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December 13, 2024

MEMORANDUM

MEMO NO.
QI-2335B [Update to QI-2335A]
FFS 23-21B [Update to FFS 23-21A]

TO: QUEST Integration (QI) Health Plans
Department of Health Developmental Disabilities Division (DDD)
1915(c) Intellectual and Developmental Disabilities (I/DD) Waiver Providers
QUEST Integration (QI) Home Health Agencies & Home Care Agency Providers
Fee-For-Service (FFS) Providers

FROM: Judy Mohr Peterson, PhD
Med-QUEST Division Administrator

SUBJECT: HAWAII WILDFIRES PUBLIC HEALTH EMERGENCY ACTION PLAN

This memo updates memorandum QI-2335A/FFS 23-21A which was issued on November 7, 2023. The text of memorandum QI-2335A/FFS 23-21A is incorporated into this revision, identified as memo QI-2335B/FFS 23-21B.

The revision in this memo reflects the end date extension of the I/DD HCBS Waivers (1915c Appendix K) to April 30, 2025 by the Centers for Medicare and Medicaid Services.

Updated guidance is inserted in shaded text and voided text from QI-2335A/FFS 23-21A is stricken.

The Department of Health and Human Services Secretary declared a Public Health Emergency (PHE) due to the Hawaii wildfires on August 11, 2023, retroactive to August 8, 2023. The

purpose of this memorandum is to outline a PHE action plan to maintain the health and safety of the Hawaii Medicaid members and the continued access to necessary services during and through the PHE.

This PHE action plan ~~shall be in effect retroactive to~~ was effective August 8, 2023.~~, through the last day of the PHEand may be extended further by Med-QUEST Division (MQD) as appropriate based on Hawaii-specific conditions and the type of the waiver.~~ The following waivers ended on October 30, 2024: General Hawaii Medicaid Waivers (1135 Blanket), State Policy Waivers, and Additional Hawaii Medicaid Waivers (Additional 1135). The waivers described here shall apply to all suppliers and providers within Maui County and for any member impacted by the wildfires. Specific waiver authorities may have different end dates, see the descriptions of the Attachments below for these differences. Despite the availability of these waivers, suppliers and providers should strive to return to their normal practice as soon as possible. Additional guidance updating the PHE action plan may be issued via subsequent memorandum.

Further guidance on the specific waivers can be found in the following attachments.

- ~~Attachment A: General Hawaii Medicaid Waivers (1135 Blanket) impacting provider enrollment, Rx/DME replacement, PASRR timing, FQHC/RHC flexibilities, ICF/IID~~
- Attachment B: Individuals with Intellectual or Developmental Disabilities (IDD) receiving Home and Community Based Services (HCBS) Waivers (1915c Appendix K) impacting multiple IDD/HCBS operational protocols
- ~~Attachment C: State Policy Waivers impacting electronic visit verification, audio-only telehealth~~
- ~~Attachment D: Additional Hawaii Medicaid Waivers (Additional 1135) impacting LTSS, 1915(c) timelines, 1915(i) evaluations and assessments, FFS eligibility fair hearings, health plan appeals, fair hearings, and continuation of benefits, provider enrollment, home health state plan services timeframes, personal care services.~~
- ~~Attachment E: Quest Integration (QI) HCBS Waivers (1115 Attachment K)~~

If you have questions, please send an email to HCSBInquiries@dhs.hawaii.gov.

~~Attachment A: General Hawaii Medicaid Waivers (1135 Blanket)~~

~~The purpose of Attachment A is to describe the CMS blanket waivers issued pursuant to section 1135 of the Social Security Act for Hawaii Medicaid during this PHE. These waivers impact the general Medicaid program and apply to all suppliers and providers within Maui County and for any member impacted by the wildfires, and shall be in effect through the end of the Hawaii wildfires PHE.~~

~~Provider Enrollment Waivers~~

~~These provider enrollment waivers supersede HOKU provider actions and deadlines outlined in QI memoranda QI-2315, QI-2304, as well as the November 11, 2023 temporarily enrolled provider remediation activities resulting from the May 11, 2023 end of the COVID-19 Public Health Emergency.~~

1. ~~Postpone all revalidation actions.~~
2. ~~Allow physicians and other practitioners to render telehealth services from their home without reporting their home address on their Medicare enrollment while continuing to bill from their currently enrolled location (currently extended through December 31, 2023).~~
3. ~~Postpone provider enrollment site visits for moderate and high-risk categories of providers and suppliers.~~
4. ~~Postpone fingerprint-based criminal background checks (FCBC) for 5% or greater owners of newly enrolling high-risk categories of providers and suppliers.~~

~~Replacement Prescription Fills~~

1. ~~Payment may be permitted for replacement prescriptions fills (for a quantity up to the amount originally dispensed) of covered drugs in circumstances where dispensed medication has been lost or otherwise rendered unusable by damage due to the PHE.~~

~~Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS)~~

1. ~~Waive replacement requirements when DMEPOS is lost, destroyed, irreparably damaged, or otherwise rendered unusable due to the PHE. The following are not required:~~
    a. ~~Face-to-face requirement;~~
    b. ~~New provider order; and~~
    c. ~~New medical necessity documentation.~~

~~Suppliers must still include a narrative description on the claim explaining the reason why the equipment must be replaced and are reminded to maintain documentation indicating that the DMEPOS was lost, destroyed, irreparably damaged, or otherwise rendered unusable or available as a result of the PHE.~~

~~Long-Term Care Facilities and Skilled Nursing Facilities (SNFs) and/or Nursing Facilities (NFs)~~

1. ~~Pre-Admission Screening and Resident Review (PASRR) for members impacted by the wildfires:~~
    a. ~~Level 1 or Level 2 Preadmission Screening will be waived.~~
    b. ~~Level 1 assessments may be performed post-admission.~~
    c. ~~New members with a mental illness (MI) or intellectual disability (ID) should be referred promptly by the nursing home to MQD's PASSR program for Level 2 Resident Review on or before the 30th day of admission.~~

2. ~~In-person visits for SNFs located in Maui County:~~
    a. ~~Waive the requirement in 42 CFR 483.30 for physicians and non-physician practitioners to perform in-person visits for nursing home residents and allow visits to be conducted, as appropriate, via telehealth options.~~

~~Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)~~

1. ~~Temporary Expansion Locations for RHCs and FQHCs located in Maui County:~~
    a. ~~Waive the requirement on location restrictions to allow flexibility for existing RHCs/FQHCs to temporarily expand service locations to meet the needs of Medicaid members. When the PHE ends, if a clinic elects to continue providing services in at the temporary location, it must independently enroll the location in the FQHC/RHC Medicaid program.~~

~~Intermediate Care Facility for Individuals with Intellectual Disabilities~~

1. ~~Staffing Flexibilities for ICF/IDDs located in Maui County:~~
    a. ~~Waive the requirements at 42 CFR §483.430(c)(4), which requires the facility to provide sufficient Direct Support Staff (DSS) so that Direct Care Staff (DCS) are not required to perform support services that interfere with direct client care. DSS perform activities such as cleaning of the facility, cooking, and laundry services. DSC perform activities such as teaching clients appropriate hygiene, budgeting, or effective communication and socialization skills. During the time of this waiver, DCS may be needed to conduct some of the activities normally performed by the DSS. This will allow facilities to adjust staffing patterns, while maintaining the minimum staffing ratios required at §483.430(d)(3).~~

~~2. Physical Environment for ICF/IDDs located in Maui County:~~

~~a. Waive certain physical environment requirements under the Intermediate Care Facilities for Individuals with Intellectual Disabilities conditions of participation at §42 CFR §483.470 to allow increased flexibilities for surge capacity. Med-QUEST Division will permit facility and non-facility space that is not normally used for patient care to be utilized for patient care, provided the location is approved by the Department of Health, Office of Health Care Assurance (ensuring that safety and comfort for patients and staff are sufficiently addressed) and is consistent with the state's PHE action plan. Intermediate Care Facilities are still subject to obligations under the integration mandate of the Americans with Disabilities Act, to avoid subjecting persons with disabilities to unjustified institutionalization or segregation.~~

Attachment B: Individuals with Intellectual or Developmental Disabilities (IDD) receiving Home and Community Based Services (HCBS) Waivers (1915c Appendix K)

The purpose of Attachment B is to describe the approved 1915c Appendix K waivers that impact the IDD HCBS program. These waivers apply to IDD HCBS suppliers and providers within Maui County and for any member impacted by the wildfires, and shall be in effect for service dates from August 8, 2023 through ~~August 7, 2024~~ April 30, 2025.

Temporarily Modify Prior Authorizations

Additional Residential Supports (ARS), Adult Day Health (ADH), Assistive Technology (AT), Chore, Community Learning Service-Individual/Group (CLS-I, CLS-G), Discovery & Career Planning (DCP), Individual Employment Supports (IES), Non-Medical Transportation (NMT), Personal Assistance/Habilitation (PAB), Private Duty Nursing (PDN), Residential Habilitation (ResHab), Respite, Specialized Medical Equipment and Supplies (SMES), Training & Consultation (T&C), Waver Emergency Services: To ensure participant health and safety needs can be met in a timely manner, the prior authorization and/or exception review process may be modified as deemed necessary by DOH-DDD:

a. In emergent situations where the participant's immediate health and safety needs must be addressed, retrospective authorization may be completed.
b. Documentation of verbal approval or email approval of changes and additions to individual plans will suffice as authorization for providers to deliver services while awaiting data input into the case management system and MMIS.

Temporarily Allow for Telehealth

Adult Day Health (ADH), Personal Assistance/Habilitation (PAB), Waiver Emergency Services – Emergency Outreach: These services may be provided through telehealth that meets privacy requirements when the type of support meets the health and safety needs of the participant. The state assures:

- That telehealth will be delivered in a way that respects the privacy of the individual especially in instances of toileting, dressing, etc.
- That telehealth will facilitate community integration.
- The successful delivery of services for individuals who need hands on assistance/physical assistance, including whether the service may be rendered without someone who is physically present or is separated from the individual.
- Support will be provided to individuals who need assistance with using the technology required for telehealth delivery of the service.

Temporarily Exceed Limits on Services

Private Duty Nursing (PDN): Suspend the per-day limits and short-term time limits on Private Duty Nursing as needed to protect participant health and safety.

Additional Residential Supports (ARS): Suspend the 60-day limit. Permit the use of the service to provide supports in licensed and certified settings when needed to replace community service the participants cannot access due to the impact of the wildfires.

Respite: Suspend the annual limit of 760 hours of Respite when needed to address potential health and safety issues due to the unavailability of services and/or natural supports that the participant has been receiving.

Assistive Technology (AT) and Specialized Medical Equipment and Supplies (SMES)

Modify the process for procuring medically necessary AT and SMES in accordance with the Fifth Emergency Proclamation issued by Governor Josh Green, M.D., to expedite the replacement of medically necessary AT and SMES for participants who lost their previously purchased device or equipment due to the PHE. The process will include using existing documentation on file, without requiring an updated physician prescription and an updated assessment if the participant's needs have not changed. AT and SMES must not be otherwise covered by the Medicaid state plan or the QUEST Integration health plan.

Temporary Exceptions to Individual Budgets

Grant exceptions to the individual budget limits described in Appendix C-4 when needed to accommodate changes in service need and/or availability for a variety of circumstances that may arise from the impacts of the wildfires.

The state assures that any increases in the budget limits will not affect cost neutrality and the waiver will remain cost neutral.

Temporarily Expanded Settings

Personal Assistance/Habilitation (PAB), Respite, Residential Habilitation (ResHab), and Adult Day Health (ADH): Temporarily allow authorized waiver services to be provided to participants, in accordance with the individualized services plan (ISP), in any location where the participant is located due to the impact of the Maui wildfires, including the participant's home (including private home, licensed or certified non-institutional setting), the home of their direct support professional, any location where they have evacuated (such as in hotels, shelters, schools, churches, campgrounds, and other designated evacuation locations, and/or where the participant has been relocated in temporary housing (including locations on neighbor islands). This flexibility is intended to continue to protect the health and safety of waiver participants

during emergency evacuations and relocations, as determined appropriate by a waiver participant's case manager and circle of support.

Respite and ResHab: Services in these expanded non-institutional settings do not include room and board expenses.

Temporarily Permit Payment for Services Rendered by Family Caregivers or Legally Responsible Individuals

Personal Assistance/Habilitation (PAB), Community Learning Services (CLS), Respite, Chore, Non-Medical Transportation (NMT): Permit legally responsible relatives to be hired as temporary workers in the absence of direct support workers related to the impacts of the Maui wildfire public health emergency. The state assures that the services provided by legally responsible relatives are extraordinary care, exceeding the ordinary care that would be provided to a person without a disability of the same age. The state ensures payments are made for services rendered through electronic visit verification for PAB and Chore. In addition, legally responsible relatives hired by a provider must adhere to the requirements in the Waiver Provider Standards Manual. Those hired through the Consumer-Directed option must follow the requirements in the Consumer-Directed Option Overview and Requirements Handbook.

Services are authorized in the ISP and delivery of supports must be documented by the legally responsible relative(s).

Temporarily Modify Provider Qualifications

Lower the minimum age requirement for direct support professionals to 16 years of age. Suspend the requirement for a high school diploma or GED. Temporarily suspend requirements for criminal history checks, staff training, CPR and first aid certification. The provider must attest that the employee meets the following: is legally able to work in the United States, is trained in the service delivery specified in the participant's ISP and can follow written and verbal instructions for performing and documenting the job duties. Providers may choose to provide training on-line in lieu of in-person training. Training may also be conducted by telehealth. The use of telehealth for conducting participant-specific training in the ISP must meet privacy requirements.

Personal Assistance/Habilitation, Additional Residential Supports, Community Learning Services, Respite, Private Duty Nursing, Chore: Expand provider qualifications to include any provider agencies enrolled in QUEST Integration health plan networks performing similar work.

Temporarily Modify Licensure or Other Requirements

Residential Habilitation: Temporarily permit the use of unlicensed group homes for residential habilitation settings when the licensed setting is inaccessible due to the impact of the wildfires.

The provider must attest and the state will verify that the home meets the participants' need for health and safety.

Temporarily Modify Level of Care Process

Level of care (LOC) initial and annual determinations may be conducted using telehealth. LOC annual redeterminations may be extended for up to one year past the due date of the approved DHS1150-C during the declared public health emergency for Maui wildfires.

Temporarily Increase Payment Rates

Maui County providers may bill at the higher Big Island rates to account for additional travel time and distance due to impacts of the declared public health emergency for Maui wildfires.

Temporarily Modify Plan Development Process

The State may modify timeframes or processes for completing the Individualized Service Plan (ISP) to use e-signatures that meet privacy and security requirements as a method for the participant or legal guardian signing the ISP to indicate approval of the plan. Services may start while waiting for the signature to be returned to the case manager, whether electronically or by mail. Signatures will include a date reflecting the ISP meeting date. Allow ISP assessments to be conducted using telehealth.

Temporarily Include Retainer Payments

Personal care/assistance is a component of all services for which retainer payments will be made.

Adult Day Health (ADH), Community Learning Services (CLS), Personal Assistance/Habilitation (PAB), Discovery and Career Planning (DCP), and Individual Employment Supports (IES): To preserve services and employment programs, that providers may not be able to deliver, and maintain a stable workforce, DDD will make retainer payments for ADH, CLS, PAB, DCP, and IES. The retainer payments will be billed and paid based on a monthly unit of service with a rate equal to 90 percent of the difference of a provider's billing for a given participant in a baseline period (the average monthly billing for state fiscal year 2023) and the month of the declared public health emergency for which the retainer is being billed. Such retainer payments will be limited to the lesser of 30 consecutive days or the number of days for which Hawaii authorizes bed-hold payments in nursing facilities.

Other Temporary Modifications

The timeframes for the submission of the evidentiary package(s) will be extended as needed pursuant to the emergency. In addition, the state may suspend the collection of data for performance measures other than those identified for the Health and Welfare assurance and notes that as a result the data will be unavailable for this time frame in ensuing reports due to the circumstances of the declared public health emergency for Maui wildfires.

~~Attachment C: State Policy Waivers~~

~~The purpose of Attachment C is to detail specific state policy waivers. These waivers impact various aspects of the general Medicaid program, and apply to all suppliers and providers within Maui County and for any member impacted by the wildfires. The duration of each waiver is described in each section.~~

~~Electronic Visit Verification (EVV) Manual Edit Waiver~~

~~This waiver applies to our QI Health Plans (HP), Department of Health Developmental Disabilities Division (DDD) and providers of Home Health (HHA) services, Home Care (HCA) services, Nursing services (LPN/RN), Self-Direct (SD)/Consumer-Directed (CD) services and I/DD waiver services that deliver services requiring Electronic Visit Verification (EVV). The goal of this waiver is to ensure provider agencies continue delivering EVV-related services to members with the least impact on claims payment during and through the PHE. This will be accomplished by temporarily eliminating EVV Manual Edit requirements for Maui County during the PHE, and this waiver shall be in effect through December 31, 2023. This may be extended further by MQD as appropriate based on specific conditions on the ground.~~

~~EVV Providers impacted by the Maui wildfires~~

~~MQD is grouping all EVV provider agency accounts that serve members in Maui County. Maui county includes the islands of Lanai, Molokai, and Maui. A list of impacted EVV accounts is listed below.~~

~~EVV Visit Capture~~

~~Per CMS, EVV visits are still required to be entered into Sandata or an alt EVV system. For providers that are unable to electronically capture visits, they may be manually entered.~~

~~EVV Manual Editing Monitoring~~

~~MQD is waiving the current manual edit monitoring for all the EVV provider agencies with members in Maui County. Home Care and Home Health provider accounts are licensed by island therefore all Maui County agencies will be included in the EVV Maui wildfire action plan. For the DDD, Nursing, and SD provider accounts licensed statewide, MQD has identified which accounts have members in Maui County and those accounts will be included under this EVV waiver. See list below.~~

~~All other DDD and Nursing provider agency accounts are required to follow the existing EVV Manual Editing requirements.~~

~~EVV Waiver Unwinding~~

~~After this waiver has expired, the months of August through December will not be considered for EVV manual edit monitoring. Agencies covered by this waiver will resume EVV manual edit measurement starting with the date of service January 1, 2024. EVV monthly corrective actions will continue February 2024 for the date of service in January 2024. An updated corrective action timeline is below.~~

~~EVV Corrective Action Timeline for Providers Impacted by the Maui wildfires:~~

~~Monitoring Period~~	~~Review Month~~	~~Equal to or less than 15% Manually Edited/Entered Visits~~	~~More than 15% Manually Edited/Entered Visits~~
~~DOS 8/1/2023-8/31/2023~~	~~N/A~~	~~N/A~~	~~N/A~~
~~DOS 9/1/2023-9/30/2023~~	~~N/A~~	~~N/A~~	~~N/A~~
~~DOS 10/1/2023-10/31/2023~~	~~N/A~~	~~N/A~~	~~N/A~~
~~DOS 11/1/2023-11/30/2023~~	~~N/A~~	~~N/A~~	~~N/A~~
~~DOS 12/1/2023-12/31/2023~~	~~N/A~~	~~N/A~~	~~N/A~~
~~DOS 1/1/2024-01/31/2024~~	~~Month plus 15 days (Mid-February 2024)~~	~~Move to next Quarterly Review – Refer to Quarterly Review Table above.~~	~~If the Manual Edited/Entered requirements are not met:~~ ~~**Provider Agencies**~~ ~~• HP/DDD will implement a pre-payment review for the provider account or SD payroll visits.~~ ~~• HP/DDD will review additional documentation to verify that the manual edits are necessary or appropriate, to pay claims appropriately.~~ ~~• All suspected cases, where manual edits were not~~

			~~appropriate and indicate potential fraud, will be reported for further investigation to the DHS and Law Enforcement.~~ ~~**SD/CD**~~: • ~~HP/DDD may move the members'/participants' services to a provider agency.~~ ~~It is at the discretion of the HP/DDD if a SD member/CD participant can be moved back to SD/CD services.~~
~~DOS 2/1/2024-2/29/2024~~	~~Month plus 15 days~~	~~Move to next Quarterly review- refer to Quarterly Review Table above.~~	~~Continue monthly~~
~~Ongoing Monitoring~~	~~Future Quarterly Reviews~~	~~Move to next Quarterly Review – Refer to Quarterly Review Table above.~~	~~Once moved to the Quarterly monitoring period and then fail to meet minimum requirements in any of the months of the quarter, the Provider Agency or SD member/CD participant starts back at Month 1.~~

~~**EVV Provider Agency Accounts Impacted by the Maui Wildfires:**~~

~~Home Health Providers~~	~~Provider Type~~	~~Provider ID(s)~~	~~NPI(s)~~
~~BAYADA-HH_MA~~	~~PT 23 (HHA)~~	~~800633~~	~~1942569702~~
~~CARERESOURCE-HH_MO~~	~~PT 23 (HHA)~~	~~000236~~	~~1821693409~~
~~HALE MAKUA HH_MA~~	~~PT 23 (HHA)~~	~~518508~~	~~1235132242~~
~~HIHOMECARE-HH_MA~~	~~PT 23 (HHA)~~	~~000589~~	~~1548843592~~
~~KAISER PERMANENTE-HH_MA~~	~~PT 23 (HHA)~~	~~000004~~	~~1962552091~~
~~LANAI KINAOLE-HH_LA~~	~~PT 23 (HHA)~~	~~000410~~	~~1962060020~~
~~MASTERCARE-HH_MA~~	~~PT 23 (HHA)~~	~~000211~~	~~1699377762~~

~~Home Care Providers~~	~~Provider Type~~	~~Provider ID(s)~~	~~NPI(s)~~
~~3GS DIR C SVC-HC_MA~~	~~PT 24 (HCA)~~	~~000231~~	~~1073117073~~
~~AMERICARE HAWAII-HC_MA~~	~~PT 24 (HCA)~~	~~834003~~	~~1992212427~~

Home Care Providers	Provider Type	Provider ID(s)	NPI(s)
ANAMCARA CARE HC_MA	PT 24 (HCA)	000229	1295330231
BAYADA-HC_MA	PT 24 (HCA)	800641	1639776578
BAYADA-HC_MO	PT 24 (HCA)	800642	1528605193
CARERESOURCE-HC_MO	PT 24 (HCA)	000239	1558966135
HIHOMECARE HC_MA	PT 24 (HCA)	000545	1366025314
HO'OKELE CAREGIV-HC_MA	PT 24 (HCA)	817421	1295280865
MASTERCARE-HC_MA	PT 24 (HCA)	000206	1124620398
MEGACARE HC_MA	PT 24 (HCA)	002541	1710461181
METROCARE-HC_MA	PT 24 (HCA)	000196	1730789751
OHANA CARE-HC_MA	PT 24 (HCA)	811481	1023406709
RAINBOW-HC_MA	PT 24 (HCA)	000219	1184182909
TRI ISLE PERSONAL HC_LA	PT 24 (HCA)	000234	1780280578
TRI-ISLE PERSONAL-HC_MA	PT 24 (HCA)	800714	1215533492
TRI-ISLE PERSONAL-HC_MO	PT 24 (HCA)	000230	1265038533
UNICARE HAWAII INC HC_MA	PT 24 (HCA)	828494	1093292575

Nursing Providers	Provider Type	Provider ID(s)	NPI(s)
3GS DIR C SVC NU	PT 46 (RN/LPN)	808264	1932440591
A CARE OF EXCELL-NU	PT 46 (RN/LPN)	000184	1881209419
ALPHA CARE HAWAII-NU	PT 46 (RN/LPN)	000227	1619501673
AMERICARE HAWAII NU	PT 46 (RN/LPN)	000202	1689285801
ATTENTION PLUS NU	PT 46 (RN/LPN)	533267	1457306961
B HOMECARE-NU	PT 46 (RN/LPN)	000256	1962099986
BAYADA-NU	PT 46 (RN/LPN)	800635	1740665488
CARERESOURCE NU	PT 46 (RN/LPN)	533390	1306046602
CRADLES N' CRAYONS-NU	PT 46 (RN/LPN)	572588	1205862851
HAWAII NURSING-NU	PT 46 (RN/LPN)	800669	1144830167
HEAVEN'S HELPERS NU	PT 46 (RN/LPN)	617136	1457443814
HICARE SOLUTIONS-NU	PT 46 (RN/LPN)	000222	1609409614
HIHOMECARE-NU	PT 46 (RN/LPN)	744872	1013354638
ISLAND PACIFIC-NU	PT 46 (RN/LPN)	800664	1992228431
KAMAAINA HEALTH NU	PT 46 (RN/LPN)	800670	1497394985
LANAI KINAOLE-NU_LA	PT 46 (RN/LPN)	000411	1578160461
LOVING CARE-NU	PT 46 (RN/LPN)	800665	1376188961
MASTERCARE NU	PT 46 (RN/LPN)	583725	1134272669
MAXICARE-NU	PT 46 (RN/LPN)	800708	1760078059
METROCARE-NU	PT 46 (RN/LPN)	800667	1679106256
MOCHI MALAMA NU	PT 46 (RN/LPN)	800662	1902424682

Nursing Providers	Provider Type	Provider ID(s)	NPI(s)
ULTIMACARE-NU	PT 46 (RN/LPN)	000217	1275167173
WILSON-NU	PT 46 (RN/LPN)	533473	1285727966

DDD Providers	Provider Type	Provider ID(s)	NPI(s)
ACUMEN FISCAL AGNT-DD	PT H1 (DDD)	833360	1720145378
ADVANTAGE HLTH CARE-DD	PT H1 (DDD)	637936	1235407776
ALTERNATIVE CARE-DD	PT H1 (DDD)	540494	1447527825
ARC OF MAUI-DD	PT H1 (DDD)	508286	1750745899
BAYADA-DD	PT H1 (DDD)	793936	1245731173
BOCHA-DD	PT H1 (DDD)	812091	1386005924
CARE HAWAII-DD	PT H1 (DDD)	569642	1770603425
CRADLES N' CRAYONS-DD	PT H1 (DDD)	823527	None
EASTER SEALS HI-DD	PT H1 (DDD)	509101	1568739878
HAWAII BEHAVIORAL-DD	PT H1 (DDD)	688715	1881742104
HEALTH RESOURCES-DD	PT H1 (DDD)	800668	None
HEAVEN'S HELPERS-DD	PT H1 (DDD)	800720	None
HORIZONS ACAD MAUI-DD	PT H1 (DDD)	697419	1922405026
KA LIMA O MAUI-DD	PT H1 (DDD)	517013	1255422879
KONA KRAFTS-DD	PT H1 (DDD)	517055	1457620650
LAA KEA FOUNDATION-DD	PT H1 (DDD)	641573	None
MASTERCARE-DD	PT H1 (DDD)	792459	1184093254
MAUI BRIDGES-DD	PT H1 (DDD)	001082	None
MAUI HOPE-DD	PT H1 (DDD)	001936	1184216194
METROCARE-DD	PT H1 (DDD)	764599	1730505918
POSITIVE BEHAVIOR-DD	PT H1 (DDD)	823543	1528405008

Health Plans - SD	Provider Type	Provider ID(s)	NPI(s)
CDS ALOHA CARE	PT 99	833493	None
CDS HMSA	PT 99	833500	None
CDS KAISER	PT 99	833518	None
CDS OHANA / WELLCARE	PT 99	691156	None
CDS UNITED HEALTHCARE	PT 99	691164	None

Audio-only Telehealth Waiver

The audio-only telehealth waiver will allow the continued delivery of services to Medicaid members impacted by the Maui wildfires. The audio-only telehealth communication modality may be used to provide medically necessary health care services (e.g., medical, behavioral health, substance use disorders, occupational therapy, physical therapy, speech therapy). This

~~waiver is in effect for services dates between August 8, 2023 through February 28, 2024, and may be extended further by MQD as appropriate based on specific conditions on the ground.~~

~~Criteria for audio-only telehealth service delivery:~~

1) ~~Services must be appropriate for the audio-only modality~~
2) ~~Services must be clinically appropriate~~
3) ~~Rendered in conformance with the full description of the procedure code~~
4) ~~Performed by a health care provider eligible to bill Hawai'i Medicaid~~
5) ~~Services provided shall be consistent with all federal and state privacy, security, and confidentiality laws~~
6) ~~FQHCs – To be eligible for PPS, FQHCs must ensure the provision of relevant wrap-around services. Efforts shall be made to ensure that beneficiaries receive relevant wrap-around services, and this may mean delivering care to the beneficiary's location as one way to ensure services are received. Wrap-around services may or may not occur on the same day as services provided through telehealth modality and the eligible FQHC provider delivering services through the telehealth modality must provide clear instructions to the beneficiary on how and when the wrap-around services will be provided. Wrap-around services must be documented in the beneficiary's medical record.~~

~~Billing information:~~

1) ~~Modifier: Use modifier "FQ service furnished using audio-only communication technology"~~
2) ~~For place of service and other billing questions, QI providers should contact their contracted QI health plan and FFS providers should contact the Hawai'i Medicaid FFS Call Center (operated by Conduent) at 1-877-439-0803.~~

~~Attachment D: Additional Hawaii Medicaid Waivers (Additional 1135)~~

~~The purpose of Attachment D is to describe the waivers issued pursuant to section 1135 of the Social Security Act for Hawaii Medicaid during this PHE, approved by CMS on October 13, 2023. These waivers impact various aspects of the general Medicaid program and apply to all suppliers and providers within Maui County and for any member impacted by the wildfires, and shall be in effect through the end of the Hawaii wildfires PHE.~~

~~Long Term Services and Supports (LTSS):~~

~~PASRR~~

1. ~~Modification of Section 1919(e)(7) and 42 C.F.R. § 483.112 to allow Level I and Level II assessments to be waived by the state for 30 days from admission. After 30 days, Level I assessments should be conducted with reasonable promptness and Level II assessments should be coordinated with the resident review.~~

   ~~Additionally, please note that per 42 C.F.R. § 483.106(b)(4), new preadmission Level I and Level II screens are not required for residents who are being transferred between nursing facilities (NF). If the NF is not certain whether a Level I had been conducted at the resident's evacuating facility, a Level I can be conducted by the admitting facility during the first few days of admission as part of intake and transfers. Positive Level I screens necessitate a Resident Review.~~

~~HCBS Settings Requirement~~

1. ~~Waive or modify the HCBS Settings Requirements for HCBS services delivered through the 1915(c), 1915(i) authorities and the Hawai'i QUEST Integration (Project Number 11-W00001/9) section 1115 Demonstration authorizing these services. In order to ensure the continuation of needed HCBS during a disaster and/or emergency, states may deliver HCBS in settings that have been assessed for compliance with the HCBS settings criteria, and may accommodate circumstances in which an individual requires relocation to an alternative setting, or must modify how the settings requirements can be implemented during the emergency.~~

~~Person Centered Plan Beneficiary and Provider Signatures – 42 C.F.R. §441.301(c)(2)(ix); 42 C.F.R. §441.725(b)(9)~~

1. ~~Waive or modify the requirement to obtain beneficiary and provider signatures of HCBS Person-Centered Service Plan under 42 C.F.R. §441.301(c)(2)(ix) for 1915(c) waiver programs, 42 C.F.R. §441.725(b)(9) for 1915(i) state plan HCBS benefit, and 1115 demonstrations, allowing states to permit documented verbal consent as an alternate to the regulatory requirement for a signature on the person-centered service plans from~~

~~beneficiaries and all providers responsible for its implementation.~~

~~1915(c) Level of Care and Person-Centered Service Plan Timelines:~~

~~Initial Evaluation of Need – 42 C.F.R. §441.302(c)(1)~~

1. ~~Delay 1915(c) HCBS Waiver LOC Evaluation of Need until after the individual begins receiving services to facilitate access to initial services. Initial evaluations of eligibility must be completed within 90 days of the PHE conclusion.~~

~~Reevaluation – 42 C.F.R. § 441.302(c)(2)~~

1. ~~Extend the 1915(c) HCBS Waiver LOC reevaluation to allow services to continue until the reassessment can occur. All reevaluations delayed by the PHE must be completed within 12 months of the original due date.~~

~~Review and Revision of Person-Centered Service Plan – 42 C.F.R. §441.301(c)(3)~~

1. ~~Delay the review and revision of the person-centered service plan beyond 12 months. This waiver does not eliminate the requirement that the person-centered service plan be updated when the individual requests a revision and/or when the circumstances or needs of the individual change significantly. MQD also encourages completion of these reviews and revisions of the person-centered service plan via telehealth as resources permit during the PHE. All reviews/revisions delayed by the PHE must be completed within 12 months of the original due date.~~

~~1915(i) Evaluations, Assessments and Person-Centered Service Plans~~

~~Initial Evaluation of 1915(i) Eligibility – 42 C.F.R. §441.715(d)~~

1. ~~Delay the initial evaluation of 1915(i) eligibility until after the individual begins receiving services in order to facilitate access to initial services. MQD also encourages completion of these initial evaluations via telehealth as resources permit during the PHE. All initial evaluations delayed by the PHE must be completed within 90 days of the PHE conclusion.~~

~~Reevaluation of 1915(i) Eligibility – 42 C.F.R. §441.715(e)~~

~~Delay the 1915(i) State Plan HCBS benefit annual required re-evaluation of 1915(i) eligibility in order to allow services to continue until the re-evaluation can occur. All reevaluations delayed by the PHE must be completed within 12 months of the original due da~~

~~Initial Independent Assessment of Need – 42 C.F.R. §441.720(a)~~

1. ~~Delay the initial 1915(i) State Plan HCBS benefit independent assessment of need until~~

~~after the individual begins receiving services in order to facilitate access to initial services. MQD also encourages completion of these initial assessments via telehealth as resources permit during the PHE. All initial assessments delayed by the PHE must be completed within 90 days of the of the PHE conclusion.~~

~~Reassessments of Need – 42 C.F.R. §441.720(b)~~

1. ~~Delay the 1915(i) State Plan HCBS benefit annual required independent reassessment of need to allow services to continue until the reassessment can occur. All reevaluations delayed by the PHE must be completed within 12 months of the original due date.~~

~~Fee for Service and Eligibility Fair Hearings~~

~~Extend fair hearing request timelines~~

1. ~~Modify requirements in 42 C.F.R. § 431.221(d) to allow applicants and beneficiaries to have more than 90 days to request a fair hearing for eligibility or fee-for-service appeals by permitting extensions of the timeline to file a fair hearing request (e.g. additional time more than 90 days). This waiver supplements the timeframe in 42 C.F.R. § 431.221(d), which requires states to choose a reasonable timeframe for individuals to request a fair hearing not to exceed 90 days for eligibility or fee-for-service appeals.~~

~~Managed Care Appeals, Fair Hearings, and Continuation of Benefits~~

~~Modify Timelines to Resolve Appeals~~

1) ~~The requirements of 42 C.F.R. § 438.408(f)(1) establish that an enrollee may request a state fair hearing only after receiving a notice that the Managed Care Organization, Prepaid Inpatient Health Plan or Prepaid Ambulatory Health Plan is upholding the adverse benefit determination but also permits, at 42 C.F.R. § 438.408(c)(3) and (f)(l)(i) that an enrollee's appeal may be deemed denied and the appeal process of the managed care plan exhausted (such that the state fair hearing may be requested) if the managed care plan fails to meet the timing and notice requirements of 42 C.F.R. § 438.408. Pursuant to section 1135(b)(5) of the Act, CMS is granting authority to modify requirements in 42 C.F.R. § 438.408(f)(1) which authorizes the state to modify the timeline for managed care plans to resolve appeals to no less than one day. If the state uses this authority, it would mean that all appeals filed through the end of the PHE are deemed to satisfy the exhaustion requirement in 42 C.F.R. § 438.408(f)(1) after one day (or more, if that is the timeline elected by the state) and allow enrollees to file an appeal to the state fair hearing level.~~

~~**Extend State Fair Hearings Timelines**~~

1. ~~Modify timeframes in 42 C.F.R. § 438.408(f)(2) for managed care member to exercise their appeal rights. If the 120-day deadline to request an appeal occurred during the PHE, managed care members will have more than 120 days from the date of the managed care plan's notice of resolution of an appeal to request a state fair hearing (e.g. additional 120 days).~~

~~**Modify Continuation of Benefits Timelines – 42 C.F.R. §438.420(a)(i)**~~

1. ~~Modify timeframes at 42 C.F.R. §438.420(a)(i) through the end of the PHE. The modified timeframes will allow the managed care plan to continue benefits if requested within the current 10-day timeframe or reinstate benefits when the member requests continuation of benefits between 11 and 30 days after receiving notice if the managed care plan has not yet made a decision on the appeal or the state fair hearing is pending. This flexibility may be used provided that the managed care plan may not seek reimbursement or payment for the additional days of services furnished during this period (aside from otherwise applicable cost sharing, if any) from the member.~~

~~**Modify Authorization Decision Timelines**~~

1. ~~Modify timeframes in 42 C.F.R. § 438.210(d)(1)(ii) and (2)(ii) for two possible extensions up to 90 days each to allow the managed care plan more time to collect additional information needed to make an authorization decision that is favorable to the member. If an authorization decision is not made within the first 90-day extension timeframe due to the PHE, the managed care plan may modify the timeframe to provide an additional 90-day extension, provided that the managed care plan continue to authorize and pay for the service(s) until a decision is made and does not seek reimbursement or payment for the services furnished during this additional period (other than otherwise applicable cost sharing, if any) from the member in the event of an adverse decision. If the service authorization decision is adverse to the member, the plan must provide timely and adequate notice of adverse benefit determination per the requirements of 42 C.F.R. § 438.404. For example, insufficient information within the 14-day time period could lead to a decision to deny the service authorization. During the extension period of up to 180 days, the managed care plan will authorize and pay for the services based on the information available until the assessment can be completed.~~

~~**Modify Adverse Benefit Appeals Filing Timelines – 42 C.F.R. §438.402(c)(2)(ii)**~~

1. ~~Modify timeframes in 42 C.F.R. §438.402(c)(2)(ii) to extend the time period to file an appeal from 60 to 120 days following the receipt of an adverse benefit determination to allow more time for the member to file a request for an internal appeal with the managed care plan. The managed care plan will continue to authorize and pay for the~~

~~service(s) until a decision is made and may not seek reimbursement or payment for the services furnished during this additional period (other than otherwise applicable cost sharing, if any) from the member in the event of an adverse decision.~~

~~Modify Standard Appeals Timelines – 42 C.F.R. §438.408(c)(1)(ii)~~

1. ~~Modify timeframes in 42 C.F.R. §438.408(c)(1)(ii) for standard appeals from 14 days to 30 days. This modification allows the managed care plan additional time to obtain necessary information, if the delay is in the member's interest such as to gather information necessary for a decision that is favorable to the member; the managed care plan must continue to authorize and pay for the service(s) until a decision is made and may not seek reimbursement or payment for the services furnished during this additional period (aside from otherwise applicable cost sharing, if any) from the member in the event of an adverse decision.~~

~~Home Health State Plan Services Timeframe (Face-to-Face Encounters) – 42 C.F.R. §§ 440.70(f)(1), 440.70(f)(2)~~

1. ~~Waiver allowing the state to modify the deadline so home health state plan face-to-face encounters do not need to be completed before the start of services and may occur at the earliest time, not to exceed 12 months from the start of service.~~

~~Use of Legally Responsible Individuals to Render Personal Care Services – 42 C.F.R. §§ 440.167(a)(2), 440.167(b)~~

1. ~~Waiver to temporarily allow payment for 1905(a) personal care services rendered by legally responsible individuals (which could be inclusive of legally responsible family caregivers) provided that the managed care plan makes a reasonable assessment that the caregiver is capable of rendering such services. This waiver will ensure that medically necessary services are furnished in the event the traditional provider workforce is diminished or there is inadequate capacity due to the public health emergency.~~

~~Provider Enrollment~~

~~Allow out-of-state provider reimbursement – Medicaid Provider Enrollment Compendium (MPEC, dated 3/22/2021), Section 1.5.1.B.2.c~~

1. ~~As described in section 1.5.1.B.2.c of the MPEC, your SMA may reimburse otherwise payable claims from out-of-state providers not enrolled with your SMA if the following criteria are met:~~

    ~~1) The item or service is furnished by an institutional provider, individual practitioner, or pharmacy at an out-of-state/territory practice location – i.e.,~~

~~located outside the geographical boundaries of the reimbursing state/territory's Medicaid plan,~~

2) ~~The National Provider Identifier (NPI) of the furnishing provider is represented on the claim,~~
3) ~~The furnishing provider is enrolled and in an "approved" status in Medicare or in another state/territory's Medicaid plan,~~
4) ~~The claim represents services furnished, and~~
5) ~~The claim represents either:~~
    i. ~~A single instance of care furnished over a 180-day period, or~~
    ii. ~~Multiple instances of care furnished to a single participant, over a 180-day period.~~

~~For claims for services provided to Medicaid participants enrolled with your SMA, CMS waives the fifth criterion listed above. Therefore, your SMA may reimburse out-of-state providers for multiple instances of care to multiple participants, so long as the other criteria listed above are met.~~

~~Attachment E: QI HCBS Waivers (1115 Attachment K)~~

~~Guidance is pending approval.~~