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HAWAII ADMINISTRATIVE RULES

TITLE 17

DEPARTMENT OF HUMAN SERVICES

SUBTITLE 12

MED-QUEST DIVISION

CHAPTER 1700.1

DEFINITIONS

§17-1700.1-1 Purpose  
§17-1700.1-2 Definitions

Historical Note: This chapter is based substantially upon chapter 17-1700, section 17-1701-2 of chapter 17-1701; 17-1702-2 of chapter 17-1702; section 17-1703-3 of chapter 17-1703; section 17-1704-2 of chapter 17-1704; sections 17-1705-2, 17-1705-36, 17-1705-44, 17-1705-51 and 17-1705-66 of chapter 17-1705; section 17-1706-2 of chapter 17-1706; section 17-1721-2 of chapter 17-1721; section 17-1721.1-2 of chapter 17-1721.1; sections 17-1722-34, 17-1722-57, 17-1722-87, 17-1722-117 and 17-1722-146 of chapter 17-1722; section 17-1722.1-2 of chapter 17-1722.1; section 17-1722.2-2 of chapter 17-1722.2; section 17-1722.3-2 of chapter 17-1722.2; section 17-1726-2 of chapter 17-1726; section 17-1727-2 of chapter 17-1727; section 17-1728-2 of chapter 17-1728; section 17-1728.1-2 of chapter 17-1728.1; section 17-1732-2 of chapter 17-1732; sections 17-1736-2, 17-1736-12 and 17-1736-32 of chapter 17-1736; sections 17-1737-2, 17-1737-11, 17-1737-27, 17-1737-90, 17-1737-100 and 17-1737-116 of chapter 17-1737; section 17-1738-2 of chapter 17-1738; section 17-1739-53 of chapter 17-1739; section 17-1739.1-2 of chapter 17-1739.1; section 17-1739.2-1 of chapter 17-1739.2; section 17-1740.1-2 of chapter 17-

## UNOFFICIAL

1740.1; section 17-1741-2 of chapter 17-1741; section 17-1744-2 of chapter 17-1744; section 17-1745-2 of chapter 17-1745. [Eff 08/01/94; am 07/20/95; am 11/13/95; am 01/29/96; am 03/30/96; am 11/25/96; am 09/14/98; am 07/06/99; am 06/19/00; am 10/26/01; am 12/03/01; am 02/16/02; am 05/10/03; am 09/01/03; am 11/20/03; am 03/11/04; am 02/07/05; am 04/08/05; am 05/05/05; am 12/26/05; am 12/29/05; am 05/24/07; am 09/17/07; am 02/18/08; am 01/31/09; am 09/10/09; am 10/19/09; am 04/01/10; am 04/30/10; am 08/19/11; am 06/25/12; am 04/12/13; R 09/30/13]

§17-1700.1-1 Purpose. The purpose of this chapter is to provide the definitions for words and terminologies used throughout subtitle 12 of title 17. [Eff 09/30/13] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §346.14; 42 C.F.R. §431.10)

§17-1700.1-2 Definitions. For the purpose of this subtitle unless the context otherwise indicates:

"Abuse" means provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.

"Active treatment" means a continuous program for each client as identified in an individualized plan of care:

- (1) For individuals with mental illness (MI) the plan shall be developed under and supervised by a physician. The prescribed components of the individualized active treatment program shall be provided by a physician or other qualified mental health professionals for the treatment of individuals who are experiencing an acute episode of severe MI which necessitates twenty-four hour

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supervision by trained mental health personnel to diagnose or reduce the individual's psychotic or neurotic symptoms which necessitated institutionalization, to improve the individual's level of functioning and, whenever possible, to achieve the individual's discharge from inpatient status at the earliest possible time;

- (2) For individuals with intellectual disability (ID) or with related conditions, the individual program plan shall be developed and supervised by an interdisciplinary team that represents areas that are relevant to identifying the individual's needs and to designing programs that meet the individual's needs, and is directed towards:
  - (A) The acquisition of the behaviors necessary for the individual to function with as much self determination and independence as possible; and
  - (B) The prevention or deceleration of regression or loss of current optimal functional status; and
- (3) It does not include, in the case of a resident of a Nursing Facility (NF), services within the scope of services which the facility shall provide or arrange for its resident.

"Actuarially sound" means an annuity, promissory note, or similar financial contract where no payments will be made beyond the life expectancy of the owner of the contract as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration.

"Acuity based reimbursement system" means the Medicaid reimbursement system for nursing facility (NF) level of care described in exhibit A of chapter 17-1739.2. The acuity based reimbursement system applies to acuity level A and acuity level C services, excluding services in critical access hospitals.

## UNOFFICIAL

"Acuity level or level of medical care" means one of the following types of inpatient services: NF or ICF-ID.

"Acuity level A" means that the department has applied its standards of medical necessity and determined that an individual requires a level of medical care from a nursing facility relatively lower than acuity level C. Prior to October 1, 1990, that level of care was appropriately obtained from an ICF.

"Acuity level B" means that the department has applied its standards of medical necessity and determined that an individual requires the level of medical care and special services that are appropriately obtained from an ICF/MR.

"Acuity level C" means that the department has applied its standards of medical necessity and determined that an individual requires a level of medical care from a nursing facility relatively higher than acuity level A. Prior to October 1, 1990, that level of care was appropriately obtained from an SNF.

"Acuity level D" means that the department has applied its standards of medical necessity and determined that an individual requires a level of medical care that is relatively higher than acuity level C, but less than acute.

"Acuity ratio" means the estimated average acuity level A direct nursing costs divided by the estimated average acuity level C direct nursing costs, as determined by the department. For the FY 98 rebasing, the department has determined the ratio to be 1.00:0.8012.

"Acute care services" means the short term medical treatment, usually in an acute care hospital, for individuals having an acute illness or injury.

"Adequate notice" means a notice sent to an individual no later than the date of the action affecting medical eligibility that includes:

- (1) A statement of the action the department has taken or intends to take;
- (2) The reason for the intended action;
- (3) The specific departmental rule supporting the action;

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- (4) The household's right to request a hearing;
- (5) The household's right to request and obtain an interpreter or auxiliary aids as needed, and shall be provided by the department at no cost;
- (6) The name of the person to contact for additional information;
- (7) The availability of continued benefits;
- (8) The liability of the household for any overpayments received while awaiting a hearing if the hearing official's decision is adverse to the household; and
- (9) The availability of free legal representation, if applicable.

"Adjusted PPS rate" means the basic PPS rate and any adjustments to that rate that are applicable to a particular provider. A formula to determine the adjusted PPS rate is defined in section 17-1739.2-19(f).

"Administrative hearing" means an administrative proceeding which affords an individual an opportunity to present an appeal of an adverse action before an impartial department representative for a formal decision.

"Adult" means an individual nineteen years of age or older.

"Adverse action" means denial of or failure to act with reasonable promptness on a claim for medical assistance, or the suspension, reduction, termination, or withholding of medical assistance, or an increase in spenddown or premium-share amounts.

"Affordable Care Act" means the Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

"Aged" means an applicant or beneficiary of medical assistance from the department who is at least sixty-five years old.

"Aid paid pending a hearing decision" means the continuation or reinstatement of medical assistance or coverage between the date of timely request for a hearing and the date the hearing decision is made.

## UNOFFICIAL

"Alien" means non-citizen.

"Allogenic organ or tissue" means the source of the organ or tissue is from another person.

"Ancillary payment" means a per diem payment outside of the basic PPS rate to reimburse certain providers for ancillary services that they provide to residents. The payment is available only to selected providers that are incapable of billing Medicaid on an itemized fee-for-services basis at this time. The payment is not an adjustment to the basic PPS rate.

"Ancillary services" mean diagnostic or therapeutic services performed by specific facility departments as distinguished from general or routine patient care such as room and board. Ancillary services generally are those special services for which charges are customarily made in addition to routine charges, and include but not limited to laboratory, radiology, and surgical services.

"Annual plan change period" means a period when an eligible individual is allowed to change from one participating health plan to another participating health plan.

"Annuity means" a financial contract where the purchaser is assured a scheduled amount of payments for the duration of the contract.

"Antigen means any substance which is capable under appropriate conditions of inducing a specific immune response.

"Applicant" means an individual who is seeking an eligibility determination for medical assistance through submission of an application or a transfer from an insurance affordability program. An applicant may be a deceased individual.

"Application" means the single streamlined application for all insurance affordability programs developed by the Secretary or an alternative single streamlined application designed specifically to determine eligibility on a basis other than the applicable MAGI standard and is not more burdensome on the applicant than the (single streamlined) application.

## UNOFFICIAL

"Asset" means cash and any other personal property, as well as real property, that an individual or family:

- (1) Owns;
- (2) Has the right, authority, or power to convert to cash (if not already cash); and
- (3) Is not legally restricted from using for the individual's or family's support and maintenance.

"Assignment" means assigning to the department, in writing, the right to obtain medical support and other third party payments.

"Assisted living facility" means a facility, as defined in HRS section 321-15.1 that is licensed by the department of health. This facility shall consist of a building complex offering dwelling units and services to allow individuals to maintain an independent assisted living lifestyle.

"Attending physician" means a medical doctor (M.D.) or a doctor of osteopathy (D.O.), authorized to practice medicine and surgery by the state, who orders and directs the services required to meet the care needs of a Medicaid beneficiary. The attending physician may be a physician from a group practice who is designated as the primary physician or an alternate physician that has been delegated the role of the attending physician by the beneficiary's initial attending physician during the physician's absence. At the time he or she elects to receive hospice care, the attending physician has the most significant role in the determination and delivery of the individual's medical care.

"Audit adjustment factor" means a reduction to the costs reported in a cost report that has not been finally settled by the department to reflect the average amount of costs that the department has historically disallowed for facilities statewide as part of the final settlement process.

"Authorized representative" means an individual or organization designated by an applicant or a beneficiary in writing with the designee's signature or by legal documentation of authority to act on

## UNOFFICIAL

behalf of an applicant or beneficiary, in compliance with federal and state law and regulations. Designation of an authorized representative may be requested at time of application or at other times as required and will be accepted through the same modalities as applications for medical assistance.

"Base year" for:

- (1) Acute and long-term care services means the state fiscal year used for initial calculation and recalculation of prospective payment rates. The base year shall be the most recent State fiscal year or years for which complete, finally-settled financial data is available. Base year data shall be supplemented with finally-settled cost data from previous years, if it is determined that extraordinary costs occurred in the most recent, finally-settled cost report. The 1983 state fiscal year shall be the base year for purposes of initial calculation of prospective payment rates.
- (2) Federally qualified health centers and rural health clinics means the first PPS year starting January 1, 2001 and ending December 31, 2001 or any subsequent year that rates are recalculated if a rebasing is determined to be necessary.

"Base year cost report" means the cost report of a provider that covers the reporting period that ends during the base year.

"Baseline PPS rate" means the rate calculated for the initial or first year under PPS.

"Baseline status" means that the individual reached a level of condition where no further medical adjustments are indicated except for adjustments for growth and development.

"Basic Health Hawaii" means the State funded medical assistance program for non-citizens age nineteen years and older who are citizens of a COFA nation, or legal permanent residents who have resided in the United States for less than five years.



## UNOFFICIAL

"Basic PPS rate" means the sum of the applicable per diem amounts for the direct nursing, capital, and general and administrative components for each provider and for each level of care that the provider is certified to provide, as calculated pursuant to the methodology defined in this chapter. It does not include the various adjustments or increases to the basic PPS rate defined in this chapter.

"Bed days" mean inpatient days on the Medicaid cost report.

"Benchmark prescription drug plan" means the Medicare Prescription Drug Plan (PDP) or the Medicare Advantage-Prescription Drug (MA-PD) plan that meets the regional low-income benchmark premium amount established by CMS.

"BENDEX" or "beneficiary data exchange system" means an automated exchange system in which the SSA transmits social security beneficiary data to the department.

"Beneficiary" means an individual who has been determined eligible and is currently receiving Medicaid.

"Benefit period" means the period from the first day of a month following the close of the annual plan change period and extending for a period as designated by the department.

"Benefit year" means a continuous twelve month period generally following an open enrollment period.

"BESSD" means the benefit, employment and support services division within the department which administers the financial assistance and supplemental nutrition assistance program (SNAP).

"Blind" means an individual who has been certified blind by the Social Security Administration or by the department's vocational rehabilitation services for the blind division, Ho'opono.

"Board to determine and certify mental disability" means a board of licensed psychologists or licensed physicians whose specialty is psychiatry designated and paid for by the department.

"Break-even point" means the point at which a hypothetical special care percentage in the base year

## UNOFFICIAL

would not have resulted in the elimination of any costs due to the application of the ceiling factors in calculating the PPS rates.

"CAH" or "critical access hospital" means a hospital designated and certified as a critical access hospital under the Medicare Rural Hospital Flexibility Program.

"Capital component reduction factor" means a fraction with the capital cost per diem projected by a new provider to obtain its initial PPS rates as the numerator and the total projected capital, direct nursing and G&A per diem costs as the denominator.

"Capital incentive adjustment" means an increase to a provider's basic PPS rate that is calculated as follows:

- (1) If the capital per diem cost component of the provider's basic PPS rate is in the lowest quartile of its peer group, then the incentive payment shall be thirty-five per cent of the difference between the median capital per diem cost for the peer group and the provider's capital per diem cost component;
- (2) If the capital per diem cost component of the provider's basic PPS rate is in the second lowest quartile of its peer group, then the incentive payment shall be twenty-five per cent of the difference between the median capital per diem cost for the peer group and the provider's capital per diem cost component;
- (3) Notwithstanding the foregoing, the capital incentive adjustment shall not increase a provider's capital cost component above the capital component ceiling for the applicable acuity level in the provider's peer group.

"Capital related costs" means costs associated with the capital costs of the provider's facilities and equipment under Medicare principles of reimbursement. For purposes of the prospective payment methodology, capital related costs shall include depreciation, interest, property taxes, property

## UNOFFICIAL

insurance, capital leases and rentals, and costs and fees related to obtaining or maintaining capital related financing.

"Capitated payment" means a fixed monthly payment paid per person by the department to a participating health plan for which the health plan provides a defined set of benefits and the payment may be prorated for the portion of the month for which the person was enrolled with the health plan.

"Capitated rate" means the fixed monthly payment per person paid by the State to a medical, behavioral or catastrophic coverage plan.

"Caretaker relative" means a relative of a dependent child by blood, adoption, or marriage, or an adult with whom the child is living, who assumes primary responsibility for the child's care (as may, but is not required to, be indicated by claiming the child as a tax dependent for Federal income tax purposes).

"Case manager" means an individual who meets the requirements specified in one of the following sections for the respective target group:

- (1) Section 17-1738-4(b);
- (2) Section 17-1738-15(b); or
- (3) Section 17-1738-26(b).

"Cash subsidies for patient services" means, without limitation, amounts appropriated by the state legislature or a local governmental entity, either as direct subsidies or general fund allotments, and paid to the provider.

"Categorically needy" refers to families and children, aged, blind, or disabled individuals, and pregnant women, described under subparts B and C of 42 C.F.R. part 435 who are eligible for Medicaid. Subpart B of 42 C.F.R. part 435 describes the mandatory eligibility groups who, generally, are receiving or deemed to be receiving cash assistance under the social security Act. These mandatory groups are specified in sections 1902(a)(10)(A)(i), 1902(e), 1902(f), and 1928 of the Social Security Act. Subpart C of 42 C.F.R. part 435 describes the optional eligibility groups of individuals who, generally, meet

## UNOFFICIAL

the categorical requirements or income or resource requirements that are the same as or less restrictive than those of the cash assistance programs and who are not receiving cash payments. These optional groups are specified in sections 1902(a)(10)(A)(ii), 1902(e), and 1902(f) of the Social Security Act.

"CCFFH" or "community care foster family home" means a home that is certified by the department to provide an individual with twenty-four hour living accommodations and home and community based services.

"C.F.R." or "Code of Federal Regulations" means the annual codification of executive agency regulations. The C.F.R. contains the general body of regulatory laws governing practice and procedures before federal administrative agencies.

"Change in circumstance" means any event, reported or unreported to the department, which alters or changes the conditions on which eligibility for benefits was last determined. A change in circumstance shall include, but shall not be limited to a change in household composition, employment, training, the source or amount of countable income, the receipt or amount of a countable resource, the beneficiary's needs, residence, or severity of disability or blindness.

"Charity care" means, without limitation, care for which the provider never expected or sought payment. Charity care includes care provided pursuant to the Hill-Burton program, but excludes cash subsidies for patient services as defined above.

"Citizenship" means status as a citizen of the United States, and includes status as a national of the United States as defined in 8 U.S.C. §1101(a)(22).

"Claim" means that document which is submitted by the provider for payment of health-related services rendered to a beneficiary.

"Claim charge data" means charges and other information obtained from billing claim forms processed by the Medicaid fiscal agent.

"Clean claim" means one that can be processed without obtaining additional information from the provider of the service from a third party.

## UNOFFICIAL

"Clinical nurse specialist" means a registered professional nurse who is currently licensed to practice in the State and who meets one or two of the following conditions:

- (1) Has completed an earned graduate degree, master's degree, or doctorate related to an advanced area of clinical practice within the scope of nursing; and
- (2) Is currently certified as a nurse specialist by a national nursing certifying organization.

"CMS" or "Centers for Medicare and Medicaid Services" means the United States federal agency which administers the Medicare program and, working jointly with State governments, the Medicaid program and the State Children's Health Insurance Program (SCHIP).

"Code" means the Internal Revenue Code of 1986.

"COFA nation" means the Federated States of Micronesia, Republic of the Marshall Islands, or Republic of Palau, which have entered into Compacts of Free Association with the United States.

"Co-insurance" means the amount that a beneficiary or a member must pay, usually a percentage, of the cost of a service.

"Collateral contact" means verification of a household's statements through a personal or telephone contact with a person outside a household.

"Community setting" means the place of residence of an individual receiving long-term care services that is not a nursing facility or a medical facility.

"Community spouse" means the spouse of an institutionalized individual who is not residing in a medical facility or nursing facility.

"Confirmation notice" means the document the individual receives from the department confirming their enrollment in a health plan.

"Consultation" means an opinion or advice requested by a practicing physician from a psychiatrist or psychologist.

"Continuing care retirement community" means a residential community that offers a long-term continuing care contract, usually for a resident's

## UNOFFICIAL

lifetime that provides for housing, residential services and nursing care.

"Contract" means a contract between a participating health plan and the department to provide medical services.

"Coordinated content" means information included in an eligibility notice regarding the transfer of the individual's or household's electronic account to another insurance affordability program for a determination of eligibility.

"Co-payment" means the amount that a beneficiary or member must pay, usually a fixed amount of the cost of a service.

"Cost reports" means the forms DHS 401 of a certified FQHC or RHC with all documentation and requirements which were necessary for acceptability.

"Cost-share" means the amount identified by the department as an individual's excess income available for meeting a portion of the individual's own health care cost.

"Cost-sharing related to Medicare part D" means any premiums, deductibles, co-payments, co-insurance, and any cost incurred within the Part D coverage gap.

"Costs" mean total finally-settled allowable costs of acute inpatient services, unless otherwise specified.

"Creditable coverage" means a medical insurance or health plan that will cover the treatment of breast or cervical cancer or a pre-cancerous condition of the breast or cervix.

"Custodian" means any organization or individual, not a public agency or officer, responsible for centrally locating the program manuals and making the manuals publicly accessible to a substantial number of the medical assistance beneficiary population served. The agencies and organizations shall accept responsibility for filing all amendments and changes forwarded by the department.

"DAC" or "disabled adult child" means a blind or disabled individual who is age eighteen years or older and who is receiving OASDI benefits as a dependent adult child of a beneficiary who is a parent,

## UNOFFICIAL

stepparent, grandparent or legal guardian of the individual.

"Date of hearing request" means the date of DHS' receipt of a request for a hearing by an individual or authorized representative. When there is no prior written request by the individual naming the authorized representative, the date of hearing request shall be the date the authorization is received by the department.

"Day-weighted median" means a numerical value determined by arraying the per diem costs and total patient days of each nursing facility and identifying the value at which half of the patient days are represented by providers with higher costs than this value. "DD" or "developmental disabilities" means a severe, chronic disability of a person to include epilepsy, cerebral palsy, or other developmental disabilities 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 twenty-two years;
- (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; or 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.

"Debt" means any liquidated sum exceeding twenty-five dollars which is due and owed to the department, regardless of whether there is an outstanding judgment for that sum and whether the sum has accrued through

## UNOFFICIAL

contract, subrogation, tort, operation of law, or judicial or administrative judgment or order.

"Debtor" means any person who owes a debt to the department.

"Deemed eligible" means an individual who is automatically eligible for the Low Income Subsidy program. These individuals are those who are:

- (1) Eligible for both Medicare and Medicaid;
- (2) Supplemental security income beneficiaries;  
or
- (3) Eligible for the Medicare savings programs.

"Deemed individual" means an individual who met the requirements of subchapter 4 of chapter 17-1722.3 and was allowed to enroll in Basic Health Hawaii without filing a new application for medical assistance.

"Dementia" means a primary diagnosis as described in the Diagnostic and Statistical Manual of Mental Disorders, 3rd edition, Revised (DSM-III-R) with the following diagnostic criteria:

- (1) Demonstrable evidence of impairment in short-term or long-term memory;
- (2) At least one of the following:
  - (A) Impairment of abstract thinking;
  - (B) Impaired judgment;
  - (C) Other disturbances of higher cortical function; and
  - (D) Personality change;
- (3) The disturbance in (1) or (2) significantly interferes with work or usual social activities or relationships with others;
- (4) Not occurring exclusively during the course of delirium; and
- (5) Either:
  - (A) Evidence from the history, physical examination, or laboratory tests, of a specific organic factor that is judged to be etiologically related to the disturbance; or
  - (B) In the absence of such evidence, an etiologic organic factor can be presumed if the disturbance cannot be



## UNOFFICIAL

accounted for by any nonorganic mental disorder.

"Dental allowance add-on" means a per diem amount added to the facility's basic PPS rate for dental services rendered to the facility's inpatients. The per diem amount will be the same for all facilities as determined by the department using historical paid dental claims data.

"Department" means the department of human services of the state of Hawaii, which includes the single state agency responsible for administering the medical assistance program.

"Dependent child" means a child who is under the age of nineteen years.

"Dependent family member" means the child, parent, or sibling of an institutionalized individual who is residing with the community spouse, or in the home of the institutionalized individual if there is no community spouse, who may be claimed as a tax dependent under the Internal Revenue Code by the institutionalized individual or the spouse of the institutionalized individual.

"DHHS" means the United States Department of Health and Human Services.

"DHS" means the department of human services.

"Direct supervision" means a healthcare provider able to independently provide services shall be present and available in an inpatient facility or outpatient clinic to provide assistance and direction to a healthcare provider unable to independently provide services but able to provide services under supervision.

"Director" means the administrative head of the department of human services unless otherwise specifically noted.

"Disabled" means an individual who has been determined disabled by the Social Security Administration or by the department's aid to the disabled review committee (ADRC).

"Discharge" means the release of an individual from an acute care facility. The following events are considered discharges:

## UNOFFICIAL

- (1) The individual is formally released from the hospital;
- (2) The individual is transferred to an out-of-state hospital;
- (3) The individual is transferred to a long-term care level or facility;
- (4) The individual dies while hospitalized;
- (5) The individual signs out against medical advice;
- (6) In the case of a delivery where the mother and baby are discharged at the same time, release of the mother and her baby shall be considered two discharges for payment purposes. In cases of multiple births, each baby will be considered a separate discharge; or
- (7) A transfer shall be considered a discharge for billing purposes but shall not be reimbursed as a full discharge except as specified in section 17-1739-70(f)(1).

"Disproportionate share" adjustment means the largest of the following adjustments:

- (1) Divide indigent acute inpatient days by total acute inpatient days. Each percentage point or fraction thereof in excess of fifteen per cent shall be converted to a decimal and added to 1.00 to obtain the disproportionate share adjustment;
- (2) Calculate the facility's Medicaid utilization rate and subtract one standard deviation above the statewide mean Medicaid utilization rate. Each percentage point in excess of this standard deviation shall be converted to a decimal and added to 1.00 to obtain the disproportionate share adjustment. A calculation resulting in a fraction of a percentage point shall be rounded up to the next percentage point. When the Medicaid utilization rate equals the rate at one standard deviation point, it will be considered a fraction of a percentage point and rounded up; or

## UNOFFICIAL

- (3) Calculate the facility's low income utilization rate and subtract twenty-five per cent. Each percentage point or fraction thereof in excess of twenty-five per cent shall be converted to a decimal and added to 1.00 to obtain the disproportionate share adjustment.

"Disproportionate share provider" means a facility that meets the following tests:

- (1) Either:
  - (A) Has at least two obstetricians with staff privileges at the facility who have agreed to provide obstetric services to individuals who are eligible for assistance under the Medicaid program; or
  - (B) Did not offer nonemergency obstetric services as of December 21, 1987; and
- (2) Either:
  - (A) Has indigent inpatient days equal to or greater than fifteen per cent of total acute inpatient days;
  - (B) Has a Medicaid utilization rate equal to or greater than one standard deviation above the statewide mean Medicaid utilization rate; or
  - (C) Has a low income utilization rate equal to or greater than twenty-five per cent.

In applying the foregoing, the Medicaid and total days and revenues shall be obtained from the facility's most recently filed cost report or related financial information for the period covered by that cost report. The Supplemental Security Income days shall be determined by the department based on the most recent information obtained from the Health Care Financing Administration. All other information shall be obtained from the most recent and reliable data available at the time the computation is made.

"Distinct part" means a portion of a medical institution or institutional complex (e.g. nursing

## UNOFFICIAL

home or a hospital) that is certified to provide long term care services.

"DOH" means the department of health.

"Domiciliary care facility" means a licensed adult residential care facility which provides twenty-four hour living accommodation, personal care services, and appropriate medical care to adult beneficiaries by individuals unrelated to the beneficiaries. A treatment facility providing rehabilitative treatment services shall not be a domiciliary care facility.

"Domiciliary care home" means any facility which provides twenty-four-hour living accommodations, personal care services, and appropriate health care, as needed, to adult beneficiaries unable to care for themselves by individuals unrelated to the beneficiaries in licensed adult residential care homes or other care homes regulated by the department of health. A domiciliary care home does not provide rehabilitative treatment services.

"DRA" means the Deficit Reduction Act of 2005 enacted on February 8, 2006.

"Drug formulary" means prescribed drugs, pursuant to 42 U.S.C. 1396r(8)(d)(4), for which payment may be made by the Hawaii Medicaid program.

"Dynamic care" means care for pediatric patients which includes a pattern of continuous change and growth in treatment.

"EAC" or "estimated acquisition cost" means the wholesale average cost.

"E-ARCH" or "expanded adult residential care home" is a facility, as defined in section 11-100.1.2 and licensed by the department of health, that provides twenty-four hour living accommodations, for a fee, to adults unrelated to the family, who require at least minimal assistance in the activities of daily living, personal care services, protection, and healthcare services, and who may need the professional health services provided in a nursing facility.

"Early intervention services" means services that are defined by 20 U.S.C. section 1472 and HRS chapter 321, part XXVIII which are available for infants and

## UNOFFICIAL

toddlers from birth through age three who have special needs.

"Earned income" means cash received or available to be received by the household which require some activity on the part of the household to produce. Examples of earned income include, but shall not be limited to, wages, jury duty income (excluding reimbursement for transportation and meals), and self-employment income, including from the sale of blood, blood plasma, and parts of the body.

"Effective date of eligibility" means the date on which health care services shall be covered either through fee-for-service reimbursement by the department, its fiscal agent, or through enrollment in a participating health plan.

"Effective date of enrollment" means the date as of which a participating health plan is required to provide benefits to an enrollee.

"Effective income level" means the income standard applicable under Medicaid for an eligibility group, after taking into consideration any disregard of a block of income applied in determining financial eligibility for such group.

"Electronic account" means an electronic file that includes all information collected and generated by the department regarding each individual's Medicaid eligibility and enrollment including any information collected or generated as part of an administrative appeal process conducted under 42 C.F.R. part 431, Subpart E, or through the Exchange appeals process conducted under 45 C.F.R. part 155, Subpart F, and including all documentation required as follows:

- (1) Facts to support the department's decision on an application in each applicant's case record.
- (2) Disposition of each individual by a finding of eligibility or ineligibility, unless:
  - (A) There is an entry in the case record that the individual voluntarily withdrew the application, and that the department sent a notice confirming this decision;

## UNOFFICIAL

- (B) There is a supporting entry in the case record that the individual has died; or
- (C) There is a supporting entry in the case record that the individual cannot be located.

"Eligibility determination" means an approval or denial of eligibility for medical assistance as well as a redetermination or termination of eligibility for medical assistance.

"Emergency" means a situation where a person's life or health is in imminent danger as the result of illness or injury and specialized services must be provided without delay.

"Emergency medical condition" means the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms substance abuse) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of emergency services or immediate medical attention to result in:

- (1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- (2) Serious impairment to body functions;
- (3) Serious dysfunction of any bodily organ or part;
- (4) Serious harm to self or others due to an alcohol or drug abuse emergency;
- (5) Injury to self or bodily harm to others; or
- (6) With respect to a pregnant woman who is having contractions:
  - (A) That there is inadequate time to effect a safe transfer to another hospital before delivery; or
  - (B) That transfer may pose a threat to the health or safety of the woman or her unborn child.

"Emergency services" means covered inpatient and outpatient services that are needed to evaluate or

## UNOFFICIAL

stabilize an emergency medical condition that is found to exist using a prudent layperson standard.

"Employer funded" means the employer is paying the temporary disability insurance benefit directly to the individual or is paying premiums to a third party.

"Encumbrance" means a financial claim or lien upon real or personal property.

"Enhanced prior authorization list" means non-preferred prescription drugs which require prior authorization.

"Enrollee" means an individual who has selected or been assigned by the department to be a member of a participating health plan.

"Enrollment fee" means the amount an enrollee is responsible to pay that is equal to the spenddown amount for a medically needy individual or cost share amount for an individual receiving long term care services. A resident of an intermediate care facility for individuals with intellectual disabilities or a participant in the Medicaid waiver program for individuals with developmental disabilities or intellectual disabilities are exempt from the enrollment fee.

"EPSDT" or "early and periodic screening, diagnosis, and treatment program" means early and periodic screening, diagnosis, and treatment services, to identify physical or mental defects in individuals, and, to provide health care, treatment, and other measures to correct or ameliorate any defects and chronic condition discovered in accordance with section 1905r of the Social Security Act. EPSDT includes services to:

- (1) Seek out individuals and their families and inform them of the benefits of prevention and the health services available;
- (2) Help the individual or family use health resources, including their own talents, effectively and efficiently; and
- (3) Assure the problems identified are diagnosed and treated early, before they become more complex and their treatment more costly.

## UNOFFICIAL

"Equity" means fair market value minus encumbrances against the property.

"Equity interest in home" means the value to the property less any encumbrances.

"Estate" means the real and personal property included in an estate under the State's probate law and any other real or personal property and other assets in which the individual had any title or interest in at the time of death (to the extent of such interest). This includes assets conveyed to a survivor, heir, or assign of the deceased through joint tenancy, tenancy in common, survivorship, life estate, living trust, or other arrangements.

"EW" or "eligibility worker" means an employee of the department responsible for the determination of eligibility for medical assistance.

"F/S NF" means freestanding nursing facility.

"Facility" means an institution that furnishes health care services to inpatients.

"Fair market value" means the amount an asset is expected to sell without discount on the open market for such asset in the geographic area involved, and under the existing economic conditions. Fair market value includes valuable consideration.

"Family" means for a MAGI individual or household those individuals for whom a taxpayer properly claims a deduction for a personal exemption under section 151 of the Internal Revenue Code for the taxable year. For a MAGI-excepted individual or a group of individuals, family means those individuals living in the same household, generally consisting of parents and their natural, or adoptive children under age nineteen years, grandparents and their grandchildren under age nineteen years, an adult sibling and his or her siblings under age nineteen years, a married couple and siblings under age nineteen years of either spouse, an uncle or an aunt and his or her nephews and nieces under age nineteen years, a married couple and their nephews and nieces under age nineteen years, a single adult and his or her first cousins under age nineteen years, married couples and first cousins under age nineteen years of one of the spouses, any



## UNOFFICIAL

combination of the preceding relationships prefixed with grand, great-grand, great, great-great, half, and step.

"Family therapy" means treatment involving three or more members of the same family and shall be considered a form of group therapy.

"Federal medical assistance" means medical assistance in accordance with the State plan under Title XIX or Title XXI, or in accordance with a demonstration under Title XI of the Social Security Act.

"Federal Register or Fed. Reg." means the daily publication for making available to the public federal agency regulations and other legal documents of the executive branch including proposed changes. The regulations and rules as finally approved appear thereafter in the C.F.R.

"Fee-for-service" means the component within the medical assistance program that reimburses providers for each eligible service provided.

"Feeding assistant" means an individual who has successfully completed a state-approved feeding assistant training program and who is paid by a nursing facility or is used under an arrangement with another agency or organization to feed nursing facility residents who have no complicated feeding problems. Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral or intravenous feeding.

"Financial assistance" means public assistance, except for payments for medical care, social service payments, transportation assistance, and emergency assistance under HRS section 346-65, including funds received from the federal government.

"Financial institution" means any bank, savings and loan association, credit union, or other similar organization.

"Fiscal agent" means an entity that processes or pays vendor claims for the Medicaid agency.

"FPL" or "federal poverty level" means the Federal poverty level updated periodically in the

## UNOFFICIAL

Federal Register by the Secretary of Health and Human Services under the authority of 42 U.S.C. §9902(2), as in effect for the applicable budget period used to determine an individual's eligibility in the medical assistance programs.

"FQHC" or "federally qualified health center" means an entity that has been determined by the Secretary of the DHHS to meet the qualifications for a federally qualified health center, as defined in section 1861(aa)(4) of the Social Security Act.

"Fraud" means an intentional deception or misrepresentation made by an individual with the knowledge that the deception could result in some unauthorized benefit to that individual or some other individual. It includes any act that constitutes fraud under applicable Federal or State law.

"Freestanding" means a medical institution that is not a part of a parent medical institution or a medical institution that is separated geographically from the parent medical institution.

"FUL" or "federal upper limits" means the price established by the Center for Medicaid and State Operations.

"Full benefit dual eligible" means an individual who is eligible for both Medicare and Medicaid.

"Furnished" means items and services provided directly by, or under the direct supervision of, or ordered by, a practitioner or other individual (either as an employee or in his or her own capacity), a provider, or other supplier of services. For purposes of denial of reimbursement within this part, it does not refer to services ordered by one party but billed for and provided by or under the supervision of another.

"FY 98 rebasing" means the rebasing that used the cost reports for fiscal years that ended during the state fiscal year ending June 30, 1995. The basic PPS rates that resulted from the FY 98 rebasing are effective July 1, 1997.

"G&A" means general and administrative.

## UNOFFICIAL

"G&A incentive adjustment" means an increase to a provider's basic PPS rates that is calculated as follows:

- (1) If the G&A per diem cost component of the provider's basic PPS rate is in the lowest quartile of its peer group, then the incentive payment shall be thirty-five per cent of the difference between the median G&A per diem cost for the peer group and the provider's G&A per diem cost component;
- (2) If the G&A per diem cost component of the provider's basic PPS rate is in the second lowest quartile of its peer group, then the incentive payment shall be twenty-five per cent of the difference between the median G&A per diem cost for the peer group and the provider's G&A per diem cost component;
- (3) Notwithstanding the foregoing, the G&A incentive adjustment shall not increase a provider's G&A cost component above the G&A component ceiling for the applicable acuity level in the provider's peer group.

"G&A small facility adjustment" means an adjustment to small F/S NF's basic PPS rates. To qualify for this adjustment, the F/S NF must:

- (1) Have fifty beds or less; and
- (2) Have a base year facility specific G&A cost per day in excess of their facility specific G&A cost component ceiling.

To calculate the adjustment, the G&A cost component of the provider's basic PPS rate calculation is recomputed as follows:

- (1) A cost differential in the average base year G&A cost per day, inflated to the PPS rate year, is computed between:
  - (A) F/S NFs with fifty beds or less, and
  - (B) F/S NFs with more than fifty beds but less than one hundred twenty-five.
- (2) The provider's G&A cost component ceiling is increased by the computed cost differential described above.

## UNOFFICIAL

- (3) The facility specific G&A cost per day is compared with the revised ceiling to determine the revised allowable G&A cost component of the provider's basic PPS rate.
- (4) The increase in the G&A portion of the provider's PPS rate as a result of the above calculations represents the adjustment.

"GET adjustment" means the adjustment to the basic PPS rate of a proprietary provider to reimburse it for gross excise taxes paid to the State of Hawaii. The GET adjustment shall be 1.04167, provided, however, that if the gross excise tax rate is increased or decreased, then the GET adjustment shall be revised accordingly.

"Grandfathered capital component" means the capital component of the basic PPS rates that a new provider or a provider with new beds was receiving immediately prior to the FY 98 rebasing.

"Grandfathered direct nursing and G&A adjustment" means an increase to an eligible provider's basic PPS rates calculated as follows: first, the department shall determine the provider's combined direct nursing and G&A components (including all incentives) as calculated in the FY 98 rebasing, second, the department shall determine the combined direct nursing and G&A component in the total PPS rates that the provider was receiving prior to the FY 98 rebasing for its old beds, third, the department shall increase that second amount by one-half of the inflation adjustment for FY 98, and finally, if the difference between the second amount and the first amount is a positive number, that number shall be multiplied by the ratio of the provider's old beds to its total beds. The product shall be the per diem increase to the provider's basic PPS rates.

"Grandfathered PPS rate" means the total PPS rate that a provider was receiving prior to the FY 98 rebasing.

"Hawaii Medicaid fee schedule" means the schedule of rate of payment for services provided by non-institutional providers of medical care.

## UNOFFICIAL

"HBCCCP" means the Hawaii Breast and Cervical Cancer Control Program that is implemented by the State Department of Health in the detection of breast and cervical cancer or a pre-cancerous condition of the breast or cervix.

"HCBS or home and community-based services" means long-term care services provided to an individual residing in a community setting who is certified by the department to be at nursing facility level of care and would be eligible for care provided to an individual in a nursing facility or a medical facility receiving nursing facility level of care.

"HCPCS" means the Healthcare Common Procedural Coding System.

"Health Insurance Exchange" or "Exchange" means a governmental agency or non-profit entity that meets the applicable standards in 45 C.F.R. Part 155 and makes qualified health plans available to qualified individuals and qualified employers. Unless otherwise identified, this term refers to State Exchanges, regional Exchanges, subsidiary Exchanges, and a Federally-facilitated Exchange.

"Health intervention" means an activity undertaken for the primary purpose of preventing, improving, or stabilizing a medical condition. Activities that are primarily custodial, or part of normal existence, or undertaken primarily for the convenience of the individual, family, or practitioner, are not considered health interventions.

"Health outcomes" mean outcomes of medical conditions that directly affect the length or quality of a person's life.

"Health plan" means a plan offered by an insurance company or other organization, which provides different health care benefit packages.

"Health plan contract period" means the period of time under which a health plan is continuously operating under a contract including amendments without a new procurement.

"Hearing officer" means an impartial person assigned by the department to conduct administrative hearings and to render a final decision. The hearing

## UNOFFICIAL

officer shall not have been directly involved in the initial determination of the action in question.

"HIB" means hospital insurance benefits of the Medicare program (part A).

"Histocompatibility" means the matching of the tissue so the graft will not be rejected due to the presence of incompatible antigens.

"HIV/AIDS" means human immunodeficiency virus/acquired immunodeficiency syndrome, an infectious disease caused by the human immunodeficiency virus that damages the body's immune system and leads to the body's inability to fight off infection.

"Home" means the property that the individual lived in and in which the individual had an equity interest, prior to becoming medically institutionalized.

"Home equity" means the fair market value of an individual's home property less financial encumbrances.

"Hospice program" means a public or private organization or subdivision of either, that is primarily engaged in providing care to terminally ill individuals and is qualified as a Medicaid provider.

"HRS" or "Hawaii Revised Statutes" means the official codification of all the laws of a general and permanent nature of the State of Hawaii.

"ICF" means intermediate care facility.

"ICF-ID" means an intermediate care facility for individuals with intellectual disabilities.

"IEVS" or "income eligibility verification system" means a system of information acquisition and exchange for purposes of income and eligibility verification which meets the requirements of section 1137 of the Social Security Act (42 U.S.C. §1320b-7).

"Illegal non-citizen" means a non-citizen who is not lawfully admitted for permanent residence in the United States or was admitted legally for a limited period and did not leave when that time expired.

"Immediate family member" means an individual, their spouse, natural or legal children, their

## UNOFFICIAL

siblings, their parents, and the spouses of these family members.

"Implementation date" means the date determined by the department, but no later than July 1, 2010, when participating health plans began delivering Basic Health Hawaii benefits to enrollees.

"INA" means the Immigration and Nationality Act.

"Income" means any monies received by an individual or household during a given month.

"Indigent" means an individual who is considered eligible for Supplemental Security Income (SSI) or Medicaid, or both.

"Individual" psychotherapy means a face-to-face interaction between a therapist and an individual. The term encompasses a wide variety of therapies that differ in intensity and duration.

"Individualized service plan" means a written plan based upon an assessment of the individual's needs.

"Inflation adjustment" means the estimate of inflation in the costs of providing nursing facility services for a particular period as estimated in the CMS Nursing Home Without Capital Market Basket as reported in the Health Care Cost Review published quarterly by Global Insight, Inc., or its successor.

"Informal review" means a preliminary review conducted by department's med-QUEST eligibility office, administrative office, recovery staff, or investigations office staff at the written or oral request of an individual. An informal review is not the same as the administrative hearing.

"Informed consent" means a voluntary, knowing assent given in writing.

"Inpatient" means an individual who has been admitted to a medical institution as an inpatient on recommendation of a physician or dentist and who:

- (1) Receives room, board and professional services in the institution for a 24 hour period or longer, or
- (2) Is expected by the institution to receive room, board and professional services in the institution for a 24 hour period or longer

## UNOFFICIAL

even though the individual subsequently dies, is discharged, or is transferred to another facility and does not actually stay in the institution for 24 hours.

"Inpatient acute care" means inpatient acute care as defined by a nationally accepted severity and intensity standards (for example: interqual severity and intensity screening standards) provided in a hospital.

"INS" means the United States Department of Justice, Immigration and Naturalization Service.

"Institution for intellectual disability" means an institution (or distinct part of an institution) that:

- (1) Is primarily for the diagnosis, treatment, or rehabilitation of individuals with intellectual disability or related conditions, and
- (2) Provides, in a protected residential setting, ongoing evaluation, planning, twenty-four hour supervision, coordination, and integration of health or rehabilitative services to help individuals function at their greatest ability.

"Institution for mental diseases" means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of individuals with mental diseases, including medical attention, nursing care and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such. An institution for the intellectually disabled is not an institution for mental diseases.

"Institution for tuberculosis" means an institution that is primarily engaged in providing diagnosis, treatment, or care of individuals with tuberculosis, including medical attention, nursing care, and related services. Whether an institution is



## UNOFFICIAL

an institution for tuberculosis is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of tuberculosis, whether or not it is licensed as such.

"Institution or institutional facility" means an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more individuals unrelated to the proprietor.

"Institutionalized individual" means an individual who is or is likely to be an inpatient at a medical facility receiving nursing facility level of care, or an inpatient at a nursing facility for a continuous period of institutionalization, or a beneficiary of home and community based services.

"Insufficient experience" means that a provider's base year cost report indicates that the provider delivered less than one hundred days of care at a particular acuity level in the base year.

"Insurance affordability program" means a program that is one of the following:

- (1) A State Medicaid program under title XIX of the Social Security Act.
- (2) A State children's health insurance program (CHIP) under title XXI of the Social Security Act.
- (3) A State basic health program established under section 1331 of the Affordable Care Act.
- (4) A program that makes coverage in a qualified health plan through the Exchange with advance payments of the premium tax credit established under section 36B of the Internal Revenue Code available to qualified individuals.
- (5) A program that makes available coverage in a qualified health plan through the Exchange with cost-sharing reductions established under section 1402 of the Affordable Care Act.

"Intellectual disability" means significantly subaverage general intellectual functioning resulting

## UNOFFICIAL

in or associated with concurrent moderate, severe, or profound impairments in adaptive behavior and manifested during the developmental period:

- (1) General intellectual functioning is defined as the results obtained by assessment with one or more of the individually administered general intelligence tests developed for the purpose of assessing intellectual functioning;
- (2) Significantly subaverage intellectual functioning is defined as approximately IQ seventy or below;
- (3) Adaptive behavior is defined as the effectiveness or degree with which individuals meet the standards of personal independence and social responsibility expected for age and cultural group; and
- (4) Developmental period is defined as the period of time between birth and the eighteenth birthday.

"IRA" means an individual retirement account.

"Irrevocable trust" means a trust whose term and conditions cannot be amended under any circumstances, including a court order.

"Joint tenancy" means equal, undivided interest in real property by two or more individuals throughout each respective owner's life. Upon the death of an owner, title automatically passes to the surviving owner or owners. Owners may sell their interest in the property without the consent of the other owners, but in doing so will break the joint tenancy and leave the new owner as tenancy in common with the remaining owners.

"Lawfully present non-citizen" means a non-citizen who

- (1) Is a qualified non-citizen;
- (2) Is in a valid nonimmigrant status, as defined in 8 U.S.C. §1101(a)(15) or otherwise under the immigration laws as defined in 8 U.S.C. §1101(a)(17);
- (3) Is paroled into the United States in accordance with 8 U.S.C. §1182(d)(5) for

## UNOFFICIAL

- less than 1 year, except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings;
- (4) Belongs to one of the following classes:
    - (A) Granted temporary resident status in accordance with 8 U.S.C. §1160 or §1255a, respectively;
    - (B) Granted Temporary Protected Status (TPS) in accordance with 8 U.S.C. §1254a, and individuals with pending applications for TPS who have been granted employment authorization;
    - (C) Granted employment authorization under 8 C.F.R. §274a.12(c);
    - (D) Family Unity beneficiaries in accordance with section 301 of Public Law 101-649, as amended;
    - (E) Under Deferred Enforced Departure (DED) in accordance with a decision made by the President;
    - (F) Granted Deferred Action status;
    - (G) Granted an administrative stay of removal under 8 C.F.R. part 241;
    - (H) Beneficiary of approved visa petition who has a pending application for adjustment of status;
  - (5) Is an individual with a pending application for asylum under 8 U.S.C. §1158, or for withholding of removal under 8 U.S.C. §1231, or under the Convention Against Torture who:
    - (A) Has been granted employment authorization; or
    - (B) Is under the age of 14 and has had an application pending for at least 180 days;
  - (6) Has been granted withholding of removal under the Convention Against Torture;
  - (7) Is a child who has a pending application for Special Immigrant Juvenile status as described in 8 U.S.C. §1101(a)(27)(J);
  - (8) Is lawfully present in American Samoa under the immigration laws of American Samoa; or,

## UNOFFICIAL

- (9) Is a victim of a severe form of trafficking in persons, in accordance with the Victims of Trafficking and Violence Protection Act of 2000, Public Law 106-386, as amended (22 U.S.C. §7105(b));
- (10) Except that an individual with deferred action under the Department of Homeland Security's deferred action for childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012 memorandum, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (9) of this definition.

"Legal permanent resident" means a non-citizen who is lawfully admitted as a permanent resident under the Immigration and Nationality Act.

"LEP" or "limited English proficient" means an individual does not speak English as their primary language and has a limited ability to read, write, speak, or understand English.

"Level A rate" means the PPS rate for care delivered by a provider to an acuity level A beneficiary in a nursing facility.

"Level B rate" means the PPS rate for care delivered by a provider to an acuity level B beneficiary in ICF/ID.

"Level C rate" means the PPS rate for care delivered by a provider to an acuity level C beneficiary in a nursing facility.

"Level D rate" means the PPS rate for care delivered by a provider to an acuity level D beneficiary in a nursing or medical facility.

"Licensed health professional" means a physician, physician assistant, nurse practitioner, physical, speech or occupational therapist, registered professional nurse, licensed practical nurse, or licensed or certified social worker.

"Life care community" means a continuing care retirement community that offers an insurance-type contract and provides all levels of care. Little or no change is made in the monthly fee, regardless of the

## UNOFFICIAL

level of medical care required by the beneficiary, except for cost of living increases.

"Life estate" means the value of a property that is allocated between the life tenant and the remainderman.

"Life interest" means a type of real property ownership that gives the owner the use of the property or the right to income generated by a property during the lifetime of the owner, or both.

"Life tenant" means a life estate holder who is entitled to certain property rights and the right to reside on the property for the duration of the holder's life or the life of another.

"Liquid asset" means cash and any other personal property that can be quickly converted to cash. Examples are bank accounts, bonds, and stocks.

"LIS" or "Low Income Subsidy program" means a program that assists with the cost of the monthly premiums and cost-sharing related to Medicare Part D.

"Long-term institutional services" means services provided to an individual by a medical institution such as a nursing facility or intermediate care facility for the intellectually or developmentally disabled.

"Look-back period" means the period prior to and including the month of application for medical assistance for long-term care services during which assets that were transferred for less than fair market value shall be evaluated to determine if a penalty period is applicable.

"Low income benchmark premium amount" means the minimum monthly premium that is charged for the standard prescription drug coverage under Part D by the CMS approved prescription drug plans.

"Low income utilization rate" means the sum of the following:

- (1) A fraction (expressed as a percentage)–
  - (A) The numerator of which is the sum (for a period) of (I) the total revenue paid the hospital for individual services under a state plan under Title XIX of the Social Security Act and (II) the

## UNOFFICIAL

- amount of the cash subsidies for individual services received directly from state and local governments; and
- (B) The denominator of which is the total amount of revenues of the hospital for individual services (including the amount of such cash subsidies for individual services) in the period; and
- (2) A fraction (expressed as a percentage)–
- (A) The numerator of which is the total amount of the hospital's charges for inpatient hospital services which are attributable to charity care in a period; and
  - (B) The denominator of which is the total amount of the hospital's charges for inpatient hospital services in the hospital in the period.

The numerator under subparagraph 2(A) shall not include contractual allowances and discounts (other than for indigent individuals not eligible for medical assistance under a state plan approved under Title XIX of the Social Security Act).

"LTC" or "long-term care" means services provided to a beneficiary by a medical institution such as a skilled nursing facility, intermediate care facility, or an intermediate care facility for the intellectually or developmentally disabled.

"LTSS" or "long-term services and supports" means services provided to a beneficiary in an inpatient medical facility receiving nursing facility level of care or to a resident of a nursing facility level of care. These facilities include assisted living facilities, expanded adult care homes, community care foster family homes, nursing facilities, and sub-acute units.

"MAGI" or "modified adjusted gross income" means adjusted gross income in accordance with 26 C.F.R. §1.62-1(c) increased by–

- (1) Amounts excluded from gross income under 26 U.S.C. §911-3;

## UNOFFICIAL

- (2) Tax-exempt interest the taxpayer receives or accrues during the taxable year; and
- (3) Social security benefits in accordance with 26 U.S.C. §86(d), not included in gross income.

"MAGI-excepted individual" means an individual, whose eligibility for medical assistance does not require a determination of income by the agency, including, but not limited to individuals:

- (1) Receiving or deemed to be receiving SSI benefits;
- (2) Age sixty-five years or older when age is a condition of eligibility;
- (3) Whose eligibility is being determined on the basis of being blind or disabled;
- (4) Requesting coverage of long-term services and supports for the purpose of being evaluated for an eligibility group under which long-term care services and supports are covered;
- (5) Eligible for Medicare cost sharing assistance; or
- (6) Who is being evaluated for coverage as medically needy.

"Maintenance therapy" means medical and psychiatric services provided to individuals to prevent, decline, or sustain the maintenance of their functional state.

"Managed care" means a comprehensive approach to the provision of healthcare that combines clinical services and administrative procedures within an integrated, coordinated system to provide timely access to primary care and other necessary services in a cost-effective manner.

"Mass change" means a change initiated by the state or federal government which affects the eligibility criteria of the entire caseload or a significant and identifiable portion of the caseload.

"Medicaid" means the following federal-state programs, established and administered by the State, that provide medical care and long-term care services to eligible individuals in the State:

## UNOFFICIAL

- (1) Medicaid under Title XIX of the Social Security Act;
- (2) The State children's health insurance program (CHIP) under Title XXI of the Social Security Act; and
- (3) The section 1115 demonstration project under Title XI of the Social Security Act (42 U.S.C. subchapters XIX, XXI, and XI).

"Medicaid agency" means the single State agency designated or established by the State in accordance with 42 C.F.R. §431.10(b) to administer or supervise the administration of the state plan.

"Medicaid qualifying trust" means a trust or similar legal device, established on or before August 10, 1993 by an individual or an individual's spouse under which the individual is the beneficiary of all or part of the payments from the trust and the distribution of the trust is determined by the trustee(s) permitted to exercise any discretion in the distribution to the individual.

"Medicaid utilization rate" means a fraction (expressed as a percentage), the numerator of which is the hospital's number of inpatient days attributable to individuals who (for such days) were eligible for medical assistance approved under Title XIX of the Social Security Act in a period, and the denominator of which is the total number of the hospital's inpatient days in that period.

"Medical assistance" means medical care and long-term care services provided to or paid for on behalf of eligible individuals through Medicaid, and state medical assistance.

"Medical condition" means a disease, an illness, or an injury. A biological or psychological condition that lies within the range of normal human variation is not considered a disease, illness, or injury.

"Medical education" means direct costs associated with an approved intern and resident teaching program as defined in the Medicare provider reimbursement manual, publication HIM-15.



## UNOFFICIAL

"Medical evaluation" means an evaluation by a physician to eliminate the possibility that the mental impairment is due to a physical illness.

"Medical facility" means a facility which:

- (1) Is organized to provide medical care, including nursing and convalescent care;
- (2) Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of the individuals on a continuing basis in accordance with accepted standards;
- (3) Is authorized under State law to provide medical care; and
- (4) Is staffed by professional personnel who have clear and definite responsibility to the institution in the provision of professional medical and nursing services including adequate and continual medical care and supervision by a physician, sufficient registered nurse or licensed practical nurse supervision and services and nurse aid services to meet nursing care needs, and appropriate guidance by a physician on the professional aspects of operating the facility.

"Medical institution" means an institution that:

- (1) Is organized to provide medical care, including nursing and convalescent care;
- (2) Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of individuals on a continuing basis in accordance with accepted standards;
- (3) Is authorized under State law to provide medical care; and
- (4) Is staffed by professional personnel who are responsible to the institution for professional medical and nursing services. The services must include adequate and continual medical care and supervision by a physician; registered nurse or licensed practical nurse supervision and services and

## UNOFFICIAL

nurses' aid services, sufficient to meet nursing care needs; and a physician's guidance on the professional aspects of operating the institution.

"Medical necessity" means those procedures and services, as determined by the department, which are considered to be necessary and for which payment will be made. Medically necessary health interventions (services, procedures, drugs, supplies, and equipment) must be used for a medical condition. There shall be sufficient evidence to draw conclusions about the intervention's effects on health outcomes. The evidence shall demonstrate that the intervention can be expected to produce its intended effects on health outcomes. The intervention's beneficial effects on health outcomes shall outweigh its expected harmful effects. The intervention shall be the most cost-effective method available to address the medical condition. Sufficient evidence is provided when evidence is sufficient to draw conclusions, if it is peer-reviewed, is well-controlled, directly or indirectly relates the intervention to health outcomes, and is reproducible both within and outside of research settings.

"Medical pensioner" means a person receiving medical assistance under the medical payments for pensioner's program.

"Medically frail" includes individuals:

- (1) With disabling mental disorders (including children with serious emotional disturbances and adults with serious mental illness);
- (2) With serious and complex medical conditions;
- (3) With a physical, intellectual or developmental disability that significantly impairs their ability to perform 1 or more activities of daily living; or
- (4) With a disability determination based on criteria under the Social Security Act.

"Medically institutionalized" means an individual who is an inpatient in a nursing facility, intermediate care facility for the developmentally or

## UNOFFICIAL

intellectually disabled, or a medical facility receiving a nursing facility level of care.

"Medically needy" means families, children, aged, blind, or disabled individuals who are otherwise eligible for Medicaid, who are not mandatory or optional categorically needy, whose resources are within limits set under the State Plan, but whose income exceeds the appropriate income standard and the excess may be reduced with incurred medical or remedial expenses or both to establish Medicaid eligibility.

"Medically needy income standard" means the medical standard of assistance as determined by the department in compliance with federal regulations related to the financial assistance program for an individual or household of applicable size.

"Medicare" means the health care insurance program for the aged and disabled administered by the Social Security Administration under title XVIII of the Social Security Act.

"Medicare Advantage - Prescription Drug (MA-PD) Plan" means a health plan approved by Medicare and run by private companies. This plan must provide all Part A and Part B services and may offer additional services including Part D drug coverage. MA-PD plans include: Medicare Preferred Provider Organizations (PPO), Medicare Health Maintenance Organizations (HMO), Medicare Private Fee-for-Service (PFFS) plans, Medicare Medical Savings Account (MSA) plans and Medicare Special Needs Plans (SNP).

"Medicare Part D Prescription Drug Benefit Program" means the federal prescription benefit provided under the Medicare Modernization Act.

"Medicare principles of reimbursement" means that body of accounting, cost finding, cost allocation, and cost limit principles that has developed over time in the administration of the Medicare program under Title XVIII of the Social Security Act. It includes, without limitation, the principles identified in the following authorities:

- (1) The Social Security Act, 42 U.S.C. §§1395 et seq.;

## UNOFFICIAL

- (2) The regulations promulgated pursuant to that Act, including 42 C.F.R. Part 413;
- (3) Manuals published by the Health Care Financing Administration, including HCFA Pub. No. 15; and
- (4) Intermediary letters and bulletins disseminated by the Health Care Financing Administration, now known as the Centers for Medicare and Medicaid Services (CMS).

"Medicare savings programs" means the Qualified Medicare Beneficiary (QMB), Specified Low Income Medicare Beneficiary (SLMB) and the Qualifying Individual (QI) programs.

"Med-QUEST administrator" means the administrative head of the Med-QUEST division of the department of human services.

"Med-QUEST Division" means the offices of the department of human services which oversees, administers, determines eligibility, and provides medical assistance and services for State residents.

"Member" means an individual who meets all eligibility requirements of the special group, and for whom all applicable expenditure shares have been paid.

"Mental illness" refers to a current primary or secondary diagnosis of a mental disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders, 3rd Edition, Revised and does not have a primary diagnosis of dementia (including Alzheimer's disease or a related disorder).

"Minimum essential coverage" means coverage defined in section 5000A(f) of subtitle D of the Code, as added by section 1401 of the Affordable Care Act, and implementing regulations of such section issued by the Secretary of the Treasury.

"MMA" means the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

"National accreditation organization" means, but is not limited to, the following national accreditation organizations for community mental health rehabilitative services:

- (1) The Council on Accreditation (COA);

## UNOFFICIAL

- (2) The Commission on Accreditation of Rehabilitation Facilities (CARF); or
- (3) The Joint Committee on Accreditation of Healthcare Organizations (JCAHO).

"New beds" means beds of providers that were placed into service after the implementation of the Hawaii Medicaid program's initial prospective payment system.

"New provider" means a provider that does not have a cost report in the base year that reflects at least a full twelve months of operations.

"NF" or "nursing facility" means a free-standing or a distinct part of a facility that is licensed and certified to provide appropriate care to individuals referred by a physician. Such individuals are those who need twenty-four hour a day assistance with the normal activities of daily living, need care provided by licensed nursing personnel and paramedical personnel on a regular, long-term basis, and may have a primary need for twenty-four hours of skilled nursing care on an extended basis and regular rehabilitation services.

"Non-applicant" means an individual who is not seeking an eligibility determination for himself and is included in an individual's household to determine eligibility for an applicant or beneficiary.

"Non-citizen" has the same meaning as the term alien as defined in section 101(a)(3) of the Immigration and Nationality Act (INA), (8 U.S.C. §1101(a)(3)) and includes any individual who is not a citizen or national of the United States, as defined in 8 U.S.C. §1101(a)(22).

"Non-covered services" means those services not covered under the scope and content of the medical assistance program.

"Non-dual eligible" means an individual who does not meet the definition of a full benefit dual eligible.

"Non-returning plan" means a participating health plan that has a current, but no new contract with the department.

## UNOFFICIAL

"Not at risk for rapid deterioration" mean individuals who can be placed in a non-acute care setting without risk to the individuals' health and safety.

"Nurse aide" means any individual providing nursing or nursing-related services to individuals in a nursing facility but does not include an individual who:

- (1) Is a licensed health professional; or
- (2) Volunteers to provide such services without monetary compensation.

"Nurse practitioner" means a registered professional nurse who is currently licensed to practice in the state, and who meets one of the following conditions for practice in a NF or ICF-ID:

- (1) Is currently certified as a gerontological nurse practitioner by the American Nurses' Association;
- (2) Has satisfactorily completed a formal one academic year educational program that:
  - (A) Prepares registered nurses to perform an expanded role in the delivery of care in the field of gerontology or intellectual disability, whichever is appropriate;
  - (B) Includes at least four months (in the aggregate) of classroom instruction and a component of supervised clinical practice; and
  - (C) Awards a degree, diploma, or certificate to individuals who successfully complete the program; or
- (3) Has successfully completed a formal educational program (for preparing registered nurses to perform an expanded role in the delivery of care in the field of gerontology or intellectual disability, whichever is appropriate) that does not meet the above requirements of (2) of this definition, and has been functioning in an expanded role in the delivery of care in the respective fields of gerontology or

## UNOFFICIAL

intellectual disability for a total of twelve months during the eighteen month period immediately preceding the effective date of appointment as a nurse practitioner by the facility administrator.

"Nursing facility level of care" means the determination that a member requires the services of licensed nurses in an institutional setting to carry out the physician's planned regimen for total care. These services can be provided in the home or in community-based programs as a cost-neutral, least restrictive alternative to institutional care in a hospital or nursing facility.

"OASDI" means old-age, survivors, and disability insurance benefits authorized under Title II of the Social Security Act and administered by the Social Security Administration.

"OBRA 87" means the Omnibus Budget Reconciliation Act of 1987, Pub. L. 100-203, and its interpretive guidelines and implementing regulations.

"OBRA 87 adjustment" means the adjustment to the basic PPS rate to reimburse a provider for the incremental costs of complying with OBRA 87. The OBRA 87 adjustment was paid under a prior version of this provision during the period beginning June 1, 1993, and ending June 30, 1997.

"Old beds" mean the beds of a provider that were placed in service prior to the implementation of the Hawaii Medicaid program's initial prospective payment system.

"Open application period" means the only period during which applications for Basic Health Hawaii shall be accepted from individuals subject to a specified duration or the statewide enrollment limit.

"Operating year" means the twelve consecutive month period beginning on the latest of the following dates:

- (1) The effective date of the plan amendment that adds this definition to the plan; or
- (2) The date that a hospital becomes a provider.

## UNOFFICIAL

"Outlier claims" means any claim which has total charges in excess of the outlier threshold, as defined in the State Plan.

"Outpatient" means an individual of an organized medical facility, or distinct part of that facility who is expected by the facility to receive and who does receive professional services for less than a twenty-four hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the individual remains in the facility past midnight.

"Over-utilization" means to misuse the services of one or more physicians or providers for the same or similar conditions over a period of time.

"PACE" means a Program of All-Inclusive Care for the Elderly authorized by the Balanced Budget Act of 1997 that provides a comprehensive service delivery system. PACE is a demonstration project to provide an array of health related services within a capitation payment.

"Parent or caretaker relative" means a person who assumes primary responsibility for the care and control of a child under age nineteen years or of an individual who is under age twenty-one years and in receipt of foster care, kinship guardianship or adoption assistance who is residing in the household and is enrolled in Medicaid.

"Participating health plan" means a health plan contracted by the State to provide covered services within the service area in which the eligible individual resides that is open to receiving new members.

"PCP" or "primary care provider" means a practitioner selected by the beneficiary to manage the beneficiary's utilization of health care services who is licensed in Hawaii and is:

- (1) A physician, either an M.D. (doctor of medicine) or a D.O. (doctor of osteopathy), and must generally be a family practitioner, general practitioner, general internist, pediatrician or obstetrician-gynecologist



## UNOFFICIAL

- (for women, especially pregnant women) or geriatrician;
- (2) An advanced practice registered nurse with prescriptive authority. PCPs have the responsibility for supervising, coordinating and providing initial and primary care to enrolled individuals and for initiating referrals and maintaining the continuity of their care; or
  - (3) A physician's assistance recognized by the State Board of Medical Examiners as a licensed physician assistant.

"PDP" means prescription drug plan.

"Pediatric" mean individuals from twenty-eight days to under twenty-one years of age.

"Penalty period" means a period in which Medicaid will not provide coverage of long-term care services for an individual, who is otherwise eligible for Medicaid, because the individual or the individual's spouse transferred assets for less than fair market value.

"Pensioner" means a person who is receiving a pension or retirement payment from the State or counties of the State.

"Periods of crisis" means a period in which the individual requires continuous care to achieve palliation or management of acute medical symptoms.

"Personal property" means any asset that is not real property.

"Personal reserve" means the amount of countable assets held by an individual or household while establishing or maintaining eligibility for medical assistance.

"Personal reserve standard" means the maximum amount of countable assets that may be held by an individual or a household while establishing or maintaining eligibility for medical assistance.

"Pharmacy provider" means every place, shop, or store fully licensed and registered under all county, state, and federal laws to dispense or sell drugs at retail, or compound physicians' prescriptions or drug

## UNOFFICIAL

preparations, and under the supervision of a registered pharmacist.

"Physical illness" means medical conditions exclusive of those listed in the current Diagnostic and Statistical Manual of Mental Disorders.

"Physician assistant" means a person who is currently approved and certified as a physician assistant by the state board of medical examiners, state department of regulatory agencies.

"Post-eligibility" means the process to determine an eligible individual's share of monthly medical expenses for an individual receiving long-term care services.

"PPS" means the prospective payment system of reimbursement.

"PPS rate" means the prospective payment system annual rate assigned each Medicaid institutional provider.

"Practitioner" mean a licensed doctor of medicine, dentistry, osteopathy, podiatry, and any other individual licensed practitioner of health care services the department chooses to include in its Medicaid program.

"Preferred drug list" means prescription drugs, within specified therapeutic classes, or that are comparatively effective, that are designated as preferred for use as determined by a committee of physicians and pharmacists and approved by the department.

"Pre-paid health benefits" means health benefits available through a current health plan.

"Prescription drug plan" means a plan provided by non-governmental entities under contract with the federal Centers for Medicare and Medicaid Services to provide prescription benefits under the MMA.

"Pretax setoff notice" means the initial setoff notice that is sent to inform the debtor that the department intends to setoff the debtor's state income tax refund.

"Primary care physician" means a physician who treats and oversees the health needs of a beneficiary.

## UNOFFICIAL

"Promissory note" means a written agreement signed by a person who promises to pay a specific sum of money at a specified time, or on demand, to the holder of the note.

"Proprietary provider" means a for-profit provider.

"Provider" means any licensed or certified person or public or private institution, agency or business concern authorized by the department to provide health care, service or supplies to individuals receiving medical assistance.

"Prudent layperson" means one who possesses an average knowledge of health and medicine.

"Prudent layperson standard" refers to the determination of an emergency medical condition based on the judgment of a prudent layperson.

"Psychiatric care" means an established mode of practice offering the most effective and humane treatment for the acutely ill.

"Psychiatric providers" means those individuals and facilities authorized to provide psychiatric services under the Medicaid program.

"Psychiatric service" means psychiatric care.

"Public assistance programs" means financial or medical assistance, child support, or social service programs.

"Public institution" means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. Examples include, but shall not be limited to, jails, prisons, correctional facilities and mental hospitals.

"QDWI" or "Qualified Disabled Working Individual" means an individual who:

- (1) Is eligible to enroll for Medicare Part A under section 1818A of the Act;
- (2) Has income, as determined in accordance with SSI methodologies that does not exceed two hundred per cent of the Federal poverty guidelines (as defined and revised annually by the Office of Management and Budget) for

## UNOFFICIAL

a family of the size of the individual's family;

- (3) Has resources, as determined in accordance with SSI methodologies, that do not exceed twice the relevant maximum amount established, for SSI eligibility, for an individual or for an individual and the individual's spouse; and
- (4) Is not otherwise eligible for Medicaid.

"QEx" means the QUEST Expanded program that delivers medical and behavioral health services through health plans employing managed care concepts, to certain individuals in accordance with the State plan under Title XIX, or in accordance with a demonstration project under Title XI of the Social Security Act.

"QExA" means the QUEST Expanded Access program that delivers medical and behavioral health services through health plans employing managed care concepts, to certain individuals who are aged, blind or disabled.

"QMB" or "Qualified Medicare Beneficiary" means an individual who:

- (1) Is entitled to Medicare Part A, with or without payment of premiums, but is not entitled solely because the individual is eligible to enroll as a QDWI;
- (2) Has resources, as determined in accordance with SSI methodologies, that do not exceed twice the maximum amount established for SSI eligibility; and
- (3) Has income, as determined in accordance with SSI methodologies that does not exceed one hundred percent of the Federal poverty guidelines.

"QMB only provider" means a provider of QMB services that is not certified to participate in the Medicaid program.

"QMHP" or "qualified mental health professionals" means:

- (1) A psychiatrist licensed to practice medicine in the State of Hawaii in accordance with

## UNOFFICIAL

HRS chapter 453 and who is certified or is eligible to be certified in psychiatry by the American Board of Psychiatry or Neurology;

- (2) A psychologist licensed in accordance with HRS chapter 465;
- (3) A clinical social worker in behavioral health licensed in accordance with HRS chapter 467E;
- (4) An advance practice registered nurse (APRN) licensed in accordance with HRS chapter 457; or
- (5) Any other person as determined by the department of human services.

"QMRP" means a qualified mental retardation professional who has at least one year of experience working directly with individuals with developmental disabilities or intellectual disabilities as defined in HRS section 333F-1, or related conditions, and is one of the following:

- (1) A doctor of medicine or osteopathy;
- (2) A registered nurse; or
- (3) An individual who holds at least a bachelor's degree in a professional category.

"Qualified non-citizen" means:

- (1) An individual who is lawfully admitted as a permanent resident under the INA (8 U.S.C. §1101 et seq);
- (2) An individual who is granted asylum under section 208 of the INA (8 U.S.C. §1158);
- (3) A refugee admitted to the United States under section 207 of the INA (8 U.S.C. §1157);
- (4) An individual who is paroled into the United States under section 212(d)(5) of the INA (8 U.S.C. §1182(d)(5)) for a period of at least one year;
- (5) An individual whose deportation is being withheld under section 243(h) of the INA (8 U.S.C. §1253) or section 241(b)(3) of the INA (8 U.S.C. §1231(b)(3));

## UNOFFICIAL

- (6) An individual who is granted conditional entry under section 203(a)(7) of the INA (8 U.S.C. §1153(a)(7)) as in effect before April 1, 1980;
- (7) An individual who is a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Educational Assistance Act of 1980);
- (8) An individual who has been battered or subjected to extreme cruelty in the U.S. by a spouse, parent, or household member with the spouse or parent's consent or acquiescence, including a child (without the active participation of the parent(s) in the battery or cruelty) as described in 8 U.S.C. §1641(c), and has been approved for or has a petition pending that sets forth a prima facie case to be granted status by USCIS as a battered spouse, a child, or a parent of a battered child under clauses (i), (ii), (iii) and (iv) of section 204(a)(1)(A) or clauses (i), (ii) and (iii) of section 204(a)(1)(B) of the INA, provided that the individual responsible for such battery does not reside in the same household as the individual subjected to the battery; and
- (9) An individual who has been granted nonimmigrant status under section 101(a)(15)(T) of the INA (8 U.S.C. §1101(a)(15)(T)) as a victim of a severe form of trafficking in individuals or who has a pending application that sets forth a prima facie case for eligibility for such nonimmigrant status, provided that the individual responsible for such cruelty does not reside in the same household as the individual subjected to the cruelty.

"QUEST" or "Hawaii QUEST" means the demonstration project developed by the department which will deliver medical and behavioral health services through health plans employing managed care concepts to certain individuals formerly covered by public assistance programs, including the aid to families with dependent

## UNOFFICIAL

children (AFDC) and related medical programs, General Assistance (GA), and the State Health Insurance Program (SHIP). Dental coverage is provided through the fee-for-service program.

"QUEST-ACE" means the QUEST-Adult Coverage Expansion program that delivers limited medical and behavioral health services through health plans employing managed care concepts.

"QUEST-Net" means the program that delivers medical and behavioral health services through health plans employing managed care concepts.

"Rate reconsideration" means the formal process of submitting documentation and requesting a review of the PPS rates because of extraordinary circumstances beyond the control of the provider.

"RCA" or "refugee cash assistance" means cash assistance provided under section 412(e) of the Immigration and Nationality Act to refugees who are ineligible for TANF, OAA, AB, APTD, AABD, or SSI.

"RCL" or "routine cost limit" means the federal routine operating cost limits. Beginning with the effective date of these rules, the routine cost limit is calculated annually using the limit in effect on June 30th of the immediately preceding fiscal year multiplied by one plus the inflation adjustment.

"Real property" means land, buildings and anything else erected on or affixed to the land or buildings.

"Rebasing" for:

- (1) Long-term care services means calculating the basic PPS rates by reference to a new base year and new base year cost reports. Rebased basic PPS rates are the end product of a rebasing.
- (2) Federally qualified health centers means a determination by Congress that it is necessary to select another base year to recalculate the PPS rates or make necessary refinements to the PPS rates.

"Recoupment" means any formal action by the State or its fiscal agent to initiate recovery of an

## UNOFFICIAL

overpayment without advance official notice by reducing future payments to a provider.

"Redetermination" means a determination of an individual's or household's eligibility to continue to receive program benefits.

"Remainder beneficiary" means the party that is designated to receive funds from an annuity, trust or similar legal contract, after the death of the owner.

"Remainderman" means an individual who is given a remainder interest in a property which he or she will inherit upon the death of the life estate holder.

"Representative" means an individual's authorized representative, legal guardian, conservator, or representative payee as designated by the Social Security Administration.

"Respiratory therapist" means a person qualified to perform respiratory therapy as exemplified by certification by the national board for respiratory care (NBRC) or a person experienced in the performance of respiratory therapy services who is employed by a Medicaid certified agency or provider to specifically provide respiratory therapy services.

"Respiratory therapy" means the performance of preventive, maintenance, and rehabilitative airway-related techniques and procedures including application of medical gasses, humidity, and aerosols, intermittent positive pressure, continuous artificial ventilation, the administration of drugs through inhalation, individual care and instruction, and the provision of consultation to other health personnel.

"Respite care" means temporary institutional, community or home-based services that allow persons who ordinarily care for the enrollee, relief from these duties.

"Revocable trust" means a trust whose terms and conditions can be amended.

"ROE" means return on equity.

"ROE adjustment" means the adjustment to the basic PPS rate to a proprietary provider to reimburse it for return on equity, as computed and paid according to this chapter.



## UNOFFICIAL

"Routine services" means daily bedside care, such as room and board, serving and feeding individuals, monitoring life signs, cleaning wounds, bathing, etc.

"RSDI" means retirement, survivors, and disability insurance benefits which are administered by the Social Security Administration under Title II of the Social Security Act.

"RHC" or "rural health clinic" means an entity that meets the qualifications for a rural health clinic, as defined in section 1861(aa)(2) of the Social Security Act.

"SDX" or "state data exchange system" means an automated exchange system in which the SSA transmits information on all individuals currently receiving SSI benefits to the department.

"Section 1915(c) or §1915(c) program" means a program established under section 1915(c) of the Social Security Act that provides home and community based services to eligible individuals.

"Section 1931 of the Social Security Act" means the section that was added to the Social Security Act by the Personal Responsibility and Work Opportunity Act of 1996, which established a new mandatory eligibility group of low-income families with children.

"Secure electronic interface" means an interface which allows for the exchange of data between Medicaid and other insurance affordability programs and adheres to the requirements in subpart C of 42 C.F.R. part 433.

"Self-employment" means the performance of services or sale of goods by an individual or a group of individuals who have the legal right to determine what must be done and how it must be done and who are not subject to the will and control of an employer.

"Service agency" means an agency providing employment services funded under the refugee resettlement program.

"Service area" means the geographical area defined by zip codes, census tracts, or other geographic subdivisions that is served by a

## UNOFFICIAL

participating health plan as defined in the health plan's contract with the department.

"Severe, disabling mental illness" means a mental disorder which exhibits emotional or behavioral functioning that is so impaired as to interfere substantially with a person's capacity to remain in the community without treatment or services of a long-term or indefinite duration. This mental disability is severe and persistent, encompassing individuals with serious mental illness (SMI), serious or persistent mental illness (SPMI), or requiring support for emotional and behavioral development (SEBD), resulting in a long-term limitation of a person's functional capacities for primary activities of daily living such as interpersonal relationships, homemaking, self-care, employment, and recreation.

"Shared eligibility service" means a common or shared eligibility system or service used by a State to determine individuals' eligibility for insurance affordability programs.

"SHIP" means the discontinued state health insurance program that was administered by the department of health.

"SHOTT" means the State of Hawaii Organ and Tissue Transplant program.

"Sixty-day grace period" means the first sixty-days after the date of the confirmation notice that an enrollee has to change health plans, with or without cause, provided the health plan is not at its maximum enrollment.

"SLMB" means a specified low income Medicare beneficiary who is a member of a special Medicaid coverage group. These group members are only eligible for coverage of premiums for Medicare supplementary medical insurance.

"SMAC" or "State maximum allowable cost" is based on drug prices obtained from a nationally recognized comprehensive data file maintained by a vendor under contract with the Department agent. A generic drug may be considered SMAC for the pricing if there are two or more therapeutically equivalent, multi-source, non-innovator drugs with a cost difference. The SMAC

## UNOFFICIAL

will be based on drug status (including non-rebatable, rebatable, therapeutic equivalency rating, etc.), marketplace availability in Hawaii and cost. The drug status will be taken into account to ensure that the SMAC pricing is not influenced by the process listed for drugs.

"SMI" means supplementary medical insurance, also known as part B, which provides Medicare coverage of outpatient medical services.

"SMI buy-in" means the enrollment and group coverage of beneficiaries for supplementary medical insurance (part B of Medicare) and payment of monthly premiums on the beneficiaries' behalf as provided in an agreement between the State and the Centers for Medicare and Medicaid Services.

"SNF" or "skilled nursing facility" means a health care institution or distinct part of an institution that is primarily engaged in providing skilled nursing care or rehabilitative services to injured, disabled, or sick individuals.

"Special care percentage" means the result of dividing the Medicaid special care days for a given cost reporting period by the total Medicaid days for the same period. The days reported in the nursery cost center on the cost report shall be excluded from the calculation.

"Spendedown" means the amount of an individual's income in excess of the medically needy income standard identified by the department as available to meet a portion of the individual's health care cost.

"Sponsor" means an individual, church, civic organization, State or local government, or other group or organization which has agreed to help in the reception and initial placement of refugees in the United States and other public and private non-profit agencies, wherever.

"Spouse" means an individual who is lawfully married under Hawaii law.

"SSA" means the Social Security Administration.

"SSI" means supplemental security income under title XVI of the Social Security Act 42 U.S.C. §§1381-1385).

## UNOFFICIAL

"SSN" means the social security number issued by the SSA.

"SSP" means the State supplementary payments program administered by the federal Social Security Administration under Title XVI of the Social Security Act (42 U.S.C. §1382e), paid by the State to certain aged, blind, or disabled individuals in domiciliary care living arrangements, community care foster family homes, or expanded adult residential care homes.

"Standard benefits package" means the minimum benefits and services that must be provided by each participating health plan to eligible medical assistance beneficiaries.

"Standard of assistance" means a State need standard, expressed in a dollar amount, against which an individual's or family's income is compared, to determine eligibility for medical assistance.

"State employment service" means the employment service of the state department of labor and industrial relations.

"State fiscal year" means the period July 1 through the following June 30 of consecutive calendar years.

"State medical assistance" means medical care and long-term care services provided or paid for by the State on behalf of to eligible individuals who are not eligible for Medicaid.

"State mental health authority" means the adult mental health division of the department of health.

"State mental health/developmental disability authority" means the developmental disabilities division of the department of health.

"State plan" or "Hawaii Medicaid state plan" means the document approved by DHHS that defines how Hawaii operates its Medicaid program. The state plan addresses areas of state program administration, Medicaid eligibility criteria, service coverage, and provider reimbursement.

"Stream of income" means income that can be anticipated to be received more than once (e.g. rental or lease payments, royalties, annuity payments, pensions, court ordered settlements, etc.).

## UNOFFICIAL

"Student" means a child under age nineteen years enrolled in a public or private elementary, secondary school, or in a program of an equivalent level of vocational or technical training, or officially released by the department of education and being provided an education in the home, and a child under eighteen years of age attending a post secondary institute, such as a college, vocational school, or technical trade institute.

"Sub-acute" means a level of care that is needed by an individual not requiring acute care, but who needs more intensive skilled nursing care than is provided to the majority of patients in a skilled nursing facility.

"Sub-acute unit" is a facility that provides care as defined in section 17-1737-116, that is needed by an individual not requiring acute care, but who needs more intensive skilled nursing care than is provided to the majority of individuals in a nursing facility.

"Subrogation" means the substitution of one creditor for another, along with transference of the claims and rights of the old creditor.

"Substance abuse" means excessive use of substances that alter or impair consciousness.

"Substitute direct nursing component" means adjusting the direct nursing care component used to obtain a basic PPS rate for an acuity level as follows:

- (1) Increasing the facility-specific level A direct nursing component by dividing that component by the acuity ratio; or
- (2) Decreasing the facility-specific level C direct nursing component by multiplying it by the acuity ratio;
- (3) In calculating the substitute direct nursing component, the acuity ratio shall be applied to the provider's direct nursing component prior to the application of the direct nursing component ceiling.

"Surveillance" means the process of monitoring the delivery and utilization of covered services and items of the beneficiaries and includes the use of

## UNOFFICIAL

itemized data and statistics to establish norms of care in order to detect improper or illegal utilization practices.

"Survivor" means the lawfully married spouse, parent, natural and legally adopted child, grandparent, grandchild, great-grandparent, great grandchild, and any subsequent grandparent or grandchild with the designation 'great,' of a deceased beneficiary.

"Suspension" means that items or services furnished by a specified provider who has been convicted of a program-related offense in a Federal, State, or local court will not be reimbursed under Medicaid.

"Targeted case management services" means services which will assist certain individuals in gaining access to needed medical, social, educational, and other services.

"Tax dependent" means an individual for whom another individual claims a deduction for a personal exemption under section 151 of the Internal Revenue Code for a taxable year.

"Tax setoff" means the interception and retention of state income tax refund to recover a delinquent debt.

"Tax setoff notice" means the notice that is sent at the time the debt is setoff against the debtor's state income tax refund.

"Temporarily absent" means the child or caretaker relative is not present in the home for a period not to exceed sixty days, and from the date of departure there was a planned date of return.

"Tenancy" means the right to possession of real property or otherwise, permanently or temporarily, with or without title to the property.

"Tenancy in common" means ownership of property by two or more individuals whose undivided interests in the property may not be proportionate. The owners may sell their interest without the consent of the other owners.

"Tenancy by the entirety" means the ownership of real or personal property by two individuals through

## UNOFFICIAL

marriage, civil union, or reciprocal beneficiary agreements at the same time through the same legal document. The right of survivorship is automatic. Neither individual can convey their interest in the property without the consent of the other individual. The ownership changes to tenancy in common with the dissolution of the marriage, civil union or reciprocal beneficiary agreement.

"Terminally ill" means a medical prognosis that an individual's life expectancy is six months or less.

"Termination for providers" means an exclusion of a provider from participation in the Hawaii medical assistance program by revoking the provider's billing privileges and the provider has exhausted all applicable appeal rights or the timeline for appeal has expired. Termination is not for a specified period of time and the providers will be required to reenroll with the applicable program if they wish billing privileges to be reinstated.

"Third party" means any individual, entity or program that is or may be liable to pay all or part of the expenditures for medical assistance.

"Third party resource" means any resource or benefits from any source to which an eligible person may be entitled.

"Title IV" means Title IV-D of the Social Security Act, child support enforcement program.

"Title XX" means Title XX of the Social Security Act (42 U.S.C. §1397).

"Total PPS rate" means the basic PPS rate plus all applicable adjustments, additions or increases to that rate that are defined and authorized in this chapter.

"TPL" means a third party liability.

"TPQY" or "third party query" request means a manual system in which the department requests SSA beneficiary or SSI information from the SSA.

"Transition period end date" means, for purposes of Basic Health Hawaii, the last day of the second month following the implementation date.

"Transplantation" means the grafting of organs and tissues taken from the individual's own body or

## UNOFFICIAL

from another for the purpose of replacing diseased tissues or diseased organ.

"Transportation" means travel or transfer by taxicab, air and ground ambulance, out-of-state or inter-island airline to, from, or between medical facilities and other providers.

"UCC" or "utilization control committee" means the committee that controls admissions and continued stay in acute hospital facilities based on the utilization control plan approved by the federal government for Hawaii's medical assistance program.

"Unclaimed body" means a deceased person for whom no legally responsible individual has been identified and no one has assumed responsibility for disposition.

"Unearned income" means cash received or available to be received by the household which is not classified as earned income.

"Upper limit" means the limit on aggregate payments to providers imposed by 42 C.F.R. §447.272.

"UR" means utilization review of inpatient long-term institutional services provided to beneficiaries in an ICF-ID to determine whether continued stay at the specific level of care is appropriate.

"URC" means the utilization review committee, which is a group composed of one or more physicians and other health care professionals that conducts utilization review.

"U.S." means the United States of America.

"U.S.C." or "United States Code" means the official codification of all the laws of a general and permanent nature of the United States.

"USCIS" means the United State Citizenship and Immigration Services, Department of Homeland Security.

"Valuable consideration" means the value that an individual receives in exchange for the individual's interest in an asset, some act, object, service, or other benefit which has a tangible or intrinsic value to the individual that is equivalent to or greater than the value of the transferred asset.

"Vendor" means a third party provider who receives payment directly from the department in



## UNOFFICIAL

return for services or goods rendered on behalf of the individual.

"Vendor payments" mean payments made by invoice billing or purchase order for valid services rendered to eligible individuals.

"Verification" means the use of third party information or documentation to establish the accuracy of statements from an individual.

"Visit" means a face-to-face encounter between an eligible beneficiary who is an individual receiving covered health care items or services from a FQHC or RHC, and either:

- (1) A health care professional; or
- (2) Another person who delivers health care services incident to the health care professional's practice.

Encounters with more than one health care professional and multiple encounters with the same health care professional that take place on the same day and at a single location constitute a single visit, except when the individual, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

"Visiting consultant" means a Medicaid provider who has expertise or knowledge in a specific area and generally recognized by the community as a specialist and this expertise or service is not readily available on a particular island. Included as a visiting consultant are specialists who are requested by other providers to render second opinions or to participate in the medical treatment of Medicaid beneficiaries.

"Voluntary resettlement agency" means a private, non-profit organization contracted by the federal government to provide initial resettlement services to refugees.

"Wait-listed patient" means an individual who no longer requires acute care and is awaiting placement to a long-term care facility.

"Wholesale average cost" means the wholesale acquisition cost (WAC) which is defined as the list price paid by a wholesaler, distributor and other direct accounts for drugs purchased from the

## UNOFFICIAL

wholesaler's supplier. Generally, it is the price set by the manufacturer of drug before any rebates, discounts, allowances or other price concessions are offered by the supplier of the product.

[Eff 09/30/13] (Auth: HRS §§88-4, 231-51 to 231-59, 325-101, 346-10, 346-12, 346-14, 346-15, 346-26, 346-29, 346-37, 346-37(c) and (e), 346-44, 346-53, 346-56, 346-59, 346-59.4, 346-70, 346-71, 346D-2; 42 C.F.R. §§400.203, 405.1020, 423.774, 423.904, 430.25, 431.10, 431.18, 431.201, 431.301, 431.625, 433.36, 433.136, 433.138, 433.145, 433.146, 433.147, 435.4, 435.110, 435.112 to 435.117, 435.145, 435.150, 435.170, 435.213 to 435.215, 435.220, 435.222, 435.223, 435.226, 435.227, 435.229, 435.301, 435.310, 435.406, 435.601, 435.845, 435.1008, 435.1009, 440.2, 440.40, 440.50, 440.150, 440.230, 440.255, 447.250(a), 447.252, 455.2, 483.35; 45 C.F.R. §§206.10, 400.2; 8 U.S.C. §1641; 42 U.S.C. §§1383c(c), 1395 et seq., 1395i-2a, 1396(a), 1396(b), 1396a(a)(10)(A)(ii), 1396a(a)(10)(E), 1396d(p)(1)(B), 1396d(p)(2)(A), 1396n, 1396p, 1396r-5, 1396r, 1396u-1) (Imp: HRS §§88-4, 231-51 to 231-59, 325-101, 346-10, 346-12, 346-14, 346-15, 346-26, 346-29, 346-37, 346-37(c) and (e), 346-44, 346-53, 346-56, 346-59, 346-59.4, 346-70, 346-71, 346D-2; 42 C.F.R. §§400.203, 405.1020, 423.774, 423.904, 430.25, 431.10, 431.18, 431.201, 431.301, 431.625, 433.36, 433.136, 433.138, 433.145, 433.146, 433.147, 435.4, 435.110, 435.112 to 435.117, 435.145, 435.150, 435.170, 435.213 to 435.215, 435.220, 435.222, 435.223, 435.226, 435.227, 435.229, 435.301, 435.310, 435.406, 435.601, 435.845, 435.1008, 435.1009, 440.2, 440.40, 440.50, 440.150, 440.230, 440.255, 447.250(a), 447.252, 455.2, 483.35; 45 C.F.R. §§206.10, 400.2; 8 U.S.C. §1641; 42 U.S.C. §§1383c(c), 1395 et seq., 1395i-2a, 1396(a), 1396(b), 1396a(a)(10)(A)(ii), 1396a(a)(10)(E), 1396d(p)(1)(B), 1396d(p)(2)(A), 1396n, 1396p, 1396r-5, 1396r, 1396u-1)