State/Territory: HAWAII

Free Choice of Providers

Section 1: Recipient over-utilization or abuse

(1) Freedom of choice in selecting health care providers shall not include the inexpedient utilization or over-utilization of the community's health care providers and supplies.

(2) When a recipient over-utilizes medical services, the department shall request the recipient's voluntary cooperation in curbing abusive utilization practices and shall monitor the recipient's case for no less than 6 months.

(3) When a recipient has been shown to be over-utilizing controlled drugs with multiple prescriptions filled at more than one pharmacy and written by multiple prescribers, the department shall require the recipient to choose one primary care physician and one pharmacy to be the only approved providers of usual care. The recipient shall select another provider if the initial provider selected is known to the department to be over-prescribing medications or medical services. Refer to section 2 for specific details regarding restrictions.

(4) When a recipient has been determined to be using excessive services provided by multiple physicians, the department may assist the recipient in receiving appropriate coordinated care. The department shall require the recipient to choose one primary care provider to coordinate all usual services for the recipient and make referrals to other providers, as needed. Refer to section 2 for specific details regarding restrictions.

State/Territory: HAWAII

Free Choice of Providers

Section 2: Restriction:

(1) If over-utilization or abuse continues, the recipient shall be administratively restricted for no less than 24 months to a primary care physician who is:

(A) Of the client's choice;

(B) Willing to provide and coordinate services to the client; and

(C) Certified by the department to participate in the medical assistance program

(2) A recipient who over-utilizes services which are provided by psychotherapists, pharmacies and dentists shall also be restricted to those providers if necessary to further curb recipient abuse.

(3) The individual who is restricted shall be afforded advance notice and appeals process.

(4) Emergency medical services shall not require the referral, assistance or approvals of the designated primary care physician.

(5) The restricted recipient shall receive a medical authorization card bearing the designated primary care physician until:

(A) Responsibility for care is transferred to another physician;

(B) The recipient requests a change in the primary care physician and the department and the affected physician concurs; or

(C) Control is no longer considered necessary by the designated primary care physician and the department's medical consultant concurs.

(6) If a recipient fails to select a primary care physician within 30 days following receipt of notice of medical service restrictions, the department shall select a physician who is in good standing with the medical program.

(7) When a physician who is willing to participate as the primary care physician cannot be found, the department's medical consultant shall provide prior approval for all health service required by restricted recipient with the exception of emergency care.

(8) The designated physician shall:

(A) Provide and coordinate all medical services to the client, except for emergency services; and

(B) Make referrals for other needed medical services; and

(C) Inform the department when the designated physician is no longer able to provide medical services to the recipient.

(9) A recipient shall continue to be restricted to a designated provider(s) until:

(A) There is documented evidence of that individual's compliance for at least one full year; and

(B) The primary care physician and the department's medical consultant concur.

(10) When the decision is made to continue restriction, the recipient shall be afforded advance notice and the appeals process.

(11) The recipient whose restriction has been terminated shall be monitored for no less than 24 months and placed back on restriction if there is evidence of recurrent over-utilization or abuse of Medicaid services during that period.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT Attachment 4.11-A

State of HAWAII

STANDARD-SETTING AUTHORITY FOR INSTITUTIONS

The following standards for private and public institutions are kept on file and made available to the Social and Rehabilitation Service on request:

(1) Public Health Regulations, Chapter 12, Hospitals

(2) Public Health Regulations, Chapter 12-A, Nursing Homes

(3) Public Health Regulations, Chapter 12-B, Care homes and Intermediate Care Facilities

TRANSMITTAL # 83-1	EFFECTIVE 1-1-83
REC'D RO 3-25-83	SUPERSEDED BY TRANSM #
APPROVED 5-13-83	EFFECTIVE

HAWAII

ATTACHMENT 4.14-B

Utilization review is provided by direct review by personnel of the medical assistance unit, by facility contract with county medical societies, by facility-based review, and by facility arrangements ~~contracts~~ with individuals.

For the majority of the ICF, SNF, and SNF/ICF facilities on Oahu, the Honolulu County Medical Society contracts with facilities to provide utilization review.

The Maui County Medical Society provides utilization review for certain ICF facilities in Maui county.

Certain other facilities have facility-based utilization review committees ~~that~~ provide review for their particular facility. or have arrangements with individuals to

Personnel of the medical assistance unit provide direct review in certain free-standing ICF's that are unable to obtain the necessary personnel to conduct utilization review.

All facilities have approved utilization review plans that are in conformity with this sub-part.

TRANSMITTAL # 85-17 EFFECTIVE 10-1-86
REC'D RO ____ SUPERSEDED BY TRANSM # ____
APPROVED 1-23-86 EFFECTIVE ____

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT Attachment 4.16-A

State of HAWAII

INTERRELATIONS WITH STATE HEALTH AND STATE VOCATIONAL REHABILITATION AGENCIES AND WITH TITLE V GRANTEES

The following is a description of the cooperative arrangements agreed upon with the State health and vocational rehabilitation agencies:

1. Identification of mutual objectives and the responsibilities of respective agencies;

2. Cooperative and collaborative relationships at the State level;

3. Arrangement for early identification of need for medical or remedial care and services for individuals under 21 years of age;

4. Arrangement for reciprocal referral service;

5. Arrangement for maintenance of medical case management;

6. Mutual exchange of information and reports for services provided under this agreement;

7. Delineation of responsibilities with respect to provision of services by both agencies at local levels;

8. Arrangement for provider reimbursement;

9. A periodic joint evaluation of provisions in the cooperative agreement and actions to effect desired changes;

10. Mutual reporting of changes in program policies of respective agencies which may affect the cooperative agreement;

11. Maintenance of continuous inter-agency liaison and designation of staff at State level to carry out the provisions of the agreement;

12. Reporting to each other any possible violation of the non-discrimination provisions of Civil Rights Act by the providers.

This Interagency Agreement shall take effect on the 1st day of April, 1984, by and between the STATE OF HAWAII, by its Department of Social Services and Housing, hereinafter referred to as "DEPARTMENT" and the Department of Health, hereinafter referred to as "PROVIDER".

I. INTRODUCTION

A. Purpose

Pursuant to 42 C.F.R. 431.615(c) which implements section 1902(a)(11) and (22) of the Social Security Act by setting forth State Plan requirements for arrangements and agreements between the Medicaid agency and State health agencies, this Agreement shall establish and maintain an interagency program coordination and a provider third party reimbursement arrangement in order to insure health care benefits for persons who are determined eligible for Medicaid and who, ipso facto, meet the standard of eligibility for DOH services under this Agreement.

This Agreement sets the policies which enables the DEPARTMENT and the respective PROVIDER programs to enter into individual agreements for specific medical services which is referred to as "Attachments".

B. Mutual Objectives

There is a mutual recognition that the programs of the PROVIDER and the DEPARTMENT have a similarity of purpose in providing optimal health care services to the maximum number of persons who are faced with selected medical needs. This mutual objective can be best achieved by the establishment of an interagency cooperative arrangement under which the fiscal

resources and services of the respective programs are coordinated both at the State and local levels.

C. Description Of Functions

1. The PROVIDER has general charge, oversight, and care of the health and lives of the people of the State. The PROVIDER administers the State's programs implemented under the Department of Health and which are included in the State Plan approved under this section of the Social Security Act.

2. The DEPARTMENT, through its Public Welfare Division, administers the Medical Assistance Program (Medicaid) under Title XIX of the Social Security Act, a program of comprehensive health care for the needy and the medically needy, on a statewide basis. Its chief responsibilities with respect to this program are determination of financial eligibility of persons for medical assistance, maintenance of utilization reviews and other methods of quality, quantity, and cost controls, making vendor payments for services which are within the scope and content of care provided under the program, identifying Medicaid recipients in need of preventive medical or remedial care and services, and encouraging comprehensive and continuous care to mutual recipients through early identification of Medicaid recipients.

II. SERVICES TO BE PROVIDED

A. Subject to the continuing availability of Federal and State funds, the PROVIDER, its designee or assignee (hereinafter referred to collectively as PROVIDER), shall provide on a continuing basis:

1. services for establishing and maintaining health and other standards for institutions participating in Medicaid, and
2. furnish Title V covered services to appropriate DSSH recipient including:
   (a) maternal and child health services,
   (b) crippled children's services,
   (c) maternal and infant care services, children and youth projects, and
   (d) projects for the dental health of children.
3. survey and certification of long-term care medical facilities, and
4. other services mutually agreed to by the DEPARTMENT and PROVIDER.

III. PAYMENT

A. The Medicaid agency shall reimburse the PROVIDER for the cost of services furnished eligible Medicaid recipients by or through the grantee in accordance with established Medicaid methods and rates as described in the State Plan.

B. The PROVIDER further agrees that no additional fees for services will be charged to Medicaid eligible recipients for services provided under the terms of this Agreement.

C. Payment by the DEPARTMENT shall be made to the PROVIDER through its fiscal agent where appropriate, upon receipt of a claim form from the PROVIDER, which shall contain the name and case number of eligible persons served by the PROVIDER, the type of service provided, and the cost of providing services to the eligible person. Claim form shall be the same form used by other Medicaid providers. Claim form shall be submitted within twelve (12) months of the date of service for which payment is requested. The failure of the PROVIDER to submit such claims within the specified time period shall result in non-payment of the entire reimbursement amount.

D. Payments by the DEPARTMENT to the PROVIDER for budgeted services shall be made upon receipt of a certified invoice from the PROVIDER which shall specify services rendered. Payment shall be made by a journal voucher or warrant to the PROVIDER.

E. The PROVIDER agrees that it shall not request payment for any services provided to any family or individual whose eligibility for services has not been determined by the DEPARTMENT or by the PROVIDER, or any service not specified. Further, payment for services not specifically allowed shall not be paid.

F. The PROVIDER agrees to refund all payments received from the DEPARTMENT for services which were not rendered or authorized by the DEPARTMENT for any family or individual.

IV. GENERAL PROVISIONS AND CONDITIONS

A. General Provisions

This Agreement is subject to all pertinent provisions of the Social Security Act as amended and Section 346-6, 346-7, and 346-8 Hawaii Revised Statutes as amended.

This system(s) of services and expenditures authorized under this Agreement shall conform to the requirements set forth in Title XIX of the Social Security Act as amended, the Code of Federal Regulations, Title 42, Chapter IV, Health and Human Services, Health Care Financing Administration, Subchapter C, "Medical Assistance Programs", and Hawaii Revised Statutes, and the Regulations of the DEPARTMENT.

B. Other Provisions and Conditions

1. Binding Effect of Federal Regulations and State Plans

   This Agreement is subject to the provisions of any other relevant Federal regulations and any relevant provisions of the Hawaii State Plan of the DEPARTMENT submitted to and approved by the United States Department of Health and Human Services.

2. Licensing and Other Quality of Service Standards

   The PROVIDER agrees to comply with all State licensing standards, any applicable Federal service standards, and any other standards or criteria established by the DEPARTMENT to assure quality of services.

3. Statement of Compliance with Low Bid Requirements

The PROVIDER agrees to use its best efforts to obtain all supplies and equipment for use in the performance of this Agreement at the lowest practicable cost, and to purchase by means of a system of competitive bidding whenever required by law or whenever practical.

4. Prohibited Discrimination in Services.

The PROVIDER shall comply with all applicable Federal and State laws and regulations prohibiting the exclusion from participation, the denial of benefits, or the subjection to discrimination of any person from or under the services to be performed by the PROVIDER under this Agreement on prohibited grounds, such as on the ground of race, color, or national origin prohibited by Section 601 of Title VI of the Civil Rights Act of 1964, 42 U.S.C. §2000d, and 45 C.F.R. Part 80; on the basis of age as prohibited by Section 303 of the Age Discrimination Act of 1975, 42 U.S.C. §6102, and 45 C.F.R. Part 90; on the basis of sex in education programs and activities as prohibited by Section 901 of the Education Amendments of 1972, as amended, 20 U.S.C. §1681, and 45 C.F.R. Part 86; or on the basis of handicap as prohibited by Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. §794, and 45 C.F.R. Part 84.

5. Prohibited Discriminatory Employment Practices.

The PROVIDER shall comply with all applicable Federal and State laws and regulations prohibiting

discriminatory employment practices, such as to fail or refuse to hire or to discharge any individual or otherwise to discriminate against any individual with respect to that individual's compensation, terms, conditions, or privileges of employment because of such individual's race, color, religion, sex, or national origin as prohibited by Section 703 of Title VII of the Civil Rights Act of 1964, as amended, 42 U.S.C. §2000e-2, and 29 C.F.R. Parts 1604, 1605, 1606, and 1607; to similarly discriminate against any individual because of such individual's age as prohibited by Section 4 of the Age Discrimination in Employment Act of 1967, as amended, 29 U.S.C. §623, and 29 C.F.R. Part 860; to similarly discriminate against any individual in employment in education programs and activities because of such individual's sex as prohibited by Section 901 of the Education Amendments of 1972, as amended, 20 U.S.C. §1681, and 45 C.F.R. Part 86E; to similarly discriminate against any individual because of such individual's handicap as prohibited by Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. §794, and 45 C.F.R. Part 84B; or to similarly discriminate against any individual because of such individual's race, sex, age, religion, color, ancestry, physical handicap, marital status, or arrest and court record that does not have a substantial relationship to the functions and

responsibilities of the prospective or continued employment as prohibited by Chapter 378, Hawaii Revised Statutes.

6. Fiscal Responsibility, Records, Control, Reports, and Monitoring Procedures

The PROVIDER agrees to maintain, in accordance with generally acceptable accounting practices, books, records, documents, and other evidence which sufficiently and properly reflect all direct and indirect current expenditures of any nature and those anticipated for the performance of this Agreement. The records shall be subject at all reasonable times to inspection, review, or audit by persons duly authorized by the DEPARTMENT, representatives of the Department of Attorney General, representatives of the Department of Accounting and General Services, and/or representatives of the Federal Department of Health and Human Services.

The PROVIDER agrees to collect statistical data of a fiscal nature and make statistical reports as required by the DEPARTMENT.

7. Program Records, Controls, Reports, and Monitoring Procedures

The PROVIDER agrees that a program and facilities review, may be conducted upon reasonable notice at any reasonable time by the State and Federal officials and other persons duly authorized by the DEPARTMENT. Program records, controls, reports

and monitoring procedures adopted jointly are described in the individual attachments.

The PROVIDER agrees to maintain records which include the names of eligible individuals as required by the DEPARTMENT, periodic program narrative, and statistical data.

The PROVIDER agrees to the exchange of reports as needed of services provided jointly to recipients, the exchange accorded the confidential treatment each agency prescribes. The procedures adopted jointly are described in the individual attachments.

8. Retention of Records

The PROVIDER agrees to retain all books, records, and other documents for a period of time determined by State and Federal statutes, State and Federal agreements entered into by the parties. Persons duly authorized by the DEPARTMENT shall have full access to and the right to examine any of said materials during said period.

9. Safeguarding Client Information

A provision to safeguard client information is agreed upon in order to insure confidential treatment each agency prescribes. The use of disclosure of any information concerning an applicant or recipient of services under this Agreement shall be subject to the limitations set

out in 42 Code of Federal Regulations Section 431.306, Hawaii Revised Statutes 346-10, and Chapter 601 of Title 17, Administrative Rules, et seq. Disclosures not authorized therein are prohibited except with the specific written consent of applicant, recipient, a minor's parent, or a legal guardian. Violation of this provision may constitute a misdemeanor under HRS 346-111. Disclosure procedures adopted jointly are described in the individual attachments.

10. Certification of Unavailability of Services Without Cost

The PROVIDER certifies that the services to be provided under this Agreement are not otherwise available without cost to eligible clients in the community.

11. Amendments

The provisions of this Agreement may be amended upon written request of either party subject to the agreement of the other. The party requesting an amendment will allow thirty (30) days for consideration and approval of the request.

All amendments shall be reduced to writing, duly signed and dated, and attached to the original of this Agreement. All provisions of all such amendments attached to the original shall be considered a modification of this Agreement.

12. Disputes Between the DEPARTMENT and the PROVIDER

In the event of any dispute between the DEPARTMENT and the PROVIDER, concerning any matter arising

under this Agreement, which cannot be resolved by mutual agreement between the parties within thirty (30) days, such dispute shall be submitted to the Attorney General of the State for resolution.

13. Termination or Reduction of Agreement

a. Termination at Will with Notice.

This Agreement may be terminated by either party at any time, with or without cause, upon sixty (60) days notice, in writing, and delivered by mail or in person to the other, provided, that any termination of this Agreement shall be without prejudice to any obligations or liabilities of either party already accrued.

b. Termination or Reduction Because of Lack of Funds.

Notwithstanding any other provisions of this Agreement, this Agreement may be terminated or amended by the DEPARTMENT without the consent of the PROVIDER upon written notice by the DEPARTMENT that the level of State or Federal funds available to support the DEPARTMENT's medical assistance programs are about to be or have been reduced, provided, however, that any such termination or amendment shall be without prejudice to any obligations or liabilities of either party already accrued.

Any termination shall be effective ten (10) days after the written notice is sent by certified mail.

Any amendments made pursuant to this subsection shall be reduced to writing, duly signed and dated, and attached to the original of this Agreement. A PROVIDER's refusal to sign such amendments shall constitute grounds for termination by default.

c. Termination for Default of PROVIDER.

Unless the PROVIDER's default is excused under the provisions of this Agreement, the DEPARTMENT may, by written notice of default to the PROVIDER, terminate this Agreement if the PROVIDER fails to perform any of the provisions of this Agreement.

Termination shall be effective ten (10) days after written notice of default is sent by certified mail. Any termination of this Agreement shall be without prejudice to any obligations or liabilities of either party already accrued.

d. Termination Arrangements.

The rights and remedies of the parties provided in this Agreement shall not be exclusive and are in addition to any other rights and remedies provided by law.

If this Agreement is terminated the PROVIDER shall:

(1) stop work under the Agreement on the date and to the extent specified by the DEPARTMENT or this Agreement;

(2) settle all obligations and claims arising out of the performance of this Agreement, including completion of any reports and refund of any payments required to be made under this Agreement. The DEPARTMENT may withhold all pending requests for payment until the final expenditure report is received.

14. Waivers

Waiver by any party of any default of the other shall not be deemed to be a waiver of any subsequent default. Waiver by any party of breach of any provision of the Agreement shall not be deemed to be a waiver of any other subsequent breach and shall not be construed to be an amendment of the terms of the Agreement unless made in compliance with the provisions of paragraph 20.

15. Continuous Liaison Between the Parties

It is recognized that a continuing interagency liaison is needed to carry out the provisions of this Agreement effectively. The PROVIDER and DEPARTMENT will designate representatives to serve as liaison both at State and local levels.

16. Indemnification

The PROVIDER shall indemnify and save harmless the DEPARTMENT, and their officers, employees, and agents from and against any and all actions, claims, suits, damages, and costs arising out of or resulting from the acts or omissions of the

PROVIDER or the PROVIDER's officers, employees, agents, or subcontractors occurring during or in connection with the performance of the PROVIDER's services under this Agreement.

17. Reciprocal Referrals

A provision for reciprocal referral services is agreed upon in order to insure optimal utilization of benefits available under the respective agency programs. Referral procedures adopted jointly are described in the individual attachments.

18. A provision to coordinate plans for health services relating to eligible recipients is agreed upon, the procedures adopted jointly are described in the individual attachments.

19. A provision for early identification of eligible individuals under 19 years of age in need of medical and remedial services is agreed upon. The method for providing this service adopted jointly is described in the individual attachments.

20. Periodic Review and Joint Planning for Changes

This Agreement will be jointly reviewed for evaluation of policies and for planning for changes annually or earlier when requested by either the DEPARTMENT or the PROVIDER.

Both parties hereby expressly acknowledge the potential for substantial changes in Federal regulations or State laws applicable to this Agreement and expressly agree to renegotiate this Agreement as necessary to comply with such changes.

21. Provision Terms and Conditions Included in the Agreement

This Agreement, together with any attachments and schedules, attached hereto and incorporated herein by reference, represent the complete, total, and final understanding of the parties and no other understandings or representations, oral or written, regarding the subject matter of this Agreement, shall be deemed to exist or to bind the parties hereto at the time of execution.

IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the date first above written.

DEPARTMENT OF SOCIAL SERVICES AND HOUSING	DEPARTMENT OF HEALTH
Director	Director

APPROVED AS TO FORM

Deputy Attorney General, State of Hawaii

ATTACHMENT A

CRIPPLED CHILDREN SERVICES

Medical Eligibility and Services

1. Provides diagnostic and treatment services for handicapped children based on definition and selection. Such services may include:
   a. Medical, surgical, dental, and hospital care.
   b. Care in convalescent or foster home.
   c. Prosthetics, appliances, transportation, and after-care to see that the child makes satisfactory personal adjustment and that treatment benefits are not lost by neglect.
2. Gives diagnostic and treatment services to children between 0-21 on all Islands for specific conditions listed below.
   a. Cleft lip and palate and serious cranial and facial anamolies;
   b. Cerebral palsy, epilepsy and other selected neurological problems;
   c. Rheumatic fever and rheumatic heart disease;
   d. Congenital heart disease;
   e. Orthopedic conditions, including arthritis;
   f. Selected surgical eye defects;
   g. Epilepsy;
   h. Selected external crippling conditions such as burns and severe disfigurements needing plastic procedure;
   i. Selected urogenital and other congenital defects;
   j. Selected hearing loss;
   k. Cystic fibrosis;
   l. Mental retardation;
   m. Conditions causing mental retardation;
   n. Hemophilia;
   o. Severe asthma;
   p. Learning disability.

ATTACHMENT B

MATERNITY AND INFANT CARE PROJECT

Medical Eligibility and Services Available

1. To any woman living in a Project area who requests family planning services including contraceptive supplies and medical counsel on infertility.
2. To any pregnant woman living in a Project area who needs:
   a. Pre-natal diagnosis and pre-natal care, except in a hospital.
   b. Post-natal care after return from the hospital;
   c. Public health nursing (for enrolled patients)*;
   d. Nutrition counselling (for enrolled patients)*;
   e. Social casework to supplement services available from other agencies (for enrolled patients)*;
   f. Drugs prescribed by the Project physician;
   g. Assistance with transportation to and from project authorized health services, when not otherwise available, and babysitting*;
   h. Any other ambulatory care needed for a pregnancy-related or pregnancy-threatening condition. Hospitalization is specifically excluded**.
   i. Dental examination and necessary treatments during pregnancy and six weeks after termination of pregnancy.
3. To every financially eligible Project maternity patient having a condition which is determined as high risk under Project guidelines, the following additional services:
   a. Complete medical and surgical care for pregnancy-related or pregnancy-threatening conditions, throughout the period of maternity up to six weeks following delivery;
   b. Hospital inpatient services for delivery of pre-natal or post-partum complications or for conditions which threaten to impair the outcome of the pregnancy;
   c. Complete newborn care for their infants; and
   d. Homemaker service*.

4. To financially eligible high-risk newborns of Project mothers during the first year of life (under Project guidelines for high-risk criteria for infants):

   a. Preventive health services, including immunizations, screening and periodic pediatric evaluations;

   b. Complete diagnostic study if needed;

   c. Complete medical and surgical treatment if needed;

   d. Hospital inpatient services;

   e. Drugs prescribed by Project physician;

   f. Nutrition counselling*;

   g. Social casework to supplement those services available from other agencies*;

   h. Public health nursing*;

   i. Transportation to and from medical facilities, when not otherwise available.

* Non-reimbursable services under Medicaid.

** To be reimbursed by DSSH if eligible for Medicaid.

ATTACHMENT C

CHILDREN AND YOUTH PROJECT

Services Available

1. To any child (birth to 16 years) living in Waimanalo:
   a. Preventive health services including screening, immunizations, routine examinations and evaluations, and parental education in child care and homemaking.
   b. Total health assessment, including medical, psychological*, speech-hearing, visual, dental, social*, nursing, nutritional, and homemaking components*.
   c. All diagnostic studies needed for assessment and diagnostic, whether done at the Project or through referral elsewhere.
2. To any financially eligible child (birth to 16 years) living in Waimanalo, in addition to the above:
   a. Medical, surgical and psychiatric treatment.
   b. Inpatient hospital care; blood and special nursing* if necessary.
   c. Psychological therapy and guidance*.
   d. Speech therapy.
   e. Dental care, excluding only orthodontia.
   f. Drugs, prosthetics, appliances, blood and the like.
   g. Public health nursing, nutrition service and social casework to complement the above, and to supplement services available from other agencies.
   h. Transportation for health care when not available otherwise (within budget limitations).
   i. Babysitting at the Project when necessary to achieve a visit for medical care*.

* Non-reimbursable services under Medicaid.

ATTACHMENT D

CHILD HEALTH CONFERENCE

Services Available

1. Physician services, including medical examinations;
2. Nursing assessments*;
3. Immunizations;
4. Diagnostic services;
5. Screening;
6. Health supervision*;
7. Nutrition counselling*;
8. Parental education in child care, guidance and safety*;
9. Transportation;
10. Outreach service*;
11. Referral and followup*.

* Non-reimbursable services under Medicaid.

ATTACHMENT E

Medicaid Reimbursement Rates

Type of Service	Amount of Reimbursement Based On
1. Inpatient hospital services	Medicare's principle of reasonable costs
2. Physician's services (not applicable to clinics)	RVS 1970, as modified by DSSH
3. Clinic services	$7.00 per visit
4. X-ray and laboratory services	RVS 1970
5. Dental services (includes orthodontia in connection with cleft lip and palate treatment)	DSSH fee schedule
6. Medical equipment and appliances	Reasonable charges (rental or purchase)
7. Prosthetics	Reasonable charges
8. Eye glasses	Manufacturer's price list plus 10 percent
9. Eye exams, refractions and servicing	DSSH fee schedule
10. Drugs	Usual and customary charges not exceeding 180% of Blue Book price list of smallest quantity
11. Physical therapy	RVS 1970
12. Occupational therapy	Included in clinic fee of $7.00 when visit was made for other services also
13. Speech therapy	$5.00 per 1/2 hour (individual) $5.00 per 1 1/2 hour per patient (group)
14. Speech evaluation	$12.00 - Oahu $18.00 - Neighbor Islands
15. Hearing evaluation, including audiogram	$12.00 - Oahu $18.00 - Neighbor Islands
16. Health screening (complete)	$15.00
17. Family planning services	
a. Initial visit, including: Breast and pelvic exams, Pap Smear, G. C. culture, other lab tests, contraceptive supplies, supportive counselling	$25.00

Type of Service	Amount of Reimbursement Based On
b. Follow-up visits	$15.00
18. Transportation	As charged
19. Immunizations and injections (If cost of injectible material exceeds $1.00, add $2.00 and identify material.)	$3.00
Oral Polio	$1.00

Attachment 4.16

DEPARTMENT OF HUMAN SERVICES

INTRA-AGENCY AGREEMENT

Between

THE VOCATIONAL REHABILITATION AND SERVICES FOR THE BLIND DIVISION

and

THE HEALTH CARE ADMINISTRATION DIVISION

I. INTRODUCTION

1. Purpose

The purpose of this agreement is to mobilize personnel and financial resources of the Health Care Administration Division (HCAD) and the Vocational Rehabilitation and Services for the Blind Division (VRSBD) in order to provide vocational rehabilitation services to Department of Human Services (DHS) eligible recipients so that they may achieve economic self-sufficiency.

2. Mutual Objective

The programs of VRSBD and HCAD have a similarity of purpose in relation to rehabilitation of the physically and mentally handicapped. This mutual objective can be best achieved through an intra-agency cooperative arrangement in which the financial resources and service responsibilities of the respective divisions are coordinated both on the State and local levels.

3. Description of Functions

A. VRSBD

1. Vocational rehabilitation services shall focus upon the goal of employment. Such services may include:

a. Diagnostic and evaluation services to determine the individual's capacity for employment;

b. Training to prepare the individual for employment;

c. Placement and follow-up services to ensure satisfactory adjustment in a suitable employment;

d. Other services as needed.

(See Attachment A for description of services)

B. HCAD

1. Services from the HCAD may include payment for:

a. Outpatient;

b. Inpatient;

c. Long Term Care and;

d. Other Ancillary Health Care Services.

II. COORDINATION OF SERVICES

1. Primary Resource

It is mutually agreed that VRSBD is the primary agency for arranging restorative services and providing counseling services for the vocational rehabilitation of persons who are handicapped due to a physical or mental disability.

2. Services

A. VRSBD Responsibility

VRSBD, having the basic responsibility under its program, will coordinate the activities necessary for the development of an individualized written rehabilitation program (IWRP) and together with the client identify the services needed, determine the cost of such services, and the responsibility of payment for needed services. VRSBD will follow through on the implementation of the IWRP.

B. HCAD Responsibility

HCAD will provide payment for covered Medicaid services to eligible recipients in accordance with Departmental rules.

C. Joint Responsibilities

Vocational Rehabilitation services will be considered in relation to the provision of goods and services that are not included in the Departmental rules governing HCAD.

3. Reciprocal Referral Services

HCAD supports the provision of referral services between VRSBD and the Public Welfare Division (PWD). Eligibility for medical assistance is determined by PWD upon policy issuance by HCAD. Thus, HCAD supports the referral procedures jointly adopted by VRSBD and PWD and attached to this Agreement as Attachment B.

III. TERMS OF AGREEMENT

1. VRSBD will assume the full cost of vocational training and placement, as well as other incidental expenses necessary to vocationally rehabilitate eligible Medicaid recipients, and which are provided for in the IWRP.

2. HCAD will pay for, under its Medicaid program, the cost of medical, dental, psychological and psychiatric services to individuals who are eligible for this program. VRSBD will arrange and engage the services of Medicaid and Board-certified or eligible specialists for Medicaid eligible individuals for medical services provided for in the IWRP or for diagnostic purposes.

3. VRSBD will be responsible for case management and authorization of other services for eligible Medicaid recipients in the same manner as done for all VR clients.

4. VRSBD will provide services to eligible Medicaid recipients which are comparable in scope, quantity, quality and duration of services it provides to other clients.

5. VRSBD will provide HCAD any significant medical report as well as information on progress of case which it believes would be helpful in coordination of plans for recipients, especially as it relates to recipient's incapacity and waiver of work requirements and need for continuous services from VRSBD.

6. HCAD will provide VRSBD medical reports as well as information of the status of a case when requested by VRSBD, subject to the confidentiality rules of the HCAD Program.

7. HCAD will make available their Dental Consultant's services to VRSBD for review and advice regarding dental treatment recommendations for any VR client.

IV. OTHER CONDITIONS OF AGREEMENT

1. There will be a mutual sharing of information at the State level.

   VRSBD will provide statistical information to HCAD showing the number of registered referrals, the total number being serviced under its programs, the number of cases closed and reasons for termination of services. This report will be prepared and a copy transmitted to HCAD in July of each year. HCAD will provide technical health care information to assist VRSBD in the administration of its program.

2. Program policies and procedures planned by either Division will be jointly evaluated if, in the judgment of either Division, such changes might affect this cooperative agreement in any way.

3. It is recognized that a continuing inter-divisional liaison is needed to carry out the provisions of this Agreement effectively. VRSBD and HCAD will designate representatives to serve as liaison both at State and local levels, with designated HCAD personnel and VRSBD supervisors meeting as needed to discuss and resolve problems related to serving disabled Medicaid HCAD clients.

4. The staff of each agency will exercise due diligence in preserving the confidentiality of information exchanged and will not use it for purposes other than the reason for which it was given or received except on the written consent of the individual.

5. If any provision in this Agreement is found to be in conflict with provisions in the DHS Administrative Rule (Title 17), the Administrative Rule shall be the final authority. Further, any provision ruled invalid by the courts shall not invalidate the remaining provisions of this Agreement.

6. It is mutually understood that participating providers of medical and related services under both programs must comply with the non-discrimination provisions of Title VI, Civil Rights Act of 1964, as revised. VRSBD and HCAD agree to report to each other any provider violation.

7. This Agreement shall take effect July 1, 1986, and shall be in effect until cancelled with the approval of the Director.

VOCATIONAL REHABILITATION AND SERVICES FOR THE BLIND DIVISION	HEALTH CARE ADMINISTRATION DIVISION
L. Livingston	Earl S. Motooka
VRSBD Administrator	Acting Health Care Administrator

APPROVED:

Verona E. Rubio

Director of the Department of Human Services

Date

TN 88-1 Approval Date 10/22/87 Effective Date 7/1/87

VOCATIONAL REHABILITATION AND SERVICES FOR THE BLIND DIVISION, DSSH

I. VOCATIONAL REHABILITATION SERVICES

The purpose of vocational rehabilitation is to assist disabled persons through a wide variety of services to prepare for, find, and maintain a suitable occupation. An individual rehabilitation plan is developed to enable the individual to pursue a gainful occupation, with services needed to develop the vocational capacity, incorporated with the plan.

A. SERVICES

1. Evaluation of rehabilitation potential, including diagnostic and related services, incidental to the determination of eligibility for, and the nature and scope of, services to be provided.

2. Counseling, guidance and referral services -- to help the disabled person discover his vocational interests and aptitudes; to discuss his problems; and to work out a plan for rehabilitation that is most suitable for the individual. Referral to resources within the community which can best meet his needs.

3. Medical examination -- to learn the nature and extent of disability; to help determine eligibility for services; to determine need for additional medical services; to assess the disabled person's work capacity.

4. Medical services -- to restore or improve the disabled person's ability to do a job by providing medical, surgical or hospital services to remove or reduce the disability. This includes physical therapy, speech and hearing therapy, short-term psychiatric therapy.

5. Physical aids -- to include artificial limbs, braces, hearing devices, eye glasses and other aids.

6. Vocational and other training services -- books, tools and other materials to help the disabled person learn a new trade or regain lost skills through training in college or university, business school, vocational school, on-the-job, to prepare a person for the world of work through personal and vocational adjustment training, usually in a rehabilitation facility.

7. Maintenance and transportation -- to help the disabled person during preparation for work or while being helped to find a job.

8. Other goods and services in a wide range -- to assist in preparing for and obtaining the right job, including tools, equipment, licenses, reader services for the blind, orientation and mobility services for the blind, interpreter services for the deaf, etc.

9. Job placement -- to assist in finding the right job within the person's physical and mental abilities.

10. Post-employment services -- to assist the disabled person to maintain suitable employment.

B. COSTS

There is no cost for services which are necessary to evaluate the individual's problems, or for counseling and guidance, and job placement. The individual will be asked to share in the cost of other services if he is able to do so.

C. ELIGIBILITY

The requirements for eligibility are:

1. The presence of a physical or mental disability which for the individual constitutes or results in a substantial handicap to employment and interferes with his ability to pursue a gainful occupation, or which threatens his or her continued employment.

2. The disabled person must have a reasonable chance of being able to engage in a suitable occupation after necessary rehabilitation services are provided.

3. Although there is no upper or lower age limits, the general guide is that the individual is at or near work age.

4. There is no residency requirement. However, the individual must be living in Hawaii and intends to make Hawaii his residence.

II. SERVICES FOR THE BLIND BRANCH (HO'OPONO)

A. SERVICES

1. Vocational rehabilitation services for the blind and visually handicapped, as enumerated in Section I-A, B, C, above.

2. Personal adjustment services at Ho'opono to assist individuals to adjust to their blindness through training in orientation and mobility, communications skills (braille, handwriting, typing, etc.), personal and home management, occupational therapy, manual arts, and group work.

3. Work evaluation and vocational adjustment training at Ho'opono -- to assess and determine the individual's abilities and skills, and to assist the individual to develop good work habits, attitudes, work tolerance, and confidence necessary for satisfactory job placement.

4. Evaluation and training of vending stand operators -- to license, place, and supervise such operators.

5. Extended employment for blind persons unable to work in the regular labor market.

6. Low Vision Clinic Services -- to individuals who are severely visually handicapped; to evaluate their ability to use optical aides to improve visual efficiency; and to provide such aides as prescribed.

7. Home teaching services -- to provide adjustment services to blind persons in their own homes.

8. Ho'opono Hale, a residential training program -- to give individuals being trained at Ho'opono an opportunity to upgrade their personal and home management skills through practical everyday experiences of cooking, housekeeping, budgeting, marketing, etc.

9. Case work services -- to assist parents of young blind children.

10. Services to elderly blind.

11. Aides and appliances for the blind to assist blind individuals in their various activities.

12. A statewide register of blind persons -- to determine causes of blindness, and to gather other data about blind persons in Hawaii.

13. Volunteer program -- to recruit, train, and use volunteers for a variety of services to blind persons in such areas as adjustment training, transportation, reader services, taping materials, etc.

14. Prevention of blindness services -- to educate the public about prevention of blindness.

15. Certify blindness.

B. ELIGIBILITY

Any blind or visually handicapped individual may be eligible for services of Ho'opono.

ATTACHMENT B

RECIPROCAL REFERRAL PROCEDURES

1. Referral to VRSBD

   A. PWD Referring Units will refer GA recipients who:

      1) are physically or mentally incapacitated (diagnosis by a physician indicating limitations in physical activities such as walking, lifting, or environmental conditions to be avoided such as dust, dampness, or currently unable to work) and

      2) are unable to work full time, and

      3) are age 16 or over, but below age 50, and

      4) might benefit from vocational rehabilitation services (e.g. doctor recommends referral to DVR) to assist them in obtaining, retaining, or preparing for employment.

   B. PWD Referring Units will refer AFDC recipients who:

      1) are physically or mentally incapacitated, and

      2) are exempt from WIN registration

         a. The PWD Referring Unit sends VR-PW 1 referral to the appropriate VRSBD Branch Office (Oahu, Services for the Blind on Oahu, Hawaii, Maui, and Kauai) and, in addition, sends out an attached letter (see Attachment C) to the recipient to inform recipient of referral to VRSBD and which office to call, if interested.

         b. The VRSBD Branch Office will hold the VR-PW 1 referral for thirty (30) days. If recipient calls to indicate interest, the VR-PW 1 will be sent to the field office for follow-up.

            If recipient does not call within thirty (30) days or indicates disinterest, Part 3 of the VR-PW 1 form will be executed and returned to the referring PWD-IM Unit by the VRSBD Branch Office.

   C. PWD Referring Units will not refer the following types of cases:

      1) recipients who have no disability (no medical or psychiatric diagnosis);

      2) recipients who have temporary disabilities which may be indicated by physician's indication that client is employable now or within 6 months;

         Persons with temporary disabilities who are screened out may be considered during continuing eligibility reviews if the condition still persists in spite of treatment.

      3) recipients whose disabilities are slight so that no restrictions are imposed--physicians usually indicate such persons to be employable;

4) recipients whose disabilities are so severe that death is predicted within a short period of time or physician recommends against employment (consider SSI);

5) recipients who are below age 16, except blind persons--blind persons are to be referred to Services for the Blind Branch (Ho'opono) if they reside on Oahu.

6) individuals 50 years or over, except on a voluntary basis; and

7) Other mutually agreed-upon exemptions

2. Referral to PWD

VR Specialist will refer clients for public assistance and/or report VR status of clients receiving public assistance but were not referred to VRSBD by PWD.

3. Procedures for referral/feedback

Whenever possible, determine client's willingness to participate in vocational rehabilitation services for employment, and explain the consequences of not cooperating (GA cases) with VRSBD.

A. Referral - PWD Referring Units

1) Prepare VR-PW 1 Referral and Feedback Form for submittal to VRSBD Branch Offices. Use ballpoint pen or type information so that information is legible on all copies of the VR-PW 1.

2) Attach current, complete medical and/or psychiatric reports to the VR-PW 1.

B. Feedback on referrals - VRSBD

1) Complete designated copies of VR-PW 1 and submit to PWD to report decision/progress/closure of referral/case.

2) Notify PWD through VR-PW 1a of public assistance recipients who are referred by other referral sources.

C. Follow-up - PWD Referring Units

1) Upon receipt of VR-PW 1a from VRSBD, IM Worker will follow up on GA clients who refuse VRSBD services or do not cooperate in the implementation of the Individualized Written Rehabilitation Program (IWRP).

2) IM Worker will notify VRSBD of cases which are terminated by PWD.

Effective

Dear

We have determined that you are exempt from registration for the Work Incentive Program (WIN) because of your disability. Many persons with disabilities, however, continue to be interested in employment. Our Department's vocational rehabilitation program may be helpful to you in this regard.

Services which are available are:

1. Medical and related services to remove or lessen your disability.

2. Training, if needed, to provide you with job skills based on your interests and aptitudes.

3. Help in securing a job.

In addition, other necessary services can be made available through our Department, such as child care during employment.

You have been referred to the Vocational Rehabilitation and Services for the Blind Division as required. Your acceptance or non-acceptance of vocational rehabilitation services will in no way affect your financial aid from public welfare.

If you are interested in vocational rehabilitation services, please call the number in your area listed below:

Oahu	- 548-4639
Hawaii	- 961-7331
Kona Office	- 323-2629
Maui	- 244-4291
Molokai Office	- 533-5323
Kauai	- 245-4333

Sincerely,

_____
Worker

_____
Unit

Effective

Trans. No. NCAS-77-4
SRS Approved 1/19/78

Revision: SRS-AT-76-116 (MSA)
July 23, 1976

Attachment 4.16-C

State HAWAII

PAYMENT FOR RESERVING BEDS IN LONG-TERM CARE FACILITIES

Payments for reserving beds in skilled nursing and intermediate care facilities are limited to the following:

1. Leave of no more than two days at a time for trial community placement in other than patient's own home.

2. Home visit of no more than two days at a time due to illness or death of a family member, or for other emergencies.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: HAWAII

LIENS AND ADJUSTMENTS OR RECOVERIES

(1) **The State uses the following process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and returned home:**

a) Send notification to inform recipients in nursing facilities that the State intends to determine if the individual can reasonably be expected to be discharged from the facility and return home for the purpose of placing a lien on the recipient's home property. The notice will include an explanation of liens and that the lien will not effect the individual's ownership of the property.

b) The individual or the individual's representative will be given an opportunity to self-certify that the stay in the institution is expected to be permanent or not.

c) If the individual does not indicate the stay in the institution is likely to be permanent, the State will make an assessment based on an evaluation of the individual's medical condition and the social-economic factors involved in caring for the individual in the home. The recipient will be determined permanently institutionalized for the purposes of lien placement by such evaluation made by a physician and a social worker, or if the recipient has been continuously authorized to receive institutional care or has been institutionalized for six months or longer with no discharge plan.

d) The notice will contain information regarding the right to an administrative hearing if they disagree with the State's determination, and the process to file for a hearing.

e) Before a lien is filed, a notice shall be sent by certified mail, informing the recipient of the Department's intent to place a lien on the home property. The recipient will have 90 days from the date of the notice, to file a request for a fair hearing if he or she does not agree with the decision to place a lien on the home property.

2) **The following criteria are used for establishing that a permanently institutionalized individual's son or daughter provided care as specified under regulations at 42 CFR §433.36(f):**

The son or daughter provided the following or insured that the following care was provided:

a) Access to medical services by transporting the individual, scheduling appointments, or calling for emergency services.

b) Medical care such as administration of medication, changing of dressing, etc.

c) Basic daily needs such as feeding, bathing, cleaning, and supervision.

d) Financial support to meet the parents need for food, shelter, and clothing.

(STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: HAWAII

e) Other services that contributed to the emotional well being of the parent.

3. **The State defines the following terms as follows:**

a) **estate:** shall mean the real and personal property included in an estate under the State's probate law and any other real and personal property and other assets in which the individual had any legal title or interest at the time of death (to the extent of such interest). This includes assets conveyed to a survivor, heir, or assign of the deceased through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangements.

b) **individual's home:** shall mean the property that the individual resided and had an equity interest in prior to becoming medically institutionalized.

c) **equity interest in the home:** shall mean the value of the property that the individual holds legal title to beyond the amount owed on it in mortgages and liens.

d) **residing in the home for at least one or two years on a continuous basis** shall mean continuously lived in the home as the sole residence.

e) **lawfully residing** shall mean permitted by law to live in.

(STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: HAWAII

4. **The State defines hardship as follows:**

Undue hardship exists if the family and heirs of the deceased recipient do not have income greater than the Federal Poverty Level, and the estate of the deceased recipient is providing the sole source of income to meet their basic living expenses, or the estate is their sole place of residence.

5. **The following standards and procedures are used by the State for waiving estate recoveries when recovery would cause an undue hardship, and when recovery is not cost effective:**

a) Recovery will not be made if estate subject to recovery is the sole income producing asset of the family and heirs of the recipient, and is a family farm or business that does not produce income greater than the Federal Poverty Limit for the number of family or heirs solely dependent on the income from the asset.

b) The estate is a home of modest value (based on the median sale price of homes obtained by the Honolulu Board of Realtors) and the family members and heirs meet the following conditions:

i) Resided in the home at least three months prior to the admission of the owner to a medical institution and provided care that delayed the admission.

ii) Have continuously resided in the home since the admission of the recipient to the medical institution.

iii) Do not have an interest in real property other than the home of the recipient.

iv) Have income not greater than the Federal Poverty Level.

c) The State will determine cost effectiveness of recovery based on the amount to be recovered, the value of the assets from which recovery will be made, and the administrative and related costs to make the recovery.

6. **The State defines cost effective as follows (include methodology/thresholds used to determine cost effectiveness):**

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State/Territory: HAWAII

If a contractor is performing the recovery work, it is cost effective if the amount of the recovery is sufficient to yield a contingency fee payment to the contractor which exceeds its cost to recover the asset. If the State is performing the recovery, it is cost effective if the amount of the recovery exceeds the administrative costs, legal fees, travel expenses and other cost factors that may be involved.

7. **The State uses the following collection procedures (includes specific elements contained in the advance notice requirement, the method for applying the waiver, hearing and appeals procedures, and time frames involved):**

a) Notify the family and heirs that the State shall seek to recover Medicaid payments from the estate of the deceased recipient 45 days prior to initiating collection activities. The notice will specify the amount to be recovered, the requirements for waiving recovery due to undue hardship, and the appeal rights and procedures.

b) The family and heirs shall file for a waiver of recovery within 30 days of the mailing of the recovery notification on a form designated by the State with the State agency or private contractor designated by the State.

c) Family and heirs must submit documentation of their finances and other requested information to support their request for waiver within 10 days of the request from the State unless there are circumstances beyond their control.

d) Family and heirs may appeal the denial of waiver by requesting an administrative hearing within 90 days of the waiver denial.

State of Hawaii

LIENS AND RECOVERIES

(1) Recovery may be waived due to hardship for the period the following conditions exist:

(A) The estate subject to recovery is the sole income producing asset of the survivors and meet the following conditions:

(1) The estate is a family farm or other family business;

(2) The income produced by the asset is not greater than one hundred percent of the Federal Poverty Level (FPL) for the number of survivors solely dependent on such asset.

(B) The estate is a homestead of modest value that is occupied by survivors who meet the following conditions:

(1) Lawfully resided in the home for a continuous period that started at least three (3) months immediately before the recipient's admission to a medical institution and provided care to the recipient during that period that allowed the recipient to reside at home rather than in an institution and has continuously lived int he home since the admission;

(2) Do not own any real property other than an interest in the home; and

(3) Have income not greater than one hundred percent of the FPL.

(2) Before a lien is filed, a notice shall be given to allow 30 days for a fair hearing.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Hawaii

1. The following charges are imposed on the categorically needy for services other than those provided under section 1905(a)(1) through (5) and (7) of the Act:

Service	Type Charge Deduct.	Coins.	Copay.	Amount and Basis for Determination
NOT APPLICABLE				

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Hawaii

B. The method used to collect cost sharing charges for categorically needy individuals:

[ ] Providers are responsible for collecting the cost sharing charges from individuals.

[X] The agency reimburses providers the full Medicaid rate for a services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

NOT APPLICABLE

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Hawaii

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

E. Cumulative maximums on charges:

☐ State policy does not provide for cumulative maximums.

☐ Cumulative maximums have been established as described below:

NOT APPLICABLE

State Hawaii

The following enrollment fee, premium or similar charge is imposed on the medically needy:

Gross Family Income (per mo.)	Charge Family Size			Liability Period	Freq of C
	1 or 2	3 or 4	5 or more		
(1)	(2)	(3)	(4)	(5)	(
$150 or less					
151 - 200					
201 - 250					
251 - 300					
301 - 350					
351 - 400					
401 - 450					
451 - 500					
501 - 550					
551 - 600					
601 - 650					
651 - 700					
701 - 750					
751 - 800					
801 - 850					
851 - 900					
901 - 950					
951 - 1000					
More than $1000					

DHEW Trans. No. MCAS-78-5
Trans. Date 9/1/78

State Hawaii

Effect on recipient of non-payment of enrollment fee, premium or similar charge:

☐ Non-payment does not affect eligibility

☐ Effect is as described below:

☒ Not applicable

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Hawaii

A. The following charges are imposed on the medically needy for services:

Service	Type of Charge Deduct.	Coins.	Copay.	Amount and Basis for Determination
NOT APPLICABLE				

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Hawaii

B. The method used to collect cost sharing charges for medically needy individuals:

☐ Providers are responsible for collecting the cost sharing charges from individuals.

☐ The agency reimburses providers the full Medicaid rate for services and collects the cost sharing charges from individuals.

C. The basis for determining whether an individual is unable to pay the charge, and the means by which such an individual is identified to providers, is described below:

NOT APPLICABLE

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Hawaii

D. The procedures for implementing and enforcing the exclusions from cost sharing contained in 42 CFR 447.53(b) are described below:

E. Cumulative maximums on charges:

☐ State policy does not provide for cumulative maximums.

☐ Cumulative maximums have been established as described below:

= NOT APPLICABLE

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

Premiums Imposed on Low Income Pregnant Women and Infants

A. The following method is used to determine the monthly premium imposed on optional categorically needy pregnant women and infants covered under section 1902(a)(10)(A)(ii)(IX)(A) and (B) of the Act:

N/A

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

N/A

*Description provided on attachment.

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State/Territory: HAWAII

C. State or local funds under other programs are used to pay for premiums:

/_/ Yes /X/ No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

N/A

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

Optional Sliding Scale Premiums Imposed on Qualified Disabled and Working Individuals

A. The following method is used to determine the monthly premium imposed on qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act:

N/A

B. A description of the billing method used is as follows (include due date for premium payment, notification of the consequences of nonpayment, and notice of procedures for requesting waiver of premium payment):

N/A

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

C. State or local funds under other programs are used to pay for premiums:

[ ] Yes [X] No

D. The criteria used for determining whether the agency will waive payment of a premium because it would cause an undue hardship on an individual are described below:

N/A

*Description provided on attachment.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

It should be noted that States can select one or more options in imposing cost sharing (including co-payments, co-insurance, and deductibles) and premiums.

A. For groups of individuals with family income above 100 percent but below 150 percent of the FPL:

1. Cost sharing

a. _X_ / No cost sharing is imposed.
b. ___ / Cost sharing is imposed under section 1916A of the Act as follows (specify the amounts by group and services (see below)):

Type of Charge

Group of Individuals	Item/Service	Deductible	Co-insurance	Co-payment	*Method of Determining Family Income (including monthly or quarterly period)

*Describe the methodology used to determine family income if it differs from your methodology for determining eligibility.

Attach a schedule of the cost sharing amounts for specific items and services and the various eligibility groups.

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b. Limitations:
The total aggregate amount of cost sharing and premiums imposed under section 1916A for all individuals in the family may not exceed 5 percent of the family income of the

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

family involved, as applied on a monthly and quarterly basis as specified by the State above.

- Cost sharing with respect to any item or service may not exceed 10 percent of the cost of such item or service.

c. No cost sharing will be imposed for the following services:

- Services furnished to individuals under 18 years of age that are required to be provided Medicaid under section 1902(a)(10)(A)(i), and including services furnished to individuals with respect to whom aid and assistance is made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age;
- Preventive services (such as well baby and well child care and immunizations) provided to children under 18 years of age, regardless of family income;
- Services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy;
- Services furnished to a terminally ill individual who is receiving hospice care, (as defined in section 1905(o) of the Act);
- Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs;
- Emergency services as defined by the Secretary for the purposes of section 1916(a)(2)(D) of the Act;
- Family planning services and supplies described in section 1905(a)(4)(C) of the Act; and
- Services furnished to women who are receiving Medicaid by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.

d. Enforcement

1. __/ Providers are permitted to require, as a condition for the provision of care, items, or services, the payment of any cost sharing.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

2. __/ (If above box selected) Providers permitted to reduce or waive cost sharing on a case-by-case basis.

3. State payments to providers must be reduced by the amount of the beneficiary cost sharing obligations, regardless of whether the provider successfully collects the cost sharing.

4. States have the ability to increase total State plan rates to providers to maintain the same level of State payments when cost sharing is introduced.

2. Premiums

No premiums may be imposed for individuals with family income above 100 percent but below 150 percent of the FPL.

B. For groups of individuals with family income above 150 percent of the FPL:

1. Cost sharing amounts

a. _X_ / No cost sharing is imposed.
b. ___/ Cost sharing is imposed under section 1916A of the Act as follows (specify the amounts by group and services (see below)):

Type of Charge

Group of Individuals	Item/Service	Deductible	Co-insurance	Co-payment	*Method of Determining Family Income (including monthly or quarterly period)

*Describe the methodology used to determine family income if it differs from your methodology for determining eligibility.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

Attach a copy of the schedule of the cost sharing amounts for specific items and the various eligibility groups.

b. Limitations:

- The total aggregate amount of all cost sharing and premiums imposed under section 1916A for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a monthly or quarterly basis as specified by the State above.
- Cost sharing with respect to any item or service may not exceed 20 percent of the cost of such item or service.

c. No cost sharing shall be imposed for the following services:

- Services furnished to individuals under 18 years of age that are required to be provided Medicaid under section 1902(a)(10)(A)(i) of the Act, and including services furnished to individuals with respect to whom aid and assistance is made available under part B of title IV to children in foster care, and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age;
- Preventive services (such as well baby and well child care and immunizations) provided to children under 18 years of age regardless of family income;
- Services furnished to pregnant women, if such services relate to the pregnancy or to any other medical condition which may complicate the pregnancy;
- Services furnished to a terminally ill individual who is receiving hospice care (as defined in section 1905(o) of the Act);
- Services furnished to any individual who is an inpatient in a hospital, nursing facility, intermediate care facility for the mentally retarded, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs;
- Emergency services as defined by the Secretary for the purposes of section 1916(a)(2)(D) of the Act;
- Family planning services and supplies described in section 1905(a)(4)(C) of the Act; and
- Services furnished to women who are receiving Medicaid by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

d. Enforcement

1. ___/ Providers are permitted to require, as a condition for the provision of care, items, or services, the payment of any cost sharing.

2. ___/ (If above box selected) Providers permitted to reduce or waive cost sharing on a case-by-case basis.

3. State payments to providers must be reduced by the amount of the beneficiary cost sharing obligations, regardless of whether the provider successfully collects the cost sharing.

4. States have the ability to increase total State plan rates to providers to maintain the same level of State payments when cost sharing is introduced.

2. Premiums

a. ___/ No premiums are imposed.
b. _X_/ Premiums are imposed under section 1916A of the Act as follows (specify the premium amount by group and income level.

Group of Individuals	Premium*	Method of Determining Family Income (including monthly or quarterly period)**
250% - 265% FPL	$15 per child/per month	For a child under age 19, countable family income is determined in the following manner: • Substract a standard deduction of $90 from the monthly gross earned income of each employed person; and • Add the monthly net earned income for each employed person as well as any monthly unearned income to determine the countable family income.
265% - 280% FPL	$30 per child/per month	
280% - 300% FPL	$60 per child/per month	

*The assessment of premium-share shall not exceed 5% of countable family income. A maximum of five enrollees in a family shall be assessed a premium-share in the following manner:

- Determine the number of persons in a family eligible for coverage who are responsible for a premium-share; and
- Assess premium-shares to a maximum of five enrollees in descending order by date of birth.

**For children under age 19 who are covered under §1902(a)(10)(A)(ii)(XIV) of the Act, the State uses §1902(r)(2) to disregard the difference in countable income between 300% and 250% of the FPL.

Attach a schedule of the premium amounts for the various eligibility groups.

b. Limitation:

- The total aggregate amount of premiums and cost sharing imposed for all individuals in the family may not exceed 5 percent of the family income of the family involved, as applied on a monthly or quarterly basis as specified by the State above.

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c. No premiums shall be imposed for the following individuals:
- Individuals under 18 years of age that are required to be provided medical assistance under section 1902(a)(10)(A)(i), and including individuals with respect to whom aid or assistance is made available under part B of title IV to children in foster care and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age;
- Pregnant women;
- Any terminally ill individual receiving hospice care, as defined in section 1905(o);
- Any individual who is an inpatient in a hospital, nursing facility, intermediate care facility, or other medical institution, if such individual is required, as a condition of receiving services in such institution under the State plan, to spend for costs of medical care all but a minimal amount of the individual's income required for personal needs; and
- Women who are receiving Medicaid by virtue of the application of sections 1902(a)(10)(A)(ii)(XVIII) and 1902(aa) of the Act.

d. Enforcement

1. ___/ Prepayment required for the following groups of individuals who are applying for Medicaid:

2. _X_/ Eligibility terminated after failure to pay for 60 days for the following groups of individuals who are receiving Medicaid:

   Children with countable family income from 250% - 300% FPL.

3. ___/ Payment will be waived on a case-by-case basis for undue hardship.

C. Period of determining aggregate 5 percent cap

Specify the period for which the 5 percent maximum would be applied.

_X_/ Quarterly
___/ Monthly

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D. Method for tracking cost sharing amounts

Describe the State process used for tracking cost sharing and informing beneficiaries and providers of their beneficiary's liability and informing providers when an individual has reached his/her maximum so further costs are no longer charged.

Also describe the State process for informing beneficiaries and providers of the allowable cost sharing amounts.

1. Process used for informing beneficiaries of premium liability:

   - Applicants who are determined eligible (250%-300% FPL): The eligibility determination staff completes and sends a notice to inform the family that the child would be assessed a premium liability, and how the premium amount is determined. If the family agrees to pay the premium liability, the child is enrolled in a health plan. Each month thereafter, an invoice is mailed.

   - Current enrollees with increased income (250%-300% FPL): The eligibility determination staff sends an advance notice (in accordance with 42 CFR §431.210 and §431.211) to inform the family that the child will be assessed a premium liability, and how the amount is determined. If the family agrees to pay the premium liability, the child's enrollment in the health plan continues. Each month thereafter, an invoice is mailed.

   As the assessment of premium-shares shall not exceed 5% of countable family income, an income review is conducted each quarter.

   Disenrollment procedures will be initiated when an enrollee whose premium-share payments are two months in arrears. During the first week of each month, the Finance Office generates a list of enrollees who have not paid their premium-shares for two months. The list is sent to the Eligibility Branch for action. The eligibility determination staff will complete and send an advance notice (in accordance with 42 CFR §431.210 and §431.211) to inform the enrollee that medical coverage will terminate at the end of the month.

2. Process used for informing providers when an individual has reached his/her maximum so further costs are no longer charged: Because Hawaii charges only premiums and collects these directly from the beneficiaries, information to providers about cost-sharing maximums are not applicable.

3. Tracking premium-shares: The State operates an accounts receivable system. This system allows the State to track all paid premiums.