled adults.

Adult Day Health Center – A licensed facility that provides organized day programs of therapeutic, social, and health services provided to adults with physical or mental impairments, or both, which require nursing oversight or care. For the purpose of restoring or maintaining, to the fullest extent possible, their capacity for remaining in the community.

Adult group - Individuals who obtain Medicaid eligibility in accordance with Hawaii Administrative Rules, 17-1718.

Advance Directive - A written instruction, such as a living will or durable power of attorney for healthcare, recognized under State law relating to provision of healthcare when the individual is incapacitated.

Advanced Practice Registered Nurse with Prescriptive Authority (APRN-Rx) – A registered nurse (RN) with advanced education and clinical experience who is qualified within his/her scope of practice under state law to provide a wide range of primary and preventive healthcare services, prescribe medication, and diagnose and treat common minor illnesses and injuries consistent with HAR Title 16, Chapter 89, Subchapter 16.

Adverse Benefit Determination - Any one of the following:

- The denial or restriction of a requested service, including the type or level or service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit. The reduction, suspension, or termination of a previously authorized service
- The denial, in whole or part, of payment for a service
- The failure to provide services in a timely manner, as defined in §8.1.C (Availability of Providers);
- The failure of the health plan to act within prescribed timeframes regarding the standard resolution of grievances and appeals
- The denial of an Member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other Member financial liabilities.

  For a rural area Member or for islands with only one health plan or limited providers, the denial of a member's request to obtain services outside the network:
  - From any other provider (in terms of training, experience, and specialization) not available within the network
  - From a provider not part of a network that is the main source of a service to the member, provided that the provider is given the same opportunity to become a participating provider as other similar providers
  - If the provider does not choose to join the network or does not meet the qualifications, the Member is given a choice of participating providers and is transitioned to a participating provider within 60 days
  - Because the only health plan or provider does not provide the service because of moral or religious objections
  - Because the member's provider determines that the Member needs related services that would subject the Member to unnecessary risk if received separately and not all related services are available within the network; and
  - The State determines that other circumstances warrant out-of-network treatment.

Aged, Blind, or Disabled (ABD) – A category of eligibility under the State Plan for persons who are aged (sixty-five [65] years of age or older), legally blind, and/or disabled.

Ambulatory Care - Preventive, diagnostic and treatment services provided on an outpatient basis by physicians, nurse practitioners, physician assistants and other PCPs.

Appeal - A review by the health plan and State Administrative Appeal of an adverse benefit determination.

Appointment – A face-to-face interaction between a provider and a member. This does include interactions made possible using telemedicine but does not include telephone or e-mail interaction.

Assisted Living Facility – A licensed facility that consists of a building complex offering dwelling units to individuals and services to allow residents to maintain an independent assisted living lifestyle. The facility shall be designed to maximize the independence and self-esteem of limited-mobility persons who feel that they are no longer able to live on their own.

Attending Physician – A medical doctor (MD) or a doctor of osteopathy (DO), authorized to practice medicine and surgery by the State, who orders and directs the services required to meet the care needs of a Medicaid Member. The attending physician may be a physician from a group practice who is designated as the primary physician or an alternate physician that has been delegated the role of the attending physician by the Member's initial attending physician during the physician's absence. At the time he or she elects to receive hospice care, the attending physician has the most significant role in the determination and delivery of the individual's medical care**.**

Authorized Representative – An individual or organization designated by an applicant or a Member in writing with the designee's signature or by legal documentation of authority to act on behalf of an applicant or Member, in compliance with federal and state law and regulations. Designation of an authorized representative may be requested at the time of application or at other times as required and will be accepted through the same modalities as applications for medical assistance.

Auto-Assignment – The process utilized by DHS to enroll Members into a Health Plan, using predetermined algorithms, who (1) are not excluded from Health Plan participation and (2) do not proactively select a Health Plan within the DHS-specified timeframe. Also, the process of assigning a new Member to a primary care provider chosen by the Health Plan, pursuant to the provisions of this Contract.

Behavioral Health Services – The full continuum of services from screening to specialty treatment services to support individuals who have mental health and substance use needs, including those with mild to moderate conditions, emotional disturbance, mental illness, or substance use conditions**.**

Benchmark – A target, standard, or measurable goal based on historical data or an objective/goal.

Beneficiary – An individual who has been determined eligible and is currently receiving Medicaid.

Benefit Year – A continuous twelve (12)-month period generally following an open enrollment period. In the event the contract is not in effect for the full benefit year, any benefit limits shall be pro-rated.
Benefits - Those health services that the Member is entitled to under the QUEST program and that the health plan arranges to provide to its Members.

Breast and Cervical Cancer Program – A program implemented by the State of Hawaii, Department of Health (DOH) to detect breast and cervical cancer or pre-cancerous conditions of the breast or cervix. Enrolled individuals receive treatment in the QUEST program when referred by DOH.

Care Team – A team of healthcare professionals from different professional disciplines who work together to manage the physical, behavioral health, and social needs of the Member.

Centers for Medicare & Medicaid Services (CMS) – The United States federal agency which administers the Medicare program and, working jointly with state governments, the Medicaid program, and the SCHIP.

Child and Adolescent Mental Health Division (CAMHD) - A division of the State of Hawaii Department of Health that provides behavioral health services to children ages three (3) through twenty (20) who require support for emotional or behavioral development.

Children's Health Insurance Program (CHIP) or State Children's Health Insurance Program (SCHIP) – A joint federal-state healthcare program for uninsured, targeted, low-income children, established pursuant to Title XXI of the Social Security Act that is implemented as a Medicaid expansion program in Hawaii.

Chronic Condition – Any on-going physical, behavioral , or cognitive disorder. Including chronic illnesses, impairments, and disabilities. There is an expected duration of at least twelve (12) months with resulting functional limitations, reliance on compensatory mechanisms and service use or needs beyond what is normally considered routine.

Claim - A document which is submitted by the provider for payment of health-related services rendered to a Member.

Clinical Practice Guideline - Written tools which are based on clinical evidence of what type of treatment works. Used to best meet medical needs. Examples of guidelines include the following:

- **[Behavioral Health Guidelines**
  - Attention Deficit Hyperactivity Disorder (ADHD) Guideline
  - Depression Guideline
- **Cancer Screening Guidelines**
  - Breast Cancer Screening
  - Cervical Cancer Screening
  - Colorectal Cancer Screening
  - Lung Cancer Screening

        - Prostate Cancer Screening
    - **Cardiovascular Health Guidelines**
        - Aspirin Recommendations
        - Blood Pressure Guideline
        - Cholesterol and Cardiovascular Risk Guideline
        - CKD: Treatment with SGLT-2 Inhibitors
        - Coronary Artery Disease (CAD) Guideline
        - Diabetes Guideline
        - Heart Failure Guideline
    - **Other Guideline Topics**
        - Asthma Guideline
        - Chronic Obstructive Pulmonary Disease (COPD) Guideline
        - HIV/STI Screening & Prevention
        - Management of Overweight and Obesity in Adults
        - Osteoporosis/Fracture Prevention Guideline]

Code of Federal Regulations (CFR) – The codification of the general and permanent rules and regulations published in the Federal Register by the executive departments and agencies of the federal government of the United States.

Cold-Call Marketing – Any unsolicited personal contact, whether by phone, mail, or any other method, by the Health Plan with a potential Member, Member, or any other individual for marketing.

Community Care Foster Family Home (CCFFH) - A home that is certified by the State DOH to provide an individual with twenty-four (24) hour a day living accommodations and home and community-based services (HCBS).

Community Care Management Agency (CCMA) - An agency that is involved with

- locating,
- coordinating and
- monitoring comprehensive services to residents in community care family homes or Members in Expanded Adult Residential Care Homes and assisted living facilities.

A health plan may be the owner of a community care management agency.

Community Care Services (CCS) – A behavioral health program administered by DHS. CCS provides eligible adult Members specialized behavioral health services to severe mental illness (SMI) and severe and persistent mental illness (SPMI).

Community Health Worker (CHW) – A frontline public health worker who is a trusted Member of and/or has a close understanding of the community served to facilitate access to services and improve the quality and cultural competence of service delivery. A CHW serves as an integral Member of the care team, providing in-home visits, accompanying Members to provider visits as needed, and assisting Members with healthcare needs.

Community Integration Services (CIS) – Pre-tenancy supports and tenancy sustaining services that support individuals to be prepared and successful tenants in housing that is owned, rented, or leased to the individual.

- Pre-Tenancy supports help to identify the individual's needs and preferences. Also, assists in the housing search process, and provides help to arrange details of the move.
- Tenancy sustaining services help with independent living sustainability. Includes:
  - tenant/landlord education,
  - tenant coaching and
  - assistance with community integration and inclusion to help develop natural support networks.

Community Paramedic (CP) – An advanced paramedic that works to increase access to primary and preventive care and decrease use of emergency departments, which in turn decreases healthcare costs. Among other things, CPs may play a key role in providing follow–up services after a hospital discharge to prevent hospital readmission. CPs can provide health assessments, chronic disease monitoring and education, medication management, immunizations and vaccinations, laboratory specimen collection, hospital discharge follow–up care, and minor medical procedures. CPs work under the direction of an Ambulance Medical Director.

Community Transition Services (CTS) – A pilot program within the CIS benefit. This program is designed to address eligible beneficiaries' specific health determinants to improve health outcomes and lower healthcare costs. CTS program benefits include transitional case management services, securing house payments, housing quality, safety improvement services, and legal assistance. CTS program benefits are authorized by CMS and shall be provided to all beneficiaries who meet CIS eligibility criteria on a voluntary basis.

Comprehensive Risk Contract – A risk contract that covers comprehensive services including, but not limited to inpatient hospital services, outpatient hospital services, rural health clinic services, federally qualified health center (FQHC) services, laboratory and x-ray services, early and periodic screening, diagnostic, and treatment (EPSDT) services, LTSS, and family planning services.

Conspicuously Visible – Individuals seeking services from, or participating in, the health program or activity could reasonably be expected to see and be able to read the information that is sufficiently conspicuous and visible as defined by HHS Office of Civil Rights at 45 CFR §92.8(f)(1).

Consumer Assessment of Healthcare Providers and Systems (CAHPS®) – A comprehensive set of surveys that ask consumers and patients to report on and evaluate various aspects of quality of their healthcare. The acronym CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Contract – The contract between the Health Plan and DHS to provide medical services. The written agreement between DHS and the contractor that includes the Competitive Purchase of Service (AG Form 103F1 [10/08]), General Conditions for Health and Human Services Contracts

(AG Form 103F [10/08]), any special conditions and/or appendices, this RFP, including all attachments and addenda, and the Health Plan's proposal.

Contract Services – The services to be delivered by the contractor that are designated by DHS.

Contractor – Successful applicant that has executed a contract with DHS.

Co-Payment – The amount that a Member shall pay, usually a fixed amount of the cost of a service.

Cost-Neutral – When the aggregate cost of serving people in the community is not more than the aggregate cost of serving the same (or comparable) population in an institutional setting.

Covered Services - Those services and benefits to which the Member has a right to under Hawaii's Medicaid programs.

Critical Access Hospital (CAH) – A hospital designated and certified as a CAH under the Medicare Rural Hospital Flexibility Program.

Cultural Competency – A set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance, and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with Members. This requires a willingness and ability to draw on community-based values, traditions and customs, to devise strategies to better meet culturally diverse Member needs, and to work with knowledgeable persons of and from the community in developing focused interactions, communications and other supports.

Days - Unless otherwise specified, the term "days" refers to calendar days .

Dental Emergency - An oral condition that does not include services aimed at restoring or replacing teeth and shall include services for relief of dental pain, eliminate serious infection, treat acute injuries to teeth or supportive structures of the oral-facial complex.

Department of Health, Developmental Disabilities Division (DOH-DDD) – The DOH-DDD provides services for persons with intellectual and/or developmental disabilities (I/DD). Most services provided are through the Medicaid 1915(c) HCBS Waiver for individuals with I/DD to support these participants to live in their homes and communities through services that promote each person's self-determination, health, community integration, and safety (Section 1915(c) of the Social Security Act).

Department of Human Services (DHS) – Department of Human Services, State of Hawaii, which also serves as the single State agency responsible for administering the medical assistance program.

Department of Health and Human Services (DHHS) – United States Department of Health and Human Services.

Director – The administrative head of the department of human services unless otherwise specifically noted.

Dual Eligible – Member eligible for both Medicare and Medicaid.

Dual Eligible Special Needs Plan (D-SNP) – A dual eligible special needs plan that enrolls beneficiaries who are entitled to both Medicare (Title XVIII) and Medicaid (Title XIX Medical Assistance from a State Plan). D-SNPs are defined in the federal regulations at 42 CFR §422.2 and authorized at Section 1859 of the Social Security Act.

Durable Medical Equipment (DME) – Medical equipment that is ordered by a doctor for use in the home. These items shall be reusable, such as walkers, wheelchairs, or hospital beds. DME is paid for under both Medicare Part B and Part A for home health services.

Early and Periodic Screening, Diagnostic and Treatment (EPSDT) – EPSDT services aim to identify physical or mental defects in individuals and provide healthcare, treatment, and other measures to correct or ameliorate any defects and chronic condition discovered in accordance with Section 1905r of the Social Security Act. EPSDT includes services to:

- Seek out individuals and their families and inform them of the benefits of prevention and the health services available;
- Help the individual or family use health resources, including their own talents, effectively, and efficiently; and
- Ensure the problems identified are diagnosed and treated early before they become more complex and their treatment more costly.

Effective Date of Enrollment – The date as of which a participating health plan is required to provide benefits to a Member.

Eligibility Determination - An approval or denial of eligibility for medical assistance, as well as a redetermination or termination of eligibility for medical assistance. .

Emergency Medical Condition – The sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms, substance abuse) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of emergency services or immediate medical attention to result in:

- Placing the health of the individual (or with respect to a pregnant woman, the health of the woman, or her unborn child) in serious jeopardy;
- Serious impairment of body functions,
- Serious dysfunction of any bodily functions;
- Serious harm to self or others due to an alcohol or drug abuse emergency;
- Injury to self or bodily harm to others; or
- With respect to a pregnant woman who is having contractions:

- That there is inadequate time to affect a safe transfer to another hospital before delivery; or
- That transfer may pose a threat to the health or safety of the woman or her unborn child.

Emergency Medical Transportation – Ambulance services for an emergency medical condition.

Emergency Room Services – Emergency services provided in an emergency room.

Emergency Services – Covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition that is found to exist using a prudent layperson standard.

Encounter – A record of medical services rendered by a provider to a Member enrolled in the Health Plan on the date of service.

Encounter Data – A compilation of encounters.

Enrollment - The process by which an individual, who has been determined eligible, becomes a Member in a health plan, subject to the limitations specified in the DHS Rules.

Enrollment fee - The amount a Member is responsible to pay that is equal to the spenddown amount for a medically needy individual or cost share amount for an individual receiving long-term care services. A resident of an intermediate care facility for I/DD or a participant in the Medicaid waiver program for individuals with developmental disabilities or intellectual disabilities are exempt from the enrollment fee.

Excluded Services – Healthcare services that health plan does not pay for or cover.

Expanded Adult Residential Care Home (E-ARCH) – A facility, as defined in Section 11-100.1.2, HAR, and licensed by the department of health, that provides twenty-four (24)-hour living accommodations, for a fee, to adults unrelated to the family, who require at least minimal assistance in the ADL, personal care services (PCS), protection, and healthcare services, and who may need the professional health services provided in a nursing facility. There are two types of expanded care ARCHs in accordance with HRS §321-15.62:

- Type I – home allowing five (5) or fewer residents provided that up to six (6) residents may be allowed at the discretion of DOH to live in a type I home, with no more than three (3) nursing facility level residents; and
- Type II – home allowing six (6) or more residents with no more than twenty percent (20%) of the home's licensed capacity as nursing facility-level residents.

Expanded Health Care Needs (EHCN) – EHCN services are provided to Members who have complex healthcare needs and conditions, or who is at risk of developing these conditions is imminent. The Members that meet EHCN criteria are considered highly impactable and likely to benefit from health coordination services. EHCN-eligible Members will have access to a future

service called Hale Ola where they reside and consent to enroll with the Hale Ola (see RFP MQD 2021-008 Section 3.6).

1) EHCN services are provided to adults and children that meet the qualifications of the EHCN population due to the Member having met one or more of these medical conditions:
   a) A serious mental illness (SMI):
      i) Members, who are not enrolled in CCS;
      ii) One or more serious and persistent behavioral health conditions; or
      iii) Including a diagnosable mental, behavioral, or emotional disorder which results in serious functional impairment and substantially interferes with or limits one or more major life activities.
   b) SUD – Members with SUD which include:
      i) Recurrent use of alcohol and/or drugs that causes clinically significant impairment;
      ii) Health problems;
      iii) Disability; and
      iv) Failure to meet major responsibilities at work, school or home.
   c) Two or more of the following chronic conditions:
      i) Asthma;
      ii) Chronic obstructive pulmonary disease (COPD);
      iii) Coronary artery disease (CAD);
      iv) Congestive heart failure (CHF);
      v) Diabetes;
      vi) Obesity;
      vii) Chronic renal disease;
      viii) Chronic liver disease; and
      ix) Members receiving palliative care.
   d) One of the identified chronic health conditions listed above and one impairment in an ADL.
   e) Any of the identified chronic health conditions listed above and have identified SRF needs and/or high utilization of health services, including emergency department utilization.
   f) For Members who have access to another form of health coordination or other service, the following criteria must be met by the contracted provider:
      i) Provider will deliver additional services that otherwise are not available;
      ii) Provider services are likely to have an impact on the Member's health outcomes; and
      iii) Provider services are not duplicative of the other services the Member is receiving.
   g) The EHCN population does not include Members who meet the above EHCN criteria and meet one of the criteria listed below:
      i) Members in a long-term nursing facility for more than ninety (90) days;
      ii) Members receiving hospice care;
      iii) Members in the transplant program; and/or
      iv) Fee-for-service Members.

2) Eligibility Determination for SHCN and EHCN
   a) The Health Plan will complete the HFA to determine needs of the Member and identify if Member would benefit from SHCN and/or EHCN services.

Federal Financial Participation (FFP) – The contribution that the federal government makes to State Medicaid programs.

Federal Poverty Level (FPL) – The federal poverty level (FPL) updated periodically in the Federal Register by the Secretary of Health and Human Services under the authority of 42 USC §9902(2), as

in effect for the applicable budget period used to determine an individual's eligibility in the medical assistance programs.

Federally Qualified Health Center (FQHC) – An entity that has been determined by the Secretary of the DHHS to meet the qualifications for an FQHC, as defined in Section 1861(aa)(4) of the Social Security Act.

Federally Qualified Health Maintenance Organization (HMO) – An HMO that CMS has determined is a qualified HMO under Section 1310(d) of the Public Health Service Act.

Fee-for-Service (FFS) – A method of reimbursement based on payment for specific services rendered to an individual eligible for coverage under Med-QUEST.

Financial Relationship – A direct or indirect ownership or investment interest (including an option or non-vested interest) in any entity. This direct or indirect interest may be in the form of equity, debt, or other means and includes an indirect ownership or investment interest no matter how many levels removed from a direct interest or a compensation management with an entity.

Fraud – An intentional deception or misrepresentation made by an individual with the knowledge that the deception could result in some unauthorized benefit to the individual or some other individual. It includes any act that constitutes fraud under applicable federal or state laws.

Going Home Plus and Institution Relocation Services

1) Person-centered relocation services are provided to help members in institutions (i.e., hospitals, psychiatric residential treatment facilities, prisons, nursing homes, or other long-term care facilities) who are: youth with mental illness; elderly; or have physical, intellectual, and developmental disabilities to move out and receive services to live in their own homes and communities.
2) Relocation activities include all transitions from institutions to communities, including:
    a) Going Home Plus (GHP) eligible Members who meet nursing facility Level of Care and have been institutionalized for at least sixty (60) days for which an enhanced Federal Medical Assistance Percentage (FMAP) is received; and
    b) CIS-eligible Members institutionalized for at least sixty (60) days.

Grievance - An expression of dissatisfaction from a Member, Member's representative, or provider on behalf of a Member about any matter other than an adverse benefit determination.

Grievance Review - A State process for the review of a denied or unresolved grievance by a Health Plan, including instances where the aggrieved party is dissatisfied by the proposed resolution.

Grievance and Appeal System – The term used to refer to the overall system that includes grievances and appeals handled at the Health Plan level with access to the State administrative hearing process.

Habilitation Devices – Devices that support the provision of Habilitation Services in inpatient and/or outpatient settings. Habilitation devices include but are not limited to:

- Mobility devices, such as wheelchairs, motorized scooters, walkers, crutches, canes, prosthetic devices, orthotic braces, and other orthotic devices.
- Devices that aid hearing loss, including hearing aids, cochlear implants (pediatric and adult), and hearing assistive technology.
- Devices that aid speech include DME, and augmentative and alternative communication devices, such as voice amplification systems.
- Prosthetic eyeglasses and prosthetic contact lenses for the management of a congenital anomaly of the eye.
- Dental devices (not for cosmetic purposes).

Habilitative/Habilitation Services – Healthcare services that help to keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Action Plan (HAP) –

a) A HAP is a person-centered plan that is based on the HFA and developed with the Member and/or authorized representative.
b) The HAP will identify the Members' goals; describe the medical, behavioral, and social needs of Members; and identify all services to be utilized to include but not limited to the frequency, quantity, and provider furnishing the services.
c) The Health Plan will develop a process on how to complete the standardized HAP. This process will be submitted to DHS upon request for review and approval.
d) The person-centered HAP for LTSS Members will be based on the HFA and be developed consistent with 42 CFR §441.301 (c).
    i) In developing the LTSS HAP, and working with the PCP and other providers, the Health Plan will consider the appropriate type, amount, and frequency of services that will enable the Member to remain in his or her home or other community placement in order to prevent or Health Action Plan

a) A HAP will be developed for each Member receiving health coordination:
    i) Within thirty (30) calendar days of assessment for SHCN, EHCN, and LTSS Members; or
    ii) Prior to admission to the home for LTSS Members living in a residential setting such as a CCFFH, E-ARCH or ALF.
b) A person-centered team-based approach will be used to create the HAP. It will involve the Care Team as defined in RFP MQD 2021- 008 Section 2.3, Member, Member's family, significant others, caregivers, and/or Member's authorized representative. It will be reviewed and updated as needed following each quarterly review and reassessment.

c) The person-centered HAP process must use plain language and include cultural considerations, strategies for solving disagreement within the planning process, choice regarding services and providers, a process for Members to request service updates, identified risk factors, and risk mitigation strategies.
d) The HAP will include the following:
   i) Member's preferences, strengths and needs;
   ii) Identified goals, problems, and interventions;
   iii) Authorized start and end dates for services;
   iv) Amount, type, frequency and duration of services which is the number of units authorized over a specified period of time, e.g., 10 hours/week for Personal Assistance and Nursing Services (PANS);
   v) Provider of service which is the name of the provider(s) who will be or are already servicing the Member (this may be left blank if the provider(s) are not known or not readily available at the time the service is authorized);
   vi) Name of lead coordinator;
   vii) Clinically appropriate care;
   viii) Gaps in care, including appropriate use of culturally appropriate, evidence- or research-based practices;
   ix) Modifications to treatment plans to address unmet service needs that limit progress;
   x) Opportunities for full integration in community life and control personal resources;
   xi) Interventions to assist a Member during a medical or behavioral health crisis;
   xii) Medication regimen;
   xiii) Back-up plan for situations when regularly scheduled providers are unavailable. Back-up plans may involve the use of non-paid caregivers and/or paid caregivers;
   xiv) Advance care plan; and
   xv) Disaster plan.
e) Additional elements in the HAP may include:
   i) Any behavioral health and other underlying conditions;
   ii) Linking and integrating care with services such as: Collaborative Care Model services, Hawai'i Coordinated Access Resource Entry System (CARES), and other behavioral health resources;
   iii) Addressing needed actions to mitigate identified SRF;
   iv) Applying the Stepped Care Approach concept to Members with behavioral health needs; and
   v) Prevention and health promotion interventions.
f) The HAP process will document the coordination and verification of assessments and evaluations with mental health, substance use disorder (SUD), and other providers.
g) The HAP will be written in accordance with the requirements described in this chapter. At a minimum, the HAP must be:

i) Signed and dated by the Health Coordinator and the Member; the Member's authorized representative or surrogate may sign for the Member;
   (1) The signature can be an electronic signature;
ii) A copy of the HAP will be made available to the Member and/or authorized representative, the PCP and the Care Team; and
iii) Documented, in the Member records or progress notes and shall include the date the signed final HAP was reviewed and discussed, Member's response, the date the copy of the HAP was given to the Member and/or authorized representative and Member's PCP, and any actions, delays or exceptions to obtaining Member or authorized representative signatures on the HAP.

h) Refer to the Reassessments section for additional information and frequency.
i) Any authorization or denial of QUEST covered services, identified in the HAP, must be a collaborative dialogue with the member and his/her family. If the Health Coordinator cannot reach an agreement with the family, the QUEST health plan shall follow their contract for denial of services (QUEST RFP Section 9.5). If the health plan authorizes the termination, suspension or reduction of the member's LTSS, the Health Coordinator shall:
   i) Update the HAP with the authorized change(s) to the start date, provider, frequency/amount and duration of the LTSS;
   ii) Review and discuss the updated HAP with the member prior to the member receiving the Notice of Adverse Benefit Determination;
   iii) Send a Notice of Adverse Benefit Determination (NABD) with appeal rights to the member within the specified timeframe in accordance with Section 9.5.G of the QUEST RFP; and
   iv) Ensure that steps in 4.3.G are followed when HAP updates include service changes that result in NABD.

Healthcare Professional – A physician, podiatrist, optometrist, psychologist, dentist, physician assistant, physical or occupational therapist, speech-language pathologist, audiologist, registered or practical nurse, licensed clinical social worker, nurse practitioner, or any other licensed or certified professional who meets the State requirements of a health care professional.

Healthcare Provider – Any individual or entity that is engaged in the delivery of healthcare services and is legally authorized to do so by the State.

Health Information Exchange (HIE) – HIE allows doctors, nurses, pharmacists, other Healthcare Providers, and patients to appropriately access and securely share a patient's vital medical information electronically—improving the speed, quality, safety, and cost of patient care.

Health Insurance – A contract that requires the health insurer to pay some or all of healthcare costs in exchange for a premium.

Health Maintenance Organization (HMO) – See Managed Care Organizations.

Health Plan - Any healthcare organization, insurance company, accountable care organization, health maintenance organization, or managed care organization that provides Covered Services on a risk basis to Members in exchange for capitated payments.

Health Plan Manual – DHS manual contains operational guidance, policies, and procedures required of the Health Plan participating in QUEST. It will clarify reporting requirements and metrics used by DHS to oversee and monitor the Health Plan's performance. The Health Plan Manual, as amended or modified, is incorporated by reference into the Contract.

Health Professional Shortage Area (HPSA) – An area designated by the United States DHHS' Health Resources and Services Administration (HRSA) as being underserved in primary medical care, dental, or mental health providers. These areas can be geographic, demographic, or institutional in nature.

Health Insurance Portability and Accountability Act (HIPAA) – The Health Insurance Portability and Accountability Act that was enacted in 1996.

Home and Community Based Services (HCBS)- Long-term care services provided to an individual residing in a community setting who is certified by DHS to be at the nursing facility level of care (LOC) and would be eligible for care provided to an individual in a nursing facility or a medical facility receiving nursing facility LOC.

Home Healthcare – Limited part-time or intermittent skilled nursing care and home health aide services, physical therapy, occupational therapy, speech-language therapy, medical social services, DME (such as wheelchairs, hospital beds, oxygen, and walkers), medical supplies, and other services.

Hospice Services – Services to provide comfort and support for Members in the last stages of a terminal illness and their families.

Hospital - Any licensed acute care facility in the service area to which a Member is admitted to receive inpatient services pursuant to arrangements made by a physician. Acute care hospitals may additionally be designated as CAHs, as defined by the Medicare Rural Hospital Flexibility Program.

Hospital Outpatient Care – Care in a hospital that usually does not require an overnight stay.

Hospital Services - Except as expressly limited or excluded by this agreement, those medically necessary services for registered bed patients that are generally and customarily provided by licensed acute care general hospitals in the service area and prescribed, directed, or authorized by the attending physician or other provider.

Hospitalization – Care in a hospital that requires admission as an inpatient for an overnight stay. An overnight stay for observation could be outpatient care.

In Lieu of Service (ILS) – Under the federal Medicaid managed care rules (42 CFR 438.3[e][2]), ILS substitute for services or settings covered in a state plan because they are a cost-effective alternative. The actual costs of providing the ILS are included when setting capitation rates, and they also count in the numerator of the medical loss ratio. ILS, however, can only be covered if the State determines the service or alternative setting is a medically appropriate and cost-effective substitute or setting for the State Plan service; if beneficiaries are not required to use the ILS; and if the ILS is authorized and identified in the contract with Medicaid managed care plans.

Incentive Arrangement – Any payment mechanism under which a Health Plan may receive funds for meeting targets specified in the contract; or any payment mechanism under which a provider may receive additional funds from the Health Plan for meeting targets specified in the contract.

Indian – The term "Indians" or "Indian", unless otherwise designated, means any person who is a Member of an Indian tribe, as defined in this §2.6, except that, for the purpose of 25 USC §§1612 and 1613, such terms shall mean any individual who:

- irrespective of whether he or she lives on or near a reservation, is a Member of a tribe, band, or other organized group of Indians, including those tribes, bands, or groups terminated since 1940 and those recognized now or in the future by the State in which they reside, or who is a descendant, in the first or second degree, of any such Member; or
- is an Eskimo or Aleut or other Alaska Native; or
- is considered by the Secretary of the Interior to be an Indian for any purpose; or
- is determined to be an Indian under regulations promulgated by the Secretary of Health and Human Services.

Indian Health Care Provider (IHCP) means a health care program operated by the Indian Health Service (IHS) or by an Indian tribe, tribal organization, or urban Indian organization (otherwise known as an I/T/U) as those terms are defined in Section 4 of the Indian Health Care Improvement Act (25 USC §1603).

Indian Tribe – The term "Indian tribe" means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) (43 USC §1601 et. seq.), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

Inquiry – A contact from a Member that questions any aspect of a Health Plan, subcontractor, or provider's operations, activities, or behavior, or requests disenrollment, but does not express dissatisfaction.

Institutional or Nursing Facility Level of Care (NF LOC)-The determination that a Member requires the services of licensed nurses in an institutional setting to carry out the physician's planned regimen for total care. These services may be provided in the home or in community-based programs as a cost-neutral, less restrictive alternative to institutional care in a hospital or nursing home.

Instrumental Activities of Daily Living (IADLs) – Activities related to independent living. Includes:

- preparing meals,
- running errands to pay bills or
- pick up medication,
- shopping for groceries or personal items, and
- performing light or heavy housework.

Kauhale Online Eligibility Assistance (KOLEA) System – The State of Hawaii certified system that maintains eligibility information for Medicaid and other medical assistance beneficiaries. Kauhale means community in Hawaiian.

Long-Term Services and Supports (LTSS) – Services provided to a Member in an inpatient medical facility receiving NF LOC or to a resident of a NF LOC. These facilities include assisted living facilities, expanded adult care homes, community care foster family homes, nursing facilities, and sub-acute units.

Managed Care – A comprehensive approach to the provision of healthcare that combines clinical services and administrative procedures within an integrated, coordinated system to provide timely access to primary care and other necessary services in a cost effective manner.

Managed Care Organization (MCO) – An entity that has, or is seeking to qualify for, a comprehensive risk contract under 42 CFR Subpart A that is: (1) a federally qualified HMO that meets the advance directives requirements under 42 CFR Subpart I; or (2) any public or private entity that meets the advance directives requirements and meets the following conditions:

- makes the service it provides to its Medicaid Members as accessible (in terms of timeliness, amount, duration, and scope) as those services that are to other Medicaid Members within the area served by the entity; and
- meets the solvency standards of 42 CFR §438.116.

Marketing – Any communication from a Health Plan to a Member or any other individual that can reasonably be interpreted as intending to influence the individual to enroll in the particular Health Plan, or dissuade them from enrolling into, or dis-enrolling from, another Health Plan.

Marketing Materials – Materials that are produced in any medium by or on behalf of a Health Plan and can reasonably be interpreted as intending to market to potential Members.

Medicaid – the following federal/state program, established and administered by the State, that provide medical care and long-term care services to eligible individuals in the State:

- Medicaid under Title XIX of the Social Security Act,
- The SCHIP under Title XXI of the Social Security Act; and
- The Section 1115 demonstration project under Title XI of the Social Security Act (42 USC subchapters XIX, XXI, and XI).

Medical Expenses – The costs, excluding administrative costs, associated with the provision of covered medical services under a Health Plan.

Medical Facility – A means a facility which:

- Is organized to provide medical care, including nursing and convalescent care;
- Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of the individuals on a continuing basis in accordance with accepted standards;
- Is authorized under state law to provide medical care;
- Is staffed by professional personnel who have clear and definite responsibility to the institution in the provision of professional medical and nursing services including adequate and continual medical care and supervision by a physician, sufficient RN, or licensed practical nurse (LPN) supervision and services and nurse aid services to meet nursing care needs, and appropriate guidance by a physician on the professional aspects of operating the facility.

Medical Necessity – Procedures and services, as determined by DHS, which are considered to be necessary and for which payment will be made. Medically necessary health interventions (services, procedures, drugs, supplies, and equipment) shall be used for a medical condition. There shall be sufficient evidence to draw conclusions about the intervention's effects on health outcomes. The evidence shall demonstrate that the intervention can be expected to produce its intended effects on health outcomes. The intervention's beneficial effects on health outcomes shall outweigh its expected harmful effects. The intervention shall be the most cost-effective method available to address the medical condition. Sufficient evidence is provided when evidence is sufficient to draw conclusions, if it is peer-reviewed, is well-controlled, directly or indirectly relates the intervention to health outcomes, and is reproducible both within and outside of research settings.

Medical Office – Any outpatient treatment facility staffed by a physician or other healthcare professional licensed to provide medical services.

Medical Services - Except as expressly limited or excluded by the contract, those medical and behavioral health professional services of physicians, other health professionals and paramedical personnel that are generally and customarily provided in the service area and performed, prescribed, or directed by the attending physician or other provider.

Medical Specialist – A physician, surgeon, or osteopath who is board certified or board eligible in a specialty listed by the American Medical Association, or who is recognized as a specialist by the participating healthcare plan or managed care health system.

Medicare - Means the healthcare insurance program for the aged and disabled administered by the Social Security Administration under title XVIII of the Social Security Act.

Medicare Special Savings Program Members – Qualified severely impaired individuals, medical payments to pensioners, qualified Medicare beneficiaries, specified low-income Medicare

beneficiaries, qualifying individuals and QDWIs who may be eligible to receive assistance with some Medicare cost sharing.

Medication-Assisted Treatment (MAT) - Treatment for opioid use disorder combining the use of medications (methadone, buprenorphine, or naltrexone) with counseling and behavioral therapies.

Medication-Assisted Treatment (MAT) Medications – The FDA has approved several different medications to treat alcohol and opioid use disorders. MAT medications relieve the withdrawal symptoms and psychological cravings that cause chemical imbalances in the body. Medications used for MAT are evidence-based treatment options and do not just substitute one drug for another.

- Opioid Dependency Medications - Buprenorphine, methadone, and naltrexone are used to treat opioid use disorders to short-acting opioids such as heroin, morphine, and codeine, as well as semi-synthetic opioids like oxycodone and hydrocodone. These MAT medications are safe to use for months, years, or even a lifetime. As with any medication, consult your doctor before discontinuing use. Source: Medication-Assisted Treatment (MAT) | SAMHSA
- Opioid Overdose Prevention Medication - Naloxone is used to prevent opioid overdose by reversing the toxic effects of the overdose. According to the World Health Organization (WHO), naloxone is one of a number of medications considered essential to a functioning health care system.

Source: Medication-Assisted Treatment (MAT) | SAMHSA

Med-QUEST Division (MQD) – The offices of the State of Hawaii, Department of Human Services, which oversees, administers, determines eligibility, and provides medical assistance and services for state residents.

Member – An individual who has been designated by the DHS to receive medical services through the QUEST program and is currently enrolled in a QUEST health plan.

Model of Care (MOC) – A quality improvement tool used to ensure the unique needs of each Member enrolled in a special needs plan (SNP) are identified and addressed. In 2010, the ACA designated the NCQA to execute the review and approval of SNPs' MOC based on standards and scoring criteria established by CMS. NCQA assess MOC from SNPs according to detailed CMS scoring guidelines.

National Committee for Quality Assurance (NCQA) – An organization that sets standards, develops HEDIS measures, and evaluates and accredits Health Plans and other MCOs.

Native Hawaiian – Refers specifically to people of native Hawaiian descent**.**

Neighbor Islands (neighbor islands) – Islands in the State of Hawaii other than Oahu – Hawaii Island, Maui, Lanai, Molokai, Kauai, and Niihau.

Network – A group of doctors, hospitals, pharmacies, and other healthcare experts hired by a health plan to take care of its Members.

New Member - A Member who has not been enrolled in a Health Plan during the prior six (6) month period.

Non-Participating Provider – A provider who does not have a contract with any health insurers or plans to provide services to Members.

Nurse Delegation – In accordance with the current HAR §16-89-100, the ability of a RN to delegate the special task for nursing care to an unlicensed assistive person.

Nursing Facility (NF) – A freestanding or a distinct part of a facility that is licensed and certified to provide appropriate care to individuals referred by a physician. Such individuals are those who need twenty-four hour a day assistance with the normal ADL, need care provided by licensed nursing personnel and paramedical personnel on a regular, long-term basis, and may have a primary need for twenty-four hours per day of skilled nursing care on an extended basis and regular rehabilitation services.

Operational Effectiveness Program - A quality assurance program for Health Plan operations.

Paraprofessional – An unlicensed, licensed, or certified healthcare team Member that provides person centered care, patient engagement, community resources, and culturally-competent care. A paraprofessional may include a medical assistant, community health worker, a peer support specialist, or other specific titles, and provides basic healthcare services in settings such as hospitals, health clinics, physical offices, nursing care facilities and patient homes.

Participating - When referring to a Health Plan it means a Health Plan that has entered into a contract with DHS to provide Covered Services to Members. When referring to a Healthcare Provider it means a Provider who is employed by or who has entered into a contract with a Health Plan to provide Covered Services to Members. When referring to a facility it means a facility that has entered into a contract with a Health Plan for the provision of Covered Services to Members.

Participating Provider – A provider who has a contract with health plans to provide services.

Patient-Centered Medical Home (PCMH) – A system of care designed to meet the needs of the whole patient. The model utilizes a team-based approach, but the PCP is responsible for the continuity and coordination of a patient's care.

Patient Protection and Affordable Care Act of 2010 (ACA) – Federal legislation that, among other things, puts in place comprehensive health insurance reforms.

Peer Support Services – Peer support services are provided by a Peer Support Specialist certified by Adult Mental Health Division of the DOH. Peer support services are coordinated within the

needs and preferences of the Member in achieving the specific, individualized goals that have measurable results and are specified in the care, service, or treatment plan.

Peer Support Specialist – An individual who uses their lived experience of recovery from mental illness, addiction, and/or chronic disease management, plus skills learned in formal training, to deliver services that promote recovery, health, and resiliency. Peer support specialists are certified by Adult Mental Health Division (AMHD) as a part of the Hawaii certified peer specialist program or a program that meets the criteria established by AMHD and shall complete ongoing continuing education requirements. Additionally, they shall be supervised by a mental health professional, as defined by the State.

Performance Improvement Project (PIP) – Quality improvement initiatives undertaken by Health Plans in accordance with 42 CFR §438.240(d) that are designed to achieve, through ongoing measurements and interventions, significant improvement, sustained over time, in clinical and non-clinical care areas that are expected to have a favorable effect on health outcomes and Member satisfaction.

Person-Centered Planning – As defined in 42 CFR §441.301(c)(1)-(3).

Personal Assistance –

1) Personal assistance, sometimes called attendant care for children, are services provided in an individual's home to help them with their IADLs and ADLs.
2) Personal assistance services Level I are provided to individuals, requiring assistance with IADLs in order to prevent a decline in the health status and maintain individuals safely in their home and communities. Personal assistance services Level I is for individuals who are not living with their family who perform these duties as part of a natural support. Personal assistance services Level I is limited to ten (10) hours per week for individuals who do not meet institutional level of care. Personal assistance services Level I may be self-directed and consist of the following:
    a) Companion Services
        i) Companion services, pre-authorized by the health coordinator in the member's health action plan, means non-medical care, supervision and socialization provided to a member who is assessed to need these services. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping/ errands, but do not perform these activities as discrete services. Providers may perform light housekeeping tasks that are incidental to the care and supervision of the individual.
    b) Homemaker/Chore Services
        i) Homemaker/Chore services means any of the activities listed below, when the individual that is regularly responsible for these activities is temporarily absent or unable to manage the home and care for himself/herself or others. Homemaker/chore services, preauthorized by the health coordinator in the member's health action plan, are of a routine nature and shall not require specialized training or professional skills such as those possessed by a nurse or home health aide. The scope of homemaker/chore

services specified in this section shall cover only the activities that need to be provided for the member. and not for other members of the household.

(1) Routine housecleaning such as sweeping, mopping, dusting, making beds, cleaning the toilet and shower or bathtub, taking out rubbish;
(2) Care of clothing and linen by washing, drying, ironing, mending;
(3) Inventory and shopping for household supplies and personal essentials (not including cost of supplies):
(4) Light yard work, such as mowing the lawn;
(5) Simple home repairs, such as replacing light bulbs;
(6) Preparing meals:
(7) Running errands, such as paying bills, picking up medication;
(8) Escort to clinics, physician office visits or other trips for the purpose of obtaining treatment or meeting needs established in the health action plan, when no other resource is available;
(9) Standby/minimal assistance or supervision of activities of daily living such as bathing, dressing, grooming, eating, ambulation/mobility and transfer;
(10) Reporting and/or documenting observations and services provided, including observation of member self-administered medications and treatments, as appropriate: and
(11) Reporting to the assigned provider, supervisor or designee, observations about changes in the member's behavior, functioning, condition, or self-care/home management abilities that necessitate more or less service.

3) Personal assistance services Level II are provided to individuals requiring assistance with moderate/substantial to total assistance to perform ADLs and health maintenance activities. Personal assistance services Level II shall be provided by a Home Health Aide (HHA), Personal Care Aide (PCA), Certified Nurse Aide (CNA) or Nurse Aide (NA) with applicable skills competency. Personal assistance services Level II may be self-directed and consist of the following:
   a) Personal hygiene and grooming, including bathing, skin care, oral hygiene, hair care, and dressing;
   b) Assistance with bowel and bladder care;
   c) Assistance with ambulation and mobility;
   d) Assistance with transfers;
   e) Assistance with medications, which are ordinarily self-administered when ordered by member's physician;
   f) Assistance with routine or maintenance healthcare services by a personal care provider with specific training satisfactorily documented performance, care coordinator consent and when ordered by member's physician;
   g) Assistance with feeding, nutrition, meal preparation and other dietary activities;
   h) Assistance with exercise, positioning, and range of motion;
   i) Taking and recording vital signs, including blood pressure;
   j) Measuring and recording intake and output, when ordered;
   k) Collecting and testing specimens as directed;

l) Special tasks of nursing care when delegated by a registered nurse, for members who have a medically stable condition and who require indirect nursing supervision as defined in Chapter 16-89. HAR;
m) Proper utilization and maintenance of member's medical and adaptive equipment and supplies. Checking and reporting any equipment or supplies that need to be repaired or replenished;
n) Reporting changes in the member's behavior, functioning, condition, or self-care abilities which necessitate more or less service; and
o) Maintaining documentation of observations and services provided.

4) When personal assistance services Level II activities are the primary services, personal assistance services Level I activities identified on the health action plan, which are incidental to the care furnished or that are essential to the health and welfare of the member, rather than the member's family, may be provided.

Physician – A licensed Doctor of Medicine or Doctor of Osteopathy.

Physician Services – Services provided by an individual licensed under state law to practice medicine.

Plan – A benefit provided by employers, unions, or other group sponsors to pay for healthcare services.

Post-Stabilization Services – Covered services related to an emergency medical condition that are provided after a Member is stabilized in order to maintain the stabilized condition or to improve or resolve the Member's condition.

Preauthorization – A decision by a Health Plan that a healthcare service, treatment plan, prescription drug, or DME is medically necessary. Sometimes called prior authorization, prior approval, or precertification. A Health Plan may require preauthorization for certain services prior to Members receiving them, except in an emergency. Preauthorization does not guarantee the Health Plan will cover the cost.

Prepaid Plan – A Health Plan for which premiums are paid on a prospective basis, irrespective of the use of services.

Prescription Drug – Drugs and medications that, by law, require a prescription.

Prescription Drug Coverage – Health plan that helps pay for prescription drugs and medications.

Prescription Monitoring Program (PMP) – The purpose of the program is to improve patient care and stop controlled substance misuse. PMPs use formulary controls, provider-directed interventions such as education, screening, and intervention programs to decrease inappropriate utilization. Additionally, PMPs include a patient review and restriction program that can limit use by Members who are seeking multiple controlled substance prescriptions from different providers, often from multiple pharmacies, within a short period of time.

Presumptive Eligibility – Initial Medicaid eligibility given to a potential Member for a specified period of time prior to the final determination of their eligibility.

Preventive Services (Adult Health) – Services that can prevent or detect illnesses and disease in earlier, more treatable stages, thereby significantly reducing the risk of illness, disability, early death, and medical costs. Examples include screening and preventive services identified in recognized clinical practice guidelines such as those published by the United States Preventive Services Task Force, the Centers for Disease Control and Prevention (CDC), HRSA's women's preventive services guidelines, and DOH's guidelines on screening for tuberculosis. Additional examples of adult preventive services include:

- Immunizations;
- Screening for common chronic and infectious diseases and cancers;
- Clinical, non-clinical, and behavioral interventions to manage chronic disease and reduce associated risks and complications;
- Support for self-management of chronic disease;
- Support for self-management for individuals at risk of developing a chronic disease;
- Screening for pregnancy intention as appropriate;
- Counseling to support healthy living;
- Support for lifestyle change when needed; and
- Screening for behavioral health conditions

Preventive Services (Pediatrics and Adolescent Health) – Services that can prevent or detect illnesses and disease in earlier, more treatable stages, thereby significantly reducing the risk of illness, disability, early death, and medical costs. This includes evidence-based screening and preventive interventions such as those recognized in Bright Futures guidelines issued by HRSA and the CDC, all screening, assessment, and preventive services covered by EPSDT, and DOH screening guidelines for tuberculosis. Additional examples of preventive services include:

- Immunizations;
- Screening for common chronic and infectious diseases and cancers;
- Clinical, non-clinical, and behavioral interventions to manage chronic disease and reduce associated risks and complications;
- Support for self-management of chronic disease;
- Support for self-management for individuals at risk of developing a chronic disease;
- Screening for pregnancy intention as appropriate;
- Counseling to support healthy living;
- Support for lifestyle change when needed; and
- Screening for behavioral health and developmental conditions.

Primary Care – Outpatient care to include: prevention, treatment of acute conditions, and management of chronic conditions. Primary care is the setting for preventive screenings and examinations, and is often the first contact care for an undifferentiated complaint which may result

in diagnostic testing and treatment, appropriate consultation or referral, and incorporates coordination and continuity of care.

Primary Care Provider (PCP) - A practitioner selected by the Member to manage the Member's utilization of health care services who is licensed in Hawaii and is:

- A physician, either an MD or a DO, and shall generally be a family practitioner, general practitioner, general internist, pediatrician, or obstetrician-gynecologist (for women, especially pregnant women) or geriatrician;
- An APRN-Rx. PCPs have the responsibility for supervising, coordinating, and providing initial and primary care to enrolled individuals and for initiating referrals and maintaining the continuity of their care; or
- A physician's assistant recognized by the State Board of Medical Examiners as a licensed physician assistant.

Prior Period Coverage – The period from the eligibility effective date as determined by DHS up to the date of enrollment in a Health Plan.

Prior Period Performance Rate – The actual score on a specific performance measure for the prior reporting period.

Private Duty Nursing (PDN) – PDN is a service provided to individuals requiring ongoing, long-term maintenance nursing care at home or in the community (in contrast to home health or part time, intermittent skilled nursing services under the Medicaid State Plan [MSP]). The service is provided by licensed nurses (as defined in HRS, Chapter 457) within the scope of state law, consistent with physician's orders, and in accordance with the Member's HAP. PDN services may be self-directed under personal assistance level II/delegated using nurse delegation procedures as outlined in HRS §457-7.5.

Private Health Insurance Policy – Any health insurance program, other than a disease-specific or accident-only policy, for which a person pays for insurance benefits directly to the carrier rather than through participation in an employer or union sponsored program.

Protected Health Information (PHI) – As defined in the HIPAA Privacy Rule, 45 CFR Section 160.103.

Provider - Any licensed or certified person or public or private institution, agency, or business concern authorized by DHS to provide healthcare, services, or supplies to individuals receiving medical assistance.

Provider Grievance – An expression of dissatisfaction made by a provider as described in §8.4.B.

Provider Preventable Conditions (PPC) – Provider-preventable conditions are conditions that meet the definition of a healthcare-acquired condition or other provider-preventable conditions. A healthcare-acquired condition (HAC) means a condition occurring in any inpatient hospital setting, identified as a HAC by the Secretary under Section 1886(d)(4)(D)(iv) of the Act; other provider-

preventable condition may include conditions that have been found based upon a review of medical literature by qualified professionals to be reasonably preventable through the application of procedures supported by evidence-based guidelines, and have a negative consequence for the Member. At a minimum, other provider-preventable conditions include wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; or surgical or other invasive procedure performed on the wrong patient.

QUEST- QUEST is the managed care program that provides healthcare benefits, including long-term services and supports, to individuals, families, and children; the program serves both non-aged, blind, or disabled (non-ABD) individuals and ABD individuals, with household income up to a specified federal poverty level (FPL). This is the demonstration project developed by DHS.

Rehabilitative/Rehabilitation Services – Healthcare services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Rehabilitation Devices – Devices that support the provision of rehabilitation services in inpatient and/or outpatient settings. Rehabilitation devices include but are not limited to:

- Mobility devices, such as wheelchairs, motorized scooters, walkers, crutches, canes, prosthetic devices, orthotic braces, and other orthotic devices.
- Devices that aid hearing loss, balance, or tinnitus disorders, including hearing aids, aural rehabilitation with cochlear implants for both pediatric and adult, and hearing assistive technology.
- Devices that aid speech include DME, speech-generating equipment, and augmentative and alternative communication devices, such as voice amplification systems.
- Cognitive aids to assist with memory, attention, and other challenges with cognition.
- Prosthetic eyeglasses and prosthetic contact lenses for the management of trauma to the eye or ophthalmologic disease.
- Dental devices, excluding devices for cosmetic purposes.

Resident of Hawaii – A person who resides in the State of Hawaii or establishes his or her intent to reside in the State of Hawaii.

Risk Share – The losses or gains associated with Health Plan costs or savings related to expected healthcare expenditures that are shared between the Health Plan and DHS. A Health Plan may separately enter into risk share arrangements with providers.

Rolling Plan Change – All QUEST members can change their Health Plan after being in a plan for 12 straight months. This is known as a Rolling Plan Change (RPC) period. When a QUEST member changes their Health Plan, the new plan starts the first day of the second month after the change. For example, if a member asks to change their Health Plan in November, the new plan starts January 1st of the next year.

Rural Health Center (RHC) – An entity that meets the qualifications for an RHC, as defined in Section 1861(aa)(2) of the Social Security Act.

Rural Providers – Primary medical care, dental, or mental health Providers who serve in a HRSA-designated HPSA. HRSA-designated HPSA can be found using the following website: http://hpsafind.hrsa.gov/.

Self-Direction – A service delivery option under LTSS HCBS. Personal assistance services provided for an LTSS Member when the Member, Member's parent, guardian, or legal representative employs and supervises a personal assistant. The personal assistant is certified by the Health Plan as able to provide assistance with ADL and/or IADL provided as an alternative to nursing facility placement to persons with a physical disability. Documentation of this certification will be maintained in the Member's individual plan of care.

Service Area – The geographical area defined by zip codes, census tracts, or other geographic subdivisions, i.e., island that is served by a participating Health Plan as defined in its contract with DHS.

Severe Mental Illness (SMI) – A mental disorder which exhibits emotional or behavioral functioning that is so impaired as to interfere substantially with a person's capacity to remain in the community without treatment or services of a long-term or indefinite duration. This mental disability is severe and persistent, encompassing individuals with SMI, SPMI, or requiring support for emotional and behavioral development (SEBD), resulting in a long-term limitation of a person's functional capacities for primary ADL such as interpersonal relationships, homemaking, self-care, employment, and recreation.

Significant Change – A change that may affect access, timeliness, or quality of care for a Member (i.e., loss of a large provider group, change in benefits, change in Health Plan operations, etc.) or that would affect the Member's understanding and procedures for receiving care.

Skilled Nursing (SN) – Skilled nursing is a service provided to individuals requiring home health or part time, intermittent skilled nursing services under the MSP (in contrast to ongoing, long-term nursing care) at home or in the community. The service is provided by licensed nurses (as defined in HRS Chapter 457) within the scope of state law, consistent with physician's orders and in accordance with the Member's HAP.

Skilled Nursing Care – A LOC that includes services that can only be performed safely and correctly by a licensed nurse (either a RN, a LPN, or APRN).

Social Determinants of Health (SDOH) – Conditions in which people are born, grow, live, work, and age that shape health. Socio-economic status, discrimination, education, neighborhood and physical environment, employment, housing, food security and access to healthy food choices, access to transportation, social support networks and connection to culture, as well as access to healthcare are all determinants of health. Hawaii state law recognizes that all state agency planning

should prioritize addressing these determinants to improve health and well-being for all, including Native Hawaiians.

Special Health Care Needs (SHCN) – SHCN services are provided to Members who have a chronic physical, behavioral, developmental, or emotional condition that requires health-related services of a type or amount that is beyond what is required for someone of their general age.

1) SHCN – Children
   a) A child with SHCN is a Member under twenty-one (21) years of age who qualifies due to having met one or more of the following conditions:
      i) Pregnant;
      ii) Has at least one chronic condition;
      iii) Has cancer, Hepatitis B, Hepatitis C, HIV/AIDS, or tuberculosis;
      iv) Takes medications for any serious behavioral/medical conditions that has lasted, or is expected to last, at least (12) months (excludes vitamins and fluoride);
      v) Has limited ability to do things that most children of the same age can do because of a serious medical/behavioral health condition that has lasted or is expected to last at least twelve (12) months (i.e., need assistance with one or more activities of daily living(ADL));
      vi) Needs or receives treatment or counseling for an emotional, developmental, or behavioral problem that has lasted or is expected to last at least twelve (12) months;
      vii) Needs or receives speech therapy, occupational therapy, and/or physical therapy for a medical condition that has lasted or is expected to last at least twelve (12) months;
      viii) Experiences social conditions such as homelessness or have multiple adverse childhood events (ACE);
      ix) Discharged from an acute care setting when the length of stay is greater than ten (10) days;
      x) Has multiple hospital and emergency department visits during a six (6) month period;
      xi) Has a hospital readmission within thirty (30) days of the previous admission; and/or
      xii) Has any combination of chronic conditions that have a moderate to high level of severity, and those conditions are not included in the EHCN target group populations.

1. SHCN – Adults
      i) An adult with SHCN is a Member who is twenty-one (21) years of age or older who qualifies due to having met one or more of the following conditions:
         (1) High-risk pregnancies;
         (2) Untreated or unmanaged chronic medical condition;
         (3) Untreated or unmanaged behavioral health conditions, including substance use;
         (4) Social conditions such as homelessness, food insecurity, lack of financial benefits, and limited English proficiency to negotiate the healthcare system;
         (5) Use of prescription medication includes the use of atypical antipsychotics, the chronic use of opioids, the chronic use of polypharmacy (e.g., five (5) or more prescription medications), and other chronic usage of specific drugs that exceed the use by other adults in the Health Plan as identified by the Health Plan;
         (6) Has cancer, chronic Hepatitis B, chronic Hepatitis C, late stage HIV/AIDS, or active tuberculosis;
         (7) Discharged from an acute care setting with a length of stay of ten (10) days or longer;
         (8) Multiple hospital or emergency department admissions during a six (6) month period;

(9) Hospital readmission within thirty (30) days of the previous admission; and/or
(10) Has any combination of chronic conditions that have a moderate to high level of severity, and those conditions are not included in the EHCN target population groups.
(11) For SHCN Members who also receive outside HCS from DHS, DOH, Department of Education (DOE) or Community Care Services (CCS), the QUEST HCS will:
  (a) Facilitate access and authorizations to State Plan provider services including medical transportation;
  (b) Coordinate and/or collaborate on person-centered team meetings with outside HCS to impact the Member's health and social outcomes; and
  (c) Not duplicate other services the Member is receiving.

Special Treatment Facility – A licensed facility that provides a therapeutic residential program for care, diagnoses, treatment, or rehabilitation services for individuals who are socially or emotionally distressed, have a diagnosis of mental illness or substance abuse, or who have a developmental disability or intellectual disability (DD/ID).

Specialist – A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage, prevent, or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of healthcare.

State - The State of Hawaii.

State Fiscal Year (SFY) – The period July 1 through the following June 30 of consecutive calendar years.

State Plan – The document approved by DHHS that defines how Hawaii operates its Medicaid program. The State Plan addresses areas of state program administration, Medicaid eligibility criteria, service coverage, and provider reimbursement.

Stepped Care – The concept of Stepped Care is that individuals can move up or down a continuum of services as needed and that treatment level and intervention will be paired with the individual's level of acuity to provide effective care without overutilization of resources. The goal is to meet individual need at the lowest level possible while ensuring high-quality results which allows the system to use limited resources to their greatest effect on a population basis.

Sub-Acute Care – A LOC that is needed by an individual not requiring acute care, but who needs more intensive skilled nursing care than is provided to the majority of patients in a SNF.

Substance Abuse and Mental Health Services Administration (SAMHSA) – The agency within DHHS that leads public heath efforts to advance the behavioral health of the nation. SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.

Substance Use Disorder (SUD) – SUDs occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.

Support for Emotional and Behavioral Development (SEBD) – A program for behavioral health services for children and adolescents administered by CAMHD.

Telehealth – As defined by HRS §346-59.1, the use of telecommunications services to encompass four modalities: store and forward technologies, remote monitoring, live consultation, and mobile health; and which shall include but not be limited to real-time video conferencing-based communication, secure interactive and non-interactive web-based communication, and secure asynchronous information exchange, to transmit patient medical information, including diagnostic-quality digital images and laboratory results for medical interpretation and diagnosis, for the purpose of delivering enhanced healthcare services and information while a patient is at an originating site and the Healthcare Provider is at a distant site. Standard telephone contacts, facsimile transmissions, or email text, in combination or by itself, does not constitute a telehealth service for the purposes of this definition.

Temporary Assistance to Needy Families – Time-limited public financial assistance program that replaced Aid to Families with Dependent Children that provides a cash grant to qualified adults and children.

Third Party Liability (TPL) – Any person, institution, corporation, insurance company, public, private or governmental entity who is or may be liable in contract, tort or otherwise by law or equity to pay all or part of the medical cost of injury, disease or disability of a Member or to Medicaid.

Transitions of Care – The movement of Members between healthcare practitioners, settings, and home as their conditions and care needs change. For example, a Member might receive care from a PCP or specialist in an outpatient setting, then transition to a hospital physician and nursing team during an inpatient admission before moving to another care team at a SNF.

Urgent Care - The diagnosis and treatment of medical conditions which are serious or acute but pose no immediate threat to life or health. Requires medical attention within 24 hours.

Utilization Management Program (UMP) - The requirements and processes established by a Health Plan to ensure Members have equitable access to care, and to manage the use of limited resources for maximum effectiveness of care provided to Members.

Value-Added Services – Under the federal Medicaid managed care rules (42 CFR §438.3[e][1][i]), services that are not covered under the State Plan, but that a Health Plan chooses to spend capitation dollars on to improve quality of care and/or reduce costs. Value-added services seek to improve quality and health outcomes, and/or reduce costs by reducing the need for more expensive care. The cost of value-added services cannot be included in the capitation rates; it can, however, be included in the numerator of the MLR if it is part of a quality initiative.

Value-Based Payment (VBP) – An approach to payment reform that links provider reimbursement to improved performance or that aligns payment with quality and efficiency. This form of payment holds Healthcare Providers accountable for both the cost and quality of care they provide. VBP strives to reduce inappropriate care and to identify and reward the highest performing

providers. VBP may include but not be limited to different reimbursement strategies such as FFS with incentives for performance, capitation payment to providers with assigned responsibility for Member care, or a hybrid model.

Waste – Overutilization of services or other practices that do not improve health outcomes and result in unnecessary costs. Generally, not caused by criminally negligent actions but rather the misuse of resources.

Whole-Person Care – Whole-person care addresses the health, behavioral health, psycho-social, and social services needs of a Member in a person-centered manner with the goals of improved health outcomes and more efficient and effective use of resources.

For more information, please call us at one of the following numbers below:

Kaiser Permanente QUEST Call Center

808-432-5330 or **1-800-651-2237** (toll free)
711 TTY (toll free) hearing/speech impaired
Monday - Friday, 7:45 a.m. - 4:30 p.m. (except holidays)

After-Hours Advice Line

24/7 advice
1-833-833-3333
711 TTY (toll free) hearing/speech impaired
Weekdays, 5 p.m. - 8 a.m.
Weekends and holidays, 24 hours

Prescription

Fill and refill at **kp.org/pharmacycenter**
Order refills by phone, 24 hours a day, 7 days a week
808-643-7979 (statewide)
711 TTY (toll free) hearing/speech impaired