Attachment E

5) The Benefit Specifications and Qualifications forms are completed for the following benefits that will be provided under the 1115 demonstration that differ from the Medicaid or CHIP State Plan.

The State included this information in the respective Long Term Services Benefit Specifications and Provider Qualifications forms instead:

1) Counseling and training services;
2) Skilled nursing (private duty nursing); and
3) Specialized medical equipment and supplies.

BENEFIT CHART

Benefit	Description of Amount, Duration and Scope	Reference
Counseling	Counseling services are provided to eligible recipients with limitations under the State Plan.	Att. 3.1-A – Item 6. d.
Skilled Nursing	Skilled nursing services are provided to eligible recipients with limitations under the State Plan.	Att. 3.1-A – Item 7.a.
Durable Medical Equipment and Medical Supplies	Durable medical equipment and medical supplies are provided to eligible recipients with limitations under the State Plan.	Att. 3.1-A – Items 4.c, 7.c. and 12.

BENEFITS NOT PROVIDED

Benefit	Description of Amount, Duration and Scope	Reference
Training	Training services are not provided under the State plan.	
Private Duty Nursing	Private duty nursing services are not provided under the State Plan.	Att. 3.1-A – Item 8.

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: Clubhouse

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

a. *A Clubhouse is a local community center that offers individuals who have mental illness opportunities to achieve their full potential by forming a community of individuals who are working together to achieve a common goal. A Clubhouse is organized to support individuals living with mental illness.*
b. *Clubhouse is an organization accredited by International Center for Clubhouse Development (ICCD). ICCD is an organization that provides resources for communities to create solutions for individuals with mental illness.*
   Clubhouse is provided to beneficiaries with a Severe Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI) if meeting the criteria described in the Behavioral Health Protocol.

Amount of Benefit/Service
Describe any limitations on the amount of service provided under the Demonstration:
There are no limitations but prior authorization is required; and monthly assessments are performed to ensure that benefits/services are medically necessary.

Benefit Amount: _____ per □ Day □ Week □ Month □ Year
☑ Other, describe:
There are no limitations if the above requirements are met.

Duration of Benefit/Service:
Describe any limitations on the duration of the service under the demonstration:
There are no limitations if the above requirements are met.

□ Day(s) _____
□ Week(s) _____
□ Month(s) _____
□ (Other) _____

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any:
Prior authorization is required; monthly assessments are performed to ensure medically necessary.

Provider Specifications and Qualifications
Provider Category(s): *Agencies*
□ Individual (list types) ☑ Agency (list types of agencies)

Agencies accredited by ICCD

The service may be provided by a: *N/A*
□ Legally Responsible Person □ Relative/Legal Guardian

Description of allowable providers:
Providers of Clubhouse shall be accredited by ICCD as a center that promotes recovery for individuals with mental illness.

Specify the types of providers for this benefit or service and their required qualifications:

Provider Type:	*Accredited Clubhouse*	
License Required:	□ Yes	☑ No
Certificate Required:	☑ Yes	□ No

Describe:
All agencies that provide Clubhouse benefits shall be accredited by International Center for Clubhouse Development (ICCD). Each Clubhouse shall meet the standards of ICCD for accreditation. Accreditation is awarded for either a one- or three-year period, subject to the degree of adherence by the Clubhouse to the ICCD International Standards. The accreditation process is both evaluative and consultative. It is conducted by members of the ICCD Faculty for Clubhouse Development (made up of veteran members and staff from certified ICCD Clubhouses from around the world).

Accreditation components include:
- *A Clubhouse self-study;*
- *A site visit by members of the ICCD Faculty for Clubhouse Development;*
- *A findings presentation and dialogue with Clubhouse leadership focusing on improvement opportunities;*
- *A written report;*
- *The award of accredited status; and*
- *Ongoing consultation with ICCD.*

Other Qualifications Required for this Provider Type (please describe):
- *Provider agreement with health plan(s), Med-QUEST Division, or Community Care Services (CCS) program*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: Peer Specialist

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

a. *The peer specialist works in collaboration with interdisciplinary team members to assist beneficiaries to:*
   i. *Understand recovery and the value of every individual's recovery experience;*
   ii. *Identify strengths and needs for recovery;*
   iii. *Understand and set goals for recovery;*
   iv. *Determine the objectives needed to reach beneficiary-centered recovery goals; and*
   v. *Help beneficiaries create, maintain and utilize their own recovery plan.*
b. *These providers help individuals with SMI or SPMI by providing support to others who are facing a similar situation that they have faced in the past. Peer specialists promote self-determination, personal responsibility, and community integration for beneficiaries.*
c. *Providers of peer specialist services are certified peer specialists.*
d. *Peer specialists may provide services to beneficiaries with a Severe Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI) if meeting the criteria described in the Behavioral Health Protocol.*

Amount of Benefit/Service
Describe any limitations on the amount of service provided under the Demonstration:
There are no limitations but prior authorization is required; and monthly assessments are performed to ensure that benefits/services are medically necessary.

Benefit Amount: _____ per □ Day □ Week □ Month □ Year
☑ Other, describe:
There are no limitations if the above requirements are met.

Duration of Benefit/Service:
Describe any limitations on the duration of the service under the demonstration:
There are no limitations if the above requirements are met.

□ Day(s) _____
□ Week(s) _____
□ Month(s) _____
□ (Other) _____

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any:
Prior authorization is required; monthly assessment to ensure medically necessary.

Provider Specifications and Qualifications

Provider Category(s):

☑ Individual (list types) — *Certified Peer Specialist*

☑ Agency (list types of agencies) — *Certified Mental Health providers*

The service may be provided by a: *N/A*

□ Legally Responsible Person

□ Relative/Legal Guardian

Description of allowable providers:

Peer specialists shall be certified by Department of Health, Adult Mental Health Division (AMHD) as part of their Hawaii Certified peer specialist (HCPS) program. Peer specialists are persons who have self-identified themselves as receiving (or previously received) mental health services for their own personal recovery. Certified mental health providers may utilize certified peer specialists as part of the IDT in the individual's plan of care.

Specify the types of providers for this benefit or service and their required qualifications:

Provider Type:	*Certified Peer Specialist*	
License Required:	□ Yes	☑ No
Certificate Required:	☑ Yes	□ No

Describe:

All individuals or agencies that provide certified peer specialist benefits shall be certified by the Department of Health, Adult Mental Health Division to provide the services described above.

Other Qualifications Required for this Provider Type (please describe):

- *Provider agreement with health plan(s), Med-QUEST Division, or Community Care Services (CCS) program*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: Representative Payee

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

a. *The representative payee service is provided by an organization that is chosen for a beneficiary that cannot manage or direct someone else to manage his or her money. This benefit is only for those without access to the social security representative payee program.*
b. *The main responsibilities of a representative payee are to use the beneficiary's income to pay for the current and foreseeable needs of the beneficiary and properly save any income not needed to meet current needs. A payee must also keep records of expenses. Reports shall be provided quarterly on each beneficiary's account.*
c. *Providers of representative payee services are agencies that are certified mental health providers by the Department of Health, Adult Mental Health Division. Representative payee services may provide services to beneficiaries with a Severe Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI) if meeting the criteria described in the Behavioral Health Protocol.*

Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:
There are no limitations but prior authorization is required; and monthly assessments are performed to ensure that benefits/services are medically necessary.

Benefit Amount: _____ per □ Day □ Week □ Month □ Year

☑ Other, describe:
There are no limitations if the above requirements are met.

Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:
There are no limitations if the above requirements are met.

□ Day(s) _____
□ Week(s) _____
□ Month(s) _____
□ (Other) _____

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any:
Prior authorization is required; monthly assessments are performed to ensure medically necessary.

Provider Specifications and Qualifications

Provider Category(s):

□ Individual (list types)

☑ Agency (list types of agencies)
Certified Mental Health provider

The service may be provided by a: *N/A*
□ Legally Responsible Person □ Relative/Legal Guardian

Description of allowable providers:
Certified Mental Health providers are agencies that are certified by the Department of Health, Adult Mental Health Division (AMHD) to provide services to individuals with SMI or SPMI who have a plan of care developed with participation by a psychiatrist or psychologist requiring this as a medically necessary service.

Specify the types of providers for this benefit or service and their required qualifications:

Provider Type:	*Certified Mental Health provider*	
License Required:	□ Yes	☑ No
Certificate Required:	☑ Yes	□ No

Describe:
All agencies that provide representative payee benefits shall be certified by DOH, AMHD to provide the services described above.

Other Qualifications Required for this Provider Type (please describe):
- *Provider agreement with health plan(s), Med-QUEST Division, or Community Care Services (CCS) program*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: *Substance Abuse Treatment*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

Substance abuse treatment services will also be provided by certified substance abuse counselors. In contrast, the Medicaid State Plan limits those services to be provided by psychiatrists, psychologists, licensed social workers in behavioral health, and advance practice registered nurses in behavioral health.

Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

There are no limitations but prior authorization is required; and monthly assessments are performed to ensure that benefits/services are medically necessary.

Benefit Amount: _____ per □ Day □ Week □ Month □ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

There are no limitations if the above requirements are met.

□ Day(s) _____

□ Week(s) _____

□ Month(s) _____

□ (Other) _____

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any:

Prior authorization is required; monthly assessments are performed to ensure medically necessary.

Provider Specifications and Qualifications

Provider Category(s):

☑ Individual (list types) □ Agency (list types of agencies)

Certified substance abuse counselors may provide services as an individual provider or as an employee of an agency.

The service may be provided by a: *N/A*

□ Legally Responsible Person □ Relative/Legal Guardian

Description of allowable providers:

Certified substance abuse counselors are trained to provide medically necessary substance abuse treatment services. Often, certain licensed providers are also certified substance abuse counselors. However, some certified substance abuse counselors are not otherwise licensed. Allowing these qualified providers to provide services to Medicaid beneficiaries expands access to medically necessary substance abuse treatment services.

Specify the types of providers for this benefit or service and their required qualifications:

Provider Type:

License Required:	□ Yes	☑ No
Certificate Required:	☑ Yes	□ No

Describe:

Certified substance abuse counselors must be certified by the International Certification and Reciprocity Consortium and meet the requirements of HAR§11-177.1-16.

Other Qualifications Required for this Provider Type (please describe):

- *Provider agreement with health plan(s), Med-QUEST Division, or Community Care Services (CCS) program*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*

- *List of Excluded Individuals and Entities (LEIE)- annually*
- *Office of Inspector General exclusion list- annually*

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: Supportive Employment

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

a. *Supportive employment includes activities needed to obtain and sustain paid work within the general workforce by beneficiaries and includes assisting the participant in locating and acquiring a job, or working with an employer to develop or customize a job on behalf of the beneficiary, transitioning the beneficiary from volunteer work to paid employment, and assisting the beneficiary in maintaining an individual job in the general workforce at or above the state's minimum wage.*
b. *Supportive employment support is conducted in a variety of settings to include self-employment. With regard to self-employment, individual employment support services may include:*
    i. *Aiding the beneficiary to identify potential business opportunities;*
    ii. *Assisting in the development of a business plan, including potential sources of business financing and other assistance in including potential sources of business financing and other assistance in developing and launching a business;*
    iii. *Identifying the supports that are necessary in order for the beneficiary to operate the business; and*
    iv. *Providing ongoing assistance, counseling and guidance once the business has been launched.*
c. *Providers of supportive employment services are agencies that are certified mental health providers by the Department of Health, Adult Mental Health Division.*
d. *Supportive employment services may be provided to beneficiaries with a Severe Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI) if meeting the criteria described in the Behavioral Health Protocol.*

Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

There are no limitations but prior authorization is required; and monthly assessments are performed to ensure that benefits/services are medically necessary.

Benefit Amount: _____ per □ Day □ Week □ Month □ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

There are no limitations if the above requirements are met.

□ Day(s) _____
□ Week(s) _____
□ Month(s) _____
□ (Other) _____

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any:
Prior authorization is required; monthly assessments are performed to ensure medically necessary.

Provider Specifications and Qualifications

Provider Category(s):

□ Individual (list types)

☑ Agency (list types of agencies)
Certified Mental Health provider

The service may be provided by a: *N/A*

□ Legally Responsible Person □ Relative/Legal Guardian

Description of allowable providers:
Certified Mental Health providers are agencies that are certified by Department of Health, Adult Mental Health Division (AMHD) to provide services to individuals with SMI or SPMI who have a plan of care developed with participation by a psychiatrist or psychologist requiring this as a medically necessary service.

Specify the types of providers for this benefit or service and their required qualifications:

Provider Type:	*Certified Mental Health provider*	
License Required:	□ Yes	☑ No
Certificate Required:	☑ Yes	□ No

Describe:
All agencies that provide supportive employment benefits shall be certified by DOH, AMHD to provide the services described above.

Other Qualifications Required for this Provider Type (please describe):

- *Provider agreement with health plan(s), Med-QUEST Division, or Community Care Services (CCS) program*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*

Benefit Specifications and Provider Qualifications

For each benefit or service that the State proposes to provide differently from that described in the State Plan, the State must complete this form by providing a description of the amount, duration and scope of the service under the Demonstration as well as the provider specifications and qualifications for the benefit or service.

Name of Benefit or Service: Supportive Housing

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

a. *This is housing-based care management focused on ensuring housing stability, recognizing housing's role as an essential platform for recovery and improved health.*
b. *This service will include assisting individuals with finding and retaining housing such as Section 8, Section 811, other Housing and Urban Development (HUD) programs, and public housing. This service is available to previously homeless individuals or others in public housing.*
c. *Providers of supportive housing are agencies that are certified mental health providers by the Department of Health, Adult Mental Health Division.*
d. *Supportive housing services may provide services to beneficiaries with a Severe Mental Illness (SMI) or Serious and Persistent Mental Illness (SPMI) if meeting the criteria described in the Behavioral Health Protocol.*

Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:
There are no limitations but prior authorization is required; and monthly assessments are performed to ensure that benefits/services are medically necessary.

Benefit Amount: _____ per □ Day □ Week □ Month □ Year

☑ Other, describe:
There are no limitations if the above requirements are met.

Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:
There are no limitations if the above requirements are met.

□ Day(s) _____
□ Week(s) _____
□ Month(s) _____
□ (Other) _____

Authorization Requirements: Describe any prior, concurrent or post-authorization requirements, if any:
Prior authorization is required; monthly assessments are performed to ensure medically necessary.

Provider Specifications and Qualifications

Provider Category(s):

□ Individual (list types)

☑ Agency (list types of agencies)
Certified Mental Health provider

The service may be provided by a: *N/A*
□ Legally Responsible Person □ Relative/Legal Guardian

Description of allowable providers:
Certified Mental Health providers are agencies that are certified by Department of Health, Adult Mental Health Division (AMHD) to provide services to individuals with SMI or SPMI that have a plan of care developed with participation by a psychiatrist or psychologist requiring this as a medically necessary service.

Specify the types of providers for this benefit or service and their required qualifications:

Provider Type:	*Certified Mental Health provider*	
License Required:	□ Yes	☑ No
Certificate Required:	☑ Yes	□ No

Describe:
All agencies that provide supportive housing benefits shall be certified by DOH, AMHD to provide the services described above.

Other Qualifications Required for this Provider Type (please describe):
- *Provider agreement with health plan(s), Med-QUEST Division, or Community Care Services (CCS) program*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*

Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

Name of Service: *Adult Day Care*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

Adult day care provides regular supportive care to four (4) or more disabled adult participants in accordance with HAR§17-1417. Services include observation and supervision by center staff, coordination of behavioral, medical and social plans, and implementation of the instructions as listed in the participant's care plan. Therapeutic, social, educational, recreational, and other activities are also provided as regular adult day care services.

Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

There are no limitations but prior authorization is required; and quarterly assessment is completed to ensure that benefits/services are medically necessary; and annual nursing facility – level of care (LOC) is completed to ensure LOC is met.

Benefit Amount: _____ per □Day □ Week □ Month □ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

There are no limitations if the above requirements are met.

□ Day(s)

_____

□ Week(s)

_____

□ Month(s)

_____

□ (Other)

_____

Authorization Requirements:

Describe any prior, concurrent or post-authorization requirements, if any:

Prior authorization is required; quarterly assessments are performed to ensure medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.

Provider Specifications and Qualifications

Provider Category(s): *Agencies*

□ Individual (list types)

☑ Agency (list types of agencies)
Licensed Adult Day Care centers

The service may be provided by a: *N/A*

□ Legally Responsible Person

□ Relative/Legal Guardian

Description of allowable providers:

Specify the types of providers for this benefit or service and their required qualifications:

Provider Type: *Adult Day Care*

License Required:	☑Yes	□No
Certificate Required:	□Yes	☑No

Describe:

All agencies are licensed by the Department of Human Services (DHS) to meet the requirements provided in Hawaii Administrative Rule 17-1417. Agencies that provide adult day care programs include Federally Qualified Health Centers, nursing facilities, and independent free-standing facilities.

Other Qualifications Required for this Provider Type (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*
  - *Criminal history record check based upon fingerprints for both State and Federal records- twice in the first two years of employment*
  - *Abuse registry screening for both Adult Protective Services and Child and Neglect – twice in the first two years of employment and biennially thereafter.*

Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

Name of Service: *Adult Day Health (ADH)*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

Adult day health refers to an organized day program of therapeutic, social, and health services provided to adults with physical, or mental impairments, or both which require nursing oversight or care in accordance with HAR §11-96 and HAR §11-94.1-47. The purpose is to restore or maintain, to the fullest extent possible, an individual's capacity for remaining in the community.

Each program shall have nursing staff sufficient in number and qualifications to meet the needs of participants. Nursing services shall be provided under the supervision of a registered nurse. If there are members admitted who require skilled nursing services, the services will be provided by a registered nurse or under the direct supervision of a registered nurse.

In addition to nursing services, other components of adult day health may include: emergency care, dietetic services, occupational therapy, physical therapy, physician services, pharmaceutical services, psychiatric or psychological services, recreational and social activities, social services, speech-language pathology, and transportation services.

Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

There are no limitations but prior authorization is required; and quarterly assessment is completed to ensure that benefits/services are medically necessary; and annual nursing facility – level of care (LOC) is completed to ensure LOC is met.

Benefit Amount: _____ per ☐Day ☐ Week ☐ Month ☐ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

There are no limitations if the above requirements are met.

☐ Day(s)

_____

☐ Week(s)

_____

☐ Month(s)

_____

☐ (Other)

_____

Authorization Requirements:

Describe any prior, concurrent or post-authorization requirements, if any:

Prior authorization as required; quarterly assessments are performed to ensure medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.

Provider Specifications and Qualifications

Provider Category(s):	*Licensed Adult Day Health Centers*
☐Individual (list types)	☑Agency (list types of agencies)

The service may be provided by a:	*N/A*
☐Legally Responsible Person	☐Relative/Legal Guardian

Description of allowable providers:

Specify the types of providers for this benefit or service and their required qualifications:

Provider Type:	*Adult Day Health Centers*	
License Required:	☑Yes	☐No
Certificate Required:	☐Yes	☑No

Describe:

All agencies are licensed by the Department of Health, Office of Health Care Assurance, Medicare Certification Section (OHCA) to meet the requirements provided in Hawaii Administrative Rule 11-94.1-47 and 11-96. Agencies that provide adult day health programs include nursing facilities, hospitals, and free-standing ADH programs.

Other Qualifications Required for this Provider Type (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*

Effective 01/01/14, the Office of Health Care Assurance will ensure that the following requirements are met.

- *Criminal history record check based upon fingerprints for both State and Federal records- twice in the first two years of employment*
- *Abuse registry screening for both Adult Protective Services and Child and Neglect – twice in the first two years of employment and biennially thereafter.*

Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

Name of Service: *Assisted Living Services*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

Assisted living services include personal care and supportive care services (homemaker, chore, companion services, and meal preparation) that are furnished to members who reside in an assisted living facility.

An assisted living facility, as defined in HRS 321-15.1, is licensed by the Department of Health. This facility shall consist of a building complex offering dwelling units to individuals and services to allow residents to maintain an independent assisted living lifestyle. The facility shall be designed to maximize the independence and self-esteem of limited-mobility persons who feel that they are no longer able to live on their own.

Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

There are no limitations but prior authorization is required; quarterly assessments are performed to ensure that benefits/services are medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.

Benefit Amount: _____ per ☐Day ☐ Week ☐ Month ☐ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

There are no limitations if the above requirements are met.

☐ Day(s)

_____

☐ Week(s)

_____

☐ Month(s)

_____

☐ (Other)

_____

Authorization Requirements:

Describe any prior, concurrent or post-authorization requirements, if any:

Prior authorization is required; quarterly assessments are performed to ensure medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.

Provider Specifications and Qualifications

Provider Category(s):	*Licensed Assisted Living Facilities*
☐Individual (list types)	☑Agency (list types of agencies)

The service may be provided by a:	*N/A*
☐Legally Responsible Person	☐Relative/Legal Guardian

Description of allowable providers:
Specify the types of providers for this benefit or service and their required qualifications:

Provider Type:	*Assisted Living Facilities*	
License Required:	☑Yes	☐No
Certificate Required:	☐Yes	☑No

Describe:
Licensing occurs by the Department of Health, Office of Health Care Assurance, Medicare Certification Section (OHCA) to meet the requirements provided in Hawaii Administrative Rule 11-90. Agencies that provide assisted living services are facilities that are dedicated to the provision of assisted living. Each building has minimal requirements for building, staffing, and services.

Other Qualifications Required for this Provider Type (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*

Effective 01/01/14, the Office of Health Care Assurance will ensure that the following requirements are met.

- *Criminal history record check based upon fingerprints for both State and Federal records- twice in the first two years of employment*
- *Abuse registry screening for both Adult Protective Services and Child and Neglect – twice in the first two years of employment and biennially thereafter.*

Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

Name of Service: *Community Care Foster Family Home (CCFFH)*
Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

CCFFH services are personal care and supportive services, homemaker, chore, companion services and medication oversight (to the extent permitted under State law) provided in a certified private home by a principal care provider who lives in the home. The number of adults receiving services in a CCFFH is determined by HAR, Title 17, Department of Human Services, Subtitle 9, Chapter 1454-43.

Amount of Benefit/Service
Describe any limitations on the amount of service provided under the Demonstration:

There are no limitations; prior authorization is required; monthly assessments are completed to ensure that benefits/services are medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.

Benefit Amount: _____ per □Day □ Week □ Month □ Year
☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:
Describe any limitations on the duration of the service under the demonstration:

There are no limitations if the above requirements are met.

□ Day(s)
_____
□ Week(s)
_____
□ Month(s)
_____
□ (Other)
_____

Authorization Requirements:
Describe any prior, concurrent or post-authorization requirements, if any:

Prior authorization is required; monthly assessments are completed to ensure that benefits/services are medically necessary; and annual nursing facility LOC assessment is completed to ensure LOC is met.

Provider Specifications and Qualifications

Provider Category(s):

☑ Individual (list types) □ Agency (list types of agencies)

Certified Community Care Foster Family Home (CCFFH) are operated by individuals (called caregivers) who are at least a nursing assistant (though some caregivers are certified nursing assistants (CNA), Licensed Practical Nurses (LPN), or registered nurses(RN)).

The service may be provided by a: *N/A*
□ Legally Responsible Person □ Relative/Legal Guardian

Description of allowable providers:
Specify the types of providers for this benefit or service and their required qualifications:

1. **Provider Type:** *Community Care Foster Family Home*

License Required:	□Yes	☑No
Certificate Required:	☑Yes	□No

Describe:
CCFFHs are certified by the State, currently by the Department of Human Services in accordance with Hawaii Administrative Rule 17-1754, Subchapter 3; however, this function will transfer to the Department of Health. Each caregiver (that owns or operates a CCFFH) shall be at least a nurse assistant though some are a CNA, LPN, or RN. CCFFHs are small home that care for no more than three (3) clients with at least one being a Medicaid beneficiary. These homes are located throughout the state. Each home is certified annually and thereafter every two years. Each client in the home shall have a case manager (see Specialized Case Manager) that oversees care provided in the CCFFH. Assessments occur every month on clients. Adverse events are reported to the Department within 24 hours of the event. Adverse events are tracked for trends.

Other Qualifications Required for this Provider Type (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*
  - *Criminal history record check based upon fingerprints for both State and Federal records- twice in the first two years of employment*
  - *Abuse registry screening for both Adult Protective Services and Child and Neglect – twice in the first two years of employment and biennially thereafter.*

Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

Name of Service: *Counseling and Training*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

Counseling and training will be provided to family members/caregivers, professional and paraprofessional caregivers to support them in caring for members regarding the nature of the disease and the disease process; methods of transmission and infection control measures; biological, psychological care and special treatment needs/regimens; employer training for consumer directed services; instruction about the treatment regimens; use of equipment specified in the service plan; employer skills updates as necessary to safely maintain the individual at home; crisis intervention; supportive counseling; family therapy; suicide risk assessments and intervention; death and dying counseling; anticipatory grief counseling; substance abuse counseling; and/or nutritional assessment and counseling. In contrast, the Medicaid State Plan only provides counseling and training services for only eligible recipients with certain limitations and conditions as specified in the State Plan.

Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

There are no limitations but prior authorization is required; quarterly assessments are completed to ensure that benefits/services are medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.

Benefit Amount: _____ per ☐Day ☐ Week ☐ Month ☐ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

There are no limitations if the above requirements are met.

☐ Day(s)

_____

☐ Week(s)

_____

☐ Month(s)

_____

☐ (Other)

_____

Authorization Requirements:
Describe any prior, concurrent or post-authorization requirements, if any:

Prior authorization is required; quarterly assessments are performed to ensure medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.

Provider Specifications and Qualifications

Provider Category(s):
☑Individual (list types) ☐Agency (list types of agencies)

The service may be provided by a: *N/A*
☐Legally Responsible Person ☐Relative/Legal Guardian

Description of allowable providers:
Specify the types of providers for this benefit or service and their required qualifications:

These individuals are licensed in the specialty needed to counsel or train the beneficiary or their family on the services they need.

Provider Type:	*Individual*	
License Required:	☑Yes	☐No
Certificate Required:	☐Yes	☑No

Describe:

- *Social Worker (LCSW)*
- *Psychiatrist (MD)*
- *Physician (MD or DO)*
- *Clinical Psychologist, PsyD*
- *Registered Nurse (RN)*
- *Registered Dietitian (RD)*
- *Physical Therapist (PT)*
- *Occupational Therapist (OT)*
- *Speech-Language Pathologist (SLP)*

Other Qualifications Required for this Provider Type (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*

Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

Name of Service: *Environmental Accessibility Adaptations*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

Environmental accessibility adaptations are those physical adaptations to the home, required by the individual's care plan, which are necessary to ensure the health, welfare and safety of the individual, or which enable the individual to function with greater independence in the home, and without which the individual would require institutionalization. Such adaptations may include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, or installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies that are necessary for the welfare of the individual. Window air conditioners may be installed when it is necessary for the health and safety of the member.

Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

There are no limitations but prior authorization is required to ensure benefits/services are medically necessary and nursing facility – level of care (LOC) is met prior to performing the adaptation.

Benefit Amount: _____ per □Day □ Week □ Month □ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

There are no limitations if the above requirements are met.

□ Day(s)

_____

□ Week(s)

_____

□ Month(s)

_____

□ (Other)

_____

Authorization Requirements:

Describe any prior, concurrent or post-authorization requirements, if any:

Prior authorization is required to ensure medically necessary and nursing facility – level of care (LOC) is met prior to performing the adaptation.

Provider Specifications and Qualifications

Provider Category(s): *Independent licensed contractors*

□ Individual (list types) ☑ Agency (list types of agencies)

The service may be provided by a: *N/A*

□ Legally Responsible Person □ Relative/Legal Guardian

Description of allowable providers:

Specify the types of providers for this benefit or service and their required qualifications:

Provider Type: *Independent licensed contractors*

License Required:	☑Yes	□No
Certificate Required:	□Yes	☑No

Describe:

Allowable providers are licensed contractors who are licensed under Hawaii Revised Statutes 444, 448E, or 464 by the Department of Commerce and Consumer Affairs (DCCA). All licensed contractors shall be confirmed with the Licensing and Business Registration Information Section of the DCCA. These agencies perform adaptation to beneficiary's homes when medically necessary. The licensed contractor may need to include licensed plumbers or electricians based upon scope of the project.

Other Qualifications Required for this Provider Type (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*

Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

Name of Service: *Home Delivered Meals*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

Home delivered meals are nutritionally sound meals delivered to a location where an individual resides (excluding residential or institutional settings). The meals will not replace or substitute for a full day's nutritional regimen (i.e., no more than 2 meals per day). Home delivered meals are provided to individuals who cannot prepare nutritionally sound meals without assistance and are determined, through an assessment, to require the service in order to remain independent in the community and to prevent institutionalization.

Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

There are no limitations but prior authorization is required; quarterly assessments are completed to ensure that benefits/services are medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.

Benefit Amount: _____ per □Day □ Week □ Month □ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

There are no limitations if the above requirements are met.

□ Day(s)

_____

□ Week(s)

_____

□ Month(s)

_____

□ (Other)

_____

Authorization Requirements:

Describe any prior, concurrent or post-authorization requirements, if any:

Prior authorization is required; quarterly assessments are performed to ensure medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.

Provider Specifications and Qualifications

Provider Category(s): *Agencies*

□ Individual (list types) ☑ Agency (list types of agencies)

Agencies that produce and distribute meals to Medicaid beneficiaries and other low income seniors.

The service may be provided by a: *N/A*

□ Legally Responsible Person □ Relative/Legal Guardian

Description of allowable providers:

Specify the types of providers for this benefit or service and their required qualifications:

Provider Type: *Home Delivered Meals*

License Required: □Yes ☑No

Certificate Required: □Yes ☑No

Describe:

Providers shall be a registered business in the State of Hawaii. These agencies are typically either connected with a hospital or nursing facility or a non-for-profit business that supports low income seniors with obtaining meals. Meals are prepared and delivered mostly Monday through Saturday.

Other Qualifications Required for this Provider Type (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*

Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

Name of Service: *Home Maintenance*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

Home maintenance is a service necessary to maintain a safe, clean and sanitary environment. Home maintenance services are those services not included as a part of personal assistance and include: heavy duty cleaning, which is utilized only to bring a home up to acceptable standards of cleanliness at the inception of service to a member; minor repairs to essential appliances limited to stoves, refrigerators, and water heaters; and fumigation or extermination services. Home maintenance is provided to individuals who cannot perform cleaning and minor repairs without assistance and are determined, through an assessment, to require the service in order to prevent institutionalization.

Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

No limitations exists for this service but prior authorization is required to ensure that benefits/services are medically necessary; and assessment of nursing facility – level of care (LOC) is completed to ensure LOC is met prior to authorization of service. This service is typically provided only once until the living environment meets acceptable standards. Thereafter, additional HCBS are utilized to assure that environment continues to meet acceptable standards.

Benefit Amount: _____ per ☐Day ☐ Week ☐ Month ☐ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

There are no limitations if the above requirements are met.

☐ Day(s)

_____

☐ Week(s)

_____

☐ Month(s)

_____

☐ (Other)

_____

Authorization Requirements:
Describe any prior, concurrent or post-authorization requirements, if any:

Prior authorization is required; assessment is conducted prior to authorization of service to ensure medically necessary; and annual nursing facility – level of care (LOC) assessment is completed prior to authorization of service to ensure LOC is met.

Provider Specifications and Qualifications

Provider Category(s): *House cleaning agencies or pest control companies*

☐Individual (list types) ☑Agency (list types of agencies)

The service may be provided by a: *N/A*

☐Legally Responsible Person ☐Relative/Legal Guardian

Description of allowable providers:
Specify the types of providers for this benefit or service and their required qualifications:

Provider Type: *Agencies*

License Required: ☑Yes ☐No

Certificate Required: ☐Yes ☑No

Pest control companies are licensed; house cleaning agencies are neither licensed nor certified. Both shall be a registered business in the State of Hawaii.

Describe:

Providers shall be a registered business in the State of Hawaii. Providers for pest control are licensed by the Department of Commerce and Consumer Affairs (DCCA) under Hawaii Administrative Rule 16-94. These agencies are responsible for performing heavy duty cleaning to bring the beneficiary's home up to a livable standard. A pest control company may need to be utilized. This service is a one-time service. Personal assistance services are added thereafter to maintain the cleanliness of the home going forward.

Other Qualifications Required for this Provider Type (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*

Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

Name of Service: *Moving Assistance*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

Moving assistance is provided in rare instances when it is determined through an assessment by the care coordinator that an individual needs to relocate to a new home. The following are the circumstances under which moving assistance can be provided to a member: unsafe home due to deterioration; the individual is wheel-chair bound living in a building with no elevator; multi-story building with no elevator, where the client lives above the first floor; member is evicted from their current living environment; the member is no longer able to afford the home due to a rent increase; or relocation to receive ongoing medically necessary services. Moving expenses include packing and moving of belongings. Whenever possible, family, landlord, community and third party resources who can provide this service without charge will be utilized.

Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

There are no limitations but prior authorization is required to ensure benefits/services are medically necessary; and nursing facility – level of care (LOC) assessment must be completed to ensure LOC is met.

Benefit Amount: _____ per □Day □ Week □ Month □ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

There are no limitations if the above requirements are met.

□ Day(s)

_____

□ Week(s)

_____

□ Month(s)

_____

□ (Other)

_____

Authorization Requirements:

Describe any prior, concurrent or post-authorization requirements, if any:

Prior authorization as required to ensure medically necessary; and nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.

Provider Specifications and Qualifications

Provider Category(s): *Moving companies in the State of Hawaii.*

□ Individual (list types) ☑ Agency (list types of agencies)

The service may be provided by a: *N/A*

□ Legally Responsible Person □ Relative/Legal Guardian

Description of allowable providers:

Specify the types of providers for this benefit or service and their required qualifications:

Provider Type: *Agency*

License Required:	☑Yes	□No
Certificate Required:	□Yes	☑No

Describe:

Providers shall be a registered business in the State of Hawaii. Providers for moving assistance are licensed with the Federal Motor Carrier Safety Administration, US Department of Transportation (FMCSA) under 49 CFR Part 375. In addition, each employee of the moving company that drives the moving truck must contain a Public Utilities Commission (PUC) license in accordance with Hawaii Administrative Rule 6-62. These agencies will move the beneficiary from one location to the other in the rare instance where a beneficiary's health is impaired by their current living location.

Other Qualifications Required for this Provider Type (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*

Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

Name of Service: *Non-Medical Transportation*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

Non-medical transportation is a service offered in order to enable individuals to gain access to community services, activities, and resources, specified by the care plan. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the Medicaid State Plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Members shall receive the most appropriate modality of transportation based on their individual needs. Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized. Members living in a residential care setting or a CCFFH are not eligible for this service.

Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

There are no limitations but prior authorization is required; quarterly assessments are completed to ensure that benefits/services are medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.

Benefit Amount: _____ per ☐Day ☐ Week ☐ Month ☐ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

There are no limitations if the above requirements are met.

☐ Day(s)

_____

☐ Week(s)

_____

☐ Month(s)

_____

☐ (Other)

_____

Authorization Requirements:

Describe any prior, concurrent or post-authorization requirements, if any:

Prior authorization is required; quarterly assessments are performed to ensure medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.

Provider Specifications and Qualifications

Provider Category(s): *Transportation providers with a fleet of vans or taxi cabs.*

☐Individual (list types) ☑Agency (list types of agencies)

The service may be provided by a: *N/A*

☐Legally Responsible Person ☐Relative/Legal Guardian

Description of allowable providers:

Specify the types of providers for this benefit or service and their required qualifications:

Provider Type: *Agency*

License Required: ☑Yes ☐No

Certificate Required: ☐Yes ☑No

Describe:

Providers shall be a registered business in the State of Hawaii. All drivers shall have a Public Utilities Commission (PUC) license in accordance with Hawaii Administrative Rule 6-62.

Other Qualifications Required for this Provider Type (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*

Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

Name of Service: *Personal Assistance Services*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

Personal assistance services Level I are provided to individuals requiring assistance with IADLs in order to prevent a decline in the health status and maintain individuals safely in their home and communities. Personal assistance services Level I consist of both companion and homemaker services. Companions may assist or supervise the individual with such tasks as meal preparation, laundry and shopping/ errands, but do not perform these activities as discrete services. Providers may also perform light housekeeping tasks that are incidental to the care and supervision of the individual. Homemaker services means any of the activities such as routine housekeeping, laundry, marketing, light yard work, when the individual regularly responsible for these activities is temporarily absent or unable to manage the home and care for himself/herself or others. Homemaker services are of a routine nature and shall not require specialized training or professional skills such as those possessed by a nurse or home health aide. The scope of homemaker services specified in this section shall cover only the activities that need to be provided for the beneficiary, and not for other members of the household.

Personal assistance services Level II are provided to individuals requiring assistance with moderate/substantial to total assistance with performing ADLs and health maintenance activities. Personal assistance services Level II shall be provided by a Home Health Aide (HHA), Personal Care Aide (PCA), Certified Nurse Aide (CNA) or Nurse Aide (NA) with applicable skills competency.

When personal assistance services Level II are provided, personal assistance services Level I identified on the care plan may also be provided, if they are essential to the health and welfare of the member. Personal assistance services Level II may be self-directed.

Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

There are no limitations but prior authorization as required; quarterly assessments are completed to ensure that benefits/services are medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.

Benefit Amount: _____ per □Day □ Week □ Month □ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:
Describe any limitations on the duration of the service under the demonstration:
There are no limitations if the above requirements are met.

□ Day(s)
_____

□ Week(s)
_____

□ Month(s)
_____

□ (Other)
_____

Authorization Requirements:
Describe any prior, concurrent or post-authorization requirements, if any:
Prior authorization is required; quarterly assessments are performed to ensure medically necessary; and nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.

Provider Specifications and Qualifications
Provider Category(s): *Individuals or Personal care agencies or home health agencies.*
☑ Individual (list types) ☑ Agency (list types of agencies)

The service may be provided by a:
☑ Legally Responsible Person ☑ Relative/Legal Guardian
Family or friends (through self-direction)
Providers include the following:
- *Family or friends (through self-direction)*
- *Personal care agencies*
- *Home health agencies*

Family or friends shall be trained to perform the necessary personal assistance services, if applicable. If an agency, they must be a registered business in Hawaii.
Oversight occurs through service planning, review of incident reports, and visiting the beneficiary without a prearranged visit.

Description of allowable providers:
Specify the types of providers for this benefit or service and their required qualifications:

1. Provider Type: *Individual*

License Required:	□Yes	☑No
Certificate Required:	□Yes	☑No

Describe:
These services may be self-directed to a family member or friend. If the beneficiary is unable to make their own decisions, a surrogate may be enacted for the beneficiary to self-direct personal care services. The self-directed service provider may be the legally responsible person or legal guardian but cannot be the surrogate as well.

Other Qualifications Required for this Provider Type (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*

Family or friends (through self-direction) are not required to be screened for criminal history record check or registry screening if waived by the beneficiary or their surrogate.

2. **Provider Type:** *Personal Care Agency*

License Required:	□Yes	☑No
Certificate Required:	□Yes	☑No

Describe:

Personal Care Agencies shall be a registered business in the State of Hawaii.

Other Qualifications Required for this Provider Type (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*
  - *Criminal history record check based upon fingerprints for both State and Federal records- twice in the first two years of employment*
  - *Abuse registry screening for both Adult Protective Services and Child and Neglect – twice in the first two years of employment and biennially thereafter*

3. **Provider Type:** *Home Health Agency*

License Required:	☑Yes	□No
Certificate Required:	□Yes	☑No

Describe:

Home Health Agencies are licensed by Department of Health, Office of Health Care Assurance, Medicare Certification Section under Hawaii Administrative Rule 11-97.

Other Qualifications Required for this Provider Type (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*

Effective 01/01/14, the Office of Health Care Assurance will ensure that the following requirements are met.

- *Criminal history record check based upon fingerprints for both State and Federal records- twice in the first two years of employment*
- *Abuse registry screening for both Adult Protective Services and Child and Neglect – twice in the first two years of employment and biennially thereafter.*

Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

Name of Service: *Personal Emergency Response System (PERS)*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

PERS is a twenty-four (24) hour emergency assistance service which enables the member to secure immediate assistance in the event of an emotional, physical, or environmental emergency. PERS are individually designed to meet the needs and capabilities of the member and includes training, installation, repair, maintenance, and response needs. PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals.

PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, have no regular caregiver for extended periods of time, or who would otherwise require extensive routine supervision. PERS services will only be provided to a member residing in a non-licensed setting.

Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

There are no limitations but prior authorization is required to ensure that benefits/services are medically necessary; and nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.

Benefit Amount: _____ per □Day □ Week □ Month □ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

There are no limitations if the above requirements are met.

□ Day(s)

_____

□ Week(s)

_____

□ Month(s)

_____

□ (Other)

_____

Authorization Requirements:
Describe any prior, concurrent or post-authorization requirements, if any:

Prior authorization is required; quarterly assessments are performed to ensure medically necessary; and nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.

Provider Specifications and Qualifications

Provider Category(s): *Agencies*

□ Individual (list types) ☑ Agency (list types of agencies)

Those that have the capacity to issue an alarm that is worn by the beneficiary and monitor for any indications for "help" 24-hours per day.

The service may be provided by a: *N/A*

□ Legally Responsible Person □ Relative/Legal Guardian

Description of allowable providers:
Specify the types of providers for this benefit or service and their required qualifications:

Provider Type: *Agency*

License Required:	□Yes	☑No
Certificate Required:	□Yes	☑No

Describe:

Providers shall be a registered business in the State of Hawaii. Providers shall have the qualifications to provide the benefit described above to the beneficiary.
Oversight occurs through service planning, review of incident reports by service coordinator, and beneficiary satisfaction.

Other Qualifications Required for this Provider Type (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*

Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

Name of Service: *Residential Care Services*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

Residential care services are personal care services, homemaker, chore, companion services and medication oversight (to the extent permitted by law) provided in a licensed private home by a principle care provider who lives in the home.

Residential care is furnished: 1) in a Type I Expanded Adult Residential Care Home (E-ARCH), allowing five (5) or fewer residents with up to six (6) residents allowed at the discretion of the DHS, of which no more than two (2) may be NF LOC; or 2) in a Type II EARCH, allowing six (6) or more residents, of which no more than twenty percent (20%) of the home's licensed capacity may be individuals meeting a NF LOC and receive services in conjunction with residing in the home.

Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

There are no limitations but prior authorization is required; monthly assessments are completed to ensure that benefits/services are medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.

Benefit Amount: _____ per ☐Day ☐ Week ☐ Month ☐ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

There are no limitations if the above requirements are met.

☐ Day(s)

_____

☐ Week(s)

_____

☐ Month(s)

_____

☐ (Other)

_____

Authorization Requirements:
Describe any prior, concurrent or post-authorization requirements, if any:

Prior authorization is required; monthly assessments are performed to ensure medically necessary; and nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.

Provider Specifications and Qualifications

Provider Category(s):
☑Individual (list types) ☑Agency (list types of agencies)
Expanded Adult Residential Care Home (E-ARCH)- Type I that are operated by individuals (called caregivers) who are at least a nursing assistant (though some caregivers are certified nursing assistants (CNA), Licensed Practical Nurses (LPN), or registered nurses(RN)).

E-ARCH- Type II is a home that consists of six or more residents with no more than twenty (20) percent of the homes capacity at NF level of care. These homes are operated by licensed businesses in the State of Hawaii.

Only residents who meet NF level of care are included in the request for Medicaid covered services.

The service may be provided by a: *N/A*
☐Legally Responsible Person ☐Relative/Legal Guardian

Description of allowable providers:
Specify the types of providers for this benefit or service and their required qualifications:

1. Provider Type: *E-ARCH Type I*

License Required:	☑Yes	☐No
Certificate Required:	☐Yes	☑No

Describe:
Licensing occurs by the Department of Health, Office of Health Care Assurance, State Licensing Section (OHCA) to meet the requirements provided in Hawaii Administrative Rule 11-100.1.

Other Qualifications Required for this Provider Type (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*

Effective 01/01/14, the Office of Health Care Assurance will ensure that the following requirements are met.

- *Criminal history record check based upon fingerprints for both State and Federal records- twice in the first two years of employment*
- *Abuse registry screening for both Adult Protective Services and Child and Neglect – twice in the first two years of employment and biennially thereafter.*

2. Provider Type: *E-ARCH – Type II*

License Required:	☑Yes	☐No
Certificate Required:	☐Yes	☑No

Describe:

Licensing occurs by the Department of Health, Office of Health Care Assurance, State Licensing Section (OHCA) to meet the requirements provided in Hawaii Administrative Rule 11-100.1.

Other Qualifications Required for this Provider Type (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*

Effective 01/01/14, the Office of Health Care Assurance will ensure that the following requirements are met.

- *Criminal history record check based upon fingerprints for both State and Federal records- twice in the first two years of employment*
- *Abuse registry screening for both Adult Protective Services and Child and Neglect – twice in the first two years of employment and biennially thereafter.*

Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

Name of Service: *Respite Care*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

Respite care services are provided to individuals unable to care for themselves and are furnished on a short-term basis because of the absence of or need for relief for those persons normally providing the care. Respite may be provided at three (3) different levels: hourly, daily, and overnight. Respite care may be provided in the following locations: individual's home or place of residence; foster home/expanded-care adult residential care home; Medicaid certified NF; licensed respite day care facility; or other community care residential facility approved by the State. Respite care services are authorized by the member's PCP as part of the member's care plan. Respite services may be self-directed.

Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

There are no limitations but prior authorization is required; quarterly assessments are completed to ensure that benefits/services are medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.

Benefit Amount: _____ per ☐Day ☐ Week ☐ Month ☐ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

There are no limitations if the above requirements are met.

☐ Day(s)

_____

☐ Week(s)

_____

☐ Month(s)

_____

☐ (Other)

_____

Authorization Requirements:

Describe any prior, concurrent or post-authorization requirements, if any:

Prior authorization is required; quarterly assessment is performed to ensure medically necessary; and nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.

Provider Specifications and Qualifications

Provider Category(s):
☑Individual (list types) ☑Agency (list types of agencies)

The service may be provided by a:
☑Legally Responsible Person ☑Relative/Legal Guardian

Description of allowable providers:
Specify the types of providers for this benefit or service and their required qualifications:

1. Provider Type: *Individual*

License Required:	☐Yes	☑No
Certificate Required:	☐Yes	☑No

Describe:
These services may be self-directed. If the beneficiary is unable to make his or her own decisions, a surrogate may be utilized. The self-directed service provider may be a family member or friend, the legally responsible person or legal guardian, but cannot be the surrogate as well.

Other Qualifications Required for this Provider Type (please describe):
- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*

Family or friends (through self-direction) are not required to be screened for criminal history record check or registry screening if waived by the beneficiary or their surrogate.

2. Provider Type: *Agency/Facility*

License Required:	☐Yes	☐No
Certificate Required:	☐Yes	☐No

Describe:
The following providers can provide respite services. The HCBS provider requirements are described in other sections of this document. Nursing facilities are licensed by the Department of Health.

Licensed providers that can provide respite services:
- *Adult day care facility*
- *Adult day health facility*
- *E-ARCH*

- *Home health agency*
- *Nursing facility*

Certified providers that can provide respite services:
- *CCFFH*

Providers that are not licensed or certified that can provide respite service:
- *Personal care agency*

Other Qualifications Required for all of these Provider Types (please describe):
- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*

The following requirements are currently met for adult day care, CCFFH, and personal care agencies. Effective 01/01/14, the Office of Health Care Assurance will ensure that the following requirements are met for all other licensed agencies.
- *Criminal history record check based upon fingerprints for both State and Federal records- twice in the first two years of employment*
- *Abuse registry screening for both Adult Protective Services and Child and Neglect – twice in the first two years of employment and biennially thereafter.*

Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

Name of Service: *Skilled Nursing (or Private Duty Nursing)*
Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

Skilled or private duty nursing is a service provided to individuals requiring ongoing nursing care (in contrast to part time, intermittent skilled nursing services under the Medicaid State Plan) listed in the care plan. The service is provided by licensed nurses (as defined in HAR § 16-89) within the scope of State law.

Amount of Benefit/Service
Describe any limitations on the amount of service provided under the Demonstration:

There are no limitations but prior authorization is required; quarterly assessments completed to ensure that benefits/services are medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.

Benefit Amount: _____ per ☐Day ☐ Week ☐ Month ☐ Year
☑ Other, describe:
There are no limitations if the above requirements are met.

Duration of Benefit/Service:
Describe any limitations on the duration of the service under the demonstration:

There are no limitations if the above requirements are met.

☐ Day(s)
_____
☐ Week(s)
_____
☐ Month(s)
_____
☐ (Other)
_____

Authorization Requirements:
Describe any prior, concurrent or post-authorization requirements, if any:

Prior authorization is required; quarterly assessments are performed to ensure medically necessary; and nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.

Provider Specifications and Qualifications

Provider Category(s):

☑Individual (list types) ☑Agency (list types of agencies)

The service may be provided by a: *N/A*

☐Legally Responsible Person ☐Relative/Legal Guardian

Description of allowable providers:

Specify the types of providers for this benefit or service and their required qualifications:

Types of individuals: Registered Nurses

Types of agencies: Personal care agencies, Home health agencies.

1. Provider Type: *Individual*

License Required:	☑Yes	☐No
Certificate Required:	☐Yes	☑No

Describe:

Individual: Licensing occurs by the Department of Commerce and Consumer Affairs (DCCA) to meet the requirements provided in Hawaii Administrative Rule 16-89.

Other Qualifications Required for this Provider Type (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*
  - *Criminal history record check based upon fingerprints for both State and Federal records- twice in the first two years of employment*
  - *Abuse registry screening for both Adult Protective Services and Child and Neglect – twice in the first two years of employment and biennially thereafter*

2. Provider Type: *Personal Care Agency*

License Required:	☐Yes	☑No
Certificate Required:	☐Yes	☑No

Describe:

Agency: Personal care agencies shall be a registered business in the State of Hawaii. Agencies may only utilize Licensed Registered Nurses to perform this service.

Other Qualifications Required for this Provider Type (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*

- *List of Excluded Individuals and Entities (LEIE)- annually*
- *Office of Inspector General exclusion list- annually*
- *Tuberculosis (TB)- annually*
- *Criminal history record check based upon fingerprints for both State and Federal records- twice in the first two years of employment*
- *Abuse registry screening for both Adult Protective Services and Child and Neglect – twice in the first two years of employment and biennially thereafter*

3. Provider Type: *Home Health Agencies*

License Required:	☑Yes	☐No
Certificate Required:	☐Yes	☑No

Describe:

Agency: Home Health agency are licensed by Department of Health, Office of Health Care Assurance, Medicare Certification Section under Hawaii Administrative Rule 11-97. Agencies may only utilize Licensed Registered Nurses to perform this service.

Other Qualifications Required for this Provider Type (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*

Effective 01/01/14, the Office of Health Care Assurance will ensure that the following requirements are met.

- *Criminal history record check based upon fingerprints for both State and Federal records- twice in the first two years of employment*
- *Abuse registry screening for both Adult Protective Services and Child and Neglect – twice in the first two years of employment and biennially thereafter.*

`Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

Name of Service: *Specialized Community Case Management (CCMA) Services*
Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

CCMA services are provided to members living in Community Care Foster Family Homes and other community settings, as required. The following activities are provided by a CCMA: continuous and ongoing nurse delegation to the caregiver in accordance with HAR Chapter 16-89 Subchapter 15; initial and ongoing assessments to make recommendations to health plans for, at a minimum, indicated services, supplies, and equipment needs of members; ongoing face-to-face monitoring and implementation of the member's care plan; and interaction with the caregiver on adverse effects and/or changes in condition of members. CCMAs shall (1) communicate with a member's physician(s) regarding the member's needs including changes in medication and treatment orders, (2) work with families regarding service needs of member and serve as an advocate for their members, and (3) be accessible to the member's caregiver twenty-four (24) hours a day, seven (7) days a week,

Amount of Benefit/Service
Describe any limitations on the amount of service provided under the Demonstration:

There are no limitations but prior authorization is required; monthly assessments are completed to ensure that benefits/services are medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.

Benefit Amount: _____ per □Day □ Week □ Month □ Year
☑ Other, describe:
There are no limitations if the above requirements are met.

Duration of Benefit/Service:
Describe any limitations on the duration of the service under the demonstration:

There are no limitations if the above requirements are met.

□ Day(s)
_____
□ Week(s)
_____
□ Month(s)
_____
□ (Other)
_____

Authorization Requirements:
Describe any prior, concurrent or post-authorization requirements, if any:

Prior authorization is required; monthly assessments are performed to ensure medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.

Provider Specifications and Qualifications

Provider Category(s): *Licensed Case Management Agencies*

□ Individual (list types) ☑ Agency (list types of agencies)

The service may be provided by a: *N/A*

□ Legally Responsible Person □ Relative/Legal Guardian

Description of allowable providers:
Specify the types of providers for this benefit or service and their required qualifications:

Provider Type: *Agency*

License Required:	☑Yes	□No
Certificate Required:	□Yes	☑No

Describe:

These agencies are specialized in the provision of case management services. Their employees who work with Medicaid beneficiaries are either licensed Registered Nurses or Licensed Social Workers. Agencies are licensed by the Department of Human Services in accordance with Hawaii Administrative Rule 17-1754, Subchapter 1 and 2. They see their beneficiaries monthly to perform an assessment to assure that their needs are being addressed in either a CCFFH or E-ARCH.

Other Qualifications Required for this Provider Type (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *Delegation oversight on-site review by health plan- annually*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*
  - *Tuberculosis (TB)- annually*
  - *Criminal history record check based upon fingerprints for both State and Federal records- twice in the first two years of employment*
  - *Abuse registry screening for both Adult Protective Services and Child and Neglect – twice in the first two years of employment and biennially thereafter*

Long Term Services Benefit Specifications and Provider Qualifications

For each Long Term Service and Support (home and community-based service) that the State proposes to include in the Demonstration, provide a description of the amount, duration and scope of the service and any authorization requirements under the Demonstration. Also provide the provider specifications and qualifications for the benefit or service.

Name of Service: *Specialized Medical Equipment and Supplies*

Scope of Benefit/Service, including what is provided, what providers can provide the service, to whom it may be provided, how comprehensive the service is, and any other limitations on the benefit's scope:

Specialized medical equipment and supplies entails the purchase, rental, lease, warranty costs, installation, repairs and removal of devices, controls, or appliances, specified in the care plan, that enable individuals to increase and/or maintain their abilities to perform activities of daily living, or to perceive, control, participate in, or communicate with the environment in which they live.

This service also includes items necessary for life support, ancillary supplies and equipment necessary to the proper functioning of such items, and durable and non-durable medical equipment not available under the Medicaid State Plan. The providers of these services are the same providers that offer Medicaid State Plan services for durable medical equipment and medical supplies. All items shall meet applicable standards of manufacture, design and installation.

Amount of Benefit/Service

Describe any limitations on the amount of service provided under the Demonstration:

There are no limitations but prior authorization is required; quarterly assessments are completed to ensure that benefits/services are medically necessary; and annual nursing facility – level of care (LOC) assessment is completed to ensure LOC is met.

Benefit Amount: _____ per ☐Day ☐ Week ☐ Month ☐ Year

☑ Other, describe:

There are no limitations if the above requirements are met.

Duration of Benefit/Service:

Describe any limitations on the duration of the service under the demonstration:

There are no limitations if the above requirements are met.

☐ Day(s)

_____

☐ Week(s)

_____

☐ Month(s)

_____

☐ (Other)

_____

Authorization Requirements:
Describe any prior, concurrent or post-authorization requirements, if any:

Prior authorization is required; quarterly assessments are completed to ensure that benefits/services are medically necessary; and annual nursing facility LOC assessment is completed to ensure LOC is met.

Provider Specifications and Qualifications

Provider Category(s): *Durable Medical Equipment Suppliers*

☐Individual (list types) ☑Agency (list types of agencies)

The service may be provided by a: *N/A*

☐Legally Responsible Person ☐Relative/Legal Guardian

Description of allowable providers:
Specify the types of providers for this benefit or service and their required qualifications:

Provider Type: *Agency*

License Required: ☐Yes ☐No

Certificate Required: ☐Yes ☐No

Describe:

All suppliers of specialized medical equipment and supplies shall be Durable Medical Equipment and Medical Supplies agencies. These agencies shall be accredited by a CMS-approved independent National Accreditation organization. All suppliers shall meet the CMS quality standards for DMEPOS as part of their accreditation as a Medicare provider.

Other Qualifications Required for this Provider Type (please describe):

- *Provider agreement with health plan(s)*
- *Annual credentialing by health plan that meets National Committee for Quality Assurance (NCQA) standards*
- *In addition, all employees are screened for:*
  - *List of Excluded Individuals and Entities (LEIE)- annually*
  - *Office of Inspector General exclusion list- annually*