

## STATE PLAN UNDER TITLE XIX FOR THE SOCIAL SECURITY ACT

State/Territory: HAWAIIRequirements for Third Party Liability -  
Identifying Liable Resources

- 1) The frequency of data exchanges are as follows: State wage information collection agency (SWICA) - Monthly; SSA wage and earnings files - semi-annual; State Title IV-A agency - weekly; State workers' Compensation - quarterly; state motor vehicle accident report files - N/A (see 42 CFR 433.138 (d)(5)). Diagnosis and trauma code edits are conducted simultaneously as claims are processed.
- 2) Within 30 days, follow-up (when appropriate) on data exchange is made in order to identify legally liable third party resources and incorporate such information into the eligibility case file and into its third party data base so the agency may process claims under the third party liability payment procedures specified in Section 433.139(b) through (f). The method is by personal contact with the applicant/recipient by the eligibility worker to investigate eligibility under the third party resource.

Health insurance information and workers' compensation data exchange information follow-up (when appropriate) will be conducted within sixty (60) days in order to identify legally liable third party resources and incorporate such information into the eligibility case file and into its third party data base so the agency and QUEST Health Plans may process claims under the third party liability payment procedures specified in Section 433.139 (b) through (f).

- 3) See item 1 above.
- 4) With the exception of code 994.6, action is taken to identify those paid claims for Medicaid recipients that contain diagnosis codes 800 through 999 and "e" prefix codes (ICDCM) International Classification of Disease, 9th Revision Clinical Modification (Volume 1), inclusive for the purpose of determining the legal liability of third parties so that the agency may process claims under the third party liability procedures specified in Section 433.139 (b) through (f).

Diagnosis codes that yield the highest third party collections are identified yearly and given highest priority for follow-up.

When a recipient who is receiving medical assistance is involved in an accident and medical treatment is necessary, the recipient is required to notify the Caseworker within ten (10) days. The DHS Forms 1125 (Assignment of Payment) and 1125A (Accident Report) are completed by the Caseworker and sent to the State Agency's Third Party Liability (TPL) Medical Recovery Unit for review. If a liable third party is identified, a medical lien is developed and notarized by the TPL Medical Recovery Unit and sent to the liable third party by certified mail. For Medicaid recipients, the medical expenses incurred information is obtained from the MMIS. For Quest Health Plan recipients, the medical expense incurred information is obtained from the Quest Health Plan.

If a recipient receives medical treatment for an accident and fails to report the accident to the Caseworker, an accident letter is generated and sent to the recipient when a \$500 or more of medical expenses are paid. The accident letter instructs the recipient to report the accident to the Caseworker. The recipient who is injured in the accident is identified by the diagnosis code(s) on the claim. (See item 4 above). Accident letters are generated on a quarterly basis.

A TPL subrogation code 41 is entered in the recipient's eligibility file by the Caseworker when the accident is reported by the recipient.

To ensure that medical expenses are recovered, Attorneys representing a claimant, by statute, must make a reasonable inquiry with the Department as to whether the claimant has received medical assistance or is receiving medical assistance related to the incident. Before the release of any award or settlement proceeds, the claimant, attorney, or representative must notify the Department immediately. If notification is received, the TPL Medical Recovery Unit takes immediate action to obtain the medical expense incurred information from the Quest Health Plan or Medicaid Program (MMIS) and pursues recovery.

STATE PLAN UNDER TITLE XIX FOR THE SOCIAL SECURITY ACT

TN No. 96-011

Supersedes

TN No. 95-010

Approval Date: MAR 06 1997

Effective Date: NOV 25 1996



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Hawaii

STATE LAWS REQUIRING THIRD PARTIES TO PROVIDE  
COVERAGE ELIGIBILITY AND CLAIMS DATA

1902(a)(25)(I)      The State has in effect laws that require third parties to comply with the provisions, including those which require third parties to provide the State with coverage, eligibility and claims data. These laws comply with the provisions of Section 202 of the Consolidated Appropriations Act of 2022.

State/Territory: Hawaii

Requirements for Third Party Liability -  
Payment of Claims

- (d)(1) Claims for services covered the State Plan that is provided to an individual on whose behalf child support enforcement is being carried out by the state Title IV-D Agency are paid if the provider certifies that before billing Medicaid, the provider has waited 30 days from the date of service and has not received payment from the third party. The methods used to determine the providers' compliance with the above billing requirements are:
- (a) The claim received date must be more than 30 days from the date of service;
  - (b) Provider must certify in writing that the TPL was billed and more than 30 days have elapsed; and
  - (c) Confirmation is made with the TPL on a sample basis to monitor that the provider filed a claim and payment has yet to be made.
- (2) All third party resources available to a recipient are ascertained and this TPL data is entered in the recipient's eligibility file. A provider must seek all reimbursements from the liable third party prior to Medicaid payments. Claims must be filed within a year from the date of service and only the amount remaining after third party coverage is reimbursable.
- Post payment recovery is initiated when a previously unknown third party resource becomes known. A refund is requested and if after two (2) notices, no refund is received, pending claims by a provider may be reduced by the amount of liability.
- (3) A threshold amount of \$500 is used in determining whether to seek reimbursement from a liable third party for accident or accident related cases involving liens or court action. Any liability below this amount is not pursued as non-cost effective. No specific time limits are applicable The Attorney General determines at which point in time to discontinue efforts to seek reimbursements.

For recipients' under managed care (Hawaii QUEST), the State assumes responsibility for recovery.

- (e) The Medicaid agency ensures that in the case of individuals who are eligible for medical assistance under the plan for service(s) which a third party or parties are liable for payment, if the total amount of the established liability of the third party or parties for the service is:
- (1) Equal to or greater than the amount payable under the State Plan (which includes, when applicable, cost -sharing payments), the provider furnishing the services to the individual may not seek to collect from the individual(or any financially responsible relative or representative of that individual) any payment amount for that service; or
  - (2) Less than the amount payable under the State Plan (including cost sharing payments) the provider furnishing the service to that individual may collect from the individual (or any financially responsible relative or representative of the individual) an amount wqhich is the lesser of:
    - (a) Any cost-sharing payment amount imposed upon the individual ; or
    - (b) An amount which represents the difference between the amount payable under the State Plan (which includes, when applicable, cost-sharing payments) and the total of the established third party liability for the services (s). This claim payment function is accomplished on a claim by claim basis when reported by the caseworker, client, or provider.

The Medicaid agency also ensures that providers do not refuse to furnish services covered under the plan to an individual who is eligible for medical assistance under the plan on account of a third party's potential liability for the service(s). The methods used to ensure compliance are:

- (1) By written notification in Medicaid Newsletter; and
- (2) By pursuing enforcement when refusal to furnish services are reported by individuals to the State Agency.

## State of Hawaii

## REQUIREMENTS FOR THIRD PARTY LIABILITY- PAYMENT OF CLAIMS

(i) The Medicaid agency ensures compliance with the TPL requirements authorized under both the Bipartisan Budget Act (BBA) of 2018 (Pub. L. 115-123) and the Medicaid Services Investment and Accountability Act (MSIAA) of 2019 (Pub. L. 116-16 affecting the BBA of 2013).

Citation Requirements for Third Party liability Payment of Claims

42CFR433.139(b) (3) (ii) (C) (1) The State will pay and chase third parties when services covered under the plan are furnished to an individual on whose behalf child support enforcement is being carried out by the State Title IV-D Agency.

For such claims, the State will only authorize payment under the following conditions:

- a. Up to 100 days have elapsed from the date of service.
- b. The provider billed the third-party.
- c. Documentation is attached verifying that a. and b. have been met.

The State will monitor the pay and chase system for such claims for improper billings made by providers and take appropriate corrective action.  
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42CFR433.139(b) (3) (ii) (B) (2) Providers who have billed a third party prior to billing Medicaid must certify on the Medicaid claim that a third party has been billed, that claim has been fully adjudicated by the third party, and that payment has not been received by Medicaid.

Section 1902(a) (25) (E) (3) The State shall make payments without regard to third party liability for

pediatric preventive services unless a determination related to cost-effectiveness and access to care that warrants cost avoidance for up to 90 days has been made.

Section 1902(a) (25) (E) (4) The State shall use standard coordination of benefits cost avoidance when processing claims for prenatal services, including labor and delivery and postpartum care claims.

<b>TN No.</b>	<u>21-0017</u>	<b>Approval</b>	<b>Effective Date:</b>	<u>12/31/2021</u>
<b>Supersedes</b>		<b>Date:</b>	<u>01/21/2022</u>	
<b>TN No.</b>	<u>NEW</u>			

State/Territory: STATE OF HAWAII

Citation

Sanctions for Psychiatric Hospitals

1902(y)(1),  
1902(y)(2)(A),  
and Section  
1902(y)(3)  
of the Act  
(P.L. 101-508,  
Section 4755(a)(2))

1902(y)(1)(A)  
of the Act

1902(y)(1)(B)  
of the Act

1902(y)(2)(A)  
of the Act

- (a) The State assures that the requirements of section 1902(y)(1), section 1902(y)(2)(A), and section 1902(y)(3) of the Act are met concerning sanctions for psychiatric hospitals that do not meet the requirements of participation when the hospital's deficiencies immediately jeopardize the health and safety of its patients or do not immediately jeopardize the health and safety of its patients.
- (b) The State terminates the hospital's participation under the State plan when the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies immediately jeopardize the health and safety of its patients.
- (c) When the State determines that the hospital does not meet the requirements for a psychiatric hospital and further finds that the hospital's deficiencies do not immediately jeopardize the health and safety of its patients, the State may:
1. terminate the hospital's participation under the State plan; or
  2. provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding; or
  3. terminate the hospital's participation under the State plan and provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the effective date of the finding.
- (d) When the psychiatric hospital described in (c) above has not complied with the requirements for a psychiatric hospital within 3 months after the date the hospital is found to be out of compliance with such requirements, the State shall provide that no payment will be made under the State plan with respect to any individual admitted to such hospital after the end of such 3-month period.

State: HAWAIICitation:1932(e)  
42 CFR 428.726Sanctions for MCOs and PCCMs

- (a) The State will monitor for violations that involve the actions and failure to act specified in 42 CFR Part 438 Subpart I and to implement the provisions in 42 CFR 438 Subpart I, in manner specified below:

The State of Hawaii's contracted EQRO and Med-QUEST Staff will perform annual reviews and evaluations in regards to compliance with State guidelines that may be imposed on the organization when the contractor fails to act or meet compliance with Medicaid guidelines included in 1903 (m) 1932 (e) (1) 42 CFR. The EQRO and the State have developed an extensive quality review tool that will be used to monitor and evaluate compliance with Medicaid rules and regulations.

The evaluations will be based on the following: on-site meetings with the contracted organization, review of appeals and grievances, provider complaints, recipient encounter data, and provider network submission, review of recipient and provider surveys, quality improvement projects, financial audits, State BBA Quality Strategies, etc.

Contracts include a description of the State's plan to monitor performance and if the contracted organization is not in compliance, the State will require a corrective action plan that will be closely monitored by the EQRO and the State Med-QUEST staff. If the contractor is not compliant with the corrective action plan, the State will move to more severe penalties.

Civil monetary penalties may be implemented, the contract may be terminated, or the State may impose temporary management upon the contracted organization if it finds that a contractor has repeatedly failed to meet substantive requirements in section 1903 (m) or section 1932 of the Act.

TN No. 03-003

Supersedes

TN No. \_\_\_\_\_

Approval Date: MAR 2 2004

Effective Date:

AUG 1 3 2004

State: HAWAII

- (b) The State uses the definition below of the threshold that would be met before an MCO is considered to have repeatedly committed violations of section 1903(m) and thus subject to imposition of temporary management:

Optional Imposition of Sanction:

The State may impose temporary management only if it finds (through on-site survey, enrollee complaints, financial audits, or any other means) that:

- There is continued egregious behavior by the contractor, including but not limited to behavior that is described in 42 CFR 438.700, or that is contrary to any requirements of section 1903(m) and 1932 of the Act;
- There is substantial risk to recipient's health; or
- The sanction is necessary to ensure the health of the contractor's recipients while improvements are made to remedy violations under 42 CFR 438.700.

The temporary management will remain in place until improvements are made to remedy violations or until there is an orderly termination or reorganization of the organization.

Required Imposition of Sanction

The State must impose temporary management (regardless of any other sanction that may be imposed) if it finds that the contracted organization repeatedly failed to meet substantive requirements in section 1903 (m) or section 1932 of the Act, or Subpart 42 CFR 438.706.

The required imposition of the Sanction will remain until the State determines that the contracted provider can ensure that the sanctioned behavior will not recur.

TN No. 03-003

Supersedes

TN No. \_\_\_\_\_

Approval Date: MAR 2 2004

Effective Date: AUG 13 2003



State: HAWAII

- (c) The State's contracts with MCOs provide that payments provided for under the contract will be denied for new enrollees when, and for so long as, payment for those enrollees is denied by CMS under 42 CFR 438.730(e).

Not applicable; the State does not contract with MCOs, or the State does not choose to impose intermediate sanctions on PCCMs.

TN No. 03-003

Supersedes

TN No. \_\_\_\_\_

Approval Date: MAR 2 2004Effective Date: AUG 13 2009

Revision: HCFA-PH-86-9 (BERC)  
MAY 1986

ATTACHMENT 4.32-A  
Page 1  
OMB NO.: 0938-0193

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Hawaii

INCOME AND ELIGIBILITY VERIFICATION SYSTEM PROCEDURES  
REQUESTS TO OTHER STATE AGENCIES

Any additional income, resource, or eligibility information concerning STATE applicants and recipients is routinely requested and verified from agencies within STATE and other States administering the programs described in 42 C.F.R. 435.948(a)(6).

TN No. 86-13  
Supersedes  
TN No. 82-2

Approval Date 5/1/87

Effective Date 10/1/86

HCFA ID: 0123P/0002P

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

METHOD FOR ISSUANCE OF MEDICAID ELIGIBILITY CARDS  
TO HOMELESS INDIVIDUALS

1. Arrangement may be made to have the individual report to the district office to pick up the card.
2. The card may be mailed "General Delivery" to the individual to the post office designated by the individual.
3. The card may be mailed to the individual at an address in care of whomever the individual may designate.
4. The card may be mailed to a facility for homeless individuals where the person may call for his mail.

TN No. 87-X 8  
Supersedes  
TN No. 8

Approval Date JUL 23 1987

Effective Date 04/01/8

HCFA ID: 1080P/O

## ATTACHMENT 434

State/Territory: HAWAII

Waiver granted accordance with section 121(c)(4)(B) of the Immigration Reform and Control Act of 1986. This waiver does not apply to the Citizen/Alien declaration required by IRCA. Waiver was granted in 11/93.

The State will continue to verify alien status through the Citizen/Alien declaration and verification of alien documents. Alien status will be verified as a condition of eligibility.

TN No. 97-006

Supersedes

TN No. \_\_\_\_\_

Approval Date DEC 1 1997Effective Date OCT - 1 1997

**SUMMARY OF HAWAII STATE LAW REGARDING  
AN INDIVIDUAL'S RIGHT TO MAKE MEDICAL TREATMENT DECISIONS**

(Hawaii Revised Statutes, Section 327D)  
(As amended by Act 321, effective July 1, 1991)

November 1, 1991

1. Hawaii has adopted a strong public policy in favor of the person's right to accept or refuse treatment. Hawaii law provides that "all competent persons have the fundamental right to control the decisions relating to their own medical care, including the decision to have medical or surgical means or procedures calculated to prolong their lives provided, continued, withheld or withdrawn. The artificial prolongation of life for persons with a terminal condition or a permanent loss of the ability to communicate concerning medical treatment decisions, may secure only a precarious and burdensome existence, while providing nothing medically necessary or beneficial to the person."

2. A competent adult may make their own health care decisions. Hawaii law permits a competent adult (age 18 or over) to make a written declaration in advance (often called a living

*Summary of Hawaii Law Regarding  
Medical Treatment Decisions/Living Wills  
Executive Office on Aging/Department of Human Services  
November 1, 1991*

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will or advance directive), instructing his or her physician to provide, withhold or withdraw life-sustaining procedures under certain conditions, such as a terminal condition or where the patient has a permanent loss of ability to communicate with others due to irreversible brain injury or coma. In other words, the person has a right to choose: the person can request all available treatment in order to stay alive as long as possible, or the person can refuse some or all treatment -- even if the treatment might keep the person alive or prolong their life.

3. How is the advance directive/living will executed? The person's written instructions must be signed by them or by someone else in the person's presence and at their instruction. It must be witnessed by two witnesses not related to the person and not currently involved with the person's medical care. The signature's of the person and the two witnesses must be notarized (all at the same time).

4. The person's instructions do not have to be in writing, but it is strongly preferred. Although written advance directives are preferable, they are not required. Hawaii law also recognizes a "verbal statement or statements if they are consistent, made by the patient to either a physician or to the patient's friend or relative." Such statement(s) "may be considered by the physician

*Summary of Hawaii Law Regarding  
Medical Treatment Decisions/Living Wills  
Executive Office on Aging/Department of Human Services  
November 1, 1991*

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in deciding whether the patient would want the physician to withdraw or to withhold life-sustaining procedures." However, as a general proposition, there is less doubt and potential confusion with written directives. It is sound policy to encourage written advance directives instead of verbal ones if the person has any interest in making their health care wishes known in advance.

5. The person's medical record. The living will or advance directive is to be made a part of the person's medical record, and all inpatient health care facilities must develop a system to visibly identify when a patient's chart contains an advance directive. A copy of the person's living will or advance directive should normally be sufficient (at least for filing purposes). The Hawaii law does not require that an original be in each of the patient's various medical files.

6. What the physician has to do. An attending physician who is aware and in possession of the patient's advance directive shall immediately take steps to certify that the patient is now in the condition described in the person's living will. Thereafter, the attending physician must a) follow as closely as possible the terms of the patient's directive, or b) if the physician is not willing to comply with the patient's advance directive, the physician must arrange for transfer of the patient to another physician's care



*Summary of Hawaii Law Regarding  
Medical Treatment Decisions/Living Wills  
Executive Office on Aging/Department of Human Services  
November 1, 1991*

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without unreasonable delay.

7. Revocation. Hawaii law makes it easy for the patient to revoke his or her advance directive, and the patient may revoke it at any time after it was executed, by various methods (both written and verbal), including:

- \* the declarant's causing it to be torn, defaced, or otherwise destroyed, or
- \* by executing a written revocation, or
- \* by the declarant's unambiguous verbal statement, in front of two adult witnesses, of the declarant's intent to revoke, or
- \* by the declarant's unambiguous verbal expression to an attending physician.

8. Euthanasia. Nothing in the Hawaii law is intended to condone, authorize, or approve mercy killings or euthanasia.

9. Effect upon life insurance/suicide. Compliance with the terms of a person's advance directive does not constitute suicide nor modify the terms of an existing policy of life insurance.

10. If there is no valid advance directive. Hawaii law also has a "catch-all" provision. In the absence of a valid advance directive, "ordinary standards of current medical practice will be followed."

11. Other states. Hawaii law recognizes living wills executed

*Summary of Hawaii Law Regarding  
Medical Treatment Decisions/Living Wills  
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November 1, 1991*

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in other states if the out-of-state document substantially complies with Hawaii law.

12. Durable Power-of-Attorney for Health Care. This is a document where the person appoints someone else (usually called a proxy, attorney-in-fact, or substitute decision-maker) to make some, many, or all medical treatment decisions for them, often including the right to make decisions to withhold or withdraw life-sustaining medical treatment. Hawaii law does not expressly authorize such a document, nor does Hawaii law expressly prohibit such a document; therefore, the law is not yet clear in Hawaii on whether such a document is legally enforceable. (Note: accordingly, until Hawaii law is more clear on this issue, the individual health care provider will set their own policies on whether or not to honor a Durable Power-of-Attorney for Health Care, including those executed in other states or countries. Consumers may wish to check with their own health care provider regarding their policy on this issue.)

13. Living Wills Executed Before July 1, 1991. If the person's living will is an "old" one (signed before the new Hawaii law went into effect on July 1, 1991), the old living will may seriously restrict the person's wishes and rights. (Note: therefore, it is good policy for any person with an "old" living

***Summary of Hawaii Law Regarding  
Medical Treatment Decisions/Living Wills  
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will to carefully review it. Then the person can take advantage of the new law -- if they want to -- by executing a new living will.)

14. Without reliable evidence of the patient's intentions or wishes, such as where there is no living will, no verbal statements, the patient is a minor, and where the patient is a now-incompetent person whose wishes were not made known while they were competent, a guardianship proceeding in court may be necessary.

15. This is merely a summary of the new Hawaii law. It does not address all possibilities or describe all of the law. For individual situations, your health care provider or other expert should be consulted.

Revision: HCFA-PM-93-4 (HSQB)  
JUNE 1995

ATTACHMENT 435-A

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State/Territory: STATE OF HAWAII

**ELIGIBILITY CONDITIONS AND REQUIREMENTS**

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**Enforcement of Compliance for Nursing Facilities**

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The State uses other factors described below to determine the seriousness of deficiencies in addition to those described at §488.404(b)(1):

**Not Applicable**

TN No. 95-005  
Supersedes  
TN No. 90-6

Approval Date: MAR 13 1997

Effective Date: 10/1/95

Revision: HCFA-PM-95-4 (HSQB)  
JUNE 1995

ATTACHMENT 435-B

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: STATE OF HAWAII

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Enforcement of Compliance for Nursing Facilities

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**Termination of Provider Agreement:** Describe the criteria (as required at §1919(h)(2)(A) for applying the remedy.

☒ Specified Remedy \*

(Will use the criteria and  
notice requirements specified  
in the regulation.)

- \* The criteria for the application  
of specified remedies are applied as  
described in Supplement to Attachment  
4.35-B through 4.35-G.

Revision: HCFA-PM-95-4 (HSQB)  
JUNE 1995

ATTACHMENT 435-C

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State/Territory: STATE OF HAWAII

**ELIGIBILITY CONDITIONS AND REQUIREMENTS**

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**Enforcement of Compliance for Nursing Facilities**

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**Temporary Management:** Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

☒ **Specified Remedy \***

(Will use the criteria and notice requirements specified in the regulation.)

☐ **Alternative Remedy**

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

- \* The criteria for the application of specified remedies are applied as described in Supplement to Attachment 435-B through 435-G.

Revision: HCFA-PM-95-4 (HSQB)  
JUNE 1995

ATTACHMENT 4.35-D

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State/Territory: STATE OF HAWAII

**ELIGIBILITY CONDITIONS AND REQUIREMENTS**

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**Enforcement of Compliance for Nursing Facilities**

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**Denial of Payment for New Admissions:**  
**§1919(h)(2)(A)) for applying the remedy.**

**Describe the criteria (as required at**

**X Specified Remedy \***

**Alternative Remedy**

**(Will use the criteria and  
notice requirements specified  
in the regulation.)**

**(Describe the criteria and  
demonstrate that the alternative  
remedy is as effective in deterring  
non-compliance. Notice requirements  
are as specified in the regulations.)**

**\* The criteria for the application  
of specified remedies are applied as  
described in Supplement to Attachment  
4.35-B through 4.35-G.**



Revision: HCFA-PM-95-4 (HSQB)  
JUNE 1995

ATTACHMENT 435-E

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State/Territory: STATE OF HAWAII

**ELIGIBILITY CONDITIONS AND REQUIREMENTS**

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**Enforcement of Compliance for Nursing Facilities**

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**Civil Money Penalty:** Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

☒ **Specified Remedy \***

(Will use the criteria and notice requirements specified in the regulation.)

☐ **Alternative Remedy**

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

- \* The criteria for the application of specified remedies are applied as described in Supplement to Attachment 435-B through 435-G.

Revision: HCFA-PM-95-4 (HSQB)  
JUNE 1995

ATTACHMENT 4.35-F

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Enforcement of Compliance for Nursing Facilities

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**State Monitoring:** Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

☒ Specified Remedy \*

(Will use the criteria and notice requirements specified in the regulation.)

☐ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

\* The criteria for the application of specified remedies are applied as described in Supplement to Attachment 4.35-B through 4.35-G.

Revision: HCFA-PM-95-4 (HSQB)  
JUNE 1995

ATTACHMENT 435-G

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Enforcement of Compliance for Nursing Facilities

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Transfer of residents; Transfer of residents with closure of facility: Describe the criteria (as required at §1919(h)(2)(A)) for applying the remedy.

☒ Specified Remedy \*

(Will use the criteria and notice requirements specified in the regulation.)

☐ Alternative Remedy

(Describe the criteria and demonstrate that the alternative remedy is as effective in deterring non-compliance. Notice requirements are as specified in the regulations.)

- \* The criteria for the application of specified remedies are applied as described in Supplement to Attachment 4.35-B through 4.35-G.

Revision: HCFA-PM-95-4 (HSQB)  
JUNE 1995

ATTACHMENT 4.35-B

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**ELIGIBILITY CONDITIONS AND REQUIREMENTS**

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**Enforcement of Compliance for Nursing Facilities**

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**Additional Remedies:** Describe the criteria (as required at §1919(h)(2)(A)) for applying the additional remedy. Include the enforcement category in which the remedy will be imposed (i.e., category 1, category 2, or category 3 as described at 42 CFR 488.408).

**Not Applicable**

TN No. 95-005  
Supersedes  
TN No. \_\_\_\_\_

Approval Date: MAR 13 1997

Effective Date: 6/1/95

§17-1737-40 Remedies for nursing facilities that do not meet the requirements for participation. (a) The department shall impose one or more of the following remedies when a nursing facility does not meet one or more of the requirements of participation and its deficiencies constitute immediate jeopardy or widespread actual harm that does not constitute immediate jeopardy to the health and safety of its residents:

- (1) Remove the jeopardy and appoint temporary management to oversee correction of the deficiencies and assure the health and safety of the facility's residents while corrections are being made to bring the facility into compliance with all of the requirements of participation, or to oversee orderly closure of a facility.

- (A) Temporary management shall be state personnel, private individuals, or a team with education and requisite work experience in nursing home administration that qualifies the individual(s) to correct the deficiencies in the facility to be managed; and be licensed in accordance with state law. The following individuals are not eligible to serve as temporary managers:

- (i) Any individual who has been found guilty of misconduct by any licensing board or professional society in any state;
    - (ii) Has or whose immediate family members have any financial interest in the facility managed; or
    - (iii) Currently serves or, within the past two years, has served as a member of the staff of the facility;

- (B) Facility management must agree to relinquish control to the temporary manager and to pay his or her salary before the temporary manager can be installed in the facility. The facility cannot retain final authority to approve changes of personnel or expenditures of facility funds and be considered to have

- relinquished control to the temporary manager;
- (C) If the facility refuses to relinquish control to the temporary manager, the facility shall be terminated;
  - (D) A temporary manager has the authority to hire, terminate, or reassign staff, obligate facility funds, alter facility procedures, and otherwise manage a facility to correct deficiencies identified in the facility operation. The temporary manager must be given access to facility bank accounts that include receipts;
  - (E) A temporary manager may be imposed fifteen days after the facility receives notice, in non-immediate jeopardy situations; and two days after the facility receives notice, in immediate jeopardy situations; and
  - (F) Temporary management shall continue until a facility is terminated, achieves substantial compliance and is capable of remaining in substantial compliance, or decides to discontinue the remedy and reassumes management control before it has achieved substantial compliance, in which case the facility faces termination;
- (2) Assess civil money penalty, with interest, and impose civil money penalty for the number of days that a facility is not in substantial compliance with one or more participation requirements, regardless of whether or not the deficiencies constitute immediate jeopardy and for the number of days of past noncompliance since the last standard survey, including the number of days of immediate jeopardy.
- (A) Civil money penalties may be imposed as a remedy for past noncompliance that is corrected at the time of the current survey. Situations for consideration of a civil money penalty may include, but may not be limited to, facilities that cannot consistently sustain substantial compliance with the requirements as noted in the facility-specified reports,

- substantiated complaints, or situations which indicate that the facility did not act to prevent a situation of noncompliance from occurring;
- (B) The amount of the civil money penalty shall be on the lower range of \$50 to \$3,000 per day or on the upper range of \$3,050 to \$10,000 per day: A civil money penalty shall not be less than \$50;
  - (C) Factors to be considered in determining the amount of the civil money penalty are:
    - (i) The facility's history of noncompliance, including repeated deficiencies;
    - (ii) The facility's financial condition;
    - (iii) Seriousness and scope of the deficiencies;
    - (iv) Likelihood that the civil money penalty will achieve correction and continued compliance;
    - (v) The facility's degree of culpability; and
    - (vi) Any other remedies being imposed in addition to the civil money penalty;
  - (D) All funds collected as a result of these civil money penalties shall be applied to the protection of the health and property of the residents of the facility;
  - (E) The funds shall be used for:
    - (i) Payment for the cost of relocating residents to other facilities;
    - (ii) State costs related to the maintenance or operation of a facility pending correction of deficiencies or closure;
    - (iii) Reimbursement of residents for personal funds or property lost as a result of actions by the facility or by individuals used by the facility to provide services to residents; and
    - (iv) Other costs related to the health and property of the residents, such as, the cost of having resident



medical records sealed, secured, and stored; the cost of picking up and transferring or delivering resident medications or drugs; the cost of using ambulance service; and etc.;

- (F) The civil money penalty may start accruing as early as the date the facility was first out of compliance, as determined by HCFA or the State. A civil money penalty cannot be collected until a provider requests a hearing. When no hearing is requested, payment of a civil money penalty will be due fifteen days after the time period for requesting a hearing has expired and a hearing request was not received or after the final administrative decision which includes a hearing and review; and
- (G) A notice of imposition of civil money penalty shall be sent to the facility and shall include the following information:
  - (i) Nature of the noncompliance (regulatory requirements not met);
  - (ii) Statutory basis for the penalty;
  - (iii) Amount of penalty per day of noncompliance;
  - (iv) Factors that were considered in determining the amount of the penalty;
  - (v) Date on which the penalty begins to accrue;
  - (vi) Statement that the penalty will stop accruing on the date on which that facility comes into substantial compliance or is terminated from participation in the program;
  - (vii) When the penalty shall be collected; and
  - (viii) Statement of the facility's right to a hearing and information regarding how to request a hearing, implications of waiving the right to a hearing, and information regarding how to waive the right to a hearing;

- (3) Close the nursing facility or transfer the residents to other facilities or both, to minimize the period of time during which residents are receiving less than adequate care.
- (A) A finding of immediate jeopardy will not require the State to close a facility and transfer residents. It may result in the immediate termination of provider agreement and the subsequent transfer of residents;
  - (B) During an emergency which relates to the facility's gross inability to provide care and related services because of fire, natural disaster, epidemic, or other conditions endangering the health and safety of the residents, the State may permanently or temporarily transfer residents to another facility until the original facility is again able to care for its residents; and
  - (C) Transfer requirements shall apply to only Medicare and Medicaid residents and not to private pay residents;
- (4) Terminate the nursing facility's Medicaid participation.
- (A) When there is immediate jeopardy to residents' health and safety, termination procedures shall be completed within twenty-three days from the last day of the survey which found the immediate jeopardy, if the jeopardy is not removed before then;
  - (B) When there is no immediate jeopardy, HCFA or the State may terminate a facility if the facility does not come into substantial compliance within six months of the date of the survey that found it to be out of substantial compliance; and
  - (C) Termination may be imposed by the State at any time when appropriate for any noncompliance. The facility's compliance history shall be taken into account when considering whether or not to terminate a facility's provider agreement;

- (5) Impose denial of payment for new admissions when a facility has been found to have provided substandard quality of care on the last three consecutive standard surveys, regardless of other remedies imposed.
- (A) Deny payment for all new admissions within the third month from the last day of the third consecutive survey.
  - (B) Facility shall be given written notice at least two days before the effective date in immediate jeopardy cases and at least fifteen days before the effective date in all others;
  - (C) Optional denial of payment for all new admissions shall be imposed only when the facility makes little or no effort to come into substantial compliance, e.g., when it fails to adhere to its plan of correction;
  - (D) Mandatory denial of payment for all new admissions shall be imposed when the facility is not in substantial compliance by the third month after the last day of the survey identifying the deficiency or when a provider has been found to have furnished substandard care on the last three consecutive standard surveys;
  - (E) The denial of payment remedy may be imposed at other times singly or in conjunction with other remedies, when a facility is not in substantial compliance;
  - (F) The denial of payments shall continue until the State has verified that the facility has achieved substantial compliance. Payment resumes prospectively from the date the State has determined that substantial compliance is achieved.
    - (i) When payment is denied for repeated instances of substandard quality of care, the remedy shall not be lifted until the facility is in substantial compliance and the State or HCFA believes that the facility will remain in substantial compliance; and

- (ii) If payment is denied for any other reason and, if a survey team finds written credible evidence that the facility corrected deficiencies or was in substantial compliance before the date the survey agency received the credible evidence, the remedy shall be lifted as of that date;
- (G) No payments shall be made for the period between the date the remedy was imposed and the date that substantial compliance was achieved; and
- (H) Residents admitted before and discharged before the effective date of the denial of payment are considered new admissions, if readmitted, and are subject to the denial of payment; and
- (6) State monitoring shall be imposed when a facility has been found on three consecutive standard surveys to have provided substandard quality of care.
  - (A) State monitoring shall oversee the correction of cited deficiencies in the facility as a safeguard against further harm to residents when harm or a situation with a potential for harm has occurred. State monitoring shall include:
    - (i) Providing special consultative services to a facility for obtaining the type of training and basic knowledge needed to achieve and remain in compliance with federal regulations or to attend an in-service training program likely to correct the deficiencies; and
    - (ii) Assisting in the development of an acceptable plan of correction;
  - (B) Situations when state monitoring may be appropriate include, but are not limited to, the following:
    - (i) Poor facility history, i.e., a pattern of poor quality of care, many complaints, etc.;
    - (ii) State agency concern that the situation in the facility has the potential to worsen;

- (iii) Immediate jeopardy exists and no temporary manager can be appointed or the facility refuses to relinquish control to a temporary manager. A monitor shall be imposed to oversee termination procedures and transfer of residents; or
  - (iv) The facility seems unable or unwilling to take corrective action for cited substandard quality of care;
  - (C) Monitoring may occur anytime in a facility, i.e., twenty-four hours a day, seven days a week, if necessary. In all instances, monitors shall have complete access to all areas of the facility as necessary for performance of the monitoring task; and
  - (D) State monitoring shall be discontinued when:
    - (i) The facility's provider agreement is terminated; or
    - (ii) The facility is terminated; or the facility has demonstrated to the satisfaction of HCFA or the State Agency, that the facility is in substantial compliance with the requirements and (if imposed for repeated substandard quality of care) that the facility will remain in substantial compliance.
- (b) The appeal and hearing provisions of chapter 17-1736 shall be available to providers subject to state imposed remedies. [Eff 08/01/94; am 01/29/96; am 11/25/96; am 09/14/98] (Auth: HRS §346-14; 42 C.F.R. §§442.118, 442.119; Pub. L. No. 100-203) (Imp: Pub. L. No. 100-203; 42 C.F.R. §§431.152, 431.202, 442.118, 442.119)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: STATE OF HAWAII

DISCLOSURE OF ADDITIONAL REGISTRY INFORMATION

N/A

TN No. 92-11  
Supersedes  
TN No. \_\_\_\_\_

Approval Date 9/4/92

Effective Date 4/1/92

HCFA ID:

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

COLLECTION OF ADDITIONAL REGISTRY INFORMATION

N/A

TN No. 92-11  
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TN No. \_\_\_\_\_

Approval Date 9/4/92

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HCFA ID:

**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

**State/Territory:** \_\_\_\_\_

**DEFINITION OF SPECIALIZED SERVICES**

**SPECIALIZED SERVICES FOR SMI**

For individuals with SMI, it is the continuous and aggressive implementation of an individualized plan of care that:

Is developed under and supervised by a physician in conjunction with an interdisciplinary team of qualified mental health professionals;

Prescribes specific therapies and activities for the treatment of individuals experiencing an acute episode of severe mental illness, which necessitates twenty-four (24) hour supervision by trained mental health personnel in an institution; and

Is directed toward diagnosing and reducing the individual's psychotic symptoms that necessitated institutionalization, improving his/her level of independent functioning and achieving a functioning level that permits reduction in the intensity of mental health services below the level of specialized services at the earliest possible time.

**SPECIALIZED SERVICES FOR MENTAL RETARDATION**

For individuals with MR/DD it is a continuous treatment program which includes aggressive, consistent implementation of a program of specialized services and generic training, treatment, and health related services that is directed toward:

The acquisition of the behaviors necessary for the individual to function with as much self-determination and independence as possible;

The prevention or deceleration of regression or loss of current optimal functional status; and

Does not include services to maintain generally independent individuals who are able to function with little supervision or in the absence of a continuous specialized services program.



## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

### CATEGORICAL DETERMINATION

#### PASRR Level II Preadmission Screening by Categorical Determination

The following categories developed by the State mental health or mental retardation authorities may be made applicable to individuals identified by Level I as possibly having serious mental illness / mental retardation when existing data about the individual appear to be current and accurate and are sufficient to allow the reviewer readily to determine that the individual fits into the category. The data available includes physical, mental, and functional assessments as required by 42 CFR 483.132(c). An adequate inspection of records for a categorical determination takes the place of the NF or the Specialized Services individualized Level II evaluation. The State mental health or mental retardation authority produces categorical evaluation and determination reports as required by 42 CFR 483.128 and .130, prior to admission. When existing data is not adequate, or any judgment is required about the presence of serious mental illness / mental retardation, the individual is referred for individualized Level II evaluation. Individuals are either discharged from the NF or evaluated by Level II Resident Review within the specified time limits (if any). *(Check each that applies, and supply definitions and time limits as required.)*

- (1) **Categorical Determination that NF placement is appropriate.** Specialized Services evaluation and determination by the SMH/MRA is individualized

- ☒ (a) Convalescent care from an acute physical illness which required hospitalization and does not meet all the criteria for an exempt hospital discharge, (which, as specified in 42 CFR 483.106(b)(2) is not subject to preadmission screening). *(Define, with time limit.) Not to exceed 120 days.*
- ☒ (b) Terminal illness, as defined for hospice purposes in 42 CFR 418.3.
- ☒ (c) Severe physical illness such as coma, ventilator dependence, functioning At a brain stem level, or diagnosis such as chronic obstructive pulmonary disease, Parkinson's disease, Huntington's disease, amyotrophic lateral sclerosis, and congestive heart failure which result in a level of impairment so severe that the individual could not be expected to benefit from specialized services.
- ☐ (d) Other category(s) defined by the State. *(Define, with time limit if applicable.)*

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- (2) **Categorical Determination that NF placement is appropriate.** Option to also categorically determine by the SMH/MRA that Specialized Services (SS) are not needed. No categorical determinations are made that Specialized Services are needed.

- ☒ (a) Provisional admission pending further assessment in case of delirium where an accurate diagnosis cannot be made until the delirium clears.

Time limit: seven days

- ☒ May also categorically determine that SS are not needed

- ☒ (b) Provisional admission pending further assessment in emergency situations requiring protective services.

Time limit: seven days (*not to exceed 7*)

- ☒ May also categorically determine that SS are not needed

- ☒ (c) Very brief and finite stays to provide respite to in-home caregivers to whom the individual with MI or MR is expected to return following the brief NF stay.

Time limit: Thirty days

- ☒ May also categorically determine that SS are not needed

- (3) **Categorical determination that Specialized Services are not needed.** No categorical determinations are made that Specialized Services are needed. Determination by the SMH/MRA that NF placement is appropriate is individualized.

- ☐ (a) Dementia and MR. The State mental retardation authority (not Level I screeners) may make categorical determinations that individuals with dementia, which exists in combination with mental retardation or a related condition, do not need specialized services.

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## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: HAWAII

## EMPLOYEE EDUCATION ABOUT FALSE CLAIMS RECOVERIES

The State will assure compliance with the requirements of Section 1902(a)(68) through the distribution of a Provider Memorandum which will inform providers statewide of the requirements in July 2007. The State will identify entities which have received or paid \$5 million of Title XIX dollars or more in the Federal Fiscal Year 2006 as those providers needing to submit attestations. Affected entities will be required to submit an attestation to the State of their compliance with the required provisions by September 30, 2007.

After the initial round of compliance attestations, beginning with the calendar year (CY) 2008, compliance assurance will be delegated to the Health Coverage Management Branch (HCMB) within the Med-QUEST Division which administers the Provider Agreements and provider contracts. In the first quarter of the CY 2008, no later than March 31<sup>st</sup> and each subsequent year thereafter, the State will identify those providers having been reimbursed \$5 million or more (Medicaid dollars) in a fiscal year and request an attestation from those entities annually to demonstrate compliance with this Section. A sampling of the providers identified as affected "entities" will be selected for verification of required policies/procedures and a copy of the employee handbook, if one exists, which contains the rights of the employees to be protected as whistleblowers and the procedures for preventing fraud, waste, and abuse. This information will be reviewed by the State annually beginning April 2008, in order to verify the attestation. Providers will be selected from provider categories including, but not limited to hospitals, FQHC'S, nursing facilities, DME's, individual practitioners, etc for annual review.

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