State: Hawaii

1. HAWAII MEDICAID FEE SCHEDULE:

State-developed fee schedule rates are the same for both governmental and private providers. The Hawaii Medicaid Fee Schedule is made effective for services rendered on or after January 1, 2024. The Medicaid Fee Schedule is located at https://medquest.hawaii.gov/en/plans-providers/fee-for-service/fee-schedules.html

2. NON-INSTITUTIONAL ITEMS AND SERVICES:

The following is a description of methods and standards for determining payment rates for non-institutional items and services, Effective 01/01/2024 unless otherwise specified.

A. Physician Services in accordance with 42 CFR 447.400(a) and Behavioral Health Services.

   i. Payment shall be paid at 100% of the current Medicare Fee Schedule in effect for the prior calendar year.

B. Providers listed in the Medicare Fee Schedule who are non physician practitioners subject to payment reductions by Medicare are paid in accordance to the current Medicare Fee Schedule in effect for the prior calendar year.

C. Other Licensed Providers not listed above (i.e. licensed practitioners within the scope of their practice as defined by state law) providing services and non institutional items are paid at no less than 60% of the current Medicare Fee Schedule in effect for the prior calendar year or as required by federal law and regulations not to exceed 100% of the applicable Medicare rate.

   i. Other licensed provider services includes services provided by licensed pharmacists (such as administration of vaccines). Payment for these services shall be made to the affiliated billing provider/Pharmacy, in accordance with the Hawaii Medicaid Fee Schedule located at https://medquest.hawaii.gov/en/plans-providers/fee-for-service/feeschedules.html Does not include dispensing fees.

(h) Smoking cessation services:

- Smoking cessation counseling services shall be according to the appropriate health Common Procedure Coding System (HCPCS) code of three to ten minutes or greater than ten minutes.

(i) Telehealth:

- The spoke or originating site is the location of an eligible individual at the time the service being furnished via a telecommunications system occurs.
- The Hub or Distant site is the site at which the physician or practitioner delivering the services is located at the time the service is provided via a telecommunications system.
- When a spoke or originating site is solely used to facilitate telehealth, payment for the facilitation shall not exceed the published Medicare rate for transmission services for spoke sites.
- Medicaid Health Care Providers, such as physicians, psychologists, nurse midwives, pediatric or family nurse practitioners, advanced practice registered nurses in behavioral health and licensed clinical social workers in behavioral health, at the hub or distant site will be reimbursed according to the payment methodology of the appropriate service provided as described in other parts of this Attachment.
- If the spoke or originating site is a FQHC/RHC, and eligible FQHC services are performed by a Medicaid Health Care Provider at a hub or distant site which is an FQHC, the hub or distant site is eligible to receive the prospective payment system (PPS)rate.
- Medicaid Health Care Providers are required to ensure synchronous and asynchronous technology with HIPAA compliance coding.
- If the spoke or originating site is not a FQHC/RHC, and eligible FQHC services are performed by an eligible Medicaid Health Care Provider at the hub or distant site that is a FQHC/RHC, the hub or distant site is eligible to claim the PPS rate.
- If eligible FQHC services are performed at a FQHC/RHC originating site and includes provision of services outside the scope of the FQHC service with a Medicaid Provider contracted by the FQHC at a non-FQHC site, the originating site gets PPS and shall compensate the contracted FQHC provider for the services that were provided as appropriate.
- Items such as technical support, line charges, depreciation on equipment, etc. are not reimbursable services under telehealth.

(j) Routine Patient Cost for Items and Services in connection with participation by Medicaid Beneficiaries in qualifying clinical trials under 1905(a)(30).

(k) Community Palliative Care Services Benefit.

The reimbursement methodology, called the Community Palliative Care Service Bundle, is based on bundled rate(s) that are established by the State. The bundled payment unit(s) are monthly.

The provider that meets the Qualifications of Providers criteria described in Supplement to Attachment 3.1-A and 3.1-B, page 4b.(13c)(7)(C)(V) is allowed to bill for the service bundle. Only one provider is allowed to receive the bundled payment per beneficiary.

At least one of the services in the bundle payment must be provided within the service payment unit in order for a provider to bill the bundled rate. Prepayment for services bundles is not allowed.

A provider that receives payment through the bundled payment cannot bill separately for services included in the bundled payment. Medicaid providers delivering separate services outside of the bundle may bill for those separate services in accordance with the State's billing procedures.

The bundled rate(s) does not include costs related to room and board or other unallowed facility costs if the services are provided in residential settings.

The State will periodically monitor the actual provision of services paid under the bundled rate(s) to ensure the beneficiaries receive the types, quantity, and intensity of services required to meet their medical needs and to ensure the rates remain economic and efficient based on the services that are actually provided as a part of the bundle.

The bundled rate(s) and billing codes are included in the FFS schedule. Other services may be covered that are billed separately from the bundled rate(s) such as initial assessments and reassessments and are included in the Hawaii Medicaid Fee Schedule.

The Hawaii Medicaid Fee schedule effective 01/01/23 is located at https://medquest.hawaii.gov/en/plans-providers/fee-for-service/fee-schedules.html. Bundled rates are the same for both governmental and private providers of community palliative care services.

2. MEDICAID PAYMENTS FOR OTHER NONINSTITUTIONAL ITEMS AND SERVICES ARE DETERMINED AS FOLLOWS:

(a) The reimbursement rates for the following services are based on a rate that is published on the agency's website at https://medquest.hawaii.gov/en/plans-providers/fee-for-service/fee-schedules.html

Durable Medical Equipment (DME) integral to a surgical service are provided as part of an outpatient surgical procedure and paid at the Medicaid fee schedule for the surgical service. DME not included in the outpatient surgical procedure (intraocular lenses, cochlear implants, neurostimulators, prosthetic devices and appliances) are paid at invoice cost, not to exceed the Medicare fee schedule. DME not included in the outpatient surgical procedure and not covered by Medicare (eyeglass frames and hearing aids) are paid at Medicaid fee schedule rates.

Effective 10/1/2019, for items of DME provided in Medicare Competitive Bidding /Areas (CBAs) where rates for specific items have been competitively bid/ under the Medicare program, the rate is set at the lower of the following:

1. The Medicare single payment amount specific to the geographic area where the item is being provided, that are in effect as of Jan. 1 of each year;
2. The provider's charge;
3. The non-rural and rural DMEPOS fee schedule rate; or
4. The Medicaid FFS rate that is in effect as of Jan. 1 of each year.

If there is no competitively bid payment rate for an item of DME in a CBA then one of two methodologies will apply:

Reimbursement for DME provided in non-rural areas is set at the lower of the following:

1. The Medicare DMEPOS fee schedule rate for Hawaii geographic, non-rural areas, that are in effect as of Jan. 1 each year;
2. The provider's charge; or
3. invoice amount
4. The Medicaid FFS rate that is in effect as of Jan. 1 of each year.

For items of DME provided in rural areas, the rate is set at the lower of the following:

1. The Medicare DMEPOS fee schedule rate for Hawaii geographic, rural areas, set as of Jan. 1 each year;
2. The provider's charge; or
3. invoice amount
4. The Medicaid FFS rate that is in effect as of Jan. 1 of the current year.

Except as otherwise noted in the plan, the state developed fee schedule rates are the same for both governmental and private providers for the same services listed below. All rates can be found at https://medquest.hawaii.gov/en/plans-providers/fee-for-service/fee-schedules.html:

- Dental Services (including dentures):

  For services on or after December 1, 2020, the fee schedule will be set at 60% of the average of the code average of the 2 major commercial dental plans for Oahu paid over the previous 12 months.

  For services for neighbor islands (Kauai, Maui Hawaii, Lanai and Molokai) on or after December 1, 2020, the fee schedule are set up to 65% of the average of the code average of the 2 major commercial dental plans for Oahu paid over the previous 12 months.

  Annual procedure code revisions are based on updates made as provided for by the American Dental Association.

Effective January 1, 2024, the following services are paid at no less than 60% of the current Medicare Fee Schedule in effect for the prior calendar year or as required by federal law not to exceed 100% of Medicare:

- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) (comprehensive periodic examination, case management, skilled nursing and personal care services.)
- Home pharmacy services;
- Medical supplies;
- Home Health Agency Services

(b) Payment for (rural/non-rural) laboratory services and X-ray services shall be at the current Medicare fee schedule for participating providers.

(c) Payments for outpatient hospital treatment room services shall not exceed the lowest of:

1. The rate established by the Department;

2. Seventy-five percent of billed charges; or

3. The Medicare fee schedule for providers who participate in Medicare.

(d) Payments for an emergency room shall not exceed the lowest of the rate established by the department, seventy-five per cent of billed charges or the Medicare fee schedule for providers who participate in Medicare.

(e) Payments for lenses for eyeglasses shall be limited to the lower of billed charges, not to exceed the lower of the cost plus ten percent or the Medicare fee schedule for providers who participate in Medicare.

(f) Payments for hearing devices shall be the actual claim charge or $300, whichever is lower. Exceptions may be made for special models or modifications.

(g) Payments for clinic services (other than physician-based clinics) shall be limited to rates established by the department. The types of clinics include government sponsored non-profit, arid hospital-based clinics.

(h) Payments for teaching physicians, shall be limited to rates established by the department. Payments are made to the teaching hospital, not to the physician, and per visit payment of $24.

(k) Payment for medical supplies shall be the lowest of billed charges, the rate established by the department, or the Medicare fee schedule for providers who participate in Medicare.

(l) Payments for home pharmacy services shall be the lower of billed charges, the rate established by the department or the Medicare fee schedule for providers who participate in Medicare.

(m) Payments for sleep services shall be the lower of billed charges, the rate established by the department or the Medicare fee schedule for providers who participate in Medicare.

(n) Payments for targeted case management services:

1. Payment is based on negotiated rates which take into consideration Medicaid allowable costs.

   The State has a system in place to accumulate claim costs for the services. Rates are reassessed annually based on historical information provided by the Department of Health and verified by the Department of Human Services. Historical data will be used to set the base each year and any new add-ons will be calculated into the new rate.

   A. Services shall be reimbursable only for calendar months during which at least one face to face or telephone contact is made with the recipient or collaterals.

   B. Payments shall not be made for services for which another payer is liable, nor for services for which no payment liability has incurred.

C. Payment shall be made for only one recipient even though more than one recipient may have been serviced during the unit of service.

D. Requests for payments shall be submitted on a form specified by the Department and shall include the:

(i) Date of service;

(ii) Recipient's name and identification number;

(iii) Name of the provider and person who provided the service;

(iv) Nature, procedure code, units of service; and

(v) Place of service.

2. Payments for Medicaid recipients, who are medically-fragile, are based on negotiated rates. The negotiated rates are based on cost data submitted by each provider agency which take into consideration allowable Medicaid cost, expenditures related to case management services, and administrative expenditures. These costs will serve as the basis from which the final rate will be negotiated. Negotiation of the rate will take into consideration items such as but not limited to type of existing services, new add-on services, and area availability.

Negotiated rates will be re-calculated by the Department of Human Services each year using the last full year of available data.

A. Payments shall not be made for services for which another payer is liable, nor for services for which no payment liability has incurred.

B. Payment shall be made for only one recipient even though more than one recipient may have been serviced during the unit of service.

C. Requests for payments shall be submitted on a form specified by the Department and shall include:

(i) Date of Service;

(ii) Beneficiary's name and identification number,

(iii) Name of the provider and person who provided the service;

(iv) Nature, procedure code, units of service; and;

(iv) Place of service.

3. Payments shall be limited to agencies that are authorized Medicaid providers for the following case management services;

A. Case Management- Inpatient hospital for ventilator dependent/tracheotomized child prior to initial discharge to home/community require authorization.

B. Case Management for ventilator dependent/tracheostomized child living in the home/community- requires authorization

C. Case Management for non-ventilator dependent/non tracheostomized child with significant medical needs requires authorization.

D. Maintenance Case Management for children with significant medical needs whose caregivers arc able to access services and supplies with little assistance from case managers - requires authorization.

E. Additional case management hours to address changing medical needs -requires authorization and a report.

(o) Community Mental Health Services

SERVICE	PROVIDER TYPE	UNITS OF SERVICE	REIMBURSEMENT METHODOLOGY
Crisis management: 1. Telephone contact	Agency	Per contact	Rate negotiated by the Department Human Services (DHS). Final rate will be determined based on the following factors: • Cost to provide the service • Comparison to comparable services by comparable Medicaid provider types • Relative value to other services within the established fee schedule • Rate will not exceed the Medicare fee schedule for providers who participate in Medicare. • Rate will be reevaluated at a minimum of once every two years for its cost basis and allowability
2. Telephone contact followed by face to face	Agency	Per contact	Rate negotiated by the Department Human Services (DHS). Final rate will be determined based on the following factors: • Cost to provide the service • Comparison to comparable services by comparable Medicaid provider types • Relative value to other services within the established fee schedule • Rate will not exceed the Medicare fee schedule for providers who participate in Medicare.

2. Telephone contact followed by face to face (continued)			• Rate will be reevaluated at a minimum of once every two years for its cost basis and allowability
Crisis residential	Agency	Daily	Rate negotiated by the Department Human Services (DHS). Final rate will be determined based on the following factors: • Cost to provide the service • Comparison to comparable services by comparable Medicaid provider types • Relative value to other services within the established fee schedule • Rate will not exceed the Medicare fee schedule for providers who participate in Medicare. • Rate will be reevaluated at a minimum of once every two years for its cost basis and allowability
Biopsychosocial rehab	Agency	Billed in 15 minute increments.	Rate negotiated by the Department Human Services (DHS). Final rate will be determined based on the following factors: • Cost to provide the service • Comparison to comparable services by comparable Medicaid provider types • Relative value to other services within the established fee schedule

Biopsychosocial rehab (continued)			• Rate will not exceed the Medicare fee schedule for providers who participate in Medicare. • Rate will be reevaluated at a minimum of once every two years for its cost basis and allowability.
Intensive family intervention	Agency	Billed in 15 minute increments.	Rate negotiated by the Department Human Services (DHS). Final rate will be determined based on the following factors: • Cost to provide the service • Comparison to comparable services by comparable Medicaid provider types • Relative value to other services within the established fee schedule • Rate will not exceed the Medicare fee schedule for providers participating in Medicare • Rate will be reevaluated at a minimum of once every two years for its cost basis and allowability
Therapeutic supports	Agency	Daily	Rate negotiated by the Department Human Services (DHS). Final rate will be determined based on the following factors: • Cost to provide the service • Comparison to comparable services by comparable Medicaid provider types • Relative value to other services within the

Therapeutic supports (continued)			established fee schedule • Rate will not exceed the Medicare fee schedule for providers participating in Medicare • Rate will be reevaluated at a minimum of once every two years for its cost basis and allowability
Intensive outpatient hospital services	Agency	Daily	Rate negotiated by the Department Human Services (DHS). Final rate will be determined based on the following factors: • Cost to provide the service • Comparison to comparable services by comparable Medicaid provider types • Relative value to other services within the established fee schedule • Rate will not exceed the Medicare fee schedule for providers participating in Medicare • Rate will be reevaluated at a minimum of once every two years for its cost basis and allowability
ACT	Agency	Billed in 15 minute increments.	Rate negotiated by the Department Human Services (DHS). Final rate will be determined based on the following factors: • Cost to provide the service • Comparison to comparable services by comparable Medicaid provider types • Relative value to other services within the established fee schedule

ACT (continued)			• Rate will not exceed the Medicare fee schedule for providers participating in Medicare • Rate will be reevaluated at a minimum of once every two years for its cost basis and allowability

(p) Medicaid reimbursement for school-based health-related services (SBHRS) is available to the Department of Education (DOE) under an interagency service agreement (ISA) with the Med-QUEST Division. The ISA provides that the DOE is responsible for:

1. Payment of the state share of Medicaid reimbursement for SBHRS provided by or through the DOE;

2. Documenting the delivery of SBHRS as required by the Med-QUEST Division;

3. Supervising or overseeing the delivery of SBHRS; and

4. Otherwise complying with all applicable Federal and State requirements.

The DOE will be reimbursed on a fee-for-service basis. Each service that is reimbursable as a SBHRS will be reimbursed in accordance with the fee schedule maintained by the Med-QUEST Division for medical services rendered by authorized Medicaid providers.

Note: The Hawaii Medicaid fee schedule has separate rates for group therapy and individual therapy.

(q) Payments to a facility for non-emergency care rendered in an emergency room shall not exceed:

1. The rate negotiated by the Department;

2. Seventy-five per cent of billed charges; or

3. The Medicare fee schedule for providers participating in Medicare.

The payment to an emergency room physician for the screening and assessment of a patient who receives who receives non-emergency care in the emergency room shall not exceed the payment for a problem focused history, examination, and straight forward medical decision making.

r. The upper limits on payments for non-institutional items and services shall be established by the department in accordance with the section 346-59, Hawaii Revised Statute (HRS), and other applicable state statutes.

s. Medicaid reimbursement for behavioral services provided by the Child and Adolescent Mental Health Division (CAMHD) under Department of Health (DOH) shall be reimbursed in accordance with the fee schedule described in Supplement 3 to Attachment 4.19-B.

If there are services provided by CAMHD that are not listed on the CAMHD Fee Schedule in Supplement 3 to Attachment 4.19-B, reimbursement rates are located on the Medicaid Fee Schedule at https://medquest.hawaii.gov/en/plans-providers/fee-for-service/fee-schedules.html in accordance to agreements between CAMHD and MQD.

3. PAYMENT FOR COVERED OUTPATIENT DRUGS AND PROFESSIONAL DISPENSING FEES

a. Payment for covered outpatient drugs:

1. Payment for ingredient cost of prescription and covered outpatient drugs:

A. For single source drugs, reimbursement shall be the lowest of:
   i. The submitted ingredient cost, plus a professional dispensing fee;
   ii. The provider's usual and customary charge to the general public;
   iii. The Wholesale Acquisition Cost (WAC), plus a professional dispensing fee; or
   iv. The National Average Drug Acquisition Cost (NADAC), plus a professional dispensing fee.

B. For multiple source drugs, reimbursement shall be the lowest of:
   i. The submitted ingredient cost, plus a professional dispensing fee;
   ii. The provider's usual and customary charge to the general public;
   iii. WAC, plus a professional dispensing fee;
   iv. Federal Upper Limit (FUL) price, plus a professional dispensing fee;
   v. The State Maximum Allowable Cost (SMAC), plus a professional dispensing fee; or
   vi. The NADAC, plus a professional dispensing fee.

C. 340B-purchased drugs shall be reimbursed at the 340B submitted ingredient cost but no more than the 340B Ceiling Price, plus a professional dispensing fee.
   i. Drugs acquired through the federal 340B drug pricing program and dispensed by 340B contract pharmacies are not covered unless the 340B contract pharmacy requests in writing and receives approval from the state to use these drugs for Medicaid beneficiaries.

D. For clotting factor, reimbursement shall be the lowest of:

i. The submitted ingredient cost, plus a professional dispensing fee;
ii. The provider's usual and customary charge to the general public;
iii. WAC, plus a professional dispensing fee;
iv. FUL price, plus a professional dispensing fee;
v. SMAC, plus a professional dispensing fee; or
vi. The NADAC, plus a professional dispensing fee.

E. For physician administered drugs, reimbursement shall be the lowest of:
   i. The submitted ingredient cost;
   ii. The provider's usual and customary charge to the general public;
   iii. WAC;
   iv. FUL price;
   v. SMAC; or
   vi. The NADAC.

F. For drugs not dispensed by a retail community pharmacy (Such as specialty drugs, primarily through the mail, or in a long-term care facility), reimbursement shall be the lowest of:
   i. The submitted ingredient cost, plus a professional dispensing fee;
   ii. The provider's usual and customary charge to the general public;
   iii. WAC, plus a professional dispensing fee;
   iv. FUL price, plus a professional dispensing fee;
   v. SMAC, plus a professional dispensing fee; or
   vi. The NADAC, plus a professional dispensing fee.

G. Federal Supply Schedule (FSS) purchased drugs will be reimbursed at their actual acquisition cost, plus a professional dispensing fee.

H. Drugs acquired at nominal price (outside of 340B or FSS) will be reimbursed at their actual acquisition cost, plus a professional dispensing fee.

I. Experimental drugs and drugs not approved by the United States Food and Drug Administration are not covered.

2. Payment of professional dispensing fees for prescription drugs dispensed by a licensed pharmacy:
   A. $10.76 per prescription;

   B. The dispensing fee for any maintenance or chronic medication shall be extended only once per thirty days without medical authorization from the medical assistance program. Other appropriate limits regarding the number of dispensing fees paid per interval of time shall be determined as necessary by the medical assistance program.

11. In compliance with section 1927(b)(2) of the Social Security Act invoice reports will be submitted to each qualifying rebate manufacturer and the Department of Health and Human Services Secretary within sixty days after the end of each calendar quarter including information on the total number of dosage units of each covered outpatient drug dispensed under the rebate plan. This report will be consistent with the standard reporting format established by the Secretary and include the total number of dosage units of each covered outpatient drug dispensed under the plan during the quarter.

b. Payments for transportation services are limited as follows:

1. Payments for ground ambulance and air ambulance services are limited to billed charges, the rate negotiated by the Department or the Medicare reasonable charge, whichever is lower. In the case of neonatal ground transportation, the upper limit on payment shall be at a rate set by the Department;

2. Except for a recipient who is a stretcher patient, payment for air transportation shall not exceed the inter-island or out-of-state airfare charged the other persons on the recipient's flight, or a contracted amount previously agreed upon between the airlines and the Department for emergency chartered flights. For transportation of a stretcher patient by the scheduled carrier, payment shall not exceed the airfare charged for four seats on the recipient's flight.

3. A round trip airfare shall be paid for an attendant whose services are recommended by the attending physician or are required by the airline. Prior approval of the Department's medical consultant is necessary, except in emergency situations, when the attending physician's authorization is sufficient, subject to the Department's medical consultant's review. In addition, payment shall be made for the attendant's service, provided the attendant is unrelated to the patient. The amount of payment for the attendant's service shall not exceed the following applicable rates:

(a) Leave and return same day $20

(b) Requiring overnight stay $40

4. Payments for emergency air ambulance services shall be based upon prearranged contracted rates between the air carrier and the Department, not to exceed the rates charged the general public or the amounts paid by Medicare, whichever is lowest. The emergency trip shall be authorized by the attending physician using the form designated by the Department;

5. Payments for emergency ground ambulance services shall be based upon prearranged contracted rates between the provider and the Department, not to exceed rates charged the general public or the amounts paid by Medicare, whichever is lowest. Additional amounts shall be paid for life-saving measures administered in the ambulance such as oxygen. The charge shall not exceed the provider's customary charge to the general public, the rate set by the Department, or Medicare's reimbursement level for the same service. Recipients requiring ambulance service shall have the emergency trip authorized by the attending physician using the form designated by the Department or by the medical consultant of the Department;

(6) Payments for medical taxi services shall be by purchase order issued by the branch office and only for trips to or from a physician's office, clinic, hospital, or airport (for covered medical transportation) and the patient's home.

Further limitations on reimbursement for such services include:

(a) No detours or side trips shall be permitted;

(b) The amount of payment shall be made on the basis of metered rates charged the public; or

(c) Payments shall not include compensation for the driver's waiting time at the clinic, hospital, physician's office, or a location of other providers of medical services.

7. Lodging and meals for Medicaid patients or attendants authorized by the attending physician, in an emergency situation, or the Department's medical consultant shall be paid through purchase orders to the providers issued by the branch unit.

8. Payments for non-emergency transportation (e.g., Handicabs, but no taxis), are limited to rates established by the Department.

c. Payment for smoking cessation services shall be at the lower of the billed charge, the rate established by the department of the current Medicare fee schedule.

d. Services provided by a certified substance abuse counselor are reimbursed at fifty per cent of the Medicaid reimbursement rate for a psychologist as specified in Attachment 4.19-B, page 1, item 1(d).

e. Services provided by a certified peer specialist shall be reimbursed according to the Child and Adolescent Mental Health Division (CAMHD) Fee Schedule located on Supplement 3 to Attachment 4.19-B

Hospice Care Services Payment

Payment for hospice services is made to a designated hospice provider based on the Medicaid hospice rates published annually in a memorandum issued by the Centers for Medicare & Medicaid Services (CMS), Center for Medicaid and CHIP Services. Additionally, the rates are adjusted for regional differences in wages using the hospice wage index published by CMS.

This rate schedule provides rates for each of the four levels of hospice care, with the exception of payment for physician services.

The reimbursement amounts are determined within each of the following categories:

1. Routine home care where most hospice care is provided Days 1-60.
2. Routine home care where most hospice care is provided Days over 60.
3. Continuous home care which is furnished during a period of crisis and primarily consists of nursing care to achieve palliation and management of acute medical symptoms.
4. Inpatient respite care which is short-term care and intended to relieve family members or others caring for the individual.
5. General inpatient hospice care which is short term and intended for pain control or acute or chronic symptom management which cannot be provided in other settings.
6. Service Intensity Add-on (SIA) will be made for a visit by a social worker or a registered nurse (RN), when provided during routine home care provided in the last 7 days of a Medicaid member's life. The SIA payment is in addition to the routine home care rate. The SIA Medicaid reimbursement will be equal to the Continuous Home Care hourly payment rate (as calculated annually by CMS), multiplied by the amount of direct patient care hours provided by an RN or social worker for up to four (4) hours total that occurred on the day of service, and adjusted by the appropriate hospice wage index published by CMS.

Section 3004 of the Affordable Care Act amended the Social Security Act to authorize a Medicare quality reporting program for hospices. In accordance with Sections 1814(i)(5)(A)(i)of the Social Security Act, the market basket update will be reduced by 2 percentage points for any hospice that does not comply with the quality data submission requirements

Hospice nursing facility room and board per diem rates are reimbursed to the hospice provider at a rate equal to 95% of the skilled nursing facility rate, less any Post Eligibility Treatment of Income (PETI) amount, for Medicaid clients who reside in a nursing facility and receive hospice services.
The hospice provider is responsible for passing the room and board payment through to the nursing facility.

For each hospice, the total number of inpatient days (both for general inpatient care and inpatient respite care) must not exceed 20 percent of the aggregate total number of days of hospice care provided to all Medicaid members enrolled in the hospice during the same period, beginning with services rendered October 1 of each year and ending September 30 of the next year.

ATTACHMENT 4.19-B

6. MAXIMUM MEDICAID PAYMENT RATES FOR PEDIATRIC PRACTITIONER PEDIATRIC SERVICES (EFFECTIVE 01/01/97)

PROCEDURE CODE	PROCEDURE DESCRIPTION	MAXIMUM PAYMENT	
		GEN PRAC	PED
	EVALUATION AND MANAGEMENT:		
	OFFICE OR OTHER OUTPATIENT SERVICES		
	New Patients:		
* 99201	Physicians typically spend 10 minutes	25.20	26.81*
* 99202	Physicians typically spend 20 minutes	40.50	40.50
* 99203	Physicians typically spend 30 minutes	60.70*	60.70*
* 99204	Physicians typically spend 45 minutes	55.00	79.80
* 99205	Physicians typically spend 60 minutes	81.15	91.80
	Established Patients:		
* 99211	Typically 5 minutes are spent supervising or performing these services	11.04	11.40
* 99212	Physicians typically spend 10 minutes	16.63	18.00
* 99213	Physicians typically spend 15 minutes	23.04	23.73
* 99214	Physicians typically spend 25 minutes	42.00	40.50
*99215	Physicians typically spend 40 minutes	47.50	58.52
	OFFICE OR OTHER OUTPATIENT CONSULTATIONS		
	New or Established Patients:		
99241	Physicians typically spend 15 minutes	51.92*	51.92*
99242	Physicians typically spend 30 minutes	71.21*	71.21*
99243	Physicians typically spend 40 minutes	82.63*	82.63*
99244	Physicians typically spend 60 minutes	117.32*	117.32*

ATTACHMENT 4.19-B

PEDIATRIC PRACTITIONER SERVICES
(Continued)

PROCEDURE CODE	PROCEDURE DESCRIPTION	MAXIMUM PAYMENT	
		GEN PRAC	PED
99245	Physicians typically spend 80 minutes	134.40*	134.40*
	CONFIRMATORY CONSULTATIONS		
	New or Established Patients:		
99271	Usually the presenting problem(s) are self limited or minor	41.14*	41.14*
99272	Usually the presenting problem(s) are of low severity	75.47*	75.47*
99273	Usually the presenting problem(s) are of moderate severity	69.20	69.20
99274	Usually the presenting problems(s) are of moderate to high severity	98.92*	98.92*
99275	Usually the presenting problem(s) are of moderate to high severity	129.97*	129.97*
	HOME SERVICES		
	New Patient:		
99341	Usually the presenting problem(s) are of low severity	50.77*	50.77*
99342	Usually the presenting problem(s) are of moderate severity	58.50	58.50
99343	Usually the presenting problem(s) are of high severity	79.97*	79.97*
	Established Patient:		
99351	Usually the patient is stable, recovering or improving	39.29*	39.29*

ATTACHMENT 4.19-B

PEDIATRIC PRACTITIONER SERVICES
(Continued)

PROCEDURE CODE	PROCEDURE DESCRIPTION	MAXIMUM PAYMENT	
		GEN PRAC	PED
99352	Usually the patient is responding inadequately to therapy or has developed a minor complication	31.49	37.27
99353	Usually the patient is unstable or has developed a significant complication or a significant new problem	48.16	47.85
	PROLONGED SERVICES		
	Prolonged Physician Services with Direct (Face-to-Face) Patient Contact:		
99354	Prolonged Physician Service in the office or other outpatient setting requiring direct patient contact beyond the usual service, first hour	By Report	By Report
99355	Each additional 30 minutes	By Report	By Report
	Prolonged Physician Service without Direct (Face-to-Face) Patient Contact:		
99358	Prolonged evaluation and management service before and/or after direct patient care; first hour	Ineligible	Ineligible
99359	Each additional 30 minutes	Ineligible	Ineligible
	PREVENTIVE MEDICINE SERVICES		
	New Patients:		
* 99381	Initial preventive medicine evaluation and management of a healthy individual requiring a comprehensive history, a comprehensive examination, the identification of risk factors, and the ordering of appropriate laboratory/diagnostic procedures; new patient; infant (age under 1 year)	27.00	36.00
* 99382	Early childhood (age 1-4 years)	46.37	31.50

ATTACHMENT 4.19-B

PEDIATRIC PRACTITIONER SERVICES
(Continued)

PROCEDURE CODE	PROCEDURE DESCRIPTION	MAXIMUM PAYMENT	
		GEN PRAC	PED
* 99383	Late childhood (age 5-11 years)	33.00	33.60
* 99384	Adolescent (age 12-17 years)	36.00	35.28
	Established Patient:		
* 99391	Periodic preventive medicine reevaluation and management of individual including a comprehensive history, comprehensive examination, counseling/anticipatory guidance/risk factor reduction interventions, and the ordering of appropriate laboratory/diagnostic procedures, established patient; infant (age under 1 year)	24.00	25.20
* 99392	Early childhood (age 1-4 years)	29.25	28.50
* 99393	Late childhood (age 5-11 Years)	30.00	31.50
* 99394	Adolescent (age 12-17 years) 12-24 hr continuous recording, infant	31.20	37.80
	COUNSELING AND/OR RISK FACTOR		
	REDUCTION INTERVENTION		
	New or Established Patient:		
	Preventive Medicine, Individual Counseling:		
99401	Counseling and/or risk factor reduction intervention(s) provided to a healthy individual; approximately 15 minutes	Ineligible	Ineligible
99402	Approximately 30 minutes	"	"
99403	Approximately 45 minutes	"	"
99404	Approximately 60 minutes	"	"

ATTACHMENT 4.19-B

PEDIATRIC PRACTITIONER SERVICES
(Continued)

PROCEDURE CODE	PROCEDURE DESCRIPTION	MAXIMUM PAYMENT	
		GEN PRAC	PED
	Preventive Medicine, Group Counseling:		
99411	Counseling and/or risk factor reduction intervention(s) provided to healthy individuals in a group setting; approximately 30 minutes	Ineligible	Ineligible
99412	Approximately 60 minutes	"	"
	Other Preventive Medicine Services:		
99420	Administration and interpretation of health risk assessment instrument(e.g., health hazard appraisal)	"	"
99429	Unlisted preventive medicine service	By Report	By Report
	NEWBORN CARE		
99432	Normal newborn care in other than hospital or birthing room setting, including physical examination of baby and conferences(s) with parent(s)	27.00	36.00
	MEDICINE		
	Immunization Injections:		
90700	Immunization, active; diphtheria, tetanus toxoids, and acellular pertussis vaccine(DTP)	Physicians are paid $2. for administration & AWP (Blue Book) current price less 10.5%. For VFC (Vaccines For Children) vaccines, no reimbursement is made	
* 90701	Diphtheria and tetanus toxoids and pertussis vaccine (DTP)		
90702	Diphtheria and tetanus toxoids (DT)		
90703	Tetanus toxoid		

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ATTACHMENT 4.19-B

PEDIATRIC PRACTITIONER SERVICES
(Continued)

PROCEDURE CODE	PROCEDURE DESCRIPTION	MAXIMUM PAYMENT	
		GEN PRAC	PED
90704	Mumps virus vaccine, live	for vaccines, but a $2.00 Administrative charge is allowed.	
90705	Measles virus vaccine, live		
90706	Rubella virus vaccine, live		
* 90707	Measles, mumps and rubella virus vaccine, live	"	"
90708	Measles and rubella virus vaccine, live	"	"
90709	Rubella and mumps virus vaccine, live	"	"
90710	Measles, mumps, rubella, and varicella vaccine	"	"
90711	Diphtheria, tetanus, and pertussis (DTP) and injectable poliomyelitis vaccine	"	"
* 90712	Poliovirus vaccine, live, oral (any type s)	"	"
90713	Poliomyelitis vaccine	"	"
90714	Typhoid vaccine	"	"
90716	Varicella (chicken pox) vaccine	"	"
90717	Yellow fever vaccine	"	"
90719	Diphtheria toxoid	"	"
90720	Diphtheria, tetanus, and pertussis (DTP) and Hemophilus influenza B (HIB) vaccine	"	"
90721	Diphtheria, tetanus toxoids, and acellular pertussis vaccine (DTaP) and Hemophilus influenza B (HIB) vaccine	"	"
90724	Influenza virus vaccine	"	"
90725	Cholera vaccine	"	"

PEDIATRIC PRACTITIONER SERVICES
(Continued)

PROCEDURE CODE	PROCEDURE DESCRIPTION	MAXIMUM PAYMENT	
		GEN PRAC	PED
90726	Rabies vaccine	"	"
90727	Plague vaccine	"	"
90728	BCG vaccine	"	"
90730	Hepatitis A vaccine	"	"
90732	Pneumococcal vaccine, polyvalent	"	"
90733	Meningococcal polysaccharide vaccine (any group(s))	"	"
* 90737	Hemophilus influenza B	"	"
90741	Immunization, passive; immune serum globulin, human (ISG) pertussis, rabies,	"	"
90742	Specific hyperimmune serum globulin (e.g. hepatitis B, measles, pertussis, rabies, RHO (D), tetanus, vaccinia, varicella-zoster)	"	"
* 90744	Immunization, active, hepatitis B vaccine; newborn to 11 years	"	"
* 90745	11 - 19 years	"	"
90749	Unlisted immunization procedure	"	"

ATTACHMENT 4.19-B

PEDIATRIC PRACTITIONER SERVICES
(Continued)

** Ineligible = Services are included in other E & M services, in global perinatal care, complete EPSDT periodic screens are reimbursed at $95.00 (global fee), targeted case management is reimbursed at $9.75 per 15 minutes, complete perinatal is reimbursed at $900.00 for vaginal and $1,400.00 for C-section deliveries.

ATTACHMENT 4.19-B

7. MAXIMUM MEDICAID PAYMENT RATES FOR OBSTETRICAL SERVICES

PROCEDURE CODE	PROCEDURE DESCRIPTION	MAXIMUM PAYMENT	
		GEN PRAC	OB-GYN
	MATERNITY CARE AND DELIVERY		
	Incision:		
59000	Amniocentesis, any method	81.00	81.00
59012	Cordocentesis (intrauterine), any method	216.96*	216.96*
59015	Chorionic villus sampling, any method	118.08*	118.08*
59020	Fetal contraction stress test	72.44*	72.44*
59025	Fetal non-stress test	...	43.24*
59030	Fetal scalp blood sampling	63.37	56.88
59050	Fetal monitoring during labor by consulting physician with written report (separate procedure); supervision and interpretation	84.28*	84.28*
	Excision:		
59051	Interpretation only	62.37	56.88
59100	Hysterotomy, abdominal (e.g. for hydatidiform mole, abortion)	375.00*	375.00*
59120	Surgical treatment of ectopic pregnancy; tubal or ovarian, requiring salpingectomy and/or oophorectomy, abdominal or vaginal approach	563.92*	563.92*
59121	Tubal or ovarian, without salpingectomy and/or oophorectomy	457.05*	457.05*
59130	Abdominal pregnancy	494.92*	494.92*
59135	Interstitial, uterine pregnancy requiring total hysterectomy	567.18*	567.18*
59136	Interstitial, uterine pregnancy with partial resection of uterus	555.58*	555.58*

ATTACHMENT 4.19-B

OBSTETRICAL PRACTITIONER SERVICES
(Continued)

PROCEDURE CODE	PROCEDURE DESCRIPTION	MAXIMUM PAYMENT	
		GEN PRAC	OB-GYN
59140	Cervical, with evacuation	343.04*	343.04*
59150	Laparoscopic treatment of ectopic pregnancy; without salpingectomy and/or oophorectomy	404.44	404.44
59151	With salpingectomy and/or oophorectomy	566.46	566.46*
59160	Curettage, postpartum (separate procedure)	209.97*	209.97*
	Introduction:		
59200	Insertion of cervical dilator	49.15	49.15*
	Repair:		
59300	Episiotomy or vaginal repair, by other than attending physician	117.43*	117.43*
59320	Cerclage or cervix, during pregnancy; vaginal	158.24*	158.24*
59325	Abdominal	246.03*	246.03*
59350	Hysterorrhaphy of ruptured uterus	316.14*	316.14*
	Vaginal Delivery, Antepartum, & Postpartum Care:		
59400	Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care	630.20	588.80
* 59409	Vaginal delivery only (with or without episiotomy and/or forceps);	415.80	379.20
* 59410	Including postpartum care	472.80	472.80
* 59412	External cephalic version, with or without tocolysis	By Report	By Report
* 59414	Delivery of placenta (separate procedure)	102.79*	102.79*

ATTACHMENT 4.19-B

OBSTETRICAL PRACTITIONER SERVICES
(Continued)

PROCEDURE CODE	PROCEDURE DESCRIPTION	MAXIMUM PAYMENT	
		GEN PRAC	OB-GYN
* 59425	Antepartum care only; 4-6 visits	124.74	113.76
* 59426	7 or more visits	249.48	227.52
* 59430	Postpartum care only (separate procedures)	48.71	54.00
	Cesarean Delivery:		
* 59510	Routine obstetric care including antepartum care, cesarean delivery, and post partum care	1042.80	1042.80
* 59514	Cesarean delivery only;	675.65	675.65
* 59515	Including postpartum care	675.65	675.65
* 59525	Subtotal or total hysterectomy after cesarean delivery	380.10*	380.10*
	Abortion:		
59812	Treatment of incomplete abortion, any trimester, completed surgically	199.98*	199.98*
59820	Treatment of missed abortion, completed surgically; first trimester	270.00	243.00
59821	Second trimester	243.00*	243.00*
59830	Treatment of septic abortion, completed surgically	By Report	By Report
59840	Induced abortion, by dilation and curettage	280.61*	280.61*
59841	Induced abortion, by dilation and evacuation	255.47*	255.47*
59850	Induced abortion, by one or more intra-amniotic injections	349.85*	349.85*
59851	With dilation and curettage and/or evacuation	366.61*	366.61*
59852	With hysterotomy (failed intra-amniotic injection)	491.77*	491.77*

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ATTACHMENT 4.19-B

OBSTETRICAL PRACTITIONER SERVICES
(Continued)

PROCEDURE CODE	PROCEDURE DESCRIPTION	MAXIMUM PAYMENT	
		GEN PRAC	OB-GYN
59855	Induced abortion, by one or more vaginal suppositories (e.g. prostaglandin) with or without cervical dilation (e.g., laminaria);	372.22	372.22
59856	With dilation and curettage and/or evacuation	561.62	561.62
59857	With hysterotomy (failed medical evaluation)	663.60	663.08
	Other Procedures:		
59870	Uterine evacuation and curettage for hydatidiform mole	By Report	By Report
59899	Unlisted procedure, maternity care and delivery documentation; complete	By Report	By Report

ATTACHMENT 4.19-B

ADEQUACY OF ACCESS BASED ON PRACTITIONER PARTICIPATION DURING 1994

I. OBSTETRICAL STANDARD:

County	No. of Providers	No. of Participants	% Participants
· Hawaii	15	10	66.7%
Kauai	6	3	50.0%
Maui *	12	4	33.3%
Honolulu	167	40	24.0%
TOTAL	**200**	**57**	**29.0%**

* = Also includes Lanai and Molokai

II. PEDIATRIC STANDARD:

County	No. of Providers	No. of Participants	% Participants
Hawaii	18	13	72.2%
Kauai	9	3	33.3%
Maui *	17	11	64.7%
Honolulu	215	70	32.6%
TOTAL	**259**	**97**	**37.5%**

Source: MMIS

* Hawaii QUEST was implemented August 1, 1994. The statistics above is based on fee-for-service access from January 1, 1996 through December 31, 1996, which covers the total eligible Medicaid population. Effective August 1, 1994, only ABD is covered through fee-for-service.

* There are approximately 1200 children statewide in the fee-for-service medical program.

8. HMO RATES FOR OBSTETRICAL AND PEDIATRIC SERVICES:

Payment for obstetrical and pediatric services are included in the monthly capitation rate for eligible Medicaid recipients enrolled in HMO. Currently, Hawaii has an 1115 Waiver with five managed care health plans. The capitation rate is actuarially calculated by the HMO based on historical and projected costs for the region (Hawaii). The State calculates the fee-for-service cost of service provided by the HMO to an actuarially equivalent non-enrolled population group. Following are the current monthly capitation rates which reflect annual increases to assure adequacy of access to obstetric and pediatric services:

Capitation Rates as of 07/01/97:

(+) Capitation rate for Kapiolani Health Hawaii is effective 09/01/97

	AlohaCare	HMSA	Kaiser	Kapiolani Health Hawaii (+)	Queen's Hawaii Care	Straub
Oahu	$151.67	$142.00	$146.71	$149.71	$146.92	$143.00
Hawaii	$135.88	$139.00	$135.88	$139.00	$138.12	
Maui	$135.21	$135.21 *	$127.11		$133.43	
Molokai		$135.02			$135.02	
Kauai	$139.88	$145.00 *		$145.00	$137.08	
Lanai		$148.70				$148.70

*coverage only until 08/31/97

Capitation Rates as of 07/01/96:

	AlohaCare	HMSA	Kaiser	Queen's Hawaii Care	Straub
Oahu	$167.06	$167.06	$167.06	$167.06	$167.06
Hawaii	$159.32	$159.32	$159.32	$159.32	
Maui	$152.21			$152.21	
Molokai	$148.57			$148.57	
Kauai	$158.19	$158.19		$158.19	
Lanai			$163.78		$163.78

Capitation Rates as of 08/01/95:

	AlohaCare	HMSA	Kaiser	Queen's Hawaii Care	Straub
Oahu	$174.00	$176.26	$177.11	$167.06	$177.50
Hawaii	$175.00	$166.78	$166.78	$159.32	
Maui	$152.21			$166.78	
Molokai	$148.57			$166.78	
Kauai	$169.50	$166.78		$158.19	
Lanai			$163.78		$164.15

Capitation Rates as of 08/01/94:

	AlohaCare	HMSA	Kaiser	Queen's Hawaii Care	Straub
Oahu	$163.22	$168.35	$151.40	$155.74	$153.16
Hawaii	$161.25	$156.66	$156.66	$144.78	
Maui	$144.08			$166.13	
Molokai	$126.84			$155.44	
Kauai	$154.29	$162.20		$144.04	
Lanai			$136.12		$177.57

9. PAYMENTS FOR ALL OTHER NON-INSTITUTIONAL ITEMS AND SERVICES:

Payments for all other non-institutional items and services shall be at a rate set by the Department. In the case of Qualified Medicare Beneficiaries, deductibles and co-insurance payments for any Medicare covered services that are not otherwise covered under the Hawaii State Plan, are based on the Medicare reasonable charge.

10. FEDERALLY QUALIFIED HEALTH CENTERS (FQHCs) AND RURAL HEALTH CLINIC (RHCs) PAYMENT SYSTEMS:

10.0 Introduction

This section describes the payment methodology for services performed on or after January 1, 2001 by federally qualified health centers (FQHCs), including FQHC look-a-likes as designated by the Public Health Service and Rural Health Clinics (RHCs) and as required by the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act ("BIPA") of 2000. The payment methodology is as follows:

(a) Effective January 1, 2001, federally qualified health center ("FQHC") and rural health clinic ("RHC") services shall be reimbursed on a prospective payment system ("PPS") that conforms to the requirements of section 702 of the Benefits Improvement and Protection Act of 2000 ("BIPA").

(b) In the period before the PPS is fully implemented, payment to FQHCs and RHCs will continue at the fee-for-service rates in effect on December 30, 2000. Following full implementation of the PPS, adjustments will be made for the period from January 1, 2001 through the date on which the PPS is fully implemented.

10.1 Prospective Payment System

(a) The baseline PPS rate for FQHCs and RHCs that have filed at least two annual cost reports as of January 1, 2001 will be calculated from the respective cost reports for the fiscal years ending in 1999 and 2000. Total visits will be obtained from "as filed" cost reports. For FQHCs and RHCs having more than one cost report ending in either of these years, a weighted average to the current year-end will be used to make both years consistent. Vision visits and costs will be included in the medical cost per visit baseline PPS rates. A separate PPS rate will be computed for dental visits. Total costs of all Medicaid covered ambulatory services provided by the FQHCs/RHCs for each year will be divided by the total number of visits in that year to determine average cost per visit for each year. The average cost per visit for each year will be added and then divided by two to determine the baseline PPS rate.

(b) For FQHCs and RHCs which could have filed two annual cost reports as of May 31, 2001 but only filed one cost report, the baseline rate will be calculated from the cost report submitted. Total visits and costs will be obtained from the "as filed" cost report. Vision visit and costs will be included in the medical cost per visit baseline PPS rate. A separate PPS rate will be computed for dental visits.

Each year's costs will be divided by total visits. Total costs should include the cost of all Medicaid covered services provided by the FQHC or RHC, including all ambulatory services previously paid on a fee-for-service basis.

(c) Service provided at a satellite service site or a mobile satellite facility that is affiliated with an FQHC or RHC shall be reimbursed at the same PPS rate as that of the affiliated FQHC or RHC, subject to the FQHC's or RHC's right to request a scope-of-service adjustment to the rate. A satellite facility or mobile unit is affiliated with an FQHC or RHC when it is owned and operated by the same entity and has been approved or certified by the Health Resources and Services Administration ("HRSA") as part of the official scope of the project on a Notice of Grant Award.

(d) Baseline rates for FQHCs and RHCs that did not file annual cost reports as of May 31, 2001 will be set at 100% of the costs of furnishing such services at the cost per visit rate established by the method described in the preceding paragraphs for the FQHC or RHC, respectively, that is most similar in scope of service and case load.

(e) For FQHCs and RHCs that submitted cost reports for their respective fiscal years ending 1999 and 2000 but, as of December 31, 2000, were not certified as FQHCs or RHCs long enough to produce two annual cost reports based on their respective fiscal years, baseline PPS rates will be set at the higher of the cost per visit rate for the FQHC or RHC that is most similar in scope of service and case load or the actual cost per visit rate calculated using the FQHC's and RHC's most recent "as filed" cost report.

(f) The FQHC/RHC PPS rates will be effective for services rendered from January 1 through December 31 of each year.

(g) Starting January 1, 2002, PPS rates will be adjusted annually using the Medicare Economic Index ("MEI"), as defined in Section 1842(i)(3) of the Social Security Act applicable to primary care services as defined in Section 1842(i)(4) of the Social Security Act, for that calendar year as published in the Federal Register.

(h) To be eligible for PPS reimbursement, services must be delivered exclusively by the following licensed health care professionals: physician, physician's assistant, nurse practitioner, nurse midwife, visiting nurse, clinical social worker, clinical psychologist, and licensed dieticians

10.2 Supplemental Managed Care Payments

(a) FQHCs and RHCs that provide services under a contract with a Medicaid managed care organization ("MCO") will receive quarterly supplemental payments that represent the estimated difference between payments received from the MCO and payments that the FQHC or RHC would receive under the PPS methodology. Not more than one month following the end of each calendar quarter, and based on the receipt of FQHC and RHC submitted claims during the prior calendar quarter, FQHCs and RHCs shall be paid the difference between the amount received from estimated supplemental quarterly payments and from MCOs (excluding payment for non-PPS services, managed care risk pool accruals, distributions or losses and pay-for-performance bonuses or other forms of incentive payments such as quality improvement recognition grants and awards) and the payment that each FQHC or RHC would have received under the PPS methodology. Any balance due from an FQHC or RHC shall be recouped from the next quarter's estimated supplemental payment.

(b) Within 150 days of the end of each calendar year, FQHCs and RHCs will file annual settlement reports, stating the amounts of MCO and supplemental payments received and the actual number of visits provided during the applicable calendar year. The Department shall also request financial data from the MCOs. The reports shall be reviewed and the total amounts received by the FQHCs and RHCs as supplemental payments and from MCOs (excluding payment for non-PPS services, managed care risk pool accruals, distributions or losses and pay-for-performance bonuses or other forms of incentive payments such as quality improvement recognition grants and awards) shall be compared with the amount that would have been paid under the PPS system for the actual number of visits provided under the FQHC's or RHC's contract with the MCO. Any discrepancies between the MCO and provider submitted claims data will be resolved on a case-by-case basis. After reviewing the reports, the Department will notify participating FQHCs and RHCs of any balance due to or from the FQHC or RHC.

10.3 Adjustments for Changes in Scope of Service

(a) PPS rates may be adjusted for changes in the scope of services provided by an FQHC or RHC upon submission of a written notice to the Department specifying the changes in scope of service and the reasons for those changes within 60 days of the effective date of the changes. If the written notice is greater than 60 days after the effective date of changes the Department will consider the effective date of change of scope of services to be the notification date.

(b) An FQHC or RHC requesting a rate adjustment for changes in scope of service must submit data/documentation/schedules that substantiate any changes in services and the related adjustment of reasonable costs following Medicare principles of reimbursement.

(c) An FQHC or RHC requesting a rate adjustment for changes in scope of service must submit a projected adjusted rate within 150 days of the changes. The projected adjusted rate is subject to approval by the Department and shall be calculated based on a consolidated basis, including both costs included in the base rate and additional costs, provided that the FQHC's or RHC's baseline PPS rate was calculated based on consolidated costs.

(d) Within one hundred twenty days of receipt of the projected adjusted rate and all additional documentation requested by the Department, the Department shall notify the FQHC or RHC of its acceptance or rejection of the projected adjusted rate. The Department will reduce the projected adjusted rate by twenty percent of the difference between the FQHC's or RHC's previously assigned PPS rate and the projected adjusted rate to eliminate the reporting of cost increases not related to a qualifying scope change. Upon approval by the Department, the FQHC or RHC will be paid the reduced projected adjusted rate effective from the date of the change in scope of services through the date that a rate is calculated based on the submission of cost reports for the first full fiscal year which include the change in scope of service.

(e) The Department will review the calculated rate of the first full fiscal year cost report if the change of scope in service is reflected in more than six months of the report. For those FQHCs or RHCs in which the change of scope of services is in effect for less than six months, the next full year cost report is also required. The Department will review the calculated inflated weighted average rate of these two cost reports. The total costs of the first year report will be adjusted to the MEI of the second year report. Each report will be weighted based on the number of patient encounters.

(f) The PPS rate will be adjusted following review of the cost reports and supporting documentation by the Department or its designated agent.

(g) Payment adjustments will be made for the period from the effective date of the change in scope of services through the date of the final adjustment of the PPS rate.

(h) To qualify for rate adjustment, a change of scope must be a change in type, intensity, duration or amount of service, or any combination therein. A change in cost alone, in and of itself will not be considered a change in scope of service.

(i) Change in scope includes any of the following only if these changes result in a change in type intensity, duration or amount of service, or any combination therein:

i. Addition of new services not incorporated in the baseline rate or deletion of services incorporated in the baseline rate;

ii. Changes necessary to maintain compliance with amended state or federal requirements or;
iii. Changes resulting from relocation;
iv. Changes resulting from the opening of a new service location;
v. Changes in the type, intensity, duration or amount of service caused by changes in technology and medical practice used;
vi. Increase in service intensity, duration, or amount of service resulting from the changes in the types of patients served, including, but not limited to, populations with HIV/AIDS, or other chronic diseases, or homeless, elderly, migrant or other special populations;
vii. Changes resulting from a change in the provider mix of a FQHC, RHC or an affiliated site;
viii. Changes in the scope of a project approved by the HRSA, where the change affects a covered service, as described below;
ix. Changes in operating costs due to capital expenditures associated with a modification of the scope of any of the services, described below, including new or expanded service facilities, regulatory compliance measures, or change in technology or medical practices at the FQHC or RHC.

(j) In addition to the criteria as stated under (h), the cost must be allowable under Medicare principles of reimbursement and the net change in the FQHC's or RHC's per visit rates equals or exceeds 3 per cent for the affected FQHC or RHC site. For FQHCs and RHCs that filed consolidated cost reports for multiple sites to establish baseline PPS rates, the net change of 3 percent shall be applied to the average per visit rate of all the sites of the FQHC or RHC for purposes of calculating the costs associated with a scope of service change. "Net change" shall mean the per visit change attributable to the cumulative effect of all increases or decreases for a particular fiscal year. "Fiscal year" shall be construed to reference the fiscal year of the specific FQHC or RHC under consideration.

10.4 Other Payment Adjustments

(a) FQHCs and RHCs may request other payment adjustments in the event of extraordinary circumstances, including but not limited to acts of God, changes in life and safety code requirements, and changes in licensure laws. Inflationary cost changes, absent extraordinary circumstances, shall not be grounds for other payment adjustments. If an FQHC's or RHC's PPS rate is sufficient to cover its overall costs including those associated with extraordinary circumstances, other payment adjustments is not warranted.

(b) The Department will accept requests for other payment adjustments at any time throughout the prospective payment year or within thirty days following the end of a prospective payment year. Such requests must be made in writing, shall set forth the reasons for the request, and be accompanied by data satisfactory to

establish the existence of extraordinary circumstances warranting other payment adjustments. Documentation shall include:

i. Presentation of data to demonstrate reasons for the FQHC's or RHC's request for other payment adjustments;

ii. Documentation showing the cost impact, which must be material and significant ($200,000 or 1% of the FQHC's or RHC's total costs, whichever is less). The documentation submitted must be sufficient to compute an adjustment amount to the PPS payment for the purpose of determining a QUEST and QExA managed care supplemental payment amount.

(c) Each other payment adjustment request will be applicable for only the remainder of the PPS rate year. If the other payment adjustment request is granted, it will be effective no earlier than the first day of the PPS rate year during which the other payment adjustment request is received. If an FQHC or RHC believes that its experience justifies continuation of the other payment adjustment in subsequent years, then it shall submit information to update the documentation provided in the prior request for each affected year.

(d) An FQHC or RHC requesting other payment adjustments will be notified of the Department's decision on the request in writing within ninety days from the date of receipt of all necessary verification and documentation.

(e) Amounts granted for other payment adjustments requests will be paid as part of the on-going payment and not as revised PPS rates.

10.5 Cost Reporting, Record Keeping and Audit Requirements

(a) All participating FQHCs and RHCs shall maintain an accounting system which identifies costs in a manner that conforms to generally accepted accounting principles and maintain documentation sufficient to support all data.

(b) Annual cost reports will be required only under the following circumstances:

i. FQHCs and RHCs that request rate changes due to changes in scope of service shall submit cost reports for the first one or two full fiscal years reflecting the change in scope of services along with significant related data. Consolidated cost reports, which combines the costs from all the FQHC or RHC sites and services, shall be prepared. Exceptions to the requirement for consolidated cost reports may be made only if the FQHC or RHC originally filed site specific cost reports during two baseline years and subsequently established site-specific PPS baseline rates using such "as filed" cost reports.

ii. FQHCs and RHCs that request other payment adjustments shall submit cost reports for the fiscal years for which the other payment adjustments were authorized.

iii. In either of the circumstances described above, the following documentation must be submitted no later than five months after the close of the FQHC's or RHC's fiscal year:

- Uniform cost report;
- Working trial balance;
- Provider cost report questionnaire;
- Audited financial statements, if available;
- Disclosure of appeal items included in the cost report;
- Disclosure of increases or decreases in scope of services; and
- Other schedules as identified by the Department.

(c) Each FQHC or RHC that submits an annual cost report shall keep financial and statistical records of the cost reporting consistent with 45 CFR 74.53(b) after submitting the cost report to the Department and shall make such records available to authorized state or federal representatives upon request.

(d) The Department or its fiscal agent may conduct periodic on-site or desk audits of cost reports, including financial and statistical records of a sample of FQHCs or RHCs.

(e) FQHCs and RHCs must submit other information (statistics, cost and financial data) as deemed necessary by the Department.

10.6 Rebasing

Baseline PPS rates will not be subject to rebasing after their initial computation unless authorized by Congress.

10.7 Eligible Services

(a) To be eligible for PPS reimbursement services must be:

i. Within the legal authority of an FQHC or RHC to deliver, as defined in Section 1905 of the Social Security Act as amended;
ii. Actually provided by the FQHC or RHC, either directly or under arrangements;
iii. Medicaid covered ambulatory services under the Medicaid program, as defined in the Hawaii Medicaid State Plan;
iv. Provided to a recipient eligible for Medicaid benefits;
v. Delivered exclusively by licensed health care professionals (physician, physician's assistant, nurse practitioner, nurse midwife, visiting nurse, clinical social worker, clinical psychologist, or licensed dieticians);
vi. Provided in an outpatient settings during business or after hours on the FQHC's or RHC's site. For full-benefit dual eligibles only, services may be provided at the patient's place of residence, which may be a skilled nursing facility, a nursing facility or other institution used as a patient's

home, within the limitation noted in Supplement 1 to Attachment 4.19-B, page 3 and;

vii. Within the scope of services provided by the State under its fee-for-service Medicaid program and its Health QUEST program, on and after August 1994.

(b) Contacts with one or more health professionals and multiple contacts with the same health professional that take place on the same day and at a single location shall constitute a single encounter unless:

i. After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment; or

ii. The patient makes one or more covered encounters for dental or behavioral health. Medicaid shall pay for a maximum of one visit per day for each of these services in addition to one medical visit.

10.8 Non-FQHC Services

It is permissible for an FQHC to bill the Department or the designated fiscal agent for the non-FQHC professional services provided by an employed or contracted practitioner. In such instances, the services provided by the practitioner are not considered FQHC services and are not to be considered in calculations pertaining to PPS-based payments to FQHCs for FQHC services. In such instances, the Department or the designated fiscal agent will reimburse the FQHC on behalf of the practitioner at the rate specified for that practitioner under the State Plan in Attachment 4.19B for the professional services provided to the Medicaid beneficiary.

10.9 Appeal

An FQHC or RHC may appeal a decision made by the Department and shall be afforded an opportunity for administrative hearing under HRS Chapter 91. An FQHC or RHC aggrieved by the final decision and order of such an administrative hearing shall be entitled to judicial review in accordance with HRS Chapter 91, or may submit the matter to binding arbitration pursuant to HRS Chapter 658A.

11. REIMBURSEMENT METHODOLOGOES FOR NON-PLAN SERVICES FOR EPSDT ELIGIBLE INDIVIDUALS

a. Reimbursement of services for organ transplant patients, whether EPSDT eligible or not, are described below in Attachment 4.19-B, item 12 titled "Reimbursement Methodologies for organ transplants".

b. Chiropractor Services

Payment for chiropractor services shall not exceed the Medicare fee schedule for provider's participating in Medicare.

c. Private Duty Nursing, Personal Care, and Case Management Services

Reimbursement for these services shall be made according to the rates established by the Department.

12. REIMBURSEMENT METHODOLOGIES FOR ORGAN TRANSPLANTS

Reimbursement for services related to organ transplants will be made by a contractor selected by the State. The contractor will also be responsible to coordinate and manage transplant services.

a. Reimbursement of services related to organ transplants will be negotiated with providers by the contractor and will be approved by the State. The negotiated case rate will not exceed Medicare or prevailing regional market rates.

b. Reimbursement of services that are not related to organ transplants shall be the lower of the actual amount billed by the provider or the fee in the Hawaii Medicaid Fee Schedule, either of which will not exceed the Medicare upper payment limit or the rate established by the Department.

Citation: 42 CFR 434, 438 and 447; and Social Security Act 1902(a)(4), 1902(a)(6), and 1903

Payment Adjustment for Provider Preventable Conditions.

The Medicaid agency meets the requirements of 42 CFR Part 447, Subpart A, and sections 1902(a)(4),1902(a)(6), and 1903 with respect to non-payment for provider-preventable conditions.

Other Provider-Preventable Conditions.

The State identifies the following Other Provider-Preventable Conditions for non-payment under section 4.19-B.

☒ Wrong surgical or other invasive procedure performed on a patient; surgical or other invasive procedure performed on the wrong body part; surgical or other invasive procedure performed on the wrong patient.

☐ Additional Other Provider-Preventable Conditions identified below of the plan:

Adjustment of outpatient/non-institutional reimbursement to account for non-payment of OPPCs.

In accordance with 42 CFR 447.26(c), no reduction in payment for a Provider Preventable Condition (PPC) will be imposed on a provider when the condition defined as a PPC for a particular patient existed prior to the initiation of treatment for that patient by that provider. Reductions in provider payment are limited to the extent that the State can reasonably isolate for non-payment, the portion of the payment directly related to treatment for, and related to, the PPC that would otherwise result in an increase in payment.

The Med-QUEST Division will utilize medical review to identify potential OPPCs on claims. For claims with identified OPPCs that were not previously existing, reimbursement associated with the OPPC will be recovered.

Lastly, in accordance with 42 CFR 447.26(c)(5), non-payment for OPPCs shall not prevent access to medically necessary covered services for Medicaid recipients.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

Except for a nominal recipient copayment (as specified in Attachment 4.18 of this State plan), if applicable, the Medicaid agency uses the following general method for payment:

1. Payments are limited to State plan rates and payment methodologies for the groups and payments listed below and designated with the letters "SP".

   For specific Medicare services which are not otherwise covered by this State plan, the Medicaid agency uses Medicare payment rates unless a special rate or method is set out on Page 3 in item ___ of this attachment (see 3. below).

2. Payments are up to the full amount of the Medicare rate for the groups and payments listed below, and designated with the letters "MR."

3. Payments are up to the amount of a special rate, or according to a special method, described on Page 3 in item ___ of this attachment, for those groups and payments listed below and designated with the letters "NR".

4. Any exceptions to the general methods used for a particular group or payment are specified on Page 3 in item ___ of this attachment (see 3. above).

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OTHER TYPES OF CARE

Payment of Medicare Part A and Part B Deductible / Coinsurance

QMBs:	Part A	NR	Deductibles	NR	Coinsurance
	Part B	NR	Deductibles	NR	Coinsurance
Other Medicaid Recipients	Part A	NR		NR	Coinsurance
	Part B	NR		NR	Coinsurance
Dual Eligibles (QMB Plus)	Part A	NR	Deductibles	NR	Coinsurance
	Part B	NR	Deductibles	NR	Coinsurance

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

METHODS AND STANDARD FOR ESTABLISHING PAYMENT RATES – OTHER TYPE OF CARE

Payment of Medicare Part A and Part B Deductible/Coinsurance

For all inpatient and outpatient hospital services payments are limited to State plan rates and payment methodologies.

For all other services, payments are up to the full amount of the Medicare rate.

For FQHC services that are covered under Medicare and Medicaid, payments will be paid first by Medicare and the difference by Medicaid, up to the States payment limit.

Reimbursement for outpatient services provided outside the FQHC or RHC facility site shall be limited to Qualified Medicare Beneficiary Plus (QMB Plus) and Full Benefit Dual Eligibles (FBDEs) up to the State Plan limit.

PHYSICIAN SERVICES

The state will reimburse for services provided by certain primary care physicians as if the requirements of 42 C.F.R. 447.400, 447.405 and 447.410 were still in effect.

☐ The rates reflect all Medicare sites of service adjustments.
☒ The rates do not reflect site of service adjustments, but reimburse at the Medicare rate applicable to the office setting.
☒ The rates reflect all Medicare geographic/locality adjustments.
☐ The rates are statewide and reflect the mean value over all counties for each of the specified evaluation and management and vaccine billing codes.

The following formula was used to determine the mean rate over all counties for each code: _____

Method of Payment

☐ The state has adjusted its fee schedule to make payment at the higher rate for each E&M and vaccine administration code.
☒ The state reimburses a supplemental amount equal to the difference between the Medicaid rate in effect on the date of service as published in the agency's fee schedule described in Attachment 4.19-B, page 1, under Physician Services of the Medicaid State Plan and the minimum payment required at 42 C.F.R. 447.405.

Supplemental payment is made: ☐ monthly ☒ quarterly

Primary Care Services Affected by this Payment Methodology

☐ This payment applies to all Evaluation and Management (E&M) billing codes 99201 through 99499.
☒ The State did not make payment as of July 1, 2009 for the following codes and will not make payment for those codes under this SPA (specify codes).

Description	Code
Hospital Inpatient	
Subsequent Observation Care, 15 minutes	99224
Subsequent Observation Care, 25 minutes	99225
Subsequent Observation Care, 35 minutes	99226
Consultations* Eliminated by Medicaid on June 1, 2010	
Office/Outpatient New or Established patients, 15 minutes	99241
Office/Outpatient New or Established patients, 30 minutes	99242
Office/Outpatient New or Established patients, 40 minutes	99243
Office/Outpatient New or Established patients, 60 minutes	99244
Office/Outpatient New or Established patients, 80 minutes	99245
Inpatient New or Established patients, 20 minutes	99251
Inpatient New or Established patients, 40 minutes	99252
Inpatient New or Established patients, 55 minutes	99253
Inpatient New or Established patients, 80 minutes	99254
Inpatient New or Established patients, 110 minutes	99255
Standby Services	
Stand-by service requiring prolonged attendance, each 30 minutes	99360

Description	Code
Interdisciplinary Conferences	
Medical team conference with interdisciplinary team (IDT) of health care professionals, face to face with patient or family, 30 minutes or more, participation by non-physician qualified health professional	99366
Medical team conference with interdisciplinary team (IDT) of health care professionals, patient or family not present, 30 minutes or more, participation by non-physician qualified health professional	99367
Participation by non-physician qualified health professional	99368
Care Plan Oversight: Patient under care of Home Health Agency (HHA), Hospice, or Nursing Facility (NF)	
Supervision of a patient under care of HHA; 15-29 min	99374
Supervision of a patient under care of hospice; 15-29 min	99377
Supervision of a patient under care of NF; 15-29 min	99379
Supervision of a patient under care of NF; 30 min or more	99380
Counseling Services: Risk Factor and Behavior Change	
Preventative medicine counseling and/or risk factor reduction intervention(s) provided to an individual: approximately 15 min	99401
Preventative medicine counseling and/or risk factor reduction intervention(s) provided to an individual: approximately 30 min	99402
Preventative medicine counseling and/or risk factor reduction intervention(s) provided to an individual: approximately 45 min	99403
Preventative medicine counseling and/or risk factor reduction intervention(s) provided to an individual: approximately 60 min	99404
Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT,DAST) and brief intervention; 15 to 30 min	99408
Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT,DAST) and brief intervention; greater than 30 min	99409
Preventative medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting; approximately 30 min	99411
Preventative medicine counseling and/or risk factor reduction intervention(s) provided to individuals in a group setting; approximately 60 min	99412
Administration and integration of health risk assessment instrument (e.g., health hazard appraisal)	99420
Telephone calls for Patient Management	
Telephone evaluation and management services; 5 to 10 minutes of medical discussion	99441
Telephone evaluation and management services; 11 to 20 minutes of medical discussion	99442
Telephone evaluation and management services; 21to 30 minutes of medical discussion	99443
Online Patient Management Services	
Online evaluation and management services performed with an already established patient not originating from a previous E&M within the previous 7 days	99444
Life/Disability Insurance Eligibility Visits	
Basic Life/Disability examination	99450
Work Related/Medical Disability examination by a physician	99455
Work Related/Medical Disability examination by a non-physician	99456

Critical Care Transport Age 24 months or younger	
Supervision by a control physician of interfacility transport care; first 30 minutes	99485
Supervision by a control physician of interfacility transport care; each additional 30 minutes	99486
Coordination of Complex Services for Chronic Care	
Complex chronic care coordination services, first hour of clinical staff time, directed by the physician or other qualified health care professional with no face-to-face visit, per calendar month	99487
Complex chronic care coordination services, first hour of clinical staff time, directed by the physician or other qualified health care professional with one face-to-face visit, per calendar month	99488
Complex chronic care coordination services, each additional 30 minutes of clinical staff time, directed by the physician or other qualified health care professional per calendar month	99489
Management of Transitional Care Services	
Transitional care management services with the patient or caregiver within two (2) business days of discharge. Medical decision making of at least moderate complexity during face-to-face visit within 14 calendar days of discharge	99495
Transitional care management services with the patient or caregiver within two (2) business days of discharge. Medical decision making of at least moderate complexity during face-to-face visit within 7 calendar days of discharge	99496

☐ The state will make payment under this SPA for the following codes which have been added to the fee schedule since July 1, 2009 (specify code and date added).

_____

_____

Physician Services – Vaccine Administration

The state reimburses vaccine administration services furnished by primary care physicians meeting the requirements of 42 C.F.R. 447.400 at the state regional maximum administration fee set by the Vaccines for Children (VFC) program.

All vaccine administration services, unless otherwise specified, regardless of billing code, the rate is $4.00.

Documentation of Vaccine Administration Rates in Effect on or after 10/15/22

The state will pay the Monkey Pox vaccine administration rate using the Medicare geographic rate for COVID-19 vaccine administration.

Effective Date of Payment

Evaluation & Management Services (E&M)

This reimbursement methodology applies to services delivered on and after October 15, 2022. All rates are published at https://medquest.hawaii.gov/en/plans-providers/fee-for-service/fee-schedules.html

Vaccine Administration

This reimbursement methodology applies to services delivered on and after October 15, 2022. All rates are published at https://medquest.hawaii.gov/en/plans-providers/fee-for-service/fee-schedules.html

Child and Adolescent Mental Health Division (CAMHD) Fee Schedule

CODE	DESCRIPTION	MODIFER	PROVIDER TYPE	UNIT	MQD rate billed to CAMHD
A0100	Transportation-Ground (car rental not included)				By report
A0140	Transportation-Air Travel	UC-client U1-first family member or attendant **No modifier**-In State TN Out of State			By report
A0180	Transportation-Lodging for attendant			per diem	By report
A0190	Transportation-Meals for attendant			per diem	By report
H0017	Behavioral health, residential (HBR) (hospital residential treatment program), without room and board, per diem		ALL	Per diem	$960.96
H0018	Transitional Family Home (TFH)		ALL	Per Diem	$211.80
H0018	Transitional Family Home (TFH)-Bed Hold	**HA** – Bedhold	ALL		$211.80
H0018	Transitional Family Home (TFH)-Therapeutic Pass	**HK** – Therapeutic Pass	ALL		$211.80
H0019	Residential treatment program where stay is typically longer than 30 days), without room and board, per diem Residential treatment for adolescents, out-of-state. (CBR OOS)	**HK** – Bed hold **HA** – Therapeutic Pass	**ALL**	Per diem	$236.14
H0019	Residential treatment program where stay is typically longer than 30 days), without room and board, per diem Residential treatment for adolescents that have sexually offended; most	**U1**-Medicaid level of care 1, as defined by each state **HA** – Bed hold **HK** – Therapeutic Pass	ALL	Per diem	$236.14

	often court ordered. (CBR1)				
H0019	Residential treatment program where stay is typically longer than 30 days), without room and board, per diem Residential treatment for adolescents with sexualized behaviors; not adjudicated (CBR2)	**U2**-Medicaid level of care 2, as defined by each state **HA** – Bed hold **HK** – Therapeutic Pass	ALL	Per diem	$236.14
H0019	Residential treatment program where stay is typically longer than 30 days), without room and board, per diem General residential treatment services (CBR3)	**U3**-Medicaid level of care 3, as defined by each state **HA** – Bed hold **HK** – Therapeutic Pass	ALL	Per diem	$236.14
H0019	Residential treatment program where stay is typically longer than 30 days without room and board per diem General residential treatment services (CBR3 SA)	**U4**-Medicaid level of care 4, as defined by each state **HA** – Bed hold **HK** – Therapeutic Pass	ALL	Per diem	$236.14
H0019	Residential treatment program where stay is typically longer than 30 days without room and board per diem Residential treatment services for girls sex traffic confirmed and at risk. (CBR3 CSEC)	**U5**-Medicaid level of care 5, as defined by each state **HA** – Bed hold **HK** – Therapeutic Pass	ALL	Per diem	$236.14
H0019	Residential treatment program where stay is typically longer than 30	**U6**-Medicaid level of care 6, as defined by each state	ALL	Per diem	$236.14

	days without room and board per diem Residential Crisis Stabilization Program limited to 30 days. (RCSP)	**HA** – Bed hold **HK** – Therapeutic Pass			
H0019	Community-Based Residential treatment- where stay is 30-60 days and treats youth who do not meet criteria for inpatient acute hospital level of care, and are near that threshold of treatment. Provided in either a hospital or outpatient residential setting. (Subacute)	**U7-Medicaid level of care 7 as defined by each state** **HA** – Bed hold **HK** – Therapeutic Pass	ALL	Per diem	S236.14
H0035	Intensive Outpatient Hospitalization (IOH) Also known as Partial Hospitalization or day treatment, the youth go from their residence to the program during the day.		ALL	Per Diem	$286.11
H0036	Community psychiatric supportive treatment face-to-face, per 15min Intensive In-Home Intervention	**HO** **95**	**MHP** (Mental Health Professional)	15 min	$24.15
H0036	Community psychiatric supportive treatment face-to-face, per 15min Intensive In-Home Intervention	**HN** **95**	**PARA** (PARA Professional)	15 min	$14.04
H0036	Community psychiatric supportive treatment face-to-face, per 15min Intensive Independent Living Skills The same as above with an	**HP** **HE** **95**	QMHP	15 min	$27.15