

State: Hawaii

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

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

Provided:  No limitation  With limitations\*

2. a. Outpatient hospital services.

Provided:  No limitation  With limitations\*

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

Provided:  No limitations  With limitations\*

Not provided.

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

Provided:  No limitations  With limitations\*

3. Other laboratory and x-ray services.

Provided:  No limitation  With limitations\*

State: HAWAII

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

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

Provided:  No limitations  With limitations\*

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

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

Provided:  No limitations  With limitations\*

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

Provided:  No limitations  With limitations\*

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

Provided:  No limitations  With limitations\*

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

a. Podiatry services

Provided:  No limitations  With limitations\*

Not provided.

\* Description provided on attachment.

TN No. 05-002

Supersedes

TN No. 92-17

Approval Date: JUN 09 2006 Effective Date: 07/01/05

State/Territory: Hawaii

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

b. Optometrists' services. ✓

Provided:  No limitations  With limitations\*

Not provided.

c. Chiropractors' services.

Provided:  No limitations  With limitations\*

Not provided.

d. Other practitioners' services.

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

Not provided.

7. Home health services. ✓

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

Provided:  No limitations  With limitations\*

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

Provided:  No limitations  With limitations\*

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

Provided:  No limitations  With limitations\*

\*Description provided on attachment.

TN No. 91-23

Supersedes

TN No. 85-12

Approval Date 12/31/91

Effective Date 10/01/91

HCFA ID: 7986E

State/Territory: Hawaii

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

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

Provided:  No limitations  With limitations\*

Not provided.

8. Private duty nursing services.

Provided:  No limitations  With limitations\*

Not provided.

\*Description provided on attachment.

TN No. 91-23

Supersedes

TN No. 85-12

Approval Date 12/31/91

Effective Date 10/01/91

HCFA ID: 7986E

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

9. Clinic services.

Provided:  No limitations  With limitations\*  
 Not provided.

10. Dental services.

Provided:  No limitations  With limitations\*  
 Not provided.

11. Physical therapy and related services.

a. Physical therapy.

Provided:  No limitations  With limitations\*  
 Not provided.

b. Occupational therapy.

Provided:  No limitations  With limitations\*  
 Not provided.

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

Provided:  No limitations  With limitations\*  
 Not provided.

\*Description provided on attachment.

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

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses, prescribed by a physician skilled in diseases of the eye or by an optometrist.
- a. Prescribed drugs.
- Provided:  No limitations  With limitations\*  
 Not provided.
- b. Dentures.
- Provided:  No limitations  With limitations\*  
 Not provided.
- c. Prosthetic devices.
- Provided:  No limitations  With limitations\*  
 Not provided.
- d. Eyeglasses.
- Provided:  No limitations  With limitations\*  
 Not provided.
13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.
- a. Diagnostic services.
- Provided:  No limitations  With limitations\*  
 Not provided.

\*Description provided on attachment.

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

b. Screening services.

Provided:  No limitations  With limitations\*  
 Not provided.

c. Preventive services.

Provided:  No limitations  With limitations\*  
 Not provided.

d. Rehabilitative services.

Provided:  No limitations  With limitations\*  
 Not provided.

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

a. Inpatient hospital services.

Provided:  No limitations  With limitations\*  
 Not provided.

b. Skilled nursing facility services.

Provided:  No limitations  With limitations\*  
 Not provided.

c. Intermediate care facility services.

Provided:  No limitations  With limitations\*  
 Not provided.

\*Description provided on attachment.

State: Hawaii

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

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

Provided:       No limitations       With limitations\*

Not provided.

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

Provided:       No limitations       With limitations\*

Not provided.

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

Provided:       No limitations       With limitations\*

Not provided.

17. Nurse-midwife services.

Provided:       No limitations       With limitations\*

Not provided.

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

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

No limitations       With limitations\*

Not provided.

\*Description provided on attachment

TN No. 11-007  
Supersedes  
TN No. 88-32

Approval Date: 02/17/2012

Effective Date: 07/01/2012

HCFA ID: 0069P/0002P



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

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

19. Case management services and Tuberculosis related services

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

Provided:  With limitations

Not provided.

- b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

Provided:  With limitations\*

Not provided.

20. Extended services for pregnant women

- a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and any remaining days in the month in which the 60th day falls.

Additional coverage ++

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

Additional coverage ++

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

\*Description provided on attachment.

TN No. 94-012  
Supersedes 94-011 Approval Date 12/13/94 Effective Date 9/1/94

State/Territory: Hawaii

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

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

Provided:  No limitations  With limitations\*

Not provided.

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

Provided:  No limitations  With limitations\*

Not provided.

23. <sup>Certified</sup> Pediatric or family nurse practitioners' services.

Provided:  No limitations  With limitations\*

\*Description provided on attachment.

TN No. 94-010

Supersedes

TN No. 92-05

Approval Date

9/22/94

Effective Date

8/1/94

HCFA ID: 7986E

State/Territory: Hawaii

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

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

a. Transportation.

Provided:  No limitations  With limitations\*  
 Not provided.

b. Services of Christian Science nurses.

Provided:  No limitations  With limitations\*  
 Not provided.

c. Care and services provided in Christian Science sanatoria.

Provided:  No limitations  With limitations\*  
 Not provided.

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

Provided:  No limitations  With limitations\*  
 Not provided.

e. Emergency hospital services.

Provided:  No limitations  With limitations\*  
 Not provided.

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

Provided:  No limitations  With limitations\*  
 Not provided.

\*Description provided on attachment.

TN No. 91-23

Supersedes

TN No. 88-23

Approval Date 12/31/91

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HCFA ID: 7986E

State: HAWAII

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

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

           provided       X       not provided

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

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

  X   Not Provided.

State: Hawaii

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

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

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

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

Provided:  No limitations  With limitations  None licensed or approved

Please describe any limitations: N/A

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

Provided:  No limitations  With limitations (please describe below)

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

Please describe any limitations: N/A

Please check all that apply:

- (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).
- (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). \*
- (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).\*

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

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TN No. 16-0003  
Supersedes                      Approval Date: June 23, 2016 Effective Date: April 1, 2016  
TN No. NEW

CASE MANAGEMENT SERVICES

A. Target Group:

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

1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;
2. Is manifested before the person attains the age 22;
3. Is likely to continue indefinitely;
4. Results in substantial functional limitations in three or more of the following areas of major life activity; self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic sufficiency; and
5. Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic care, treatment, or other services which are of lifelong or extended duration and are individually planned and coordinated.

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

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

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

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

C. Comparability of Services:

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

D. Definition of Services:

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

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

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Supersedes

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2. Service Coordination - Arranging for community residential, (i.e., care home, foster home, domiciliary home), habilitation, support, (i.e., respite, transportation, personal care), and protective services, (i.e., adult and child abuse), and coordination of services with other agencies who are involved with the individual, (i.e., Adult Residential Care Homes, Easter Seals Society, Association for Retarded Citizens of Hawaii, United Cerebral Palsy Association, Medical Personnel Pool for respite and personal care, Department of Human Services, Adult and Family Services Division for adult and child protective services, Vocational Rehabilitation Division, Community Long Term Care Branch, Social Security Administration, Department of Education, Family Court, Mental Health Services Systems, Office of the Public Guardian, and other public and private agencies.
3. Advocacy - Activities with the client/family and providers for the purpose of facilitating access to needed services, providing information and referral, arranging emergency services, and modifying service systems to increase accessibility and appropriateness for people with developmental disabilities.

*HS 5/13/91*  
E. Qualification of Providers:

*of the Department of Health,*

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

*5/13/91*

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

F. Freedom of Choice:

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

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

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

CASE MANAGEMENT SERVICES

A. Target Group:

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

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

Target group is defined along three dimensions:

1. Diagnosis;
2. Level of disability which is likely to continue indefinitely;
3. Impaired role functioning which results in substantial functional limitations in three or more of the following areas of major life activity; self care, learning, mobility, self-direction, capacity for independent living, and economic sufficiency; and

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

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

Entire State

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

C. Comparability of Services:

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

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

D. Definition of Services:

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

1. Individualized Service Plan Development

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

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

2. Service Coordination

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

3. Client Support & Advocacy

With or on behalf of the client to gain access to

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

- a. Seeking and assisting the client in applying for entitlement benefits, services, etc.;
- b. Arranging appointments;
- c. Establishing and maintaining communications with service providers; and
- d. Accompanying/transporting of client to scheduled appointment to assure access and to minimize trauma to client.
- e. Immediate intervention by case managers to refer clients who are decompensating (grossly psychotic, suicidal/homicidal ideation) and may be in need of psychiatric hospitalization/evaluation. Immediate intervention by case managers who would also include assisting the client by referral and linkaging to resolve immediate crisis situations that may jeopardize the client's functioning in the community (e.g., eviction, serious physical illness/injury, serious inter-personal conflicts, substance abuse episodes, medication problems, etc.).

4. Collateral Contacts

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

5. Monitoring/Follow-Up Services

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

- a. Determining that satisfactory referral connections have been established;
- b. Contacts with service providers to assess the level of client compliance;

- c. Assuring ongoing appropriateness and effectiveness of service plan; and
- d. Identify and determine if additional services may be appropriate or required.

**E. Qualification of Providers:**

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

**F. Freedom of Choice:**

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

- 1. Eligible recipients will have free choice of the providers of case management services.
- 2. Eligible recipients will have free choice of the providers of other medical care under the plan.

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

**CASE MANAGEMENT SERVICES**

**A. Target Group:**

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

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

**B. Areas of the State to be Covered:**

Entire State

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

**C. Comparability of Services:**

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

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

**D. Definition of Services:**

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

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

services, and handling questions that the family may have;

2. Coordinating the performance of evaluation and other needed diagnostic services;
3. Facilitates and participates in the development of the IFSP;
4. Assisting families in identifying available service providers and formal and informal resources;
5. Coordinating and monitoring the delivery of services, including the provision of early intervention services with other services that the child or family needs or is being provided, including medical services, respite care, and the purchase of prosthetic devices;
6. Facilitating the development and coordination of a transition plan for infants and toddlers with continuing special needs (e.g., from hospital to home; home to program; program to program; early intervention to preschool, etc.);
7. Providing family support services, which may include counseling, co-facilitating support groups for family members; and
8. Advocating on behalf of infants and toddlers with special needs and their families.

E. Qualification of Providers:

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

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



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

**F. Freedom of Choice:**

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

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

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

## CASE MANAGEMENT SERVICES

### A Target Group:

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

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

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

- (1) Eligible for medical assistance from the department and under 21 years of age;
- (2) Determined medically-fragile and has a medical need for case management due to the medical condition of the individual and the need for coordination of multiple medical services/items;
- (3) Able to safely reside in a home or foster home and does not need to be cared for in a facility for medical reasons; but is unable to reside safely in the home without receiving specialized medical services/items; and
- (4) The provisions of such services will improve the care the family and service providers furnish to the individual and enable the individual to remain in the home safely.

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

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

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

TN No. 01-009

Supersedes \_\_\_\_\_

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

Approval Date: OCT 18 2001 Effective Date: July 1, 2001

**C** Comparability of Services:

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

**D.** Definition of Services:

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

1. The case management provider must keep written documentation of his/her case management activities which includes assessment/reassessment, plan of care development, implementation and changes, advocacy, liaison, coordination of care and quality.
2. All records must be dated and signed.
3. All federal and state privacy and confidentiality requirements must be met.

**E.** Qualification of Providers:

1. The case management provider must be a Medicaid provider.
2. The case management provider must be an entity that employs licensed professional nurses and/or licensed physicians. The nurse must work with a physician. The physician may be an employer, a consultant to the nursing staff, an employee, or the recipient’s physician.
3. In all cases, the primary case manager must be a licensed professional nurse or a licensed physician.
4. Although case management services may be provided by the staff of the entity, the licensed professional nurse and/or physician must supervise, consult, and/or advise the staff providing the activities.
5. The assessment of the patient’s medical condition must be performed by a licensed professional nurse or licensed physician.

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TN No. 01-009

Supersedes

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

Approval Date: OCT 18 2001 Effective Date: 11 1 2001

F. Freedom of Choice:

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

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

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TN No. 01-009  
Supersedes \_\_\_\_\_ Approval Date: OCT 18 2001 Effective Date: JUL 1 2001  
TN No. \_\_\_\_\_

Revision: HCFA-PH-86-20 (BERC)  
SEPTEMBER 1986

ATTACHMENT 3.1-B  
Page 1  
OMB No. 0938-0193

State/Territory: Hawaii

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

The following ambulatory services are provided.

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

\*Description provided on attachment.

TN No. 86-11  
Supersedes  
TN No. 82-4

Approval Date FEB 17 1987

Effective Date 10/1/86

HCFA ID: 0140P/0102A

State: Hawaii

**AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): \_\_\_\_\_**

1. Inpatient hospital services other than those provided in an institution for mental diseases.  
 Provided:       No limitations       With limitations\*
2. a. Outpatient hospital services.  
 Provided:       No limitations       With limitations\*
- b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise covered under the Plan).  
 Provided:       No limitations       With limitations\*
- c. Federally qualified health center (FQHC) services and other ambulatory services that are covered under the Plan and furnished by an FQHC in accordance with section 4231 of the State Medicaid Manual (HCFA-Pub. 45-4).  
 Provided:       No limitations       With limitations\*
3. Other laboratory and x-ray services.  
 Provided:       No limitations       With limitations\*
4. a. Nursing facility services (other than services in an institution for mental diseases) for individuals 21 years of age or older.  
 Provided:       No limitations       With limitations\*
- b. Early and periodic screening, diagnostic and treatment services for individuals under 21 years of age, and treatment of conditions found. +  
 Provided
- c. Family planning services and supplies for individuals of childbearing age.  
 Provided:       No limitations       With limitations\*

\*Description provided on attachment.

TN No. 11-007  
Supersedes  
TN No. 92-05

Approval Date: 02/17/2012

Effective Date: 07/01/2012  
HCFA ID: 7986E

State/Territory: HAWAII

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

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

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

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

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

\* Description provided on attachment.

TN No. 92-17  
Supersedes \_\_\_\_\_ Approval Date 10/13/92 Effective Date 10/01/92  
TN No. 92-05

State/Territory: HAWAII

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

6. Medical care and any other type of remedial care recognized under State law, furnished by licensed practitioners within the scope of their practice as defined by State law.
- a. Podiatry Services  
 Provided:      \_\_\_ No limitations       With limitations
  - b. Optometrists' Services  
 Provided:      \_\_\_ No limitations       With limitations
  - c. Chiropractors' Services  
\_\_\_ Provided:      \_\_\_ No limitations      \_\_\_ With limitations
  - d. Other Practitioners' Services  
 Provided:      \_\_\_ No limitations       With limitations
7. Home Health Services
- a. Intermittent or part-time nursing services provided by a home health agency or by a registered nurse when no home health agency exists in the area.  
 Provided:      \_\_\_ No limitations       With limitations
  - b. Home health aide services provided by a home health agency.  
 Provided:      \_\_\_ No limitations       With limitations
  - c. Medical supplies, equipment, and appliances suitable for use in the home.  
 Provided:      \_\_\_ No limitations       With limitations
  - d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitation facility.  
 Provided:      \_\_\_ No limitations       With limitations

\*Description provided on attachment.

TN No. 05-002  
Supersedes  
TN No. 86-11

Approval Date: JUN 09 2006 Effective Date: 07/01/05



State/Territory: Hawaii

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

8. Private duty nursing services.  
 Provided:  No limitations  With limitations\*
9. Clinic services.  
 Provided:  No limitations  With limitations\*
10. Dental services.  
 Provided:  No limitations  With limitations\*
11. Physical therapy and related services.
- a. Physical therapy.  
 Provided:  No limitations  With limitations\*
- b. Occupational therapy.  
 Provided:  No limitations  With limitations\*
- c. Services for individuals with speech, hearing, and language disorders provided by or under supervision of a speech pathologist or audiologist.  
 Provided:  No limitations  With limitations\*
12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.
- a. Prescribed drugs.  
 Provided:  No limitations  With limitations\*
- b. Dentures.  
 Provided:  No limitations  With limitations\*

\*Description provided on attachment.

TN No. 86-11  
Supersedes  
TN No. 82-4

Approval Date FEB 1 1987

Effective Date 10/1/86

State/Territory: Hawaii

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

- c. Prosthetic devices.  
 Provided:  No limitations  With limitations\*
- d. Eyeglasses.  
 Provided:  No limitations  With limitations\*
13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.
- a. Diagnostic services.  
 Provided:  No limitations  With limitations\*
- b. Screening services.  
 Provided:  No limitations  With limitations\* *# 1-13-87*
- c. Preventive services.  
 Provided:  No limitations  With limitations\* *# 2-13-87*
- d. Rehabilitative services.  
 Provided:  No limitations  With limitations\*
14. Services for individuals age 65 or older in institutions for mental diseases.
- a. Inpatient hospital services.  
 Provided:  No limitations  With limitations\*
- b. Skilled nursing facility services.  
 Provided:  No limitations  With limitations\*

\*Description provided on attachment.

TN No. 86-11  
Supersedes  
TN No. 84-1

Approval Date FEB 17 1987

Effective Date 10/1/86

State/Territory: Hawaii

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

- c. Intermediate care facility services
- Provided:       No limitations       With limitations\*
15. a. Intermediate care facility services (other than such services in an institution for mental diseases) for persons determined, in accordance with section 1902(a)(31)(a) of the Act, to be in need of such care.
- Provided:       No limitations       With limitations\*
- b. Including such services in a public institution (or distinct part thereof) for the mentally retarded or persons with related conditions.
- Provided:       No limitations       With limitations\*
16. Inpatient psychiatric facility services for individuals under 22 years of age.
- Provided:       No limitations       With limitations\*
17. Nurse-midwife services.
- Provided:       No limitations       With limitations\*
18. Hospice care (in accordance with section 1905(o) of the Act).
- Provided in accordance with section 2302 of the Affordable Care Act:
- No limitations       With limitations\*

\*Description provided on attachment

TN No. 11-007  
Supersedes  
TN No. 88-32

Approval Date: 02/17/2012

Effective Date: 07/01/2012  
HCFA ID 0140P/0102A

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

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

19. Case management services and Tuberculosis related services

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

Provided:  With limitations\*

Not provided.

- b. Special tuberculosis (TB) related services under section 1902(z)(2)(F) of the Act.

Provided:  With limitations\*

Not provided.

20. Extended services for pregnant women.

- a. Pregnancy-related and postpartum services for a 60-day period after the pregnancy ends and for any remaining days in the month in which the 60th day falls.

Provided:  Additional coverage<sup>++</sup>

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

Provided:  Additional coverage<sup>++</sup>  Not provided.

21. Certified pediatric or family nurse practitioners' services.

Provided:  No limitations  With limitations\*

Not provided.

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

Refer to Supplement to Attachment 3.1-A and 3.1-B

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

\*Description provided on attachment.

TN No. 94-012

Supersedes  
TN No. 94-011

Approval Date

12/13/94

Effective Date

9/1/94

State/Territory: HAWAII

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

22. Respiratory care services (in accordance with section 1902(e)(9)(A) through (C) of the Act).  
 Provided:  No limitations  With limitations\*  
 Not provided.
23. Any other medical care and any other type of remedial care recognized under State law, specified by the Secretary.
- a. Transportation.  
 Provided:  No limitations  With limitations\*
- b. Services of Christian Science nurses.  
 Provided:  No limitations  With limitations\*
- c. Care and services provided in Christian Science sanatoria.  
 Provided:  No limitations  With limitations\*
- d. Skilled nursing facility services provided for patients under 21 years of age.  
 Provided:  No limitations  With limitations\*
- e. Emergency hospital services.  
 Provided:  No limitations  With limitations\*
- f. Personal care services in recipient's home, prescribed in accordance with a plan of treatment and furnished by a qualified person under supervision of a registered nurse.  
 Provided:  No limitations  With limitations\*

TN No. 90-5  
Supersedes  
TN No. 88-23

Approval Date JUL 9 1990

Effective Date APR 1 1990

HCFA ID: 1042P/0016P

State/Territory: HAWAII

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

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

\_\_\_ Provided      X Not Provided

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

\_\_\_ Provided:      \_\_\_ State Approved (Not Physician) Service Plan Allowed  
                         \_\_\_ Services Outside the Home Also Allowed  
                         \_\_\_ Limitations Described on Attachment  
X Not provided.

State/Territory: Hawaii

**AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED  
MEDICALLY NEEDY GROUP(S): \_\_\_\_\_**

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

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

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

Provided:  No limitations  With limitations  None licensed or approved

Please describe any limitations: N/A

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

Provided:  No limitations  With limitations (please describe below)

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

Please describe any limitations: N/A

Please check all that apply:

- (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).
- (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). \*
- (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).\*

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

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TN No.	<u>16-0003</u>	Approval Date:	<u>June 23, 2016</u>	Effective Date:	<u>April 1, 2016</u>
Supersedes					
TN No.	<u>NEW</u>				



1. The utilization control committee of an acute hospital facility shall determine the medical necessity for admission and continued stay for all recipients. Extension of hospital stay shall be requested when a patient is awaiting placement in a long-term facility.
  
- 2a. Outpatient psychiatric services for substance abuse treatment (SAT) services that are medically necessary shall be provided with no limits on the number of visits. The providers for SAT services are psychiatrists, psychologists, licensed social workers in behavioral health, and advance practice registered nurses (APRN) in behavioral health. Setting where services will be delivered are in outpatient hospital/clinic including methadone clinics, and physician/provider offices. Only professional fees are paid when services are provided in an outpatient clinic setting and are paid at or below the Medicare fee schedule rate. SAT services that are medically necessary shall be reimbursed with the existing approved Medicaid Fee Schedule located in Attachment 4.19-B, Section 1., Hawaii Medicaid Fee Schedule, item (a) and (d) and Section 2., Medicaid Payment for Other Non-Institutional Items and Services are determined as Follows, item (i), or PPS methodology.
  
- 2c. FQHC and RHC services are congruent with the general scope and limitations to services of Hawaii's Medicaid program.

FQHC and RHC services shall be delivered exclusively by the following health care professionals who are licensed by, and a resident of, the State of Hawaii:

- i. Physician (Doctor of Medicine, Doctor of Osteopathy, Doctor of Dentistry, Doctor of Optometry, and Doctor of Podiatry);
- ii. Physician Assistant;
- iii. Nurse Practitioner;
- iv. Nurse Midwife;
- v. Visiting Nurse;
- vi. Clinical Social Worker;
- vii. Clinical Psychologist; or
- viii. Licensed dietitians

3. Prior authorization is required for the following services:

**Radiology:**

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

**Laboratory:**

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

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

- 4a. Authorization by the Department's medical consultant is required for level of care and admission to a NF.
  
- 4b. All services listed under 1905(a) of the Social Security Act are available to EPSDT eligible individuals when medically necessary, even though the services are not covered in this plan. Services limitation may be exceeded when determined by the State to be medically necessary.

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TN No.	<u>12-004</u>	Approval Date:	<u>09/20/2012</u>	Effective Date:	<u>07/01/2012</u>
Supersedes					
TN No.	<u>11-007</u>				

**School-Based Health-Related Services (SBHRS):**

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

**SBHRS are defined below:**

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

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

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

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

**Physical Therapy:** Therapy services are provided by:

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

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TN No. 11-007  
Supersedes  
TN No. 05-002

Approval Date: 02/17/2012

Effective Date: 01/01/2012

SUPPLEMENT TO ATTACHMENT 3.1-A and 3.1-B

**Occupational Therapy:** Therapy services are provided by:

- Occupational therapist registered (OTR) who is registered and licensed to practice in the State of Hawaii. Occupational therapist will meet the Federal requirements at 42 C.F.R. §440.110(b)(2);
- Certified occupational therapy assistant (COTA) who is a graduate of an accredited occupational therapy assistance program recognized by the American Medical Association and American Occupational Therapy Association with an Associate.

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

**Auditory therapy:** Therapy services are provided by:

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

**Speech Language Therapy:** Therapy services are provided by:

- Speech pathologist licensed to practice in the State of Hawaii and meets the Federal provider requirements at 42 C.F.R. §440.110(c). Providers or speech language therapy services will meet the Federal provider requirements at 42 C.F.R §440.110(c)(2);
- Communication aide to meet the specific needs of an eligible student. Communication aides are paraprofessional equivalents of speech pathologists. The communication aide must have a high school degree and general and special experience recognized by the DOE. All-or part of general experience may be substituted for by education in programs of Associate of Science in Teacher's Aid or possession of an Associate of Science degree in Teacher's Aid from an accredited community college or possession of a bachelor's degree in education or equivalent from an accredited college or university or possession of a bachelor's degree in speech pathology as specified by the DOE and working under the supervision of a licensed and Federally qualified speech pathologist that meets the requirements of 42 C.F.R. §440.110. Communication aides do therapy under the supervision of the speech pathologist. They are not hired to do audiology services. They do not teach Braille or sign language. The qualified speech pathologist must see the student initially, prescribe the type of care provided, review the need for continued services throughout treatment, and see the student at least annually. The speech pathologist must assume professional responsibility for the services provided and ensure that the services are medically necessary. The qualified speech pathologist must spend as much time as

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TN No. 11-007  
Supersedes  
TN No. 02-006

Approval Date: 02/17/2012

Effective Date: 07/01/2012

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

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

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

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

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

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

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

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

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TN No. 02-006  
 Supersedes  
 TN No. 93-010

Approval Date: JUL 25 2003 Effective Date: 10/01/02

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

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

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

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

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

TN No. 02-006  
 Supersedes  
 TN No. 93-010

Approval Date: JUL 25 2003 Effective Date: 10/01/02

4c. The limitation on family planning are:

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

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

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

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

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

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

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

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TN No.	<u>16-0004</u>	Approval Date:	<u>03/15/2017</u>	Effective Date:	<u>01/01/2017</u>
Supersedes					
TN No.	<u>05-003</u>		<u>1.5</u>		

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6a. Podiatry services are provided with the following limitations:

- 1) Hospital inpatient services and appliances costing more than \$100.00 require prior approval by the department.

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

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

6d. Services of a Psychologist are provided with the following limitations:

- 1) Testing is limited to a maximum of 4 hours once every 12 months or to 6 hours, if a comprehensive test is justified.
- 2) Prior authorization is required for all psychological testing except for tests that are requested by the department's professional staff.

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

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

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'N No. 21-0002  
Supersedes 12-004 Approval Date: 05/20/2021 Effective Date: 01/01/2021  
'N No. 12-004

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

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

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

Medical supplies, equipment and appliances require prior authorization by the department when the cost exceeds \$50.00 per item.

Physical and occupational therapy and services for speech, hearing and language disorders are subject to the limitations set forth in #11.

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

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

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

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TN No. 21-0002  
Supersedes  
TN No. 12-004

Approval Date: 05/20/2021

Effective Date: 01/01/2021



10. **DENTAL SERVICES:**

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

(1) **Exclusions to dental services are:**

- (a) Orthodontic services, except following repair of cleft palate or other developmental defect or injury resulting in malalignment or malocclusion of the teeth in a child or when recommended by DOH's, crippled children branch.
- (b) Fixed bridgework.
- (c) Plaque control.
- (d) Gold crowns and gold inlays.
- (e) Procedures, appliances, or restoration solely for cosmetic purposes. Composite resin or acrylic restoration in posterior teeth and all primary teeth shall be considered purely cosmetic.
- (f) Overdentures.
- (g) Tooth preparation, temporary restorations, cement bases, impressions, or local anesthesia.

(2) **Limitations to dental services provided are:**

- (a) X-rays.
- (b) Dental work done under intravenous, inhalation or general anesthesia shall be allowed only once per treatment plan and limited to cases of medical necessity.
- (c) Restorative dentistry limited to use of certain materials. Non-duplicated restorative procedures are allowed once per tooth every two years as needed in the treatment of fractured or carious teeth.
- (d) Dental prostheses:

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TN No. 06-002

Supersedes

TN No. 02-002

Approval Date: SEP 14 2006 Effective Date: July 1, 2006

SUPPLEMENT to ATTACHMENT 3.1-A and 3.1-B

- (i) Partial dentures are limited to fill the space due to the loss of one or more anterior teeth and to fill the space due to the loss of two or more posterior teeth exclusive of third molars.
  - (ii) Temporary dentures allowed only when teeth have been extracted recently with prior authorization and shall be subject to maximum benefits for dentures.
  - (iii) Only one prosthetic appliance in any five-year period is allowed for a maximum of one for each type, partial and full dentures, per arch per recipient; lifetime. This is allowed only when present and previous dentures cannot be repaired or adjusted.
  - (iv) Dentures relines are limited to once per denture every two years.
  - (e) Topical application of fluoride is limited to individuals under age twenty-one.
  - (f) Sealants for occlusal surface of caries free permanent molar teeth only for children age six through fifteen.
  - (g) Anterior, molars and premolar root canal shall be covered for a maximum of once per tooth, with authorization, except in cases of poor prognosis possibly due to extensive root decay or bone loss or prior root canal therapy failure.
  - (h) Acrylic jackets and acrylic veneer crowns, if authorized, shall be limited to anterior teeth for a maximum of once per tooth.
  - (i) Except for emergency treatments, prior authorization is required for certain dental work.
- (3) The above limitations will be exceeded based on a determination of medical necessity under the EPSDT provisions at 1905(r)(5).
- (B) Individuals age 21 years and older — Dental Services:**
- (1) Emergency treatment shall include the following services:
    - (a) Relief of dental pain;
    - (b) Elimination of infection; and
    - (c) Treatment of acute injuries to the teeth or supporting structures of the orofacial complex.

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TN No. 11-007  
Supersedes  
TN No. 09-004

Approval Date: 02/17/2012

Effective Date: 07/01/2012

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

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

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

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<b>TN No.</b>	<u>12-004</u>	<b>Approval Date:</b>	<u>09/20/2012</u>	<b>Effective Date:</b>	<u>07/01/2012</u>
<b>Supersedes</b>					
<b>TN No.</b>	<u>11-007</u>				

**SUPPLEMENT TO ATTACHMENT 3.1-A and 3.1-B**

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

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

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

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

The following excluded drugs are not covered:

- (a) Used for cosmetic purposes or hair growth;
  - (b) With associated tests or monitoring purchased exclusively from the manufacturer or designee as a condition of sale;
  - (c) Which are classed as "less than effective" as described in Section 107(c)(3) of the Drug Amendments of 1962 or are identical, similar or related; and
  - (d) Agents used to promote fertility.
- (2) The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit - Part D.

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TN No. 05-006

Supersedes

TN No. 03-004

Approval Date: DEC - 9 2005 Effective Date: 01/01/06

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

The following excluded drugs are covered:

- (a) Agent when used for anorexia, weight loss, weight gain (see specific drug categories below)
  - Marinol
- (b) Agents when used for symptomatic relief cough and colds (see specific drug categories below)
  - Brompheniramine with pseudoephedrine (tablets, liquid)
  - Chlorpheniramine (all forms)
  - Diphenhydramine (all forms)
  - Guaifenesin with or without dextromethorphan (all strength/liquid)
  - Loratadine with or without a decongestant (for age 20 years old and younger; for age 61 years old and older; age 21 to 60 continue to require PA)\*
  - Pseudoephedrine (all forms)
- (c) Prescription only vitamins and mineral products, except prenatal vitamins and fluoride (prior authorization required)

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TN No. 13-004d  
Supersedes  
TN No. 05-006

Approval Date: 08/25/2014 Effective Date: 10/01/2013

(d) Non-legend drugs (see specific drug categories below)

- Analgesics
- Anti-Allergy
- Anti-Inflammatory
- Antibacterial/Antifungals
- Antidiarrheals
- Antihemorrhoidals
- Antacids
- Cough and cold
- Gastrointestinal (H2 and PPDI)
- Laxatives
- Ophthalmics
- Otics
- Schedule V OTC Products

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TN No. 14-005  
Supersedes  
TN No. 13-004d

Approval Date: 11/19/2014 Effective Date: 01/01/2014

**Schedule 3  
Supplemental Rebate Calculation**

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

**SUPPLEMENT TO ATTACHMENT 3.1-A and 3.1-B**

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

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

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

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

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TN No. 05-006

Supersedes

TN No. 03-004

Approval Date: DEC - 9 2005 Effective Date: 01/01/06



**SUPPLEMENT to ATTACHMENT 3.1-A and 3.1-B**

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

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

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**TN No. 11-007**  
**Supersedes**  
**TN No. 08-003**

**Approval Date: 02/17/2012**

**Effective Date: 07/01/2012**

- (4) The maximum quantity of any medication to be paid equals the larger of a one month supply or one hundred units. The State may implement stricter quantity restrictions to help ensure proper utilization and reduce billing errors.
- (5) In compliance with Section 1927(b)(2) of the Social Security Act, the fiscal agent is engaged to report to each manufacturer not later than sixty days after the end of each calendar quarter and in a form consistent with a standard reporting format established by the Secretary, information on the total number of dosage units of each covered outpatient drug dispensed under the plan during the quarter and shall promptly transmit a copy of such report to the Secretary as instructed by CMS.

12b. Partial dentures limited to fill the space due to the loss of one or more anterior teeth and to fill the space due to the loss of two or more posterior teeth exclusive of third molars. Temporary dentures allowed only when teeth have been extracted recently with prior authorization and subject to maximums or prosthetics.

Only one prosthetic appliances in any five year period is allowed for a maximum of one for each type, partial and full dentures, per arch per recipient; lifetime. This is allowed when present or previous dentures cannot be repaired or adjusted.

Denture relines are limited to once per denture every two years.

Dentures are authorized only when provided under EPSDT.

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

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TN No.	<u>12-004</u>	Approval Date:	<u>09/20/2012</u>	Effective Date:	<u>07/01/2012</u>
Supersedes					
TN No.	<u>11-007</u>				

12d. Same as 6b.

13a. The diagnostic procedures or out of state procedures requiring prior authorization are:

- Psychological testing
- Neuropsychological testing
- Standardized cognitive testing

13c. Preventive services assigned a grade A or B recommendation by the United States Preventive Services Task Force (USPSTF), approved vaccines and their administration recommended by the Advisory Committee on Immunization Practices (ACIP), preventive care and screening of infants, children and adolescents recommended by HRSA's Bright Futures program and additional preventive services for women recommended by the Institute of Medicine (IOM) will be covered without cost-sharing in accordance with section 2713 of the Public Health Service Act, which is in alignment with the Alternative Benefit Plan.

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

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

Smoking cessation counseling and pharmacotherapy shall be consistent with the Treating Tobacco Use and Dependence practice guidelines issued by the Agency for Healthcare Research and Quality. Two quit attempts per benefit period and a minimum of four in person counseling sessions per quit attempt provided by trained and licensed providers practicing within their scope of practice shall constitute each quit attempt. Two effective components of counseling, practical counseling and social support delivered as part of the treatment is emphasized. Settings where services will be delivered are in outpatient hospital/clinics and physician/provider offices. Limits may be exceeded based on medical necessity.

Smoking cessation counseling services can be provided by the following licensed providers: psychologists, licensed clinical social workers in behavioral health, advance practice registered nurses (APRN), dentist, licensed mental health counselors (MHC) in behavioral health and Certified Tobacco Treatment Specialists under the supervision of a licensed provider and the supervision is within the scope of practice of the licensed practitioner.

13d. Rehabilitative services are subject to the limitations specified on these supplement pages for particular services, i.e., physical therapy, speech therapy, etc.

**Community Mental Health Rehabilitative Services:**

The covered Community Mental Health Rehabilitative Services will be available to all Medicaid eligibles who are medically determined to need mental health and/or drug abuse/alcohol services. These services must be recommended by a physician or other licensed practitioner to promote the maximum reduction and/or restoration of a recipient to his/her best possible functional level relevant to their diagnosis of mental illness and/or abuse of drugs/alcohol.

These services are to be provided by the following qualified mental health professionals: licensed psychiatrist, licensed psychologist, licensed clinical social worker (CSW) with experience in behavioral health, licensed advance practical nurse (APRN) in behavioral health, or a licensed Marriage and Family Therapist (LMFT) with experience in behavioral health. Additionally, provider qualification must be in

**SUPPLEMENT TO ATTACHMENT 3.1-A and 3.1-B**

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

The services are defined as follows:

1. **Crisis Management.** This service provides mobile assessment for individuals in an active state of crisis (24 hours per day, 7 days per week) and can occur in a variety of community settings including the consumer's home. Immediate response is required. Included in Crisis Management services are an assessment of risk, mental status, and medical stability, and immediate crisis resolution and de-escalation. If necessary, this may include referral to licensed psychiatrist, licensed psychologist, or to an inpatient acute care hospital. The presenting crisis situation may necessitate that the services be provided in the consumer's home or natural environment setting. Thus, crisis management services may be provided in the home, school, work environment or other community setting as well as in a health care setting. These services are provided through JCAHO, CARF, or COA accredited agencies. In addition, agencies must have staff that includes one or more qualified mental health professionals. If the services are provided by staff other than a qualified mental health professional, the staff must be supervised at a minimum by a qualified mental health professional.
  
2. **Crisis Residential Services.** Crisis Residential Services are short-term, interventions provided to individuals experiencing crisis to address the cause of the crisis and to avert or delay the need for acute psychiatric inpatient hospitalization or inpatient hospital based psychiatric care at levels of care below acute psychiatric inpatient. Crisis Residential Services are for individuals who are experiencing a period of acute stress that significantly impairs the capacity to cope with normal life circumstances. The program provides psychiatric services that address the psychiatric, psychological, and behavioral health needs of the individuals. Specific services are: psychiatric medical assessment, crisis stabilization and intervention, medication management and monitoring, individual, group and/or family counseling, and daily living skills training. Services are provided in a licensed residential program, licensed therapeutic group home or foster home setting. All crisis residential programs will have less than 16 beds. The services do not include payment for room and board. The staff providing crisis residential services must be qualified mental health professionals. If the services are provided by staff other than a qualified mental health professional, the staff must be supervised at a minimum by a qualified mental health professional.
  
3. **Biopsychosocial Rehabilitative Programs :** A therapeutic day rehabilitative social skill building service which allows individuals with serious mental illness to gain the necessary social and communication skills necessary to allow them to remain in or return to naturally occurring community programs. } = club  
1115

TN No. 01-010

Supersedes \_\_\_\_\_

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

Approval Date: MAY 15 2002

Effective Date: 07/01/01

## SUPPLEMENT TO ATTACHMENT 3.1-A and 3.1-B

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

4. **Intensive Family Intervention.** These are time limited intensive interventions intended to stabilize the living arrangement, promote reunification or prevent the utilization of out of home therapeutic resources (i.e. psychiatric hospital, therapeutic foster care, residential treatment facility) for children with serious emotional or behavioral disturbance or adults with serious mental illness. These services: 1) diffuse the current crisis, evaluate its nature and intervene to reduce the likelihood of a recurrence; 2) assess and monitor the service needs of the identified individual so that he/she can be safely maintained in the family; 3) ensure the clinical appropriateness of services provided; and 4) improve the individual's ability to care for self and the family's capacity to care for the individual. This service includes focused evaluations and assessments, crisis case management, behavior management, counseling, and other therapeutic rehabilitative mental health services toward improving the individual's ability to function in the family. Services are directed towards the identified individual within the family. Services can be provided in-home, school or other natural environment. Services are provided by a multidisciplinary team comprised of qualified mental health professionals. If the services are provided by staff other than that listed above, the staff must be supervised by one of the licensed disciplines noted above and at a minimum be a qualified mental health professional. Additionally, provider qualifications must be in compliance with requirements and standards of a national accreditation organization (JCAHO, CARF, COA).
  
5. **Therapeutic Living Supports and Therapeutic Foster Care Supports.** These are services covered in settings such as group living arrangements or therapeutic foster homes. Group living arrangements usually provide services for 3 to 6 individuals per home but not more than 15. Therapeutic foster homes provide services for a maximum of 15 individuals per home. Although these group living arrangements and therapeutic foster homes may provide 24 hour per day of residential care, only the therapeutic services provided are covered. There is no reimbursement of room and board charges. Covered

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Supersedes \_\_\_\_\_

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

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**SUPPLEMENT TO ATTACHMENT 3.1-A and 3.1-B**

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

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

13d. **Limitations continued**

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

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TN No. 01-010  
Supersedes \_\_\_\_\_ Approval Date: MAY 15 2002 Effective Date: 07/01/01  
TN No. \_\_\_\_\_

13d. Community Mental Health Rehabilitative Services (continued)

8. **Substance Abuse Treatment (SAT) services:** SAT services furnished under §440.130(d) are provided by a qualified mental health professional to include but not limited to a licensed psychiatrist, licensed psychologist, licensed clinical social worker with experience in behavioral health, licensed advance practical nurse in behavioral health, licensed mental health counselor, or a licensed marriage and family therapist with experience with behavioral health or a substance abuse counselor certified by the State. SAT services shall be provided without limits on the number of visits when medically necessary; prior authorization is required, and monthly assessments are performed to ensure that services are medically necessary. SAT services are recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law. The substance abuse provider assists an individual in achieving specific objectives of treatment or care for a substance use or mental health disorder through a face-to-face, one-to-one therapeutic relationship. Services are generally directed toward reducing psychosocial stress and teaching coping and problem-solving skills, using supportive and cognitive-behavioral approaches that restore a participant's best possible functional level.
  
9. **Peer support services:** Peer support services may be provided by a peer specialist certified by the State Department of Health, Adult Mental Health Division (AMHD) as part of their Hawaii certified peer specialist (HCPS) program or a program that meets the criteria established by the AMHD. Peer support services are provided without limits on the number of visits when medically necessary; prior authorization is required, and monthly assessments are performed to ensure that benefits are medically necessary. Peer support providers are self-identified consumers who are in recovery from mental illness and/or substance use disorders. Peer support providers meet the following minimum requirements for supervision, care coordination and training: 1) Supervision is provided by a mental health professional (as defined by the State); 2) Peer support services are coordinated within the context of a comprehensive, individualized plan of care that reflects the needs and preferences of the participant in achieving the specific, individualized goals that have measurable results and are specified in the service plan; 3) Training and Credentialing: Peer support providers must complete training and certification as defined by the State. The peer specialist must demonstrate the ability to support the recovery of others from mental illness and or substance use disorders. Peer support providers must complete ongoing continuing educational requirements.

Limitations (continued)

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

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TN No.	<u>13-004c</u>	Approval Date:	<u>12/16/2013</u>	Effective Date:	<u>10/05/2013</u>
Supersedes					
TN No.	<u>NEW</u>				



**SUPPLEMENT TO ATTACHMENT 3.1-A and 3.1-B**

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

16. **Psychiatric services for individuals under age 21.**

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

Services are not limited and must be authorized.

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

17. Limited to nurse midwives sponsored by a physician.

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TN No. 01-010

Supersedes \_\_\_\_\_

Approval Date: MAY 15 2002 Effective Date: 07/01/01

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

SUPPLEMENT to ATTACHMENT 3.1-A and 3.1-B

- 18. Authorization by the Department's medical consultant is required for services during a transitional period.
- 20.a. & b. Extended services to pregnant women includes all major categories of services provided for the categorically needy recipients, as long as the services are determined to be medically necessary and related to the pregnancy.
- 22. Prior authorization is required by the medical consultant for the provision of respiratory care services for ventilator-dependent individuals.
- 23. Nurse practitioner services shall be limited to the scope of practice a nurse practitioner is legally authorized to perform under State law.
- 24a. Except for emergencies, prior authorization is required for air transportation. Taxi service to obtain medical services may be authorized by the payment worker if there is not bus system, no means of transportation, etc.
- 24d. Must meet the skilled nursing level of care requested by a physician and approved by the department's medical consultant.

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TN No. 11-007  
Supersedes  
TN No. 94-010

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State of HAWAII

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I. Eligibility

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

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

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

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

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

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TN No. 11-007  
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**Regular Post Eligibility**

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

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

1. Allowances for the needs of the:

(A.) Individual (check one)

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

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

2.  The following dollar amount: \$

Note: If this amount changes, this item will be revised.

3.  The following formula is used to determine the needs allowance:

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

(B.) Spouse only (check one):

- 1.  SSI Standard
- 2.  Optional State Supplement Standard
- 3.  Medically Needy Income Standard
- 4.  The following dollar amount: \$

Note: If this amount changes, this item will be revised.

5.  The following percentage of the following standard that is not greater than the standards above:  % of  standard.

6.  The amount is determined using the following formula:

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7.  Not applicable (N/A)

(C.) Family (check one):

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

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

3.  The following dollar amount: \$ \_\_\_\_\_  
 Note: If this amount changes, this item will be revised.
4.  The following percentage of the following standard that is not greater than the standards above: \_\_\_\_\_ % of \_\_\_\_\_ standard.
5.  The amount is determined using the following formula:  
 \_\_\_\_\_  
 \_\_\_\_\_
6.  Other
7.  Not applicable (N/A)

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

#### Regular Post Eligibility

2.  209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.
- (a) **42 CFR 435.735** -- States using more restrictive requirements than SSI.
1. Allowances for the needs of the:
- (A) Individual (check one)
1.  The following standard included under the State plan (check one):
- (a)  SSI
- (b)  Medically Needy
- (c)  The special income level for the institutionalized
- (d)  Percent of the Federal Poverty Level \_\_\_\_\_%
- (e)  Other (specify):
2.  The following dollar amount: \$ \_\_\_\_\_  
 Note: If this amount changes, this item will be revised.
3.  The following formula is used to determine the needs allowance:  
 \_\_\_\_\_  
 \_\_\_\_\_

TN No. 11-007  
 Supersedes  
 TN No. 08-010

Approval Date: 02/17/2012

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

(B.) Spouse only (check one):

1.  The following standard under 42 CFR 435.121:

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2.  The Medically Needy Income Standard

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

---

6.  Not applicable (N/A)

(C.) Family (check one):

1.  AFDC need standard
2.  Medically needy income standard

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

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

---

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

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

**Spousal Post Eligibility**

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

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

(a) Allowances for the needs of the:

1. Individual (check one)

(A)  The following standard included under the State plan (check one):

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

(B).  The following dollar amount: \$ \_\_\_\_\_

Note: If this amount changes, this item will be revised.

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

\_\_\_\_\_  
\_\_\_\_\_

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

II. Rates and Payments

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

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

III. Enrollment and Disenrollment

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

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TN No. 11-007

Supersedes

Approval Date:

02/17/2012

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TN No. 08-010



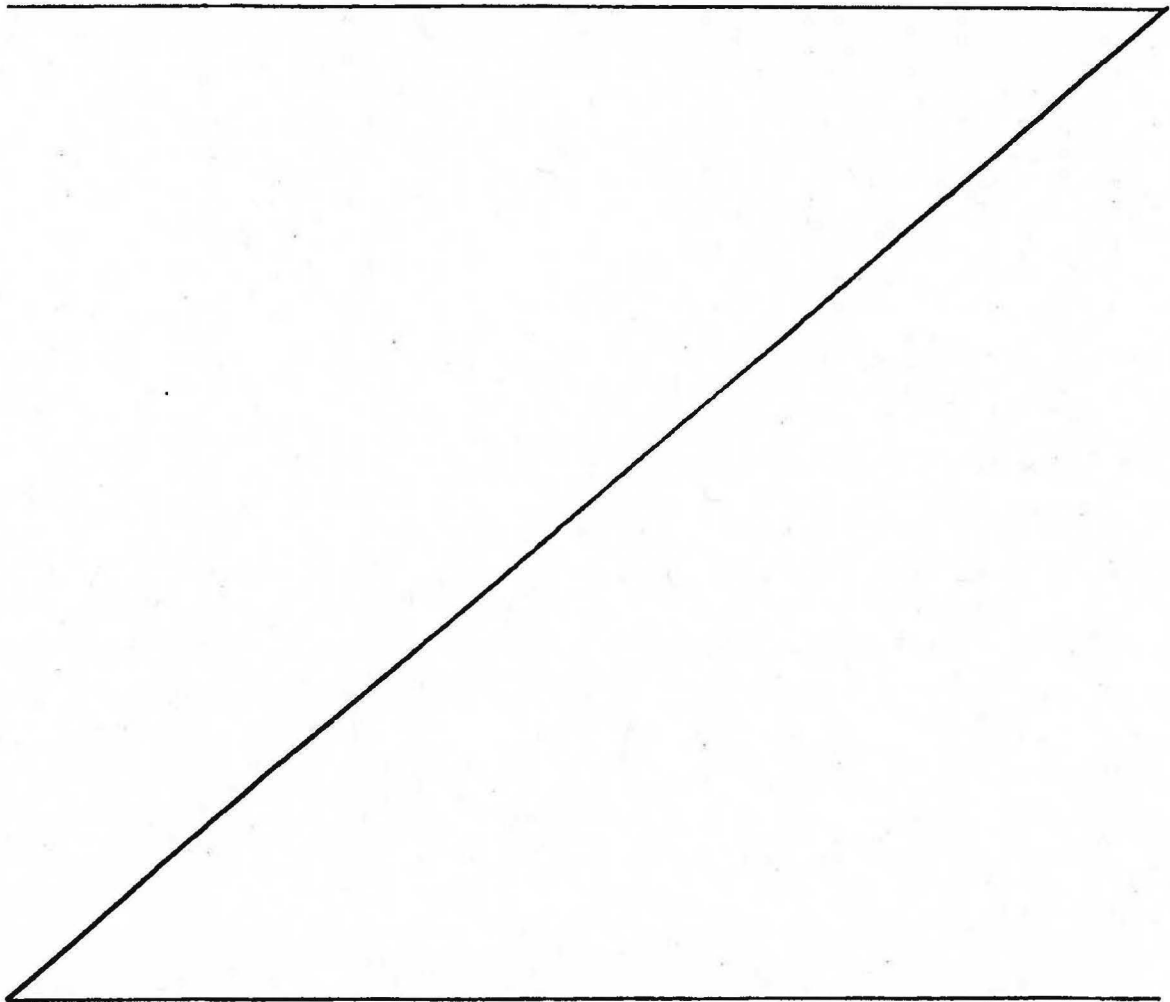
Described below are the methods which are used to assure that the medical and remedial care and services provided under the program are of high quality.

- (1) In the context of inpatient and outpatient hospital services and physicians' services, provisions are made for specialists' services and consultation.
- (2) Provision for transportation is made so that the required special medical services which are not available in communities where recipients reside may be obtained elsewhere.
- (3) There is an arrangement under which the agency's medical consultant may call on a member of the local medical association for consultation on cases involving questions of over-utilization or appropriateness of services recommended or provided.
- (4) NF standards are rigidly enforced jointly with the Department of Health. Both agencies provide consultation to such facilities to correct identified deficiencies or upgrade nursing care. A general surveillance is maintained by this agency to assure that such facilities continuously meet the required standards.
- (5) Prospective reviews and prior authorization requirements are maintained so that determination may be made by this agency as to the appropriateness of recommended medical services.
- (6) Periodic visits are made by the agency's representative to participating medical facilities to confer with the medical staff, review medical records and generally observe the services being provided recipients.
- (7) Planning and development of statewide EPSDT services are done jointly with the physician-administrators of Title V programs and in consultation with the local pediatric society.
- (8) Periodic on-site medical reviews are conducted by the agency's multi-disciplinary team at participating NF's to determine the adequacy of services and to evaluate the level of care required by recipients. Physician's patient certifications are examined and utilization review activities are monitored.

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TN No. 92-10  
Supersedes      Approval Date 9/4/92      Effective Date 4/1/92  
TN No. 89-8

- (9) Medical and remedial care and services which are unproven or of experimental nature are excluded under the program. Medicare's definition and guidelines are utilized in determining which procedures are experimental or unproven.
- (10) Described below are the methods used to implement the nursing home reform provisions of OBRA '87.
  - A. PASARR Level I was provided on an interim basis by HCAD consultants. Effective September 1, 1989, LTC facilities assumed responsibility for Level I;
  - B. By interagency agreement, PASARR Level II determinations are performed by Mental Health Division and Developmental Disabilities Division of the Department of Health:



TN No. 92-10  
Supercedes Approval Date 9/4/92 Effective Date 4/1/92  
TN No. 89-8

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Described below are the methods used to assure necessary transportation of recipients to and from providers of service.

- (1) Taxi transportation is provided for recipients residing in areas not served by a bus system, or when travel by bus would be either hazardous or cause extreme hardship to a recipient who is ill or has a physical or mental impairment.
- (2) Ambulance service is provided in emergencies or when a recipient, due to the nature of his physical impairment, is unable to travel by taxi.
- (3) Air transportation is provided when required specialized medical services are not available on the island of recipient's residence. Attendant's service is also made available when recommended by the attending physician or required by the airline.
- (4) Out-of state transportation is provided when required specialized medical services are not available in the State. Attendant's service is also made available when recommended by the attending physician or required by the airline.

State/Territory: HAWAII

## STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

1. The standards for coverage of organ transplant services are applied equally to the categorically and medically needy individuals as described in ATTACHMENT 3.1-E, pages 2 through 7.
2. The guidelines for approving organ transplants for EPSDT eligible individuals which are not covered under this Plan are as follows:
  - a. Shall have prior medical authorization
  - b. Shall be performed at a Medicare certified facility
  - c. Shall be an established non-experimental procedure
  - d. Shall be medically necessary, specifically:
    - i. The condition is life-threatening and unresponsive to other medical or surgical therapy, with a prognosis of six to twelve months of life.
    - ii. There is significant reason to believe that the transplant will improve the quality of life of the patient.
    - iii. There is significant reason to believe that the patient's medical status is adequate to tolerate the transplant procedure and follow-up medical and surgical care.
    - iv. The initial or primary disease process is confined to the organ with no life threatening involvement of other organ systems and no anticipation that life threatening recurrence of the disease process will involve the transplanted organ or other organ systems.

TN No. 96-013

Supersedes

Approval Date:

MAR 20 1991

Effective Date:

NOV 25 1996

TN No. 91-07

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

(b) Kidney transplantations are covered under this program.

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

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

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

(f) Immunosuppressive therapy shall be covered as required.

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

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

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

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

- (a) **Indications of penetrating keratoplasty include:**
- (1) **Corneal opacification that sufficiently obscures visibility (vision) through the anterior segment of the eye with at least light perception present. Causes for this problem include:**
    - (A) **Corneal injury and scarring;**
    - (B) **Corneal degeneration (from Fuch's or other dystrophy or from previous cataract or intraocular lens implantation, or both);**
    - (C) **Corneal degeneration from keratoconus or familial causes;**
    - (D) **Corneal infection (e.g., herpes); and**
  - (2) **Therapeutic graft for relief of pain with at least light perception vision present, from corneal degeneration because of inflammation with pain in the eye and useful vision still present.**
- (b) **Indications of lamellar keratoplasty include:**
- (1) **Superficial layer corneal scarring and deformity due to:**
    - (A) **Trauma;**
    - (B) **Degeneration;**
    - (C) **Infection; or**
    - (D) **Congenital deformity (anterior);**
  - (2) **Aphakia;**
  - (3) **High myopia;**
  - (4) **High refractive error;**
  - (5) **Keratoconus; and**
  - (6) **Recurrent pterygium.**
- (c) **Conditions and limitations affecting corneal transplant include:**
- (1) **A relative contraindication is intractable glaucoma in the eye under consideration for surgery;**

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

**§17-1737-93 Allogenic bone marrow transplant.**

(a) Indications for allogenic bone marrow transplant include:

- (1) Severe aplastic anemia unresponsive to usual therapy;
- (2) Acute myelogenous leukemia in first remission;
- (3) Acute lymphocytic leukemia in second remission; and
- (4) Chronic leukemia after first year.

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

- (1) Human leukocyte group A (HLA) histocompatible donor shall be available;
- (2) Patient has no other major systemic disease which would result in poor potential for recovery (such as a heart condition, liver disease, kidney damage, brain lesions, cancer in other organs or lung disease);
- (3) Patient shall have been properly evaluated by a qualified authority in Hawaii and bone marrow transplant is recommended as a possible curative procedure or if palliative, with reasonable likelihood for prolongation of life and return to an active life;
- (4) No active infection at the time of the procedure;
- (5) No general medical contraindication for the procedure and anesthesia;
- (6) Informed consent shall be obtained from the patient or the patient's representative; and
- (7) Age restricted to fifty or under except when identical twin is histocompatible and then age limit may be fifty-five. [Eff 08/01/96]  
(Auth: HRS §346-14; 42 C.F.R. §431.10)  
(Imp: 42 C.F.R. §440.230; 42 U.S.C. §1396b(i))



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

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

(b) Conditions and limitations affecting kidney transplant include:

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

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

COORDINATION OF TITLE XIX WITH PART B OF TITLE XVIII

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

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

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

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

Yes

No

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

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

Yes

No

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

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

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

All groups specified above.

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

State: Hawaii

COORDINATION OF TITLE XIX WITH WIC

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

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

Dear

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

To obtain more information about the WIC program, call:

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

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

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

2. The information and referral notice is sent to all newly approved medicaid recipients involving pregnant women and situations involving children under age five. Breastfeeding or postpartum women would be included.
3. The information and referral notice is sent, no less than annually to all AFDC and medically needy AFDC-related cases, including the poverty level cases involving women and children. This is handled by HAWI.