

QUEST (Medicaid) Member Handbook

Your introduction to Kaiser Permanente



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 <https://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. Kekeru **1-800-651-2237** ka ereni kich meni fosun fonu ke kan fos non. (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**).

(Laotian) ທ່ານຕ້ອງການຄວາມຊ່ວຍເຫຼືອໃນພາສາອື່ນຫຼືບໍ່? ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ ລວມທັງການຊ່ວຍເຫຼືອ ແລະ ການບໍລິການຊ່ວຍເຫຼືອເສີມທີ່ເໝາະສົມ, ໂດຍບໍ່ເສຍຄ່າ, ແມ່ນມີໃຫ້ທ່ານ. ໂທຫາ **1-800-651-2237** ເພື່ອບອກພວກເຮົາວ່າທ່ານເວົ້າພາສາໃດ. (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 jipaŋ ilo kajin ko jet? Ro rej ropajikin jipaŋ eok ikijjien kajin im jermal ko jet repojakin jermal ippam ilo ejjelok oŋaer. Kūr tok **1-800-651-2237** ñan kaaroŋ tok kōm kōn kajin eo am. (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**).

(Thai) คุณต้องการความช่วยเหลือในภาษาอื่นหรือไม่ คุณสามารถขอรับบริการช่วยเหลือด้านภาษารวมทั้งเครื่องช่วยเหลือนและบริการเสริมที่เหมาะสมได้ฟรี โทร **1-800-651-2237** เพื่อแจ้งให้เราทราบว่าคุณพูดภาษาอะไร (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**).



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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

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

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

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 a 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 for providing and arranging 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.

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu), **1-800-651-2237** (toll-free), **711** (TTY)

Changing plans. QUEST members can change their Health Plan at any time after they have been in the same plan for at least 12 months. To change plans, call the DHS Med-QUEST Division toll-free at 1-800-316-8005 (TTY 711) or visit a Med-QUEST Eligibility Office.

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
- Identifiers for prescription, Bank Identification Number/Processor Control Number (BIN/PCN), a group number and an active date

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

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu), **1-800-651-2237** (toll-free), **711** (TTY)

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).

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **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, (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.

For help or for more information, please visit **kpquest.org** or call **808-432-5330** (Oahu), **1-800-651-2237** (toll-free), **711** (TTY)

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.

For help or for more information, please visit **kpquest.org** or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

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 17). 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.

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

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

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu), **1-800-651-2237** (toll-free), **711** (TTY)

Permanent 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)

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu), **1-800-651-2237** (toll-free), **711** (TTY)

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.

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu), **1-800-651-2237** (toll-free), **711** (TTY)

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
 - 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

Have a health need that can't wait? You have options to get care, day or night. Learn more about your care options at kp.org/getcare.

24/7 Advice Line

Talk with a registered nurse anytime. Call **1-833-833-3333 (TTY 711)** for things like:

- Medical and mental health questions
- Help choosing the right care
- Self-care advice

Get Care Now

24/7 virtual care by video or phone with a clinician.* No appointment needed. Get Care Now is for things like:

- Coughs, cold, or flu
- Urinary tract infections
- Pink eye

*When appropriate and available. If you travel out of state, phone appointments and video visits may not be available in some states due to the states' health care provider licensing laws. These laws differ by state.

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:

Oahu

Honolulu Medical Office

1010 Pensacola Street

Honolulu, HI 96814

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

401 Kamokila Blvd.

Kapolei, HI 96707

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.

Adventist Health Castle Urgent Care-Kailua

660 Kailua Rd.

Kailua, HI 96734

7 days a week, 7 a.m.–7 p.m.

Please call **1-833-833-3333** for an appointment before your visit.

Maui

Wailuku

Maui Lani Medical Office

55 Maui Lani Pkwy

Wailuku, HI 96793

Monday–Friday, 8 a.m.–8 p.m.

Weekends and most holidays, 8 a.m.–5 p.m.

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

Closed Christmas and New Year's Day

Members can also visit the following affiliated urgent care centers on Maui. Before getting care, please call **1-833-833-3333 (TTY 711)** so we can help to direct your care appropriately.

Hana

Hana Health
4590 Hana Highway
Hana, HI 96713

Kahului

Minit Medical Urgent Care
Maui Marketplace
270 Dairy Rd., #239
Kahului, HI 96732

Kihei

Doctors On Call Urgent Care
The Shops at Wailea
3750 Wailea Alanui Dr., Unit B34, Level 1
Kihei, HI 96753

Minit Medical Urgent Care Kihei
1325 S. Kihei Rd., Ste. 103
Kihei, HI 96753

Lahaina

Doctors on Call
Times Market Place / North Kaanapali
3350 Lower Honoapiilani Rd., Unit 211
Lahaina, HI 96761

Minit Medical Urgent Care Lahaina
2580 Kekaa Dr., Ste. 111
Lahaina, HI 96761

E-visit

Fill out an online questionnaire. Get advice or treatment within 24 hours. E-visits are for things like:

- Urinary tract infections
- Diarrhea
- Cold symptoms
- Insomnia
- Anxiety

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

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 Permanente'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:

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

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
Kealahou, 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 Kawaihau 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

Waianae Coast Comprehensive

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

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

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 (1/2) 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).

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

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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.
 - 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.

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu), **1-800-651-2237** (toll-free), **711** (TTY)

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.

Please see our QUEST Medication-Assisted Treatment (MAT) policy found here: [KP QUEST Hawaii Policy Medication-Assisted Treatment \(MAT\)](#). This policy describes coverage of MAT for opioid use disorders (OUD) to meet the requirements for MAT within the QUEST Contract and federal rules. This policy does not address MAT for other SUDs.

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.

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

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.

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

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**.

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

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 needed.
Cognitive Rehabilitation Services	These services help people who have problems with thinking, memory, behavior, or communication. This often includes people with a brain injury. The services help members build skills needed for daily life. Five skill areas may be reviewed: • Attention skills, such as staying focused or switching between tasks • Vision skills, such as seeing clearly, tracking objects, scanning, and remembering what is seen • Information skills, such as understanding sounds, organizing information, and using information quickly • Memory skills, such as knowing where you are, remembering events, and recalling information • Planning and self-management skills, such as setting goals, solving problems, and checking progress Services may include: • Education • Process training • Helping the member learn and use helpful strategies • Practicing skills in daily activities • Selected approaches should match the appropriate level of awareness of cognitive skills • Some techniques/strategies include: ○ Speech/language/communication ○ Neuropsychological assessment ○ Compensatory memory techniques ○ Executive functions strategies ○ Reading/writing skills retraining
Diagnostic Testing	Services may include: • Screening, X-rays, and imaging tests • Screening and lab tests • Other screening, imaging, or lab services These services are covered when medically needed.

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Service	Description
	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	Dialysis may be provided by: • Medicare-certified hospitals • Medicare-certified end stage renal disease (ESRD) providers Dialysis may be provided in: • 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 needed • Hepatitis B surface antigen • Anti-HB testing for patients on hemodialysis • 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

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1-800-651-2237 (toll-free), **711** (TTY)

Service	Description
	• 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 is covered when it is 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 needed durable medical equipment covered by the Hawaii Medicaid program Prior approval is required.
Emergency and Post-Stabilization Services	Emergency room services are covered for emergency conditions. If the condition is not an emergency, you may have to pay for charges related to the visit. Kaiser Permanente will not deny payment for emergency services if a reasonable person would think emergency care was needed, even if it is later found that emergency care was not needed. This applies to in-network and out-of-network providers. You are also covered for care that keeps your condition stable after an emergency. Post-stabilization services include follow-up outpatient specialist care. 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 age 21 may include: • Medical and behavioral health screening • Dental screening and referral to dentist • Diagnostic tests • Immunizations • Preventive care, etc.

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1-800-651-2237 (toll-free), **711** (TTY)

Service	Description
	• Additional services to correct or amend defects of physical, mental/emotional, and conditions discovered as a result of EPSDT screens when medically needed.
Family Planning Services	Services for members who can become pregnant and need family planning support: • 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	Fluoride varnish is covered for children ages 1 through 6 when applied by a qualified primary care provider. This applies if the child has not received fluoride treatment from a dentist or qualified primary care provider in the past six months. Qualified primary care providers include doctors and nurse practitioners. They may ask a physician assistant, registered nurse, licensed practical nurse, or certified medical assistant to apply the varnish under direct supervision.
Habilitation Services	Habilitation services and devices help members build, improve, or keep daily living skills when medically needed. These services and devices may include: • Audiology services • Occupational therapy • Physical therapy • Speech-language therapy • Vision services • Augmentative communication devices • Reading devices • Visual aids

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Service	Description					
	Devices used only for school activities are not covered unless they are medically needed. This does not include routine services listed under Vision Services.					
Hearing Services	Hearing services may include: • Diagnostic services • Screening • Preventive care • Corrective services/equipment/supplies					
	Service	Age 3 years or younger	Age 4 years or older	Under age 21	Age 21 and older	Prior approval required
	Initial Exam			One time a year	One time a year	No
	Electroacoustic Exam	4 times per year	2 times per year			
	Fitting, teaching, and hearing aid check			Two times every three years	One time every three years	Yes
	Hearing aid devices, including warranty and trial or rental period a trial or rental period			One hearing aid per ear every 24 months	One hearing aid per ear every 24 months	Yes
	Services are provided by, or under the direction of, an ear, nose, and throat doctor or an audiologist when medically needed.					
Home Health Services	Home health services are part-time care for members who do not need to stay in the hospital. A doctor directs the care to help prevent another hospital stay or the need to live in a care facility. Qualified home health agencies may provide these services in the member's home: • Skilled nursing • Home health aides • Medical supplies and DME • Therapeutic services (physical and occupational therapy) • Audiology and speech pathology					
Immunizations	Covered vaccines may include those recommended by the CDC's Advisory Committee, such as:					

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Service	Description
	• Influenza • Diphtheria usually combined with Tetanus • Pneumococcal vaccine • Other vaccines as needed
Inpatient Hospital Services for Medical, Surgical, Maternity/Newborn Care, and Rehabilitation	This includes room and meals during a hospital stay. Covered hospital services may 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 Services are covered when medically needed.
Inpatient Hospital Maternity/Newborn Care Services	Healthy members with uncomplicated deliveries may stay in the hospital for up to: • 48 hours after a natural birth • 96 hours after a cesarean section The member and doctor may agree to leave the hospital earlier.
Medical Services Related to Dental Needs	Kaiser Permanente covers dental-related medical services when they are medically needed and provided in a medical facility, such as a hospital. This may include: • Referrals to other providers • Follow-up care • Help coordinating care • Medical services related to dental needs, such as: • Emergency room treatment • Hospital stays • Other services received during a hospital stay • Operating room services • Surgery to remove tumors • Removal of cysts or growths • Surgery involving bone tissue or surgical cuts • Treatment for simple or serious fractures • Oral surgery to repair injury-related wounds and related surgical supplies • Blood transfusion services and outpatient surgery center services • X-rays • Laboratory services • Drugs • Doctor exams • Consultations

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Service	Description
	• Second opinions • Sedation by a doctor anesthesiologist • Dental or medical services caused by a dental condition when provided in a medical facility, such as a hospital or outpatient surgery center This also includes: • Medical services for adults and children that are needed as part of dental treatment • Dental procedures done by oral surgeons or doctors, such as plastic surgeons, ear/nose/throat doctors, or general surgeons • Services by a dentist or doctor for a medical emergency, such as a car accident, when the care is mainly medical • Services for mouth or face injuries or disease. This may include infections from the mouth, cysts, tumors, or face reconstruction surgery done during a hospital stay. • Kaiser Permanente does not cover services in a private office or hospital outpatient dental clinic when the services are not medically needed or are available through government-sponsored or subsidized dental clinics. Also see “Covered by Med-QUEST but not by Kaiser Permanente” at the end of this section.
Nutrition Counseling	Nutrition counseling services may include: • Learning how to manage diabetes • Nutrition counseling for obesity • Nutrition counseling for other health problems related to how the body uses food, when medically needed
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: ○ Behavioral health providers (psychologists, marriage and family therapists, mental health counselors, and CSACs) When services are Medically needed
Outpatient Hospital Services	Outpatient hospital services help prevent, find, or treat an illness or injury. These services may include: • Family planning • Medical services related to dental needs • Imaging services • Laboratory studies • Oncology services • Diagnostic testing

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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 done in a freestanding or hospital outpatient surgery center • Emergency services available 24 hours a day, 7 days a week • Urgent care services • Medical supplies, equipment, and drugs Services are covered when medically needed.
Physician Services	Services provided by doctors, or by staff working under a doctor's direct supervision, may include: • Physical examinations • Screening examinations • EPSDT screenings for children and youth under age 21 Services are covered when medically needed and may be provided in places such as: • Physician's office • Clinic • Private home • Licensed hospital • Licensed skilled nursing or intermediate care facility • Licensed or certified residential setting
Podiatry (foot and ankle) Services	Treatment for foot and ankle conditions may include: • Office or clinic care that does not include surgery • Diabetic foot care, inpatient or outpatient, that does not include surgery • X-rays and imaging for the ankle and below • Surgery for the ankle and below • Office or outpatient clinic care for foot or ankle infection or injury • Bunion surgery when the bunion has a skin sore or a nerve problem caused by the bunion
Pregnancy-Related Services for Pregnant Women and Expectant Parents	Services support the health of the pregnant member and baby during pregnancy and for up to 60 days after birth, when medically needed. Pregnancy and maternity care may include:

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Service	Description
	• Prenatal care • Diagnostic tests, such as imaging, lab tests, and other needed tests • Care for miscarriage-related conditions, when medically needed • Health education and screening for conditions that could make a pregnancy high risk • Fetal development • Labor, delivery, and care after birth • Diagnostic ultrasound • Fetal stress and non-stress testing • Prenatal vitamins • Screening, diagnosis, and treatment for pregnancy-related conditions. This may include substance use screening, depression screening, and needed behavioral health or substance use care. • 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 • Hospital, doctor, other practitioner, and other services that may affect pregnancy outcomes • Inpatient and outpatient substance use treatment for pregnant and parenting members and their children *May be extended with prior approval.
Prescription Drugs	Prescription drugs are covered when medically needed to help improve or manage the member's health. This includes behavioral health medicines for children who get services from CAMHD. This may include: • Prescription drugs and some over-the-counter drugs on the approved drug list, when prescribed by a licensed provider • Help managing medicines and counseling about medicines • Medicines for non-pulmonary and latent tuberculosis when not covered by the Department of Health
Preventive Services – Adult (21 years or older)	Adult preventive services may include: • Screening for abdominal aortic aneurysm for members who meet the rules • Blood pressure • Breast cancer screening • Cervical cancer screening • Medicine to help prevent illness, when appropriate • Colorectal cancer screening

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Service	Description
	• Diabetes screening for members who meet the rules • Health education and counseling • Hepatitis C screening for members who meet the rules • 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)	Children’s preventive services may include: • Dental checkups and fluoride based on the child’s age • Health education based on the child’s age • EPSDT services • Hospital stay for a healthy newborn born at full term • Immunizations • Newborn screening • Other lab screening tests based on the child’s age • Screening to check the child’s health • Tuberculin skin testing 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 covered dental benefits and help you find a dentist near you.
Preventive Services – Pregnant Women	Preventive services for pregnant members may include: • Amniocentesis, ultrasound, fetal stress tests, and non-stress tests used to check the baby’s health • Checking for early labor • Health education and screening • Hospital stays • Lab screening tests during pregnancy • Prenatal visits • Prenatal vitamins, including folic acid
Radiology/Laboratory/Other Diagnostic Services	These services may include: • X-rays, imaging, and treatments using radiology • Screening and lab tests used to find health problems • Other medically needed tests or treatments Some services may need prior approval.
Rehabilitation Services	Rehabilitation services are for members who are expected to improve within a reasonable time. Care may be provided by a licensed physical therapist,

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Service	Description
	occupational therapist, audiologist, or speech-language pathologist. A physical therapy assistant or certified occupational therapy assistant may help when directly supervised by the appropriate licensed therapist. Services may include: • Physical therapy • Occupational therapy • Audiology • Speech-language pathology Services are for members who are expected to improve within a reasonable time. Services for children under EPSDT may have different rules. Prior approval is required for all rehabilitation services except for the initial evaluation.
Sleep Laboratory Services	Sleep labs and sleep disorder centers help find and treat sleep problems. Sleep lab providers must be approved by the American Academy of Sleep Medicine.
Smoking Cessation Services	• Services may include: • At least four counseling sessions for each quit attempt. Each session must be at least 10 minutes. Sessions may be in person, by phone, one-on-one, or in a group. • Counseling focuses on two key supports: learning problem-solving skills and getting social support during treatment. • Counseling must be provided by trained licensed providers, or by certified tobacco treatment specialists working under a licensed provider. • Medicines approved by the U.S. Food and Drug Administration (FDA) • No out-of-pocket cost or copayment is required for these services or medicines. • No prior approval or step therapy is needed for treatment.
Sterilizations and Hysterectomies	Sterilization and hysterectomy services may be covered for members when these rules are met: • The member is age 21 or older when they give consent. • The member is able to understand and make the decision. • The required consent form is signed at least 30 days before the procedure, but not more than 180 days before the procedure, unless an exception applies. • For premature delivery or emergency abdominal surgery, the procedure may be done if at least 72 hours have passed since the consent form was signed.

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Service	Description
	- For premature delivery, the consent must be signed at least 30 days before the expected delivery date. The expected delivery date must be written on the consent form. - An interpreter or other communication help is provided when needed. - The member is not living in an institution, such as a prison, mental hospital, or rehabilitation facility. - If the member cannot make the decision, a court order is required and the required waiting period must be followed. Hysterectomies are not covered when: - The main reason is to make the member unable to become pregnant or cause pregnancy. - There is more than one reason, but the main reason is to make the member unable to become pregnant or cause pregnancy. - It is done to try to prevent cancer when it is not medically needed.
Telehealth Services	Telehealth services include live visits by video or web call. They are covered when an in-network provider refers you and you have trouble getting to the provider. Telehealth services are not available from providers outside the United States.
Transportation Services	Transportation services may include emergency and non-emergency ground or air transportation. Transportation is covered to and from medically needed covered appointments for: - Members who do not have transportation - Members who live where public transportation is not available or cannot use public transportation Transportation is also covered when the member needs treatment that is not available nearby. Travel services may include: - Ground and air transportation - Lodging - Meals Prior approval is required. Travel may be covered for the member and, if needed, one attendant. Transportation may also be covered when specialty providers, such as psychiatrists or specialty doctors, are not available nearby.

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Service	Description
Urgent Care Services	Urgent care is for a serious medical problem that is not life threatening but needs care 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 outside the service area is covered only for members under age 21.

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Service	Description		
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
	Vision aids** such as glasses***, contact lenses****, frames, parts of glasses, fittings, and adjustments	One every 24 months	One every 24 months
	*More visits may be covered with prior approval when medically needed. **Vision aids must be prescribed by an eye doctor or optometrist and must be medically needed. Members under age 40 need a medical reason for bifocals. ***Replacement glasses or new glasses may be covered during the benefit period with prior approval when the prescription changes a lot. ****Contact lenses are covered only when medically needed. A new 24-month period starts each time vision aids are given. Also covered for all members: • Prescription lenses • Cataract removal • Prosthetic eyes • Cornea transplants when allowed by Hawaii Administrative Rules Emergency eye care is covered for all members without prior approval. Vision services not covered: • Orthoptic training • Prescription fee • Progress exams • Radial keratotomy • Visual training • Lasik procedure		
Other Facility Services			

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
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Service	Description
Hospice Care	Hospice care is for members who are terminally ill and are expected to live six months or less. Hospice may be provided at home, in a nursing facility, or in an inpatient setting. Children under age 21 may still receive treatment to manage or cure their illness while getting hospice care.
Nursing Facility	Nursing facility services may include: • 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)	Standard behavioral health services may include: • Room and board • Nursing care • Medical supplies • Equipment • Medications • Medication management • Diagnostic services • Professional services • Medically needed services • Substance abuse treatment services Triage lines, screening tools, telemedicine, e-visits, and other technology-based services are covered when appropriate. Services are covered for members who are involuntarily committed for evaluation and treatment when medically needed. These services are not covered for members who receive behavioral health services through the CCS program.
Ambulatory Mental Health Services	Ambulatory mental health services may include: • 24-hour access line • Mobile crisis response • Crisis stabilization • Crisis management • Crisis residential services The State covers psychiatric evaluation and treatment for members who are criminally committed to ambulatory mental health settings.

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Service	Description
	Medical and standard behavioral health services for these members may be billed to Kaiser Permanente.
Collaborative Care Model	This service is provided by a primary care team. The team includes a primary care provider and a care manager who works with a psychiatric consultant, such as a psychiatrist.
Psychotropic Medications and Medication Management	Medicines and medicine management may include: • Evaluation, prescriptions, and ongoing management of behavioral health medicines • Medication management • Counseling • Education • Use of treatment guidelines and recommended steps for care •
Inpatient Psychiatric Hospitalizations	Inpatient psychiatric hospital services may include: • Room/board • Nursing care • Medical supplies • Equipment • Medications and Medication Management • Diagnostic services • Psychiatric and other behavioral health practitioner services • Ancillary services • Other services Services are covered when medically needed.
Psychiatric or Psychological Evaluation and Treatment	Services to evaluate and treat behavioral health needs may include: • Individual and group counseling and monitoring
Medically needed Alcohol and Chemical Dependency Services	Inpatient and outpatient substance use treatment services are covered when medically needed. Services must be provided in a setting approved under standards from the Alcohol and Drug Abuse Division (ADAD) of the Hawaii State Department of Health.
Medication-Assisted Treatment (MAT)	Medication-Assisted Treatment uses medicines with counseling and behavioral therapy to treat substance use disorders.

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Service	Description
	Medicines must be approved by the FDA and chosen based on each member's needs.
Parity in Mental Health and SUD	Services are covered as needed to meet federal rules for equal coverage of mental health and substance use disorder benefits.
SBIRT	SBIRT provides early help for members who have a substance use disorder or may be at risk for one.
Substance Use Disorder (SUD) Treatment	Substance use disorder treatment is covered when medically needed. Treatment may be inpatient or outpatient and must be provided in an ADAD-approved setting. Services may include: • Medication approved by FDA for SUDs. • Methadone/Levomethadyl acetate services for acute opiate detoxification as well as maintenance.
Long-Term Services and Supports (LTSS)	
Older adults and members with disabilities may get care in a nursing facility or in the community. Community settings may include care homes, foster homes, or the member's own home through Home and Community Based Services (HCBS). The DHS 1147 - Level of Care (LOC) and At-Risk Evaluation Form is used to decide what kind of help the member needs. This form is completed at least once a year to see if the member's needs have changed. Members who live in their own home and are At-Risk may get limited services, such as: • 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 get more LTSS services, a member must meet the Intermediate Care Facility (ICF) level of care and be approved by the State for long-term care benefits.	
Acute Waitlisted SNF/ICF	Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF) level of care may be provided in an acute care hospital bed while the member is waiting for SNF or ICF placement.
Adult Day Care Center (ADC)	ADC provides supportive care for four or more adults with disabilities. Services may include: • Staff watching over and supporting members during the day

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Service	Description
	Helping coordinate and follow behavioral, medical, and social care plans. This includes following instructions in the Health Action Plan and offering therapy, social, learning, and recreational activities. Services are provided only by qualified or trained people. This may include family members and professionals, such as an RN or LPN, from an authorized agency. ADC does not include giving medicine, tube feedings, or other tasks that require health care training.
Adult Day Health Center (ADH)	ADH is an organized day program with nursing oversight. It is for adults with physical or mental health conditions. The goal is to help members stay in the community as much as possible. ADH is provided under the supervision of an RN. Members who need skilled nursing services receive care from an RN or under the direct supervision of an RN. ADH services may 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.

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

Service	Description
	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 • 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)

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

Service	Description
Counseling and Training	Counseling and training services are provided to the member, family members, caregivers, and professional or paraprofessional caregivers who help the member. Services may be given one-on-one or in a group. They may be provided in the member's home or another approved location. Counseling and training may include: • Training for members, families, and caregivers about the member's condition, illness, and how the illness may change over time • Information about how illnesses spread and how to prevent infection • Training on the member's physical, emotional, and special treatment needs • Employer training for consumer-directed services • Instructions about treatment plans • Training on how to use equipment listed in the Health Action Plan (HAP) • Updates on employer skills needed to keep the member and home safe • Crisis intervention • Supportive counseling • Family therapy • Suicide risk assessments and support • Counseling about death and dying • Counseling for grief before a loss happens • Substance Use Disorder counseling • Nutrition assessment and counseling • Help learning coping skills to manage stress caused by changes in the member's physical, medical, or mental health
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 needed to ensure the health, welfare, and safety of the member, allowing the 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:

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Service	Description
	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	Moving help may be approved only in rare cases. The Health Coordination team must review the member's needs and decide that the member needs to move to a new home. Examples include: • The member's home is unsafe or in poor condition. • The member is being evicted from their current home. • The member can no longer afford the home because the rent went up. • The member uses a wheelchair and lives above the first floor in a building with no elevator. • The home cannot support the member's added equipment needs. • Moving costs may include packing and moving the member's 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.

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Service	Description
Nursing Facility (NF), Skilled Nursing Facility (SNF), or Intermediate Care Facility (ICF)	Nursing facility services are provided in a licensed and certified nursing facility. These facilities provide skilled nursing care and rehabilitation services on a regular basis. Members in a nursing facility need help 24 hours a day with daily activities. This may include Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). Members also need regular, long-term care from licensed nursing staff and other trained health care staff. Services may include skilled nursing care, health-related care, and rehabilitation services in an inpatient facility. Nursing facility services may also include: • Individual and group activities • Meals and snacks • Housekeeping and laundry • Nursing services • Social work services • Nutrition services and monitoring • Counseling • Pharmacy services • Rehabilitation services
Personal Assistance Service Level I (PA1)	For members who do not live with family and may need help with daily activities. The member may direct these services. Services may include: • Companion services, such as help with meal preparation, laundry, and errands. Prior approval is needed. • Homemaker and chore services, such as: ○ Routine cleaning, including sweeping, mopping, dusting, making beds, cleaning the toilet, shower, or bathtub, and taking out trash ○ Washing, drying, ironing, and mending clothes and linens ○ Shopping for household supplies and personal items, not including the cost of the items ○ Light yard work, such as mowing the lawn ○ Simple home repairs, such as changing light bulbs ○ Preparing meals ○ Going with the member to clinics, doctor visits, or other trips needed for care listed in the Health Action Plan, when no other help is available ○ Providing standby help, limited help, or supervision with daily activities, such as bathing, dressing, grooming, eating, walking, moving around, and transferring ○ Reporting or writing down what was seen and what services were provided, including watching the member take their own medicine or treatment, when appropriate

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Service	Description
	○ Reporting changes in the member's behavior, ability to function, health, or ability to care for themselves or manage their home when services may need to change
Personal Assistance Service Level II (PA2)	For members who need: • Moderate to total assistance with Activities of Daily Living (ADLs) and health maintenance activities The member may self-direct these services. Services may include: • Help with personal hygiene and grooming, such as bathing, skin care, oral hygiene, hair care, and dressing • Help with bowel and bladder care • Help with walking and moving around • Help with transfers • Help taking medications that the member would usually take on their own, when ordered by the member's physician • Help with feeding, nutrition, meal preparation, and other dietary activities • Help 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 nursing tasks when delegated by a registered nurse, for members who have a medically stable condition and need indirect nursing supervision as defined in Chapter 16-89, Hawaii Administrative Rules (HAR) • Proper use and care of the member's medical and adaptive equipment and supplies • Checking and reporting equipment or supplies that need repair or replacement • Reporting changes in the member's behavior, functioning, condition, or self-care abilities when services may need to increase or decrease • Keeping records of observations and services provided • When Personal Assistance Services Level II activities are the main services, Personal Assistance Services Level I activities listed in the Health Action Plan may also be provided if they support the member's care, health, or safety. Services may be provided by a Home Health Aide, Personal Care Aide, Certified Nurse Aide, or Nurse Aide.
Personal Emergency Response Systems (PERS)	A Personal Emergency Response System (PERS) is an electronic device with a 24-hour emergency help service. It helps members get quick help during an emotional, physical, or environmental emergency. PERS is planned to meet each Member's needs and abilities. It may include:

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1-800-651-2237 (toll-free), **711** (TTY)

Service	Description
	• Training • Installation • Repair • Maintenance • Emergency response support PERS may be provided through an electronic device for members who are at high risk of institutionalization and need help in an emergency. The Member may also wear a portable “help” button so they can move around safely. The response center is staffed by trained professionals. Allowable types of PERS items may include • 24-hour answering or paging • Beepers • Med-alert bracelets • Medication reminder services • Intercoms • Life lines • Fire and safety devices, such as fire extinguishers and rope ladders • Monitoring services • Light fixture changes, such as blinking lights • Telephone adaptive devices that are not available from the telephone company • Other electronic devices or services made for emergency help PERS is limited to members who: • Live alone • Are alone for large parts of the day • Do not have a regular caregiver for long periods of time • Would otherwise need a lot of regular supervision PERS is only provided to Members who live in a non-licensed setting, except for an Assisted Living Facility (ALF).
Residential Care Services or Type I or Type II Expanded Adult Residential Care Home (E-ARCH)	Services are provided in a licensed private home by a principal care provider who lives in the home. Services may include: • Personal care • Nursing • Homemaker services • Chores • Companion services • Medication oversight by the principal care provider who lives in the home Residential care is provided in:

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Service	Description
	• Type I E-ARCH: A home with five or fewer residents. DHS may allow up to six residents in a Type I home. No more than three residents may meet Nursing Facility Level of Care (NF LOC). • Type II E-ARCH: A home with six or more residents. No more than 20% of the home's licensed capacity may be residents who meet NF LOC and receive these services while living in the home. Members who receive residential care services must also receive 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)	This includes the purchase, rental, lease, warranty, assessment, installation, repair, and removal of devices, controls, or appliances listed in the Health Action Plan. These items help members increase or maintain their ability to do Activities of Daily Living (ADLs). They may also help members see, control, take part in, or communicate in the place where they live. Services may include, but are not limited to: • Items needed for life support • Specialized infant car seats • Changes to a parent-owned motor vehicle to meet the child's needs, such as wheelchair lifts • Intercoms to monitor the child's room • Shower seats • Portable humidifiers • Electric utility bills related to electrical life support devices, such as a ventilator or oxygen concentrator • Medical supplies • Heavy duty equipment, such as patient lifts or beds, that cost more than \$1,000 per month • Rental equipment that costs more than \$1,000 per month, such as ventilators • Emergency back-up generators for electrical life support devices, such as a ventilator or oxygen concentrator • Other equipment, such as customized wheelchairs, specialty orthotics, and bath equipment, that costs more than \$1,000 per month

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1-800-651-2237 (toll-free), **711** (TTY)

Service	Description
	Items paid for under this service are in addition to medical equipment and supplies covered under the MSP. Items are not covered if they do not directly help the member's medical care or treatment needs. Specialized medical equipment and supplies must 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 Plus (CIS+)	
To be eligible, you need to be eighteen (18) years of age or older and you must meet the following to qualify for CIS+: 1. Has a social risk factor (i.e., being homeless or at risk of homelessness); and 2. Has a clinical need (i.e., complex physical or mental health condition, and/or need for medical respite service). The CIS+ Program includes two types of housing-related benefits: Housing Navigation Supports and Medical Respite. Housing Navigation Supports include both pre-tenancy support and tenancy sustaining services, while Medical Respite includes short term pre-procedure housing, short-term recuperative care, and short-term post-hospitalization housing.	
Housing Navigation Supports	Pre-tenancy Services: • 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: • 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

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
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Service	Description
	• 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
Medical Respite Services	Medical respite services, also known as episodic interventions, provide short-term room and board with clinical services and other supports. Medical respite services are time-limited based on clinical need, not to exceed six (6) months within a rolling twelve (12) month period. There are three (3) distinct medical services: Short-term pre-procedure housing services are intended for eligible Members who have a planned medical procedure or treatment that requires care prior to or following the procedure or treatment. This service provides: • Housing; and • Clinically oriented recuperative or rehabilitative services and supports. Short-term recuperative care services are intended for eligible Members who have ongoing medical or psychiatric needs. This service provides: • Housing; • Clinically oriented recuperative or rehabilitative services and supports; • On-going patient monitoring; and • Continuous access to medical care. Short-term post-hospitalization housing services are intended for eligible Members who are recovering from a physical, psychiatric, or substance use condition following discharge or that exists from an institutional setting. This service provides: • Housing; and • Clinically oriented recuperative or rehabilitative supports and services.
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.

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
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Service	Description
	Children under the age of twenty-one years may receive treatment to manage or cure their disease while concurrently receiving hospice services.

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
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Value-Added Services

Service	Description	Eligibility
Inpatient Palliative Care	Palliative care helps members who have a long-term illness that may limit their life. This care supports the member's body, mind, emotions, spiritual needs, and social needs. It also supports the family member. The goal is to ease pain, symptoms, stress, and suffering caused by the illness. Care is provided by a team that may include a doctor, nurse, social worker, and chaplain.	Members with life limiting illness in hospital setting. Prior Approval 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 Approval 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 Approval 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 kpnhawaii.org/our-services

Covered by DHS Med-QUEST but not by Kaiser Permanente

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

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
Prosthetic 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 needed emergency dental services

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
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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 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)**. Authorization is required. Your provider must contact **MQD's Clinical Standards Office (CSO)** for ITOP requests. **MQD** can also help arrange transportation.
- **State of Hawaii Organ and Tissue Transplant (SHOT'T) Program:** **DHS** provides transplant services through the **SHOT'T Program**. Covered transplants must not be experimental or investigational for the organ, tissue, or medical condition being treated.

Covered transplants may include:

- o Liver
- o Heart
- o Heart-lung
- o Lung
- o Kidney
- o Kidney-pancreas
- o Allogenic and autologous bone marrow transplants

Children may also be covered for small bowel transplants, with or without a liver transplant.

Children and adults must meet medical rules set by the **State** and the **SHOT'T Program contractor**. We can help with a referral to the **SHOT'T Program** when it is medically appropriate.

Services from other agencies in the community:

- **Early Intervention Program (EIP)**
The Early Intervention Program (EIP) helps children from birth to age 3 who have special needs. Services are provided where the child lives, learns, and grows. Parents and caregivers are coached on how to help the child do well in their daily setting. Covered services may 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**
Head Start is a federal program that helps prepare children ages 3 to 5 for school. Programs may include part-day or full-day centers, home-based services, Head Start DOE combined classrooms, and family activities. To apply or learn more, call 808-847-2400.
- **Women, Infants, and Children (WIC)**
WIC helps low-income pregnant women, new moms, and children under age 5 who need nutrition support. WIC provides healthy foods, nutrition education, screenings, and referrals

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

to other health, welfare, and social programs. Healthy foods may include 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 helps with the diagnosis, treatment, finding, prevention, and proper care of tuberculosis. For more information, call the Tuberculosis Control Branch at 808-832-5731.

- **Hansen's Disease Community Program**

This program helps patients with Hansen's Disease. It provides treatment, education, help for family members and health care providers, and support to help patients get needed services. For more information, call the Hansen's Disease Branch at 808-733-9831.

- **Community Care Services (CCS) Behavioral Health Program provided by AlohaCare**

Adult Members age 18 or older with serious mental illness (SMI) or serious and persistent mental illness (SPMI) may be eligible for more behavioral health services through the CCS program. Specialized behavioral health services may include inpatient and outpatient therapy, tests to check how the Member is responding 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 people. Kaiser Permanente and DOH/DDD work together to support 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 and youth under age 21 who have emotional or behavioral development disorders. The Department of Health, through the Child and Adolescent Mental Health Division (CAMHD) SEBD program, provides behavioral health services, including transportation, for children and youth ages 3 through 20 who need intensive behavioral health services. To learn more, call one of the Family Guidance Centers listed below.

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

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 Kalanianaʻole 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 Kāpoli, 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

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

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

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

- 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.

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

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.

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

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.

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

- 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 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.

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

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

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

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)

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

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.

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

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.

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

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**.

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

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

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

- 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

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

- 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

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

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.

For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

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- 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.
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For help or for more information, please visit kpquest.org or call **808-432-5330** (Oahu),
1-800-651-2237 (toll-free), **711** (TTY)

- 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, phone: 1-888-488-7988 (toll-free) or 808-746-3324 (Oahu). TTY users may call 1-877-447-5590 or 711. Medicare patients may contact the Medicare Beneficiary Ombudsman to get help with Medicare-related questions or concerns, at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. Or you can use an online form at www.medicare.gov/MedicareComplaintForm/home.aspx. 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. Patients 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, email: info@aaahc.org, website: www.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.

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- **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

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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.

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-
- 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).

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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.

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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.

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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:

- o **Behavioral Health Guidelines**

- Attention Deficit Hyperactivity Disorder (ADHD) Guideline
- Depression Guideline

- o **Cancer Screening Guidelines**

- Breast Cancer Screening
- Cervical Cancer Screening
- Colorectal Cancer Screening

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- 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

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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 Plus (CIS+) – A program to address a Member’s housing-related needs that includes housing navigation supports and medical respite services which are also known as episodic interventions.

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.

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.

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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.

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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.

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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.

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- 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.

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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

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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.
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- 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);

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- 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.
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- 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

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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.

Health Related Social Needs (HRSN) – Individual-level adverse social conditions that can negatively impact a person's health or health care, such as financial instability, lack of access to healthy food, lack of access to affordable and stable housing and utilities, lack of access to health care, and lack of access to transportation.

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.

Housing Navigation Supports – Includes two services: 1) Pre-tenancy supports, and 2) Tenancy supports.

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.

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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.

Legally Responsible Individuals (LRI) – Persons who have a duty under State law to care for another person. This category typically includes: the biological or adoptive parent of a minor child; the guardian of a minor child who must provide care to the child; or the spouse of a Member. An LRI authorized as a paid provider under the self-direction option must meet Hawaii's employment qualifications and training standards.

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.

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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 Respite Services – Also known as episodic interventions, provide short-term room and board with clinical services and other supports. Medical respite services are time-limited based on clinical need, not to exceed six (6) months within a rolling twelve (12) month period. There are three (3) distinct medical respite services: 1) Short-term pre-procedure housing, 2) Short-term recuperative care, and 3) Short-term post-hospitalization housing.

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

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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 Qualified Disabled Working Individuals (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.

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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-Emergency Medical Transportation (NEMT) – Transportation to and from Medicaid covered medical appointments when Medical Necessity is established for the Members who have no means of transportation and who reside in areas not served by public transportation or cannot access public transportation. Non-emergency medical transportation services include both ground and air services.

Non-medical Transportation (NMT) - Services may be provided to and from CIS+ services, as authorized in the Member's care plan. This service is offered in addition to medical transportation required under 42 CFR §431.53 and transportation services under the MSP, defined at 42 CFR §440.170(a), if applicable, and shall not replace them.

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.

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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.

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- 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

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- (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.

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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;

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- 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.

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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:

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- 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 – QUEST members can change their Health Plan at any time after they have been in the same plan for at least 12 months. This is known as Rolling Plan Change (RPC). When a QUEST member changes their Health Plan, the new plan starts on 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 will start on January 1.

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

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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;

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- 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.

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State - The State of Hawaii.

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

State Medicaid Agency Contract (SMAC) – Pursuant to the Medicare Improvements for Patients and Providers Act of 2008, the State Medicaid Agency Contract is a federally required contract between Health Plans offering D-SNPs and the Hawaii Department of Human Services, Med-QUEST Division. The SMAC includes federally required elements, as well as additional provisions required by DHS to advance its Medicare-Medicaid integration goals.

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 health 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.

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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[c][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.

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Kaiser Permanente QUEST Call Center

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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

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