State: Hawaii

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

1. Inpatient hospital services other than those provided in an institution for mental diseases.

   Provided: ☐ No limitation ☒ With limitations*

2. a. Outpatient hospital services.

   Provided: ☐ No limitation ☒ With limitations*

   b. Rural health clinic services and other ambulatory services furnished by a rural health clinic. (which otherwise included in the State Plan)

   ☒ Provided: ☐ No limitations ☒ With limitations*

   ☐ Not provided.

   c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

   Provided: ☐ No limitations ☒ With limitations*

3. Other laboratory and x-ray services.

   Provided: ☐ No limitation ☒ With limitations*

State:	HAWAII

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

4.a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

Provided: ___ No limitations x With limitations*

4.b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found.*

4.c. Family planning services and supplies for individuals of child-bearing age.

Provided: ___ No limitations x With limitations*

5.a. Physicians' services whether furnished in the office, the patient's home, a hospital, a skilled nursing facility or elsewhere.

Provided: ___ No limitations x With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: ___ No limitations x With limitations*

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatry services

Provided: ___ No limitations x With limitations*

___ Not provided.

* Description provided on attachment.

State/Territory: Hawaii

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Optometrists' services.

/x/ Provided: /_/ No limitations /x/With limitations*

/_/ Not provided.

c. Chiropractors' services.

/_/ Provided: /_/ No limitations /_/With limitations*

/x/ Not provided.

d. Other practitioners' services.

/x/ Provided: Identified on attached sheet with description of limitations, if any.

/_/ Not provided.

7. Home health services.

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

Provided: /_/No limitations /x/With limitations*

b. Home health aide services provided by a home health agency.

Provided: /_/No limitations /x/With limitations*

c. Medical supplies, equipment, and appliances suitable for use in the home.

Provided: /_/No limitations /x/With limitations*

*Description provided on attachment.

State/Territory: Hawaii

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

/x/ Provided: /_/ No limitations /x/ With limitations*

/_/ Not provided.

8. Private duty nursing services.

/_/ Provided: /_/ No limitations /_/ With limitations*

/x/ Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

9. Clinic services.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

10. Dental services.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

11. Physical therapy and related services.

a. Physical therapy.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

b. Occupational therapy.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

c. Services for individuals with speech, hearing, and language disorders (provided by or under the supervision of a speech pathologist or audiologist).

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

b. Dentures.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

c. Prosthetic devices.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

d. Eyeglasses.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

*Description provided on attachment.

AMOUNT, DURATION AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

b. Screening services.

/X/ Provided: /X/ No limitations /_/ With limitations*

/_/ Not provided.

c. Preventive services.

/X/ Provided: /X/ No limitations /_/ With limitations*

/_/ Not provided.

d. Rehabilitative services.

/X/ Provided: /_/ No limitations /X/ With limitations*

/_/ Not provided.

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

/_/ Provided: /_/ No limitations /_/ With limitations*

/X/ Not provided.

b. Skilled nursing facility services.

/_/ Provided: /_/ No limitations /_/ With limitations*

/X/ Not provided.

c. Intermediate care facility services.

/_/ Provided: /_/ No limitations /_/ With limitations*

/X/ Not provided.

*Description provided on attachment.

State: Hawaii

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(A) of the Act, to be in need of such care.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not provided.

16. Inpatient psychiatric facility services for individuals under 22 years of age.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

17. Nurse-midwife services.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

18. Hospice care (in accordance with section 1905(o) of the Act).

☒ Provided in accordance with section 2302 of the Affordable Care Act:

☐ No limitations ☒ With limitations*

☐ Not provided.

*Description provided on attachment

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT
State: Hawaii

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

19. Case management services and Tuberculosis related services
a. Case management services as defined in, and to the group specific in, Supplement 1 to ATTACHMENT 3.1-a (in accordance with section 1905(a)(190 or section 1915(g) of the Act).

☒Provided: ☒With limitations*
☐Not provided.

b. Special tuberculosis (TS) related services under section 1902(x)(2)(F) of the Act.

☐Provided: ☒With limitations*
☐Not provided.

20. Extended services for pregnant women
a. Pregnancy-related and postpartum services for 12 months after the pregnancy ends.

☐ Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

☐Additional coverage ++

++ Attached is a description of increases in covered services beyond limitation for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment

State/Territory: Hawaii

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

21. Ambulatory prenatal care for pregnant women furnished during a presumptive eligibility period by a ~~qualified~~ eligible provider (in accordance with section 1920 of the Act).

[ ] Provided: [ ] No limitations [ ] With limitations*

[X] Not provided.

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

23. Certified Pediatric or family nurse practitioners' services.

Provided: [ ] No limitations [X] With limitations*

*Description provided on attachment.

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

24. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

/x/ Provided: / / No limitations /x/With limitations*

/ / Not provided.

b. Services of Christian Science nurses.

/ / Provided: / / No limitations / /With limitations*

/x/ Not provided.

c. Care and services provided in Christian Science sanitoria.

/ / Provided: / / No limitations / /With limitations*

/x/ Not provided.

d. Nursing facility services for patients under 21 years of age.

/x/ Provided: / / No limitations /x/With limitations*

/ / Not provided.

e. Emergency hospital services.

/x/ Provided: /x/ No limitations / /With limitations*

/ / Not provided.

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and provided by a qualified person under supervision of a registered nurse.

/ / Provided: / / No limitations / /With limitations*

/x/ Not provided.

*Description provided on attachment.

State: HAWAII

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

25. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

_____ provided X not provided

26. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

__ Provided: __ State Approved (Not Physician) Service Plan Allowed
__ Services Outside the Home Also Allowed
__ Limitations Described on Attachment

X Not Provided.

State: Hawaii

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

☐ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan services.

☒ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided: ☐ No limitations ☐ With limitations ☒ None licensed or approved

Please describe any limitations: N/A

28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: ☐ No limitations ☐ With limitations (please describe below)

☒ Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations: N/A

Please check all that apply:

☐ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

☐ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

☐ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services: N/A

State: Hawaii

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
CATEGORICALLY NEEDY GROUP(S)

29. Coverage of Routine Patient Cost in Qualifying Clinical Trials

*The state needs to check each assurance below.

Provided: X

General Assurances:

Routine Patient Cost – Section 1905(gg)(1)

X Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.

Qualifying Clinical Trial – Section 1905(gg)(2)

X A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).

Coverage Determination – Section 1905(gg)(3)

X A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #74). Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

CASE MANAGEMENT SERVICES

A. Target Group:

Targeted case management services are provided to eligible Medicaid recipients (categorically and medically needy) who have a developmental disability or are mentally retarded. "Developmental disabilities" means a severe, chronic disability of a person which:

1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;

2. Is manifested before the person attains the age 22;

3. Is likely to continue indefinitely;

4. Results in substantial functional limitations in three or more of the following areas of major life activity; self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic sufficiency; and

5. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

"Mental retardation" means significantly subaverage general intellectual functioning resulting in or associated with concurrent moderate, severe, or profound impairments in adaptive behavior and manifested during the development period.

Recipients receiving services under the Home & Community Based Waiver Services Program shall be eligible to receive non-duplicative case management services.

B. Areas of State in which services will be provided:

(X) Entire State.

( ) Only in the following geographic areas (authority of Section 1915 (g) (1) of the Act is invoked to provide services less than statewide).

C. Comparability of Services:

( ) Services are provided in accordance with section 1902 (a) (10) (B) of the Act.

(X) Services are not comparable in amount, duration, and scope. Authority of section 1915 (g) of the Act is invoked to provide services without regard to the requirements of section 1902 (a) (10) (B) of the Act.

D. Definition of Services:

The purpose of case management is to support, coordinate, link, monitor, and review services and resources for individuals with DD/MR. Case management will assist eligible individuals under the plan in gaining access to needed medical, social, education and other services. Case management services include:

1. Service Plan Development – The development and ongoing updating and monitoring of the Individual Service Plan based upon assessment/reassessment of clients' needs with the participation of the client, Parents, and legally appointed guardian, service providers, and other pertinent parties.

2. Service Coordination - Arranging for community residential, (i.e., care home, foster home, domiciliary home), habilitation, support, (i.e., respite, transportation, personal care), and protective services, (i.e., adult and child abuse), and coordination of services with other agencies who are involved with the individual, (i.e., Adult Residential Care Homes, Eastcr Seals Society, Association for Retarded Citizens of Hawaii, United Cerebral Palsy Association, Medical Personnel Pool for respite and personal care, Department of Human Services, Adult and Family Services Division for adult and child protective services, Vocational Rehabilitation Division, Community Long Term Care Branch, Social Security Administration, Department of Education, Family Court, Mental Health Services Systems, Office of the Public Guardian, and other public and private agencies.

3. Advocacy - Activities with the client/family and providers for the purpose of facilitating access to needed services, providing information and referral, arranging emergency services, and modifying service systems to increase accessibility and appropriateness for people with developmental disabilities.

E. Qualification of Providers:

HCD 5/13/91 of the Department of Health,

Case management services will be provided under this amendment by individuals employed by the Developmental Disabilities Division or working under a personal services contract with Developmental Disabilities Division, who meet the qualifications and entrance requirements established by the Department of Personnel Administration for the title Social Worker III and IV or Registered Professional Nurse III and IV, or meet the definition of a Qualified Mental Retardation Professional as defined at 42 C.F.R. §483.430. ~~(Copies of the position descriptions for the Social Worker and Registered Professional Nurse are attached).~~ Section 4118(i) of the Omnibus Budget Reconciliation Act of 1987 was amended to allow states to limit the case managers available for eligible individuals with

AD 5/13/91

developmental disabilities to ensure that the case managers are capable of ensuring that the individuals receive the full range of services they need. The individuals identified above as providers of case management services will be aware of the services that are available for people with developmental disabilities and how to access these services.

F. Freedom of Choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

CASE MANAGEMENT SERVICES

A. Target Group:

Targeted case management services are provided to eligible Medicaid recipients regardless of where they are residing, which may be in community residential settings, with families, in independent apartments, or, in the case of the homeless person, with no fixed place of residence. This group would also include Medicaid recipients who have dual diagnosis of severe, disabling mental illness and substance abuse or severe, disabling mental illness and developmental disabilities.

"Severe, Disabled Mentally Ill" means a person who, as a result of a mental disorder exhibits emotional or behavioral functioning which is so impaired as to interfere substantially with the person's capacity to remain in the community without verified supported treatment or services of a long-term or indefinite duration. This mental disability must be severe and persistent, resulting in a long-term limitation of the person's functional capacities for primary activities of daily living such as interpersonal relationships, homemaking, self-care, employment and recreation.

Target group is defined along three dimensions:

1. Diagnosis;

2. Level of disability which is likely to continue indefinitely;

3. Impaired role functioning which results in substantial functional limitations in three or more of the following areas of major life activity; self care, learning, mobility, self-direction, capacity for independent living, and economic sufficiency; and

   Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or of extended duration and are individually planned and coordinated.

B. Areas of the State in which Services will be provided:

[X] Entire State

[ ] Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than statewide).

C. Comparability of Services:

[ ] Services are provided in accordance with section 1902(a)(10)(B) of the Act.

[X] Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

The purpose of case management is to support, coordinate, link, monitor, and review services and resources for individuals with severe, disabling mental illness. Case Management will assist eligible individuals under the plan in gaining access to needed medical, social, education and other services. Case management services include:

1. Individualized Service Plan Development
The development and ongoing updating, evaluation, and monitoring of the comprehensive individualized service plan based on a timely accurate assessment/reassessment of clients individualized needs. Service planning shall include active participation by client, parent(s) and/or legal appointed guardian, service providers, and other pertinent parties incorporating client's expectations and choices and agreed-upon goals.

Individual service plans shall be evaluated/reviewed for appropriateness and effectiveness of outcomes minimally once every quarter or as clinically required.

2. Service Coordination
Coordinating and arranging initial appointments for clients with service providers in order to assure access to needed service/benefits, or informing client/consumers of services, assistance availability.

3. Client Support & Advocacy
With or on behalf of the client to gain access to

needed services/benefits to effectively assure clients subsistence in a community setting. Activities to include but not be limited to:

a. Seeking and assisting the client in applying for entitlement benefits, services, etc.;

b. Arranging appointments;

c. Establishing and maintaining communications with service providers; and

d. Accompanying/transporting of client to scheduled appointment to assure access and to minimize trauma to client.

e. Immediate intervention by case managers to refer clients who are decompensating (grossly psychotic, suicidal/homicidal ideation) and may be in need of psychiatric hospitalization/evaluation. Immediate intervention by case managers who would also include assisting the client by referral and linkaging to resolve immediate crisis situations that may jeopardize the client's functioning in the community (e.g., eviction, serious physical illness/injury, serious inter-personal conflicts, substance abuse episodes, medication problems, etc.).

4. Collateral Contacts
With family members and/or significant others in order to gain assistance/support and to coordinate or evaluate the implementation of service plan objectives by increasing their understanding and ability to cope with their loved one.

5. Monitoring/Follow-Up Services
Contacting client/family or significant others, either in person or by telephone to assure that clients are following prescribed services/service plan of action and monitoring the success of the plans implementation. Activities include but are not limited to:

a. Determining that satisfactory referral connections have been established;

b. Contacts with service providers to assess the level of client compliance;

c. Assuring ongoing appropriateness and effectiveness of service plan; and

d. Identify and determine if additional services may be appropriate or required.

E. Qualification of Providers:

Case management services will be provided under this amendment by individuals employed by the Adult Mental Health Division and/or Child and Adolescent Mental Health Division of the Department of Health, or working under a personal services contract with the Adult Mental Health Division and/or Child and Adolescent Mental Health Division who meet the qualifications and entrance requirements established by the Department of Personnel Administration for the title Social Worker III and IV or Registered Professional Nurse III and IV, Case Manager I, II, and III, IV and V, or meets the definition of Qualified Mental Health Professional as defined by the Department of Health. Section 4118(i) of the Omnibus Budget Reconciliation Act of 1987 was amended to allow states to limit the case managers available for eligible individuals with chronic mental illness (severe, disabling mental illness) to ensure that the case managers are capable of ensuring that the individuals receive the full range of services they need. The individuals identified above as providers of case management services will be aware of the services that are available for people with severe, disabling mental illness and how to access these services.

F. Freedom of Choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

CASE MANAGEMENT SERVICES

A. Target Group:

All Medicaid-eligible infants and toddlers (from birth to the age of three) who are eligible for early intervention services as defined by P.L. 99-457 and Hawaii Statute 107-89. This will not include infants and toddlers who reside in ICF/MRs and nursing facilities.

Recipients receiving services under the Home & Community-Based Services Waiver Program are excluded.

B. Areas of the State to be Covered:

[X] Entire State

[ ] Only in the following geographic areas (authority of section 1915(g)(1) of the Act is invoked to provide services less than statewide).

C. Comparability of Services:

[ ] Services are provided in accordance with section 1902(a)(10)(B) of the Act.

[X] Services are not comparable in amount, duration, and scope. Authority of section 1915(g)(1) of the Act is invoked to provide services without regard to the requirements of section 1902(a)(10)(B) of the Act.

D. Definition of Services:

Case management is defined as an on-going service, system and process of shared responsibility between families and professionals, that identifies needs and assists in obtaining coordinated, appropriate services and resources. Specifically for this population, "case management services" means services provided to families of infants and toddlers with handicaps to assist them in gaining access to early intervention services identified in the individualized family support plan (IFSP). This includes the following:

1. Initiating contact with the families shortly after the referral through a home visit, orienting the family with the purpose of early intervention

services, and handling questions that the family may have;

2. Coordinating the performance of evaluation and other needed diagnostic services;

3. Facilitates and participates in the development of the IFSP;

4. Assisting families in identifying available service providers and formal and informal resources;

5. Coordinating and monitoring the delivery of services, including the provision of early intervention services with other services that the child or family needs or is being provided, including medical services, respite care, and the purchase of prosthetic devices;

6. Facilitating the development and coordination of a transition plan for infants and toddlers with continuing special needs (e.g., from hospital to home; home to program; program to program; early intervention to preschool, etc.);

7. Providing family support services, which may include counseling, co-facilitating support groups for family members; and

8. Advocating on behalf of infants and toddlers with special needs and their families.

E. Qualification of Providers:

of the Department of Health
JLW 10/24/91
10/24/91

Case management services will be provided under this amendment by individuals employed by the Family Health Services Division or working under a personal services contract with Family Health Services Division who meet the qualifications and entrance requirements established by the Department of Personnel Administration for the title Social Worker III and IV or Registered Professional Nurse III and IV, or meets the definition of a Qualified Mental Retardation Professional as defined at 42 C.F.R. §483.430. Section 4118(i) of the Omnibus Budget Reconciliation Act of 1987 was amended to allow states to limit the case managers available for eligible individuals with developmental disabilities to ensure that the case managers who are capable of ensuring that the

individuals receive the full range of services they need. The individuals identified above as providers of case management services will be aware of the services that are available for children with developmental disabilities and how to access these services.

F. Freedom of Choice:

The State assures that the provision of case management services will not restrict an individual's free choice of providers in violation of section 1902(a)(23) of the Act.

1. Eligible recipients will have free choice of the providers of case management services.

2. Eligible recipients will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

CASE MANAGEMENT SERVICES

A Target Group:

Targeted case management services are provided to eligible Medicaid recipients (categorically and medically needy) who are medically-fragile.

"Medically-fragile" means an individual, who is ventilator-dependent, tracheostomy-dependent, or otherwise requires intensive, continuous medical monitoring and interventions performed by trained family/caregiver or professional nurses, because of chronic serious medical conditions.

An individual in this target group shall meet the following conditions to qualify for medically-fragile case management services:

(1) Eligible for medical assistance from the department and under 21 years of age;

(2) Determined medically-fragile and has a medical need for case management due to the medical condition of the individual and the need for coordination of multiple medical services/items;

(3) Able to safely reside in a home or foster home and does not need to be cared for in a facility for medical reasons; but is unable to reside safely in the home without receiving specialized medical services/items; and

(4) The provisions of such services will improve the care the family and service providers furnish to the individual and enable the individual to remain in the home safely.

An individual who is receiving case management services under the Medicaid Home and Community Based Waiver Programs is excluded.

B. Areas of State in which services will be provided:

(x) Entire State.

( ) Only in the following geographic areas (authority of Section 1915(g)(1) of the Act is invoked to provide services less than statewide).

C Comparability of Services:

( ) Services are provided in accordance with section 1902(a)(10)(B) of the Act.

(x) Services are not comparable to amount, duration, and scope. Authority of section 1915 (g) of the Act is invoked to provide services without regard to the requirements of section 1902 (a)(10)(B) of the Act.

D. Definition of Services:

"Medically-fragile case management" means services which will assist a medically-fragile individual eligible for medical assistance in gaining access to needed medical, social, educational and other services.

1. The case management provider must keep written documentation of his/her case management activities which includes assessment/reassessment, plan of care development, implementation and changes, advocacy, liaison, coordination of care and quality.

2. All records must be dated and signed.

3. All federal and state privacy and confidentiality requirements must be met.

E. Qualification of Providers:

1. The case management provider must be a Medicaid provider.

2. The case management provider must be an entity that employs licensed professional nurses and/or licensed physicians. The nurse must work with a physician. The physician may be an employer, a consultant to the nursing staff, an employee, or the recipient's physician.

3. In all cases, the primary case manager must be a licensed professional nurse or a licensed physician.

4. Although case management services may be provided by the staff of the entity, the licensed professional nurse and/or physician must supervise, consult, and/or advise the staff providing the activities.

5. The assessment of the patient's medical condition must be performed by a licensed professional nurse or licensed physician.

F. Freedom of Choice:

1. Eligible recipient will have free choice of the providers of case management services.

2. Eligible recipient will have free choice of the providers of other medical care under the plan.

G. Payment for case management services under the plan does not duplicate payments made to public agencies or private entities under other program authorities for this same purpose.

State/Territory: Hawaii

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

The following ambulatory services are provided.

Ambulatory services are provided equally to categorically and medically needy individuals as described in Attachment 3.1-B, pages 2 through 12.

*Description provided on attachment.

State: Hawaii

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

1. Inpatient hospital services other than those provided in an institution for mental diseases.

   ☒ Provided: ☐ No limitations ☒ With limitations*

2. a. Outpatient hospital services.

   ☒ Provided: ☐ No limitations ☒ With limitations*

   b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise covered under the Plan).

   ☒ Provided: ☐ No limitations ☒ With limitations*

   c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the Plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).

   ☒ Provided: ☐ No limitations ☒ With limitations*

3. Other laboratory and x-ray services.

   ☒ Provided: ☐ No limitations ☒ With limitations*

4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.

   ☒ Provided: ☐ No limitations ☒ With limitations*

   b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found. +

   ☒ Provided

   c. Family planning services and supplies for individuals of childbearing age.

   ☒ Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment.

State/Territory: HAWAII

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

5.a. Physicians' services, whether furnished in the office, the patient's home, a hospital, a skilled nursing facility, or elsewhere.

Provided: ___ No limitations X With limitations*

b. Medical and surgical services furnished by a dentist (in accordance with section 1905(a)(5)(B) of the Act).

Provided: ___ No limitations X With limitations*

* Description provided on attachment.

State/Territory:	HAWAII

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.

a. Podiatry Services

x Provided: ___ No limitations x With limitations

b. Optometirists' Services

x Provided: ___ No limitations x With limitations

c. Chiropractors' Services

___ Provided: ___ No limitations ___ With limitations

d. Other Practitioners' Services

x Provided: ___ No limitations x With limitations

7. Home Health Services

a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.

x Provided: ___ No limitations x With limitations

b. Home health aide services provided by a home health agency.

x Provided: ___ No limitations x With limitations

c. Medical supplies, equipment, and appliances suitable for use in the home.

x Provided: ___ No limitations x With limitations

d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.

x Provided: ___ No limitations x With limitations

*Description provided on attachment.

State/Territory: Hawaii

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

8. Private duty nursing services.

[ ] Provided: [ ] No limitations [ ] With limitations*

9. Clinic services.

[X] Provided: [ ] No limitations [X] With limitations*

10. Dental services.

[X] Provided: [ ] No limitations [X] With limitations*

11. Physical therapy and related services.

a. Physical therapy.

[X] Provided: [ ] No limitations [X] With limitations*

b. Occupational therapy.

[X] Provided: [ ] No limitations [X] With limitations*

c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.

[X] Provided: [ ] No limitations [X] With limitations*

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

[X] Provided: [ ] No limitations [X] With limitations*

b. Dentures.

[X] Provided: [ ] No limitations [X] With limitations*

*Description provided on attachment.

State/Territory: Hawaii

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

c. Prosthetic devices.

[X] Provided: [ ] No limitations [X] With limitations*

d. Eyeglasses.

[X] Provided: [ ] No limitations [X] With limitations*

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

a. Diagnostic services.

[X] Provided: [ ] No limitations [X] With limitations*

b. Screening services.

[X] Provided: [X] No limitations [ ] With limitations* 2-13-87

c. Preventive services.

[X] Provided: [X] No limitations [ ] With limitations* 2-13-87

d. Rehabilitative services.

[X] Provided: [ ] No limitations [X] With limitations*

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services.

[ ] Provided: [ ] No limitations [ ] With limitations*

b. Skilled nursing facility services.

[ ] Provided: [ ] No limitations [ ] With limitations*

*Description provided on attachment.

State/Territory: Hawaii

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

c. Intermediate care facility services

☐ Provided: ☐ No limitations ☐ With limitations*

15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(a) of the Act, to be in need of such care.

☒ Provided: ☐ No limitations ☒ With limitations*

b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.

☐ Provided: ☐ No limitations ☐ With limitations*

16. Inpatient psychiatric facility services for individuals under 22 years of age.

☒ Provided: ☐ No limitations ☒ With limitations*

17. Nurse-midwife services.

☒ Provided: ☐ No limitations ☒ With limitations*

18. Hospice care (in accordance with section 1905(o) of the Act).

☒ Provided in accordance with section 2302 of the Affordable Care Act:

☐ No limitations ☒ With limitations*

*Description provided on attachment

State: Hawaii

AMOUNT, DURATION, AND SCOPE OF MEDICAL
AND REMEDIAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDY GROUP(S):

19. Case management services and Tuberculosis related services
a. Case management services as defined in, and to the group specific in, Supplement 1 to ATTACHMENT 3.1-a (in accordance with section 1905(a)(190 or section 1915(g) of the Act).

☒Provided: ☒With limitations*
☐Not provided.

b. Special tuberculosis (TS) related services under section 1902(x)(2)(F) of the Act.

☐Provided: ☐With limitations*
☒Not provided.

20. Extended services for pregnant women

a. Pregnancy-related and postpartum services for 12 months after the pregnancy ends.

☒Provided +: ☐Additional coverage ++

b. Services for any other medical conditions that may complicate pregnancy.

☒Provided +: ☐Additional coverage ++ ☐Not provided.

21. Certified pediatric or family nurse practitioners' services.

☒Provided +: ☐No limitations ☒With limitations*
☐Not provided.

+Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.

Refer to Supplement to Attachment 3.1-A and 3.1-B
++ Attached is a description of increases in covered services beyond limitation for all groups described in this attachment and/or any additional services provided to pregnant women only.

*Description provided on attachment

State/Territory: HAWAII

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.

a. Transportation.

/X/ Provided: / / No limitations /X/ With limitations*

b. Services of Christian Science nurses.

/ / Provided: / / No limitations / / With limitations*

c. Care and services provided in Christian Science sanitoria.

/ / Provided: / / No limitations / / With limitations*

d. Skilled nursing facility services provided for patients under 21 years of age.

/X/ Provided: / / No limitations /X/ With limitations*

e. Emergency hospital services.

/X/ Provided: /X/ No limitations / / With limitations*

f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.

/ / Provided: / / No limitations / / With limitations*

State/Territory: HAWAII

AMOUNT, DURATION, AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

24. Home and Community Care for Functionally Disabled Elderly Individuals, as defined, described and limited in Supplement 2 to Attachment 3.1-A, and Appendices A-G to Supplement 2 to Attachment 3.1-A.

___ Provided X Not Provided

25. Personal care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for the mentally retarded, or institution for mental disease that are (A) authorized for the individual by a physician in accordance with a plan of treatment, (B) provided by an individual who is qualified to provide such services and who is not a member of the individual's family, and (C) furnished in a home.

___ Provided: ___ State Approved (Not Physician) Service Plan Allowed

___ Services Outside the Home Also Allowed

___ Limitations Described on Attachment

X Not provided.

State/Territory: Hawaii

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S): _____

27. Program of All-Inclusive Care for the Elderly (PACE) services, as described in Supplement 3 to Attachment 3.1-A.

☐ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

☒ No election of PACE: By virtue of this submittal, the State elects to not add PACE as an optional State Plan service.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

AMOUNT, DURATION, AND SCOPE OF MEDICAL AND
REMEDIAL CARE AND SERVICES PROVIDED TO THE MEDICALLY NEEDY

28. (i) Licensed or Otherwise State-Approved Freestanding Birth Centers

Provided: ☐ No limitations ☐ With limitations ☒ None licensed or approved

Please describe any limitations: N/A

28. (ii) Licensed or Otherwise State-Recognized covered professionals providing services in the Freestanding Birth Center

Provided: ☐ No limitations ☐ With limitations (please describe below)

☒ Not Applicable (there are no licensed or State approved Freestanding Birth Centers)

Please describe any limitations: N/A

Please check all that apply:

☐ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

☐ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

☐ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

*For (b) and (c) above, please list and identify below each type of professional who will be providing birth center services: N/A

State: Hawaii

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED
MEDICALLY NEEDY GROUP(S)

29. Coverage of Routine Patient Cost in Qualifying Clinical Trials

*The state needs to check each assurance below.

Provided: X

General Assurances:

Routine Patient Cost – Section 1905(gg)(1)

X Coverage of routine patient cost for items and services as defined in section 1905(gg)(1) that are furnished in connection with participation in a qualified clinical trial.

Qualifying Clinical Trial – Section 1905(gg)(2)

X A qualified clinical trial is a clinical trial that meets the definition at section 1905(gg)(2).

Coverage Determination – Section 1905(gg)(3)

X A determination with respect to coverage for an individual participating in a qualified clinical trial will be made in accordance with section 1905(gg)(3).

PRA Disclosure Statement - This information is being collected to assist the Centers for Medicare & Medicaid Services in implementing Section 210 of the Consolidated Appropriations Act of 2021 amending section 1905(a) of the Social Security Act (the Act), by adding a new mandatory benefit at section 1905(a)(30). Section 210 mandates coverage of routine patient services and costs furnished in connection with participation by Medicaid beneficiaries in qualifying clinical trials effective January 1, 2022. Section 210 also amended sections 1902(a)(10)(A) and 1937(b)(5) of the Act to make coverage of this new benefit mandatory under the state plan and any benchmark or benchmark equivalent coverage (also referred to as alternative benefit plans, or ABPs). Under the Privacy Act of 1974 any personally identifying information obtained will be kept private to the extent of the law. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid Office of Management and Budget (OMB) control number. The OMB control number for this project is 0938-1148 (CMS-10398 #74). Public burden for all of the collection of information requirements under this control number is estimated to take about 56 hours per response. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to CMS, 7500 Security Boulevard, Attn: Paperwork Reduction Act Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

1. The utilization control committee of an acute hospital facility shall determine the medical necessity for admission and continued stay for all Medicaid beneficiaries. Extension of hospital stay shall be requested when a patient is awaiting placement in a long-term facility.

2a. Outpatient Hospital Services are covered pursuant to 42 CFR 440.20(a).

2b. Rural Health Clinics (RHC) services and other ambulatory services offered by a RHC are covered consistent with section 1905(a)(2)(B) of the Act.
RHC services shall be delivered exclusively by the following health care professionals who are licensed by the State of Hawaii:

i. Physician (Doctor of Medicine, Doctor of Osteopathy, Doctor of Dentistry, Doctor of Optometry, and Doctor of Podiatry);
ii. Physician Assistant;
iii. Nurse Practitioner;
iv. Nurse Midwife;
v. Visiting Nurse;
vi. Clinical Social Worker;
vii. Clinical Psychologist; or
viii. Licensed dieticians
ix. Mental Health Counselors
x. Marriage and Family Therapists

2c. Federally Qualified Health Centers (FQHC)services and other ambulatory services offered by a RHC are covered consistent with section 1905(a)(2)(C) of the Act.
FQHC services shall be delivered exclusively by the following health care professionals who are licensed by the State of Hawaii:

i. Physician (Doctor of Medicine, Doctor of Osteopathy, Doctor of Dentistry, Doctor of Optometry, and Doctor of Podiatry);
ii. Physician Assistant;
iii. Nurse Practitioner;
iv. Nurse Midwife;
v. Visiting Nurse;
vi. Clinical Social Worker;
vii. Clinical Psychologist; or
viii. Licensed dieticians
ix. Mental Health Counselors
x. Marriage and Family Therapists

3. Prior authorization is required for the following services:

Radiology:

- MRI (magnetic resonance imaging)
- MRA (magnetic resonance angiography)
- PET (positron emission tomography)

Laboratory:

- Reference lab tests that cannot be done in Hawaii and not specifically billable by clinical labs in Hawaii
- Disease specific new technology lab tests
- Chromosomal analysis

Coverage of laboratory services are made only for tests performed by standard procedures and techniques commonly accepted by the medical community.

4a. Authorization by the Department's medical consultant is required for level of care and admission to a Nursing Facility (NF). Pre-admission screening is also required for admission to the NF.

4b. The state covers all benefits and services coverable under section 1905(a) of the Act to correct or ameliorate defects and physical and mental illness and conditions that meet a determination of medical necessity under the state program's definition of medical necessity.

School-Based Health-Related Services (SBHRS):

School-based health-related services (SBHRS) are services that are medically necessary and otherwise reimbursable hereunder and are provided by or through the Hawaii Department of Education (DOE) to public school and charter school students who are eligible for medical assistance and have special needs pursuant to IDEA and are included in each child's Individualized Education Plan (IEP).

SBHRS are defined below:

Direct care providers of SBHRS employed by or contracted by the Department of Education (DOE) must meet all Medicaid provider qualifications in order for the SBHRS that is claimed to be determined Medicaid reimbursable.

If any service is provided under the supervision of a qualified provider, the following specifications must also be met:

There must be a supervising professional who meets all the service specific professional standards under Federal and state law and is affiliated with the entity providing the services (e.g., the school). The supervising professional must see the student initially, prescribe the type of care provided, periodically review the need for the continued services, and subsequently see the student at least once annually (twelve-month interval). The supervising professional must assume responsibility for the services provided and assure that such services are medically necessary. The supervising professional should co-sign the progress notes used for Medicaid billing.

For the qualified professional to be affiliated with a school district, there must be a contractual agreement or some type of formal arrangement between the supervising professional and the school district by which the supervising professional is legally bound to supervise the school's district patients.

Physical Therapy: Therapy services are provided by:

- A physical therapist (PT) licensed to practice in the state of Hawaii. All physical therapists providing services or supervising the provision of physical therapy services will, at a minimum, meet the Federal requirements of 42 C.F.R. §440.110(a)(2);
- Physical therapy assistant (PTA) with an associate degree in a two-year, American physical therapy association approved, college program for physical therapist and working under the supervision of a licensed and Federally qualified physical therapist;

Occupational Therapy: Therapy services are provided by:

- Occupational therapist registered (OTR) who is registered and licensed to practice in the State of Hawaii. Occupational therapist will meet the Federal requirements at 42 C.F.R. §440.110(b)(2);

- Certified occupational therapy assistant (COTA) who is a graduate of an accredited occupational therapy assistance program recognized by the American Medical Association and American Occupational Therapy Association with an Associate.

  Degree of Science in Occupational therapy, successfully completed supervised fieldwork, has certification from the National Board for Certification in Occupational Therapy (NBCOT), and works under the supervision of a licensed and Federally qualified OTR;

Auditory therapy: Therapy services are provided by:

- Audiologist licensed to practice in the State of Hawaii and meets the Federal provider requirements at 42 C.F.R. §440.110(c)(3)

Speech Language Therapy: Therapy services are provided by:

- Speech pathologist licensed to practice in the State of Hawaii and meets the Federal provider requirements at 42 C.F.R. §440.110(c). Providers or speech language therapy services will meet the Federal provider requirements at 42 C.F.R §440.110(c)(2);

- Communication aide to meet the specific needs of an eligible student. Communication aides are paraprofessional equivalents of speech pathologists. The communication aide must have a high school degree and general and special experience recognized by the DOE. All-or part of general experience may be substituted for by education in programs of Associate of Science in Teacher's Aid or possession of an Associate of Science degree in Teacher's Aid from an accredited community college or possession of a bachelor's degree in education or equivalent from an accredited college or university or possession of a bachelor's degree in speech pathology as specified by the DOE and working under the supervision of a licensed and Federally qualified speech pathologist that meets the requirements of 42 C.F.R. §440.110. Communication aides do therapy under the supervision of the speech pathologist. They are not hired to do audiology services. They do not teach Braille or sign language. The qualified speech pathologist must see the student initially, prescribe the type of care provided, review the need for continued services throughout treatment, and see the student at least annually. The speech pathologist must assume professional responsibility for the services provided and ensure that the services are medically necessary. The qualified speech pathologist must spend as much time as

necessary directly supervising services to ensure the student is receiving services in a safe and efficient manner in accordance with accepted standards of medical practice. Documentation must be kept supporting the speech pathologist's supervision of services and ongoing involvement in the treatment.

Physical therapy, Occupational therapy, and Speech language therapy services include evaluations, re-evaluations, assessments, or re-assessments that result in the provision of IEP services.

Physical therapy, Occupational therapy, and Speech language therapy services are provided to facilitate a child's achievement of the goals and objectives delineated in the IEP. Intervention may be delivered through individual and/or group therapy.

Other services included under Physical Therapy, Occupational Therapy, and Speech Language Therapy Services are:

1. **Assistive Technology Device Services:** Only supplies and equipment necessary for the provision of physical therapy, occupational therapy and speech and language services will be covered.

   Assessments, evaluations or re-evaluations, re-assessments are included when they result in the provision of IEP services.

2. **Assistive Technology Device Therapy:** Assistive technology device therapy Services are services provided in connection with the physical therapy, occupational therapy, and speech therapy as required by 42 C.F.R. §440.110. Assistive technology device therapy includes:

   - The evaluation of the needs of a student with a disability, including a functional evaluation of the student in the student's customary environment;
   - Assessments, evaluations or re-evaluations, re-assessments are included and results in the provisions of IEP services.
   - Coordinating and using other therapies, interventions, or services with assistive technology devices such as those associated with existing education and rehabilitation plans and programs; and

- Training or technical assistance for a student with a disability or as appropriate, that student's family.

Services must be provided by or under the direction of: speech therapist or audiologist licensed to practice in the State of Hawaii who meet the Federal requirements at 42 CFR 440.110(c); physical therapists licensed to practice in the State of Hawaii who meet the Federal provider requirements at 42 C.F.R. 440.110(a); and occupational therapists licensed in the State who meet the Federal requirements of 42 C.F.R. §440.110(b).

Hearing, Audiology, and Language Services: Includes both articulation and language therapy in either individual or group settings. Audiologist or speech pathologist must be licensed to practice in the State of Hawaii and meet the Federal provider requirements at 42 C.F.R. §440.110(c).. Assessments, evaluations or re-evaluations, re-assessments are included and results in the provisions of IEP services.

Nursing Services: Direct service interventions that are medically based and within the scope of professional practice of a registered nurse or licensed practical nurse, who are licensed to practice in the State of Hawaii, such as catheterization, suctioning, medication management, equipment associated with nursing services, and DME's such as oxygen concentrator suctioning machines. Direct nursing services are provided face-to-face and are generally provided on a one-to-one basis. These services are being provided in accordance with the requirements in 42 C.F.R. § 440.130(d).

Behavioral Health Services: A behavioral health service includes the provision of counseling for children. All services must be for the direct benefit of the child and includes individual, group, and family therapy. Assessments, evaluations or re-evaluations, re-assessments are included and results in the provisions of IEP services. These services are covered in accordance with the requirements in 42C.F.R § 440.130. Behavioral health services are provided by licensed social workers, psychologist, and psychiatrist licensed to practice in the State of Hawaii.

4c. The limitation on family planning are:

(1) Hysterectomies are not covered when performed solely to render the person incapable of reproducing.

The individual undergoing a hysterectomy must be informed by the physician, prior to the procedure that the hysterectomy will render the individual incapable of reproducing. A signed acknowledgement is required.

(2) Sterilizations are not authorized for any person under age 21 years; institutionalized; or mentally incompetent. Informed consent shall be obtained prior to a sterilization procedure.

Following the consent, the procedure may not be performed before 30 days and no later than 180 days. Some exceptions to this time limitation are allowed, i.e., premature delivery, and abdominal surgery.

5a. Physicians' services are limited to two (2) visits a month for patients in NF except for acute episodes. Limits may be exceeded based on medical necessity. Physician services do not extend to procedures or services considered to be experimental or unproven as determined by Medicare.

5b. Medical and surgical services that will be covered when furnished by either a dentist or a physician must be related to the treatment of a medical condition such as acute pain, infection, or fracture of the jaw and include examination of the oral cavity, required radiographs, and complex oral surgical procedures. Routine post-operative visits shall be considered part of the total surgical procedure and shall not be separately compensable.

Additional non-covered services may be covered as determined by the department.

6b. Routine eye exams provided by qualified optometrists are authorized once in a one-year period for individuals under twenty-one years of age and once in a two-year period for adults age twenty-one years and older. Visit done more frequently maybe prior authorized and covered when medically necessary. Emergency eye care shall be covered without prior authorization. The following limitations apply:

1) Approval required for contact lenses, subnormal visual aids costing more than $50.00 and to replace glasses or contacts within one year for individuals under age twenty-one years and within two years for adults agetwenty-one and older. Medical justification required for bifocal lenses.
2) Trifocal lenses are covered only for those currently wearing these lensessatisfactorily and for specific job requirements.
3) Bilateral plano glasses covered as safety glasses for persons with one remaining eye.
4) Individuals with presbyopia who require no or minimal distance correctionshall be fitted with ready made half glasses instead of bifocals.

6d. Service of Other Providers:

1) Services of a licensed Psychologist within the scope of practice according to state law are provided with the following limitations:

a. Testing is limited to a maximum of 4 hours once every 12 months or to 6 hours, if a comprehensive test is justified.

b. Prior authorization is required for all psychological testing except for tests that are requested by the department's professional staff.

The providers for SAT services are psychologists, licensed clinical social workers in behavioral health, advance practice registered nurses (APRN), marriage and family therapists (MFT), and licensed mental health counselors (MHC), in behavioral health. Settings where services will be delivered are in outpatient hospitals/clinics including methadone clinics, and physician/provider offices.
Only professional fees are paid when services are provided in an outpatient or clinic setting and are paid at or below the Medicare fee schedule rate.

SAT services that are medically necessary shall be provided with no limits on the number of visits in accordance with the parity law. SAT services that are medically necessary shall be reimbursed with the existing approved Medicaid fee Schedule or PPS methodology.

2) Services provided by a licensed Pharmacist within their scope of practice according to state law.

6d. Services of Other Providers (continued)

i. Services provided by Pharmacy Interns and Pharmacy Tech Specialists under the supervision of a Licensed Pharmacist. The licensed pharmacist assumes the professional liability for services furnished by pharmacy interns and technicians.

7a to d. Home health services mean the following items and services, provided to a recipient at his/her place of residence on physician's order as part of a written plan of care:

1) Nursing services (as defined in the State Nurse Practice Act and subject to the limitations set forth in 42 CFR 440.70(b)(1));
2) Home health aide service provided by a home health agency;
3) Medical supplies, equipment, and appliances suitable for use in the home (subject to an annual review by a physician of need for the service); and
4) Physical therapy, occupational therapy, or speech pathology and audiology services, provided by a home health agency or by a facility licensed by the State to provide medical rehabilitation services.

Home health services shall be reimbursed on the basis of "per visit"; Daily home visits permitted for home health aide and nursing services in the first two weeks of patient care if part of the written plan of care; No more than three visits per week for each service for the third week to the seventh week of care; No more than one visit a week for each service from the eighth week to the fifteenth week of care; No more than one visit every other month for each service from the sixteenth week of care. Services exceeding these parameters shall be prior authorized by the medical consultant or it's authorized representative. Medical social services not covered.

Medical supplies, equipment and appliances require prior authorization by the department when the cost exceeds $50.00 per item.
Physical and occupational therapy and services for speech, hearing and language disorders are subject to the limitations set forth in #11.

Initial physical therapy and occupational therapy evaluations do not require prior approval. However, physical and occupational therapy and reevaluations require approval of the medical consultant providing diagnosis, recommended therapy including frequency and duration, and for chronic cases, long term goals and a plan of care.

All speech, hearing, and language evaluations and therapy require authorization by the medical consultant including rental or purchase of hearing aids.

9. Limitations on the amount, duration or scope of clinic services are the same as the limitations included for state plan outpatient services listed in Attachment 3.1-A and 3.1-B of the state plan, not to include inpatient services (hospital, nursing facility, psychiatric facility services for individuals under 22 years of age, emergency hospital services). Physicians that provide direction/supervision of others in the clinic assume professional responsibility for the care of the patients.

10. DENTAL SERVICES:

(A) Dental services for individuals under twenty-one years of age:

(1) The following dental services may only be provided based upon medical necessity:

(a) Orthodontic services.

(b) Fixed bridgework.

(c) Plaque control.

(d) Tooth preparation, temporary restorations, cement bases, impressions, or local anesthesia.

(e) X-rays.

(f) Sealants for occlusal surface of caries free permanent molar teeth.

(2) Limitations to dental services provided are:

(a) Dental work done under intravenous, inhalation or general anesthesia shall be allowed only once per treatment plan and limited to cases of medical necessity.

(b) Restorative dentistry limited to use of certain materials. Non-duplicated restorative procedures are allowed once per tooth every two years as needed in the treatment of fractured or carious teeth.

(c) Anterior, molars and premolar root canal shall be covered for a maximum of once per tooth, with authorization, except in cases of poor prognosis possibly due to extensive root decay or bone loss or prior root canal therapy failure.

(d) Acrylic jackets and acrylic veneer crowns, if authorized, shall be limited to anterior teeth for a maximum of once per tooth.

(e) Except for emergency treatments, prior authorization is required for certain dental work.

(3) The above limitations will be exceeded based on a determination of medical necessity under the EPSDT provisions at 1905(r)(5).

(4) Any item or service that is considered to be unsafe or experimental is not covered.

(B) Individuals age 21 years and older — Dental Services:

1. **Preventive services:**
   a. Comprehensive Oral Evaluation - Once every 5 years
   b. Periodic screening examinations - 2 per year
   c. Prophylaxis - 2 per year
   d. Topical fluoride or fluoride varnish -2 per year

2. **Diagnostic and radiology services:**
   a. Bitewing x-rays - 2 per year
   b. Full series x-rays - 1 every 5 years
   c. Periapical x-rays
   d. Biopsy of oral tissue

3. **Endodontic therapy services:**
   a. Root canal therapy on permanent molars

4. **Restorative services:**
   a. Amalgams on primary and permanent posterior teeth.
   b. Composites on anterior and posterior teeth.
   c. Pin and/or post reinforcements
   d. Cast cores
   e. Recement inlays and crowns
   f. Stainless steel crowns

5. **Oral surgery**

6. **Periodontal therapy services:**
   a. Scaling and root planning – one every 24 months

7. **Emergency and palliative treatment which includes services to control bleeding, relieve pain, eliminate acute infection and treatment of injuries to the teeth or supporting structures**:
   a. Gingivectomy, for gingival hyperplasia
   b. Other medically necessary emergency dental services

Procedures needed over the limits stated above may be allowed through a prior authorization process demonstrating medical necessity.

11a to c. Medically necessary physical and occupational therapy and services for speech, hearing and language disorders are limited to patients who are expected to improve in a reasonable period of time with therapy. Prior authorization is required.

Provider qualifications are the same as those listed under 4b.

Duplicate services provided under 4b will not be authorized or approved.

12a. Effective January 1, 2006, the Medicaid agency will not cover any Part D drug for full-benefit dual eligible individuals who are entitled to receive Medicare benefits under Part A and Part B.

Prescribed drugs must be listed in the Hawaii Medicaid Drug Formulary. All other prescribed drugs require prior authorization.

Select prescribed drugs when medically necessary: Select prescribed drugs that are not covered outpatient drugs (including drugs authorized for import by the Food and Drug Administration) are also covered when medically necessary during drug shortages identified by the Food and Drug Administration.

(1) Those drug products produced by manufacturers who have entered into and comply with an agreement under Section 1927(a) of the Act may be considered for payment by being listed in the Hawaii Medicaid Drug Formulary or may require prior authorization approval. Pursuant to 42 U.S.C. section 1396r-8(d)(5), certain medications may require prior authorization.

The Medicaid agency does not provide coverage for the following excluded or otherwise restricted drugs or classes of drugs or their medical uses, subject to restriction under 1927, to all Medicaid beneficiaries, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit-Part D.

The following excluded drugs are not covered:

a. Used for cosmetic purposes of hair growth;

b. With associated tests or monitoring purchased exclusively from the manufacturer or designee as a condition of sale;

c. Which classes as “less than effective” as described in Section 107(c)(3) of the Drug Amendments of 1962 or are identical, similar or related; and

d. Agents used to promote fertility.

(2) The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid beneficiaries, including under the Medicare Prescription Drug Benefit- Part D.

The following drugs or classes of drugs, produced by manufacturers complying with Section 1927(a) of the Act, or their medical uses will be selectively covered as decided by the Advisory Medicaid Formulary Committee (the responsibilities for which have been delegated to the State Drug Review Board or the Pharmacy and Therapeutics Committee:

The following excluded drugs are covered:

(a) Agent when used for anorexia, weight loss, weight gain (see specific drug categories below)

- Marinol

(b) Agents when used for symptomatic relief cough and colds (see specific drug categories below)

- Brompheniramine with pseudoephedrine (tablets, liquid)
- Chlorpheniramine (all forms)
- Diphenhydramine (all forms)
- Guaifenesin with or without dextromethorphan (all strength/liquid)
- Loratadine with or without a decongestant (for age 20 years old and younger; for age 61 years old and older; age 21 to 60 continue to require PA)*
- Pseudoephedrine (all forms)

(c) Prescription only vitamins and mineral products, except prenatal vitamins and fluoride (prior authorization required)

(d) Selective Non-legend drugs will be covered as listed on the state Medicaid website.

Schedule 3
Supplemental Rebate Calculation

This Schedule 3 to the SUPPLEMENTAL DRUG-REBATE AGREEMENT provides as follows:

(3) Preferred Drug List (PDL) / Prior Authorization

Prior authorization may be established for high cost and/or highly utilized items to ensure products are being utilized appropriately. Additionally, certain designated therapeutic classes will be reviewed periodically to consider which products are clinically appropriate and most cost-effective. Those products within the therapeutic class that are not determined to be clinically superior and/or are not cost-effective will be prior authorized.

Pursuant to 42 U.S.C. section 1396r-8, the State will establish prior authorization for certain drugs, including a preferred drug list with prior authorization for drugs not included on the PDL. Prior authorization request will be responded to within 24-hour of receipt by telephone or other telecommunication; and in an emergency, a 72-hour supply of the drug desired by the prescribing physician will be allowed (an emergency is defined as a situation that exists when the withholding of medication chosen by the prescribing physician will cause the patient's medical condition to worsen or prevent improvement and the person designated to approve prior authorization is not available for approval by telephone or ther means)..

The Department may maintain a Preferred Drug List containing the names of pharmaceutical drugs for which prior authorization will not be required under the medical assistance program. All other pharmaceutical drugs not on the Preferred Drug List, and determined by the Department to be in the same drug class and used for the treatment of the same medical condition as drug(s) placed on the Preferred Drug List, will require prior authorization. The Med-QUEST administrator may seek the recommendations of an

advisory committee to be comprised of medical and pharmaceutical professionals regarding the pharmaceutical drugs that may be placed on a Preferred Drug List.

The State may appoint a Pharmacy and Therapeutics (P&T) Committee consisting of physicians and pharmacists or utilize the Drug Utilization Review (DUR) board in accordance with federal law.

(4) The maximum quantity of any medication to be paid equals the larger of a one month supply or one hundred units. The State may implement stricter quantity restrictions to help ensure proper utilization and reduce billing errors.

(5) In compliance with Section 1927(b)(2) of the Social Security Act, the fiscal agent is engaged to report to each manufacturer not later than sixty days after the end of each calendar quarter and in a form consistent with a standard reporting format established by the Secretary, information on the total number of dosage units of each covered outpatient drug dispensed under the plan during the quarter and shall promptly transmit a copy of such report to the Secretary as instructed by CMS.

12b. Prosthodontic services:

These limits may be exceeded based upon medical necessity.

a. Complete Upper and Lower Dentures-one every 5 years

b. Partial Dentures-one every 5 years

(i) Partial dentures are limited to fill the space due to the loss of one or more anterior teeth and to fill the space due to the loss of two or more posterior teeth exclusive of third molars.

(ii) Temporary dentures allowed only when teeth have been extracted recently with prior authorization and shall be subject to maximum benefits for dentures.

(iii) Only one prosthetic appliance in any five-year period is allowed for a maximum of one for each type, partial and full dentures, per arch per beneficiary lifetime. This is allowed only when present and previous dentures cannot be repaired or adjusted.

(iv) Dentures relines are limited to once per denture every two years.

12c. Prosthetic devices require prior authorization when the cost of purchase, repair or manufacture exceeds $50.00.

12d. Same as 6b.

13a. Diagnostic Services, except as otherwise provided under this subpart, includes any medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts, within the scope of practice under State law, to enable the provider to identify the existence, nature, or extent of illness, injury, or other health deviation in a beneficiary.

The diagnostic procedures or out of state procedures requiring prior authorization are:

- Psychological testing
- Neuropsychological testing
- Standardized cognitive testing

13b. Screening service means the use of standardized tests given under medical direction in the mass examination of a designated population to detect the existence of one or more diseases or health deviations or to identify for more definitive studies individuals suspected of having certain diseases.

13c. Preventive Services

1. Preventive Services mean services recommended by a physician or other licensed practitioner of the healing arts acting within the scope of authorized practice under State law to:

    a. Prevent disease, disability, or other health conditions or their progression;
    b. Prolong life; and
    c. Promote physical and mental health and efficiency.

2. Preventive services assigned a grade A or B recommendation by the United States Preventive Services Task Force (USPSTF), approved vaccines and their administration recommended by the Advisory Committee on Immunization Practices (ACIP), preventive care and screening of infants, children and adolescents recommended by Health Resources & Services Administration HRSA's Bright Futures program and additional preventive services for women recommended by the National Academy of Medicine (NAM) formally known as the Institute of Medicine (IOM) will be covered without cost-sharing in accordance with section 2713 of the Public Health Service Act, which is in alignment with the Alternative Benefit Plan.

3. The state will maintain documentation supporting expenditures claimed for and ensure that coverage and billing codes comply with USPSTF or ACIP recommendations, in accordance with section 4106 of the Affordable Care Act and section 1905(a)(13)(B).

4. Preventive services are covered under the rural health clinic, federally qualified health center, EPSDT, family planning services and supplies for individuals of child-bearing age, physician, other licensed practitioner, clinic, preventive, nurse midwife and nurse practitioner service benefits and are reimbursed according to the methodologies provided in Attachment 4.19-B for such services.

13d. **Community Mental Health Rehabilitative Services (continued)**

8. **Substance Abuse Treatment (SAT) services**: SAT services furnished under §440.130(d) are provided by a qualified mental health professional to include but not limited to a licensed psychiatrist, licensed psychologist, licensed clinical social worker with experience in behavioral health, licensed advance practical nurse in behavioral health, licensed mental health counselor, or a licensed marriage and family therapist with experience with behavioral health or a substance abuse counselor certified by the State. SAT services shall be provided without limits on the number of visits when medically necessary; prior authorization is required, and monthly assessments are performed to ensure that services are medically necessary. SAT services are recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law. The substance abuse provider assists an individual in achieving specific objectives of treatment or care for a substance use or mental health disorder through a face-to-face, one-to-one therapeutic relationship. Services are generally directed toward reducing psychosocial stress and teaching coping and problem-solving skills, using supportive and cognitive-behavioral approaches that restore a participant's best possible functional level.

- 9. **Peer support services**:

Peer Support Services are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self- sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities. Peer support providers are self-identified consumers who are in recovery from mental illness, physical illness and/or substance use disorders.

Peer support services are delivered directly to Medicaid beneficiaries with mental health, physical illness and/or substance use disorders. Peer support services furnished to parents/caretakers/family members are for direct benefit of the beneficiary.

Peer support services may be provided to Medicaid consumers and their family members (or parents/caretakers) by a peer support specialist certified by the State Department of Health, Adult Mental Health Division (AMHD) as part of their Hawaii Certified Peer Specialist (HCPS) program or a peer support program established by another State agency that meets existing and established national peer support criteria.

Peer support providers meet the following minimum requirements for supervision, care coordination and training: 1) A Certified Youth Peer Partner is a youth who has 1) personal experience with children's and adolescent's mental health, child welfare, the judicial system or similar system involvement; 2) who is willing to share their personal experiences for the benefit of those they are working with; 3) who has at least a high school diploma or GED; and 4) who has satisfactorily completed a Peer Specialist training program approved by the state. Peer Support services shall be provided under the supervision of a former peer partner with at least

2 years of experience or a professional who has at least a year of experience working with peer partners.

A Certified Parent Partner is a parent who has 1) personal experience parenting a child or adolescent with mental health challenges, was involved in the child welfare system or the judicial system; 2) who is willing to share their personal experiences for the benefit of those they are working with; 3) who has at least a high school diploma or GED; and 4) who has satisfactorily completed a Peer Specialist training program approved by the state. Peer Support services shall be provided under the supervision of a former peer partner with at least 2 years of experience or a professional who has at least a year of experience working with peer partners.

2) Peer support services are coordinated within the context of a comprehensive, individualized plan of care that reflects the needs and preferences of the participant in achieving the specific, individualized goals that have measurable results and are specified in the service plan;

3) Training and Credentialing: Peer support providers must complete training and certification as defined by the State. The peer specialist must demonstrate the ability to support the recovery of others from mental illness and or substance use disorders. Peer support providers must complete ongoing continuing educational requirements.

The covered services are available only to Medicaid eligible recipients with a written plan of care developed with the participation of a qualified mental health professional to include but not limited to a licensed psychiatrist, licensed psychologist, licensed clinical social worker with experience in behavioral health, licensed advance practical nurse in behavioral health, licensed mental health counselor, or a licensed marriage and family therapist with experience with behavioral health.

Peer support services include one or more of the following service components:

- Educational Skill Building Groups means providing a supportive environment in which beneficiaries and their families learn coping mechanisms and problem-solving skills to help the beneficiaries achieve desired outcomes. These groups promote skill building for the beneficiaries in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.
- Engagement means Peer Support Specialist led activities and coaching to encourage and support beneficiaries to participate in treatment. Engagement may include supporting beneficiaries in their transitions and supporting beneficiaries in developing their own recovery goals and processes.
- Therapeutic Activity means a structured non-clinical activity provided by a Peer Support Specialist to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the

beneficiary's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the beneficiary; promotion of self-advocacy; resource navigation; and collaboration with the beneficiaries and others providing care or support to the beneficiary, family members, or significant support persons.

Limitations (continued)

Peer support services are provided without limits on the number of visits when medically necessary; prior authorization is required, and monthly assessments are performed to ensure that benefits are medically necessary.

Peer support services are not provided in an institution for mental disease as defined in SSA Sec. 1905(i) and 42 CFR 435.1010

compliance with requirements and standards of a national accreditation organization (JCAHO, CARF, COA).

The services are defined as follows:

1. **Crisis Management.** This service provides mobile assessment for individuals in an active state of crisis (24 hours per day, 7 days per week) and can occur in a variety of community settings including the consumer's home. Immediate response is required. Included in Crisis Management services are an assessment of risk, mental status, and medical stability, and immediate crisis resolution and de-escalation. If necessary, this may include referral to licensed psychiatrist, licensed psychologist, or to an inpatient acute care hospital. The presenting crisis situation may necessitate that the services be provided in the consumer's home or natural environment setting. Thus, crisis management services may be provided in the home, school, work environment or other community setting as well as in a health care setting. These services are provided through JCAHO, CARF, or COA accredited agencies. In addition, agencies must have staff that includes one or more qualified mental health professionals. If the services are provided by staff other than a qualified mental health professional, the staff must be supervised at a minimum by a qualified mental health professional.

2. **Crisis Residential Services.** Crisis Residential Services are short-term, interventions provided to individuals experiencing crisis to address the cause of the crisis and to avert or delay the need for acute psychiatric inpatient hospitalization or inpatient hospital based psychiatric care at levels of care below acute psychiatric inpatient. Crisis Residential Services are for individuals who are experiencing a period of acute stress that significantly impairs the capacity to cope with normal life circumstances. The program provides psychiatric services that address the psychiatric, psychological, and behavioral health needs of the individuals. Specific services are: psychiatric medical assessment, crisis stabilization and intervention, medication management and monitoring, individual, group and/or family counseling, and daily living skills training. Services are provided in a licensed residential program, licensed therapeutic group home or foster home setting. All crisis residential programs will have less than 16 beds. The services do not include payment for room and board. The staff providing crisis residential services must be qualified mental health professionals. If the services are provided by staff other than a qualified mental health professional, the staff must be supervised at a minimum by a qualified mental health professional.

3. **Biopsychosocial Rehabilitative Programs :** A therapeutic day rehabilitative social skill building service which allows individuals with serious mental illness to gain the necessary social and communication skills necessary to allow them to remain in or return to naturally occurring community programs.

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Services include group skill building activities that focus on the development of problem-solving techniques, social skills and medication education and symptom management. All services provided must be part of the individual's plan of care. The therapeutic value of the specific therapeutic recreational activities must be clearly described and justified in the plan of care. At a minimum the plan of care must define the goals/objectives for the individual, educate the individual about his/her mental illness, how to avoid complications and relapse, and provide opportunities for him/her to learn basic living skills and improve interpersonal skills. Services are provided by qualified mental health professionals or staff that are under the supervision of a qualified mental health professional. Provider qualifications to provide these services are ensured by provider compliance with requirements and standards of a national accreditation organization (JCAHO, CARF, COA).

4. **Intensive Family Intervention.** These are time limited intensive interventions intended to stabilize the living arrangement, promote reunification or prevent the utilization of out of home therapeutic resources (i.e. psychiatric hospital, therapeutic foster care, residential treatment facility) for children with serious emotional or behavioral disturbance or adults with serious mental illness. These services: 1) diffuse the current crisis, evaluate its nature and intervene to reduce the likelihood of a recurrence; 2) assess and monitor the service needs of the identified individual so that he/she can be safely maintained in the family; 3) ensure the clinical appropriateness of services provided; and 4) improve the individual's ability to care for self and the family's capacity to care for the individual. This service includes focused evaluations and assessments, crisis case management, behavior management, counseling, and other therapeutic rehabilitative mental health services toward improving the individual's ability to function in the family. Services are directed towards the identified individual within the family. Services can be provided in-home, school or other natural environment. Services are provided by a multidisciplinary team comprised of qualified mental health professionals. If the services are provided by staff other than that listed above, the staff must be supervised by one of the licensed disciplines noted above and at a minimum be a qualified mental health professional. Additionally, provider qualifications must be in compliance with requirements and standards of a national accreditation organization (JCAHO, CARF, COA).

5. **Therapeutic Living Supports and Therapeutic Foster Care Supports.** These are services covered in settings such as group living arrangements or therapeutic foster homes. Group living arrangements usually provide services for 3 to 6 individuals per home but not more than 15. Therapeutic foster homes provide services for a maximum of 15 individuals per home. Although these group living arrangements and therapeutic foster homes may provide 24 hour per day of residential care, only the therapeutic services provided are covered. There is no reimbursement of room and board charges. Covered

therapeutic supports are only available when the identified individual resides in a licensed group living arrangement or licensed therapeutic foster home. The identified individual must be either a child with serious emotional or behavioral disturbance or the adult with a serious mental illness. Services provided in therapeutic group homes and therapeutic foster homes include: supervision, monitoring and developing independence of activities of daily living and behavioral management, medication monitoring, counseling and training (individual, group, family), directed at the amelioration of functional and behavioral deficits and based on the individual's plan of care developed by a team of licensed and qualified mental health professionals. Services are provided in a licensed facility and are provided by a qualified mental health professional or staff under the supervision of a qualified mental health professional with 24-hour on-call coverage by a licensed psychiatrist or psychologist.

6. **Intensive outpatient hospital services.** These are outpatient hospital services for the purpose of providing stabilization of psychiatric impairments as well as enabling the individual to reside in the community or to return to the community from a more restrictive setting. Services are provided to an individual who is either a child with serious emotional or behavioral disturbance or an adult with a serious mental illness. In addition, the adult or child must meet at least two of the following criteria: 1) at high risk for acute inpatient hospitalization, homelessness or (for children) out-of-home placement because of their behavioral health condition; 2) exhibits inappropriate behavior that generates repeated encounters with mental health professionals, educational and social agencies, and/or the police; or 3) are unable to recognize personal danger, inappropriate social behavior, and recognize and control behavior that presents a danger to others. The goals of service are clearly identified in an individualized plan of care. The short term and long term goals and continuing care plan are established prior to admission through a comprehensive assessment of the consumer to include a severity-adjusted rating of each clinical issue and strength. Treatment is time-limited, ambulatory and active offering intensive, coordinated clinical services provided by a multi-disciplinary team. This service includes medication administration and a medication management plan. Services are available at least 20 hours per week. All services are provided by qualified mental health professionals, or by individuals under the supervision of a qualified mental health professional. Additionally, provider qualifications must be in compliance with requirements and standards of a national accreditation organization (JCAHO, CARF, COA). Registered nurses or licensed practical nurses must be available for nursing interventions and administration of medications. Licensed psychiatrists or psychologist must be actively involved in the development, monitoring, and modification of the plan of care. The services must be provided in the outpatient area or clinic of a licensed JCAHO certified hospital or other licensed facility that is Medicare certified for

coverage of partial hospitalization/day treatment. These services area not provided to individuals in the inpatient hospital setting and do not include acute inpatient hospital stays.

7. **Assertive Community Treatment (ACT).** This is an intensive community rehabilitation service for individuals who are either children with serious emotional or behavioral disturbance or adults with a serious mental illness. In addition, the adult or child must meet at least two of the following criteria: 1) at high risk for acute inpatient hospitalization, homelessness or (for children) out-of-home placement because of their behavioral health condition; 2) exhibits inappropriate behavior that generates repeated encounters with mental health professionals, educational and social agencies, and/or the police; or 3) is unable to recognize personal danger, inappropriate social behavior, and recognize and control behavior that presents a danger to others. The ACT rehabilitative treatment services are to restore and rehabilitate the individual to his/her maximum functional level. Treatment interventions include crisis management (crisis assessment, intervention and stabilization); individual restorative interventions for the development of interpersonal, community coping and independent living skills; services to assist the individual develop symptom monitoring and management skills; medication prescription, administration and monitoring medication and self medication; and treatment for substance abuse or other co-occurring disorders. Services include 24 hours a day, 7 days a week coverage, crisis stabilization, treatment, and counseling. Also, individuals included in ACT receive case management to assist them in obtaining needed medical and rehabilitative treatment services within their ACT treatment plan. Services can be provided to individuals in their home, work or other community settings. ACT services are provided by agencies whose staffs include one or more licensed qualified mental health professionals. If the services are provided by staff other than a licensed qualified mental health professional, the staff must be supervised by a licensed qualified mental health professional. Provider qualifications to provide these services are ensured by provider compliance with requirements and standards of a national accreditation organization (JCAHO, CARF, COA). Case management is an integral part of this service and reimbursement for case management as a separate service is not allowed. If biopsychosocial rehabilitation is part of the individual's plan of care under intensive case management, reimbursement for biopyschosocial rehabilitation as a separate service is not allowed.

13d. **Limitations continued**

The covered services are available only to Medicaid eligible recipients with a written plan of care developed with the participation of a licensed psychiatrist or psychologist. Services provided must be medically necessary. Prior approval is required.

13d. **Community Mental Health Rehabilitative Services (continued)**

8. **Substance Abuse Treatment (SAT) services**: SAT services furnished under §440.130(d) are provided by a qualified mental health professional to include but not limited to a licensed psychiatrist, licensed psychologist, licensed clinical social worker with experience in behavioral health, licensed advance practical nurse in behavioral health, licensed mental health counselor, or a licensed marriage and family therapist with experience with behavioral health or a substance abuse counselor certified by the State. SAT services shall be provided without limits on the number of visits when medically necessary; prior authorization is required, and monthly assessments are performed to ensure that services are medically necessary. SAT services are recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law. The substance abuse provider assists an individual in achieving specific objectives of treatment or care for a substance use or mental health disorder through a face-to-face, one-to-one therapeutic relationship. Services are generally directed toward reducing psychosocial stress and teaching coping and problem-solving skills, using supportive and cognitive-behavioral approaches that restore a participant's best possible functional level.

- 9. **Peer support services**:

Peer Support Services are culturally competent individual and group services that promote recovery, resiliency, engagement, socialization, self- sufficiency, self-advocacy, development of natural supports, and identification of strengths through structured activities. Peer support providers are self-identified consumers who are in recovery from mental illness, physical illness and/or substance use disorders.

Peer support services are delivered directly to Medicaid beneficiaries with mental health, physical illness and/or substance use disorders. Peer support services furnished to parents/caretakers/family members are for direct benefit of the beneficiary.

Peer support services may be provided to Medicaid consumers and their family members (or parents/caretakers) by a peer support specialist certified by the State Department of Health, Adult Mental Health Division (AMHD) as part of their Hawaii Certified Peer Specialist (HCPS) program or a peer support program established by another State agency that meets existing and established national peer support criteria.

Peer support providers meet the following minimum requirements for supervision, care coordination and training: 1) A Certified Youth Peer Partner is a youth who has 1) personal experience with children's and adolescent's mental health, child welfare, the judicial system or similar system involvement; 2) who is willing to share their personal experiences for the benefit of those they are working with; 3) who has at least a high school diploma or GED; and 4) who has satisfactorily completed a Peer Specialist training program approved by the state. Peer Support services shall be provided under the supervision of a former peer partner with at least

2 years of experience or a professional who has at least a year of experience working with peer partners.

A Certified Parent Partner is a parent who has 1) personal experience parenting a child or adolescent with mental health challenges, was involved in the child welfare system or the judicial system; 2) who is willing to share their personal experiences for the benefit of those they are working with; 3) who has at least a high school diploma or GED; and 4) who has satisfactorily completed a Peer Specialist training program approved by the state. Peer Support services shall be provided under the supervision of a former peer partner with at least 2 years of experience or a professional who has at least a year of experience working with peer partners.

2) Peer support services are coordinated within the context of a comprehensive, individualized plan of care that reflects the needs and preferences of the participant in achieving the specific, individualized goals that have measurable results and are specified in the service plan;

3) Training and Credentialing: Peer support providers must complete training and certification as defined by the State. The peer specialist must demonstrate the ability to support the recovery of others from mental illness and or substance use disorders. Peer support providers must complete ongoing continuing educational requirements.

The covered services are available only to Medicaid eligible recipients with a written plan of care developed with the participation of a qualified mental health professional to include but not limited to a licensed psychiatrist, licensed psychologist, licensed clinical social worker with experience in behavioral health, licensed advance practical nurse in behavioral health, licensed mental health counselor, or a licensed marriage and family therapist with experience with behavioral health.

Peer support services include one or more of the following service components:

- Educational Skill Building Groups means providing a supportive environment in which beneficiaries and their families learn coping mechanisms and problem-solving skills to help the beneficiaries achieve desired outcomes. These groups promote skill building for the beneficiaries in the areas of socialization, recovery, self-sufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.
- Engagement means Peer Support Specialist led activities and coaching to encourage and support beneficiaries to participate in treatment. Engagement may include supporting beneficiaries in their transitions and supporting beneficiaries in developing their own recovery goals and processes.
- Therapeutic Activity means a structured non-clinical activity provided by a Peer Support Specialist to promote recovery, wellness, self-advocacy, relationship enhancement, development of natural supports, self-awareness and values, and the maintenance of community living skills to support the

beneficiary's treatment to attain and maintain recovery within their communities. These activities may include, but are not limited to, advocacy on behalf of the beneficiary; promotion of self-advocacy; resource navigation; and collaboration with the beneficiaries and others providing care or support to the beneficiary, family members, or significant support persons.

Limitations (continued)

Peer support services are provided without limits on the number of visits when medically necessary; prior authorization is required, and monthly assessments are performed to ensure that benefits are medically necessary.

Peer support services are not provided in an institution for mental disease as defined in SSA Sec. 1905(i) and 42 CFR 435.1010

15a. & 15b. Authorization by the department's medical consultant for the recommended level of care is required. } P.A. do late

16. **Psychiatric services for individuals under age 21.**
Provides secure locked residential treatment consisting of highly structured daily programming, close supervision, educational services, and integrated service planning designed for severely emotionally/behaviorally disturbed to function in a less restrictive setting. Services include multi-disciplinary assessment of the child, skilled milieu of services by trained staff who are supervised by a licensed professional on a 24 hour per day basis, individual psychotherapy and/or counseling, individualized adjunctive therapies, and substance abuse education and counseling, as appropriate and as part of an interdisciplinary treatment plan. Services are required to be staff secure at all times. Hospital-based residential services are provided in a licensed inpatient facility serving individuals who are under the age of 21 and are provided by a qualified mental health professional. If the services are provided by staff other than that listed above, the staff must be supervised by a qualified mental health professional.

Services are not limited and must be authorized.

In communities where a psychiatric facility is not readily available, emergency inpatient psychiatric services may be provided for up to forty-eight hours at the closest licensed general hospital.

17. Limited to nurse midwives sponsored by a physician.

18. Authorization by the Department's medical consultant is required for services during a transitional period.

20.a.& b. Extended services to pregnant women includes all major categories of services provided for the categorically needy recipients, as long as the services are determined to be medically necessary and related to the pregnancy.

22. Prior authorization is required by the medical consultant for the provision of respiratory care services for ventilator-dependent individuals.

23. Nurse practitioner services shall be limited to the scope of practice a nurse practitioner is legally authorized to perform under State law.

24a. Transportation:

Emergency Medical Transportation Services

a. Ground or air ambulance service is provided in emergencies or when a beneficiary, as determined by medical necessity criteria, is unable to travel by other non-emergency medical transportation mode.

b. Out of state travel is covered consistent with 42 CFR 431.52

Non-Emergency Medical Transportation Services

a. Non-emergency medical transportation modes, which includes taxi, wheelchair van, stretcher car, transportation network company and commercial carrier transportation, is provided for beneficiaries residing in areas not served by a bus or public transportation system, or when travel by bus or public transportation would be either hazardous or cause extreme hardship to a beneficiary based on state medical necessity criteria.

b. Air transportation is provided when required specialized medical services are not available on the island of beneficiary's residence.

c. Out of state travel is covered consistent with 42 CFR 431.52.

d. The state covers related travel expenses when necessary for accessing covered services.

e. Except for emergencies, prior authorization is required for air transportation and other non-emergency transportation modes.

24d. Must meet the skilled nursing level of care requested by a physician and approved by the department's medical consultant.

State of HAWAII

I. Eligibility

The State determines eligibility for PACE enrollees under rules applying to community groups.

A. ___ The State determines eligibility for PACE enrollees under rules applying to institutional groups as provided for in section 1902(a)(10)(A)(ii)(VI) of the Act (42 CFR 435.217 in regulations). The State has elected to cover under its State plan the eligibility groups specified under these provisions in the statute and regulations. The applicable groups are:

(If this option is selected, please identify, by statutory and/or regulatory reference, the institutional eligibility group or groups under which the State determines eligibility for PACE enrollees. Please note that these groups must be covered under the State's Medicaid plan.)

B. ___ The State determines eligibility for PACE enrollees under rules applying to institutional groups, but chooses not to apply post-eligibility treatment of income rules to those individuals. (If this option is selected, skip to II – Compliance and State Monitoring of the PACE Program)

C. ___ The State determines eligibility for PACE enrollees under rules applying to institutional groups, and applies post-eligibility treatment of income rules to those individuals as specified below. Note that the post-eligibility treatment of income rules specified below are the same as those that apply to the State's approved HCBS waiver(s).

Regular Post Eligibility

1. _____ SSI State. The State is using the post-eligibility rules at 42 CFR 435.726. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a). Sec. 435.726 – States which do not use more restrictive eligibility requirements than SSI.

1. Allowances for the needs of the:

(A.) Individual (check one)

1. ___ The following standard included under the State plan (check one):

(a) ____ SSI
(b) ____ Medically Needy
(c) ____ The special income level for the institutionalized
(d) ____ Percent of the Federal Poverty Level ____ %
(e) ____ Other (specify):

2. ___ The following dollar amount: $ _____
Note: If this amount changes, this item will be revised.
3. ___ The following formula is used to determine the needs allowance:

_____
_____

Note: If the amount protected for PACE enrollees in item 1 is equal to, or greater than the maximum amount of income a PACE enrollee may have and be eligible under PACE, enter N/A in items 2 and 3.

(B.) Spouse only (check one):

1. ___ SSI Standard
2. ___ Optional State Supplement Standard
3. ___ Medically Needy Income Standard
4. ___ The following dollar amount: $ _____
Note: If this amount changes, this item will be revised.
5. ___ The following percentage of the following standard that is not greater than the standards above: _____ % of _____ standard.
6. ___ The amount is determined using the following formula:

_____
_____

7. ___ Not applicable (N/A)

(C.) Family (check one):

1. ___ AFDC need standard
2. ___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. ___ The following dollar amount: $ _____
Note: If this amount changes, this item will be revised.
4. ___ The following percentage of the following standard that is not greater than the standards above: _____ % of _____ standard.
5. ___ The amount is determined using the following formula:

_____

_____

6. Other
7. ___ Not applicable (N/A)

(2). Medical and remedial care expenses in 42 CFR 435.726

Regular Post Eligibility

2. ___ 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) **42 CFR 435.735** -- States using more restrictive requirements than SSI.

1. Allowances for the needs of the:
(A) Individual (check one)
1. ___ The following standard included under the State plan (check one):
(a) ___ SSI
(b) ___ Medically Needy
(c) ___ The special income level for the institutionalized
(d) ___ Percent of the Federal Poverty Level ____%
(e) ___ Other (specify):
2. ___ The following dollar amount: $ _____
Note: If this amount changes, this item will be revised.
3. ___ The following formula is used to determine the needs allowance:

_____

_____

Note: If the amount protected for PACE enrollees in item 1 is **equal to, or greater than** the maximum amount of income a PACE enrollee may have and be eligible under PACE, **enter N/A in items 2 and 3.**

(B.) Spouse only (check one):

1. ___ The following standard under 42 CFR 435.121:

_____

2. ___ The Medically Needy Income Standard

_____

3. ___ The following dollar amount: $ _____
   Note: If this amount changes, this item will be revised.
4. ___ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
5. ___ The amount is determined using the following formula:

_____

_____

6. ___ Not applicable (N/A)

(C.) Family (check one):

1. ___ AFDC need standard
2. ___ Medically needy income standard

The amount specified below cannot exceed the higher of the need standard for a family of the same size used to determine eligibility under the State's approved AFDC plan or the medically needy income standard established under 435.811 for a family of the same size.

3. ___ The following dollar amount: $ _____
   Note: If this amount changes, this item will be revised.
4. ___ The following percentage of the following standard that is not greater than the standards above: _____% of _____ standard.
5. ___ The amount is determined using the following formula:

_____

_____

6. ___ Other
7. ___ Not applicable (N/A)

(b) Medical and remedial care expenses in 42 CFR 435.735.

Spousal Post Eligibility

3. ____ State uses the post-eligibility rules of Section 1924 of the Act (spousal impoverishment protection) to determine the individual's contribution toward the cost of PACE services if it determines the individual's eligibility under section 1924 of the Act.

There shall be deducted from the individual's monthly income a personal needs allowance (as specified below), and a community spouse's allowance, and an amount for incurred expenses for medical or remedial care, as specified in the State Medicaid plan.

(a) Allowances for the needs of the:
1. Individual (check one)
(A) ___ The following standard included under the State plan (check one):

(1) ___ SSI
(2) ___ Medically Needy
(3) ___ The special income level for the institutionalized
(4) ___ Percent of the Federal Poverty Level: _____ %
(5) ___ Other (specify)

(B). ___ The following dollar amount: $ _____
Note: If this amount changes, this item will be revised.

(C). ___ The following formula is used to determine the needs allowance:

_____

_____

If this amount is different than the amount used for the individual's maintenance allowance under 42 CFR 435.726 or 42 CFR 435.735, explain why you believe that this amount is reasonable to meet the individual's maintenance needs in the community:

_____

_____

_____

_____

_____

II. Rates and Payments

A. The State assures CMS that the capitated rates are equal to or less than the cost to the agency of providing those same fee-for-service State plan approved services on a fee-for-service basis, to an equivalent non-enrolled population group based upon the following methodology. Please attach a description of the negotiated rate setting methodology and how the State ensures that rates are less than the cost in fee-for-service.

1. ___ Rates are set at a percent of fee-for-service costs
2. ___ Experience-based (contractors/State's cost experience or encounter date) (please describe)
3. ___ Adjusted Community Rate (please describe)
4. ___ Other (please describe)

III. Enrollment and Disenrollment

The State assures that there is a process in place to provide for dissemination of enrollment and disenrollment data between the State and the State Administering Agency. The State assures that it has developed and is implementing procedures for the enrollment and disenrollment of its participants in the State's management information system, including procedures for any adjustment to account for the difference between the estimated number of participants on which the prospective monthly payment is upon and the actual number of participants in that month.

Palliative Care Interdisciplinary Team

#	Interdisciplinary Team Member (IDT)	Brief Description of Services Performed	Scope of Practice	Minimum Qualifications	Adult and/or Pediatric Care	Required or Optional Member of the IDT
1	Physician (Medical Doctor, MD and Doctor of Osteopathy, DO)	Provides direct clinical care and oversight of patient care.	Legally authorized to practice medicine or osteopathy by the State and acts within their scope of license.	Licensed physician (MD or DO); at least one physician must have a certification in palliative care or related field.	Adult and pediatric care.	Required.
2	Registered Nurse (RN)	Provides and coordinates patient care and educates patients about their health.	Legally authorized to provide nursing care by the State and acts within their scope of license.	Licensed to provide services.	Adult and pediatric care.	Required.
3	Licensed Clinical Social Worker (LCSW)	Promotes social change and development, social cohesion, and the empowerment and liberation of patients. Engages patients and structures to address life challenges and enhances wellbeing.	Legally authorized to provide clinical social work services by the State and acts within their scope of license.	Licensed to provide services.	Adult and pediatric care.	Required.
4	Grief Counselor	Grief counseling with consent of the beneficiary.	Grief counseling care commensurate with the needs, desires, and voluntary consent of the beneficiary.	Bachelor's degree in theology or counseling or equivalent.	Adult and pediatric care.	Required.
5	Child Life Specialist (CLS)	CLS work with children and families to help them cope with the challenges of illness, and disability. They provide children with age-appropriate coping strategies, play and self-expression activities, etc.	Accountable for the planning and implementa-tion of child life services.	Bachelor's degree in Child Development, Child Life, or related field.	Pediatric only.	Required.

#	Interdisciplinary Team Member (IDT)	Brief Description of Services Performed	Scope of Practice	Minimum Qualifications	Adult and/or Pediatric Care	Required or Optional Member of the IDT
6	Advanced Practice Practitioner - Nurse Practitioner (NP) or Physician Assistant (PA)	Diagnose and treat a wide variety of medical concerns.	Legally authorized to provide services by the State and acts within their scope of license.	Licensed to provide services.	Adult and pediatric care.	Optional.
7	Licensed Practical Nurse (LPN) or Licensed Vocational Nurses (LVN)	Conduct focused nursing assessments, administer medications, maintain patient care records and collaborate with other healthcare professionals.	Provide basic medical care under the direction of registered nurses, advance practice registered nurses, physicians, and other healthcare professionals.	Licensed to provide services.	Adult and pediatric care.	Optional.
8	Certified Nursing Aid (CNA) or Home Health Aid	Working under the direct supervision of a licensed healthcare professional, they assist patients with activities of daily living such as grooming, bathing, and eating.	Legally authorized to provide services by the States and acts within their scope of license.	Licensed to provide services.	Adult and pediatric care.	Optional.
9	Community Health Worker	Serves as a liaison/link/ intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of services delivery.	Outreach, community education, informal counseling, social support, and advocacy.	Lived experience and a trusted member of the community; the State may require additional qualifications such as experience or certification(s).	Adult and pediatric care.	Optional.
10	Licensed Mental Health	Provide mental health and substance use care.	Legally authorized to provide	Licensed to provide services.	Adult and	Optional.

#	Interdisciplinary Team Member (IDT)	Brief Description of Services Performed	Scope of Practice	Minimum Qualifications	Adult and/or Pediatric Care	Required or Optional Member of the IDT
	Professional (Counselor)		services by the States and acts within their scope of license.		pediatric care.	
11	Social Worker - Master of Social Work (MSW)	Provides macro-, mezzo-, and micro-aspects of professional social work practice.	Legally authorized to provide services by the States and acts within their scope of license.	Licensed to provide services.	Adult and pediatric care.	Optional.
12	Pharmacist – Doctor of Pharmacy (PharmD)	Dispense prescription medications and provide information to patients about the drugs and their use.	Legally authorized to provide services by the States and acts within their scope of license.	Licensed to provide services.	Adult and pediatric care.	Optional.

Described below are the methods which are used to assure that the medical and remedial care and services provided under the program are of high quality.

(1) In the context of inpatient and outpatient hospital services and physicians' services, provisions are made for specialists' services and consultation.

(2) Provision for transportation is made so that the required special medical services which are not available in communities where recipients reside may be obtained elsewhere.

(3) There is an arrangement under which the agency's medical consultant may call on a member of the local medical association for consultation on cases involving questions of over-utilization or appropriateness of services recommended or provided.

(4) NF standards are rigidly enforced jointly with the Department of Health. Both agencies provide consultation to such facilities to correct identified deficiencies or upgrade nursing care. A general surveillance is maintained by this agency to assure that such facilities continuously meet the required standards.

(5) Prospective reviews and prior authorization requirements are maintained so that determination may be made by this agency as to the appropriateness of recommended medical services.

(6) Periodic visits are made by the agency's representative to participating medical facilities to confer with the medical staff, review medical records and generally observe the services being provided recipients.

(7) Planning and development of statewide EPSDT services are done jointly with the physician-administrators of Title V programs and in consultation with the local pediatric society.

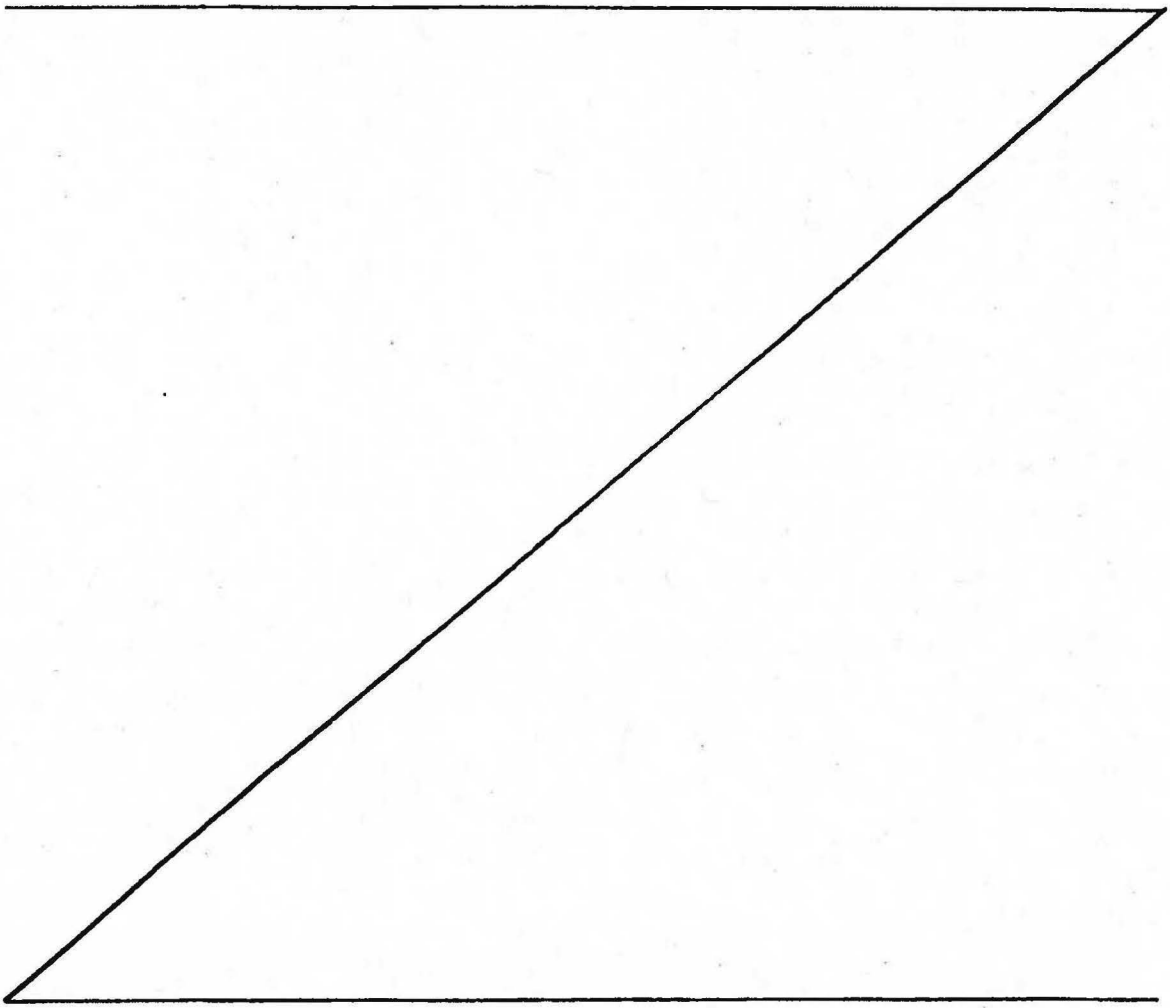
(8) Periodic on-site medical reviews are conducted by the agency's multi-disciplinary team at participating NF's to determine the adequacy of services and to evaluate the level of care required by recipients. Physician's patient certifications are examined and utilization review activities are monitored.

(9) Medical and remedial care and services which are unproven or of experimental nature are excluded under the program. Medicare's definition and guidelines are utilized in determining which procedures are experimental or unproven.

(10) Described below are the methods used to implement the nursing home reform provisions of OBRA '87.

A. PASARR Level I was provided on an interim basis by HCAD consultants. Effective September 1, 1989, LTC facilities assumed responsibility for Level I;

B. By interagency agreement, PASARR Level II determinations are performed by Mental Health Division and Developmental Disabilities Division of the Department of Health:



State: HAWAII

Transportation:

To assure necessary transportation for beneficiaries and their approved attendants to and from providers of covered services, several types of transportation are used to meet the beneficiary's transportation needs.

Described below are the methods used:

1. Non-Emergency Medical Transportation (NEMT)Types:

   a. These services are covered as an administrative activity and not included as an optional medical service:

      i. Bus and public transportation are provided for beneficiaries residing in areas served by the bus and public transportation system.

      ii. Mileage reimbursement is provided for participating drivers who drive a beneficiary to and from a Medicaid-covered service in a personal car.

   b. These services are covered as an optional medical service consistent with 42 CFR 440.170(a).

      i. As described in Supplement to Attachment 3.1-A and 3.1-B pg.5 under Transportation.

      ii. The state covers related travel expenses (including meals, lodging, and attendant) when necessary for accessing covered services.

2. Emergency Medical Transportation

   As described in Supplement to Attachment 3.1-A and 3.1-B pg.5 under Transportation services are covered as an optional medical service consistent with 42 CFR 440.170(a)

3. Non-Emergency Medical Transportation Models

   Non-emergency medical transportation (NEMT) is provided through two models and authorities:

   a. Medicaid beneficiaries in a managed care model by managed care organizations under the authority of the Section 1115 Demonstration waiver and section 1915(a) of the Social Security Act; and

   b. Medicaid beneficiaries in a fee-for-service model under the provisions of 42 C.F.R. §431.53 and 440.170(a).

4. Single State Agency Responsibilities

   This single state agency is responsible for determining each beneficiary's Medicaid eligibility, NEMT eligibility and benefit coverage. The single agency ensures the following:

   a. Transportation services are provided only by contracted or enrolled Medicaid transportation providers.

   b. Transportation services are provided only in conjunction to a Medicaid-covered service.

   c. Medicaid is the payor of last resort, with certain exceptions allowed by federal regulations or law.

   d. Medicaid beneficiary is informed about rights and responsibilities.

e. All Medicaid beneficiaries (including Early Periodic Screening and Developmental Testing beneficiaries) have a means of being informed of transportation and other benefit coverage.

8. Program Limitations
Covered transportation is limited to trips for Medicaid beneficiaries, and their approved attendants, to and from Medicaid-covered services.

9. Program Monitoring and Oversight
Transportation program oversight includes monitoring of complaints made by beneficiaries related to transportation access and quality including, but not limited to, courteous and respectful drivers and scheduling staff, clean vehicles, and timely rides. The state holds accountable the operational organizations that administer day-to-day transportation, such as transportation companies, managed care organizations, and drivers.

The state Medicaid agency attests that all the minimum requirements outlined in 1902(a)(87) of the Act are met.

State/Territory: HAWAII

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

1. The standards for coverage of organ transplant services are applied equally to the categorically and medically needy individuals as described in ATTACHMENT 3.1-E, pages 2 through 7.

2. The guidelines for approving organ transplants for EPSDT eligible individuals which are not covered under this Plan are as follows:

   a. Shall have prior medical authorization

   b. Shall be performed at a Medicare certified facility

   c. Shall be an established non-experimental procedure

   d. Shall be medically necessary, specifically:

      i. The condition is life-threatening and unresponsive to other medical or surgical therapy, with a prognosis of six to twelve months of life.

      ii. There is significant reason to believe that the transplant will improve the quality of life of the patient.

      iii. There is significant reason to believe that the patient's medical status is adequate to tolerate the transplant procedure and follow-up medical and surgical care.

      iv. The initial or primary disease process is confined to the organ with no life threatening involvement of other organ systems and no anticipation that life threatening recurrence of the disease process will involve the transplanted organ or other organ systems.

§17-1737-91 General Provisions. (a) Allogenic bone marrow and cadaveric corneal transplants are covered under this program.

(b) Kidney transplantations are covered under this program.

(c) Other non-experimental, non-investigational organ and tissue transplantation are covered when performed in a facility certified by Medicare for the specific transplantation and approved for medical necessity by the department's medical consultants.

(d) Transplantation shall be performed by experienced specialists with transplantation training and with established success records in an approved Medicare certified facility with proper equipment and adequate and appropriately trained support staff, except as provided in subsection (i).

(e) Prior authorization shall be required from the department's medical consultant for all transplants.

(f) Immunosuppressive therapy shall be covered as required.

(g) If a transplant should fail or be rejected and the patient is still within the age limits for transplantation, the program's medical consultant may review the case for one additional transplantation for that patient.

(h) The program shall cover costs of tissue typing of potential donors and cost of acquisition of the tissue or organ as well as other studies necessary to determine the appropriateness of the procedure and any post transplantation follow-up evaluations as required.

(i) When approved by the department's medical consultant, a patient may be treated at an appropriate out-of-state Medicare certified transplant center for the authorized procedure. [Eff 08/01/94; am 11/25/96] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §440.230; 42 U.S.C.§1396b(i))

§17-1737-92 Corneal transplant (keratoplasty).

(a) Indications of penetrating keratoplasty include:

(1) Corneal opacification that sufficiently obscures visibility (vision) through the anterior segment of the eye with at least light perception present. Causes for this problem include:

(A) Corneal injury and scarring;

(B) Corneal degeneration (from Fuch's or other dystrophy or from previous cataract or intraocular lens implantation, or both);

(C) Corneal degeneration from keratoconus or familial causes;

(D) Corneal infection (e.g., herpes); and

(2) Therapeutic graft for relief of pain with at least light perception vision present, from corneal degeneration because of inflammation with pain in the eye and useful vision still present.

(b) Indications of lemellar keratoplasty include:

(1) Superficial layer corneal scarring and deformity due to:

(A) Trauma;

(B) Degeneration;

(C) Infection; or

(D) Congenital deformity (anterior);

(2) Aphakia;

(3) High myopia;

(4) High refractive error;

(5) Keratoconus; and

(6) Recurrent pterygium.

(c) Conditions and limitations affecting corneal transplant include:

(1) A relative contraindication is intractable glaucoma in the eye under consideration for surgery;

(2) No active eye infection at the time of surgery;
(3) No general medical contraindications to surgery or anesthesia;
(4) Informed consent shall be obtained from the patient or patient's representative; and
(5) no age restriction. [Eff 08/01/84] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §440.230; 42 U.S.C. §1396b (I))

§17-1737-93 Allogenic bone marrow transplant.

(a) Indications for allogenic bone marrow transplant include:

(1) Severe aplastic anemia unresponsive to usual therapy;

(2) Acute myelogenous leukemia in first remission;

(3) Acute lymphocytic leukemia in second remission; and

(4) Chronic leukemia after first year.

(b) Conditions and limitations affecting allogenic bone marrow transplant include:

(1) Human leukocyte group A (HLA) histocompatible donor shall be available;

(2) Patient has no other major systemic disease which would result in poor potential for recovery (such as a heart condition, liver disease, kidney damage , brain lesions, cancer in other organs or lung disease);

(3) Patient shall have been properly evaluated by a qualified authorityin Hawaii and bone marrow transplant is recommended as a possible curative procedure or if palliative, with reasonable likelihood for prolongation of life and return to an active life;

(4) No active infection at the time of the procedure;

(5) No general medical contraindication for the procedure and anesthesia;

(6) Informed consent shall be obtained from the patient or the patient's representative; and

(7) Age restricted to fifty or under except when identical twin is histocompatible and then age limit may be fifty-five. [Eff 08/01/96] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §440.230; 42 U.S.C. §1396b(i))

§17-1737-94 Kidney transplant. (a) Indications are irreversible kidney failure that has progressed to a point that a useful, comfortable life can no longer be sustained by conventional medical treatment. The following conditions may deteriorate tot he point when kidney transplant may be required.

(1) Glomerulonephritis:
  (A) Proliferative;
  (B) Membranous;
  (C) Mesangio-capilliary;
(2) Chronic pyelonephritis;
(3) Hereditary:
  (A) Polycystic disease;
  (B) Medullary cystic disease;
  (C) Nephritis (including Alport's syndrome);
(4) Hypertensive nephrosclerosis;
(5) Metabolic:
  (A) Cystinosis;
  (B) Amyloid;
  (C) Gout;
(6) Congenital:
  (A) Hyperplasia;
  (B) Horseshoe kidney;
(7) Toxic:
  (A) Analgesic nephropathy;
  (B) Heavy metal poisoning;
(8) Irreversible acute renal failure:
  (A) Cortical necrosis;
  (B) Acute tubular necrosis; and

(b) Conditions and limitations affecting kidney transplant include:

(1) A living, related donor with major blood group (ABO) and human leukocyte group A (HLA) histocompatibility, or an appropriate cadaveric kidney with major blood group (ABO) and human leukocyte group A (HLA) histocompatibility shall be available;
(2) Patient shall be in a stable emotional state;
(3) There is no active infection at the time of transplant;

(4) There are no general medical contraindications to major surgery and anesthesia;
(5) Patient has a normal lower urinary tract;
(6) There are no other major systemic disease which would preclude successful recovery potential (such as cancer, polyarteritis, systemic lupus erythematosis or heart, lung or liver disease);
(7) Patient is evaluated by a qualified authority in Hawaii and renal transplant is recommended;
(8) Informed consent shall be obtained from the patient or the patient's representative; and
(9) Age limits five through fifty. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §440.230; 42 U.S.C. §1396B(i))

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

COORDINATION OF TITLE XIX WITH PART B OF TITLE XVIII

The following method is used to provide the entire range of benefits under Part B of title XVIII to the groups of Medicare-eligible individuals indicated:

/X/ A. Buy-in agreements with the Secretary of HHS. This agreement covers:

1. / / Individuals receiving SSI under title XVI or State supplementation, who are categorically needy under the State's approved title XIX plan.

   Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

   / / Yes / / No

2. / / Individuals receiving SSI under title XVI, State supplementation, or a money payment under the State's approved title IV-A plan, who are categorically needy under the State's approved title XIX plan.

   Persons receiving benefits under title II of the Act or under the Railroad Retirement System are included:

   / / Yes / / No

3. /X/ All individuals eligible under the State's approved title XIX plan.

/ / B. Group premium payment arrangement entered into with the Social Security Administration. This arrangement covers the following groups:

/X/ C. Payment of deductible and coinsurance costs. Such payments are made in behalf of the following groups:

All groups specified above.

This relates only to comparability of devices - benefits under XVIII to what groups - not how XIX pays. ...if State has buy-in (which covers premium), it does not check #3 for same group-only if it does #3 for another group, e.g. does #1 for money payment receipts and #3 for non-$-receipts. How it handles deductibles and coinsurance for money payment receipts is a matter for reimbursement attachment.

State: Hawaii

COORDINATION OF TITLE XIX WITH WIC

The following method is used for the coordination of Medicaid with WIC:

1. The following information and referral notice has been programmed into our Hawaii Automated Welfare Information System (HAWI).

Dear

This is to inform you that if someone in your household is pregnant, has given birth within the past six months, is breastfeeding a child under age one, or is a child under age five, that person may be eligible for benefits under a special supplemental food program for women, infants and children (WIC). WIC is a federally funded program that provides food and nutrition education. One of the benefits that is provided through the WIC program is food coupons, which can be redeemed for items such as milk, cereal, eggs, cheese, juice and formula. Money saved from not having to purchase these items may be used to buy other nutritious foods such as fresh meat, fish, poultry, fruits, and vegetables.

To obtain more information about the WIC program, call:

Honolulu/Windward	548-5301	Hawaii	935-4775
Kalihi-Palama Health Clinic	841-0011	Kauai	335-3513
Kokua Kalihi Valley	848-0976	Kona	329-3704
Leeward	548-5304	Maui	242-5956
Wahiawa	548-5305	Molokai ...	567-6355
Waianae Coast Comprehensive Health Center	696-5561		

Fair hearing rights and other important information are explained on the back of this notice.

If you have any questions regarding the WIC program, call the appropriate phone number listed above. If you have any questions regarding your medical benefits, call the phone number listed above.

2. The information and referral notice is sent to all newly approved medicaid recipients involving pregnant women and situations involving children under age five. Breastfeeding or postpartum women would be included.

3. The information and referral notice is sent, no less than annually to all AFDC and medically needy AFDC-related cases, including the poverty level cases involving women and children. This is handled by HAWI.