State: Hawaii

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

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

   Provided: ☐ No limitation ☒ With limitations*

2. a. Outpatient hospital services.

   Provided: ☐ No limitation ☒ With limitations*

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

   ☒ Provided: ☐ No limitations ☒ With limitations*

   ☐ Not provided.

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

   Provided: ☐ No limitations ☒ With limitations*

3. Other laboratory and x-ray services.

   Provided: ☐ No limitation ☒ With limitations*

State:	HAWAII

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

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

Provided: ___ No limitations x With limitations*

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

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

Provided: ___ No limitations x With limitations*

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

Provided: ___ No limitations x With limitations*

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

Provided: ___ No limitations x With limitations*

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

a. Podiatry services

Provided: ___ No limitations x With limitations*

___ Not provided.

* Description provided on attachment.

State/Territory: Hawaii

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

b. Optometrists' services.

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

/_/ Not provided.

c. Chiropractors' services.

/_/ Provided: /_/ No limitations /_/With limitations*

/X/ Not provided.

d. Other practitioners' services.

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

/_/ Not provided.

7. Home health services.

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

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

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

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

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

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

*Description provided on attachment.

State/Territory: Hawaii

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

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

/x/ Provided: /_/ No limitations /x/ With limitations*

/_/ Not provided.

8. Private duty nursing services.

/_/ Provided: /_/ No limitations /_/ With limitations*

/x/ Not provided.

*Description provided on attachment.

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

9. Clinic services.

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

/_/ Not provided.

10. Dental services.

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

/_/ Not provided.

11. Physical therapy and related services.

a. Physical therapy.

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

/_/ Not provided.

b. Occupational therapy.

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

/_/ Not provided.

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

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

/_/ Not provided.

*Description provided on attachment.

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

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

b. Dentures.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

c. Prosthetic devices.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

d. Eyeglasses.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in the plan.

a. Diagnostic services.

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

*Description provided on attachment.

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

b. Screening services.

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

/_/ Not provided.

c. Preventive services.

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

/_/ Not provided.

d. Rehabilitative services.

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

/_/ Not provided.

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

a. Inpatient hospital services.

/_/ Provided: /_/ No limitations /_/ With limitations*

/X/ Not provided.

b. Skilled nursing facility services.

/_/ Provided: /_/ No limitations /_/ With limitations*

/X/ Not provided.

c. Intermediate care facility services.

/_/ Provided: /_/ No limitations /_/ With limitations*

/X/ Not provided.

*Description provided on attachment.

State: Hawaii

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

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

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

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

☐ Provided: ☐ No limitations ☐ With limitations*

☒ Not provided.

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

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

17. Nurse-midwife services.

☒ Provided: ☐ No limitations ☒ With limitations*

☐ Not provided.

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

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

☐ No limitations ☒ With limitations*

☐ Not provided.

*Description provided on attachment

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State/Territory: _____

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

19. Case management services and Tuberculosis related services

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

X Provided: X With limitations

___ Not provided.

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

___ Provided: ___ With limitations*

X Not provided.

20. Extended services for pregnant women

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

___ Additional coverage ++

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

___ Additional coverage ++

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

*Description provided on attachment.

State/Territory: Hawaii

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

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

[ ] Provided: [ ] No limitations [ ] With limitations*

[X] Not provided.

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

[X] Provided: [ ] No limitations [X] With limitations*

[ ] Not provided.

23. Certified Pediatric or family nurse practitioners' services.

Provided: [ ] No limitations [X] With limitations*

*Description provided on attachment.

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

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

a. Transportation.

/x/ Provided: / / No limitations /x/ With limitations*

/ / Not provided.

b. Services of Christian Science nurses.

/ / Provided: / / No limitations / / With limitations*

/x/ Not provided.

c. Care and services provided in Christian Science sanitoria.

/ / Provided: / / No limitations / / With limitations*

/x/ Not provided.

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

/x/ Provided: / / No limitations /x/ With limitations*

/ / Not provided.

e. Emergency hospital services.

/x/ Provided: /x/ No limitations / / With limitations*

/ / Not provided.

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

/ / Provided: / / No limitations / / With limitations*

/x/ Not provided.

*Description provided on attachment.

State: HAWAII

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

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

_____ provided X not provided

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

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

X Not Provided.

State: Hawaii

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

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

☐ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan services.

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

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

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

Provided: ☐ No limitations ☐ With limitations ☒ None licensed or approved

Please describe any limitations: N/A

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

Provided: ☐ No limitations ☐ With limitations (please describe below)

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

Please describe any limitations: N/A

Please check all that apply:

☐ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

☐ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

☐ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

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

CASE MANAGEMENT SERVICES

A. Target Group:

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

1. Is attributable to a mental or physical impairment or combination of mental and physical impairments;

2. Is manifested before the person attains the age 22;

3. Is likely to continue indefinitely;

4. Results in substantial functional limitations in three or more of the following areas of major life activity; self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living, and economic sufficiency; and

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

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

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

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

(X) Entire State.

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

C. Comparability of Services:

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

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

D. Definition of Services:

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

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

2. Service Coordination - Arranging for community residential, (i.e., care home, foster home, domiciliary home), habilitation, support, (i.e., respite, transportation, personal care), and protective services, (i.e., adult and child abuse), and coordination of services with other agencies who are involved with the individual, (i.e., Adult Residential Care Homes, Eastcr Seals Society, Association for Retarded Citizens of Hawaii, United Cerebral Palsy Association, Medical Personnel Pool for respite and personal care, Department of Human Services, Adult and Family Services Division for adult and child protective services, Vocational Rehabilitation Division, Community Long Term Care Branch, Social Security Administration, Department of Education, Family Court, Mental Health Services Systems, Office of the Public Guardian, and other public and private agencies.

3. Advocacy - Activities with the client/family and providers for the purpose of facilitating access to needed services, providing information and referral, arranging emergency services, and modifying service systems to increase accessibility and appropriateness for people with developmental disabilities.

E. Qualification of Providers:

HCD 5/13/91 of the Department of Health,

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

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

F. Freedom of Choice:

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

1. Eligible recipients will have free choice of the providers of case management services.

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

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

CASE MANAGEMENT SERVICES

A. Target Group:

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

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

Target group is defined along three dimensions:

1. Diagnosis;

2. Level of disability which is likely to continue indefinitely;

3. Impaired role functioning which results in substantial functional limitations in three or more of the following areas of major life activity; self care, learning, mobility, self-direction, capacity for independent living, and economic sufficiency; and

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

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

[X] Entire State

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

C. Comparability of Services:

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

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

D. Definition of Services:

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

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

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

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

3. Client Support & Advocacy
With or on behalf of the client to gain access to

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

a. Seeking and assisting the client in applying for entitlement benefits, services, etc.;

b. Arranging appointments;

c. Establishing and maintaining communications with service providers; and

d. Accompanying/transporting of client to scheduled appointment to assure access and to minimize trauma to client.

e. Immediate intervention by case managers to refer clients who are decompensating (grossly psychotic, suicidal/homicidal ideation) and may be in need of psychiatric hospitalization/evaluation. Immediate intervention by case managers who would also include assisting the client by referral and linkaging to resolve immediate crisis situations that may jeopardize the client's functioning in the community (e.g., eviction, serious physical illness/injury, serious inter-personal conflicts, substance abuse episodes, medication problems, etc.).

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

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

a. Determining that satisfactory referral connections have been established;

b. Contacts with service providers to assess the level of client compliance;

c. Assuring ongoing appropriateness and effectiveness of service plan; and

d. Identify and determine if additional services may be appropriate or required.

E. Qualification of Providers:

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

F. Freedom of Choice:

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

1. Eligible recipients will have free choice of the providers of case management services.

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

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

CASE MANAGEMENT SERVICES

A. Target Group:

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

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

B. Areas of the State to be Covered:

[X] Entire State

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

C. Comparability of Services:

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

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

D. Definition of Services:

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

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

services, and handling questions that the family may have;

2. Coordinating the performance of evaluation and other needed diagnostic services;

3. Facilitates and participates in the development of the IFSP;

4. Assisting families in identifying available service providers and formal and informal resources;

5. Coordinating and monitoring the delivery of services, including the provision of early intervention services with other services that the child or family needs or is being provided, including medical services, respite care, and the purchase of prosthetic devices;

6. Facilitating the development and coordination of a transition plan for infants and toddlers with continuing special needs (e.g., from hospital to home; home to program; program to program; early intervention to preschool, etc.);

7. Providing family support services, which may include counseling, co-facilitating support groups for family members; and

8. Advocating on behalf of infants and toddlers with special needs and their families.

E. Qualification of Providers:

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

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

F. Freedom of Choice:

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

1. Eligible recipients will have free choice of the providers of case management services.

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

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

CASE MANAGEMENT SERVICES

A Target Group:

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

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

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

(1) Eligible for medical assistance from the department and under 21 years of age;

(2) Determined medically-fragile and has a medical need for case management due to the medical condition of the individual and the need for coordination of multiple medical services/items;

(3) Able to safely reside in a home or foster home and does not need to be cared for in a facility for medical reasons; but is unable to reside safely in the home without receiving specialized medical services/items; and

(4) The provisions of such services will improve the care the family and service providers furnish to the individual and enable the individual to remain in the home safely.

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

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

(x) Entire State.

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

C Comparability of Services:

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

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

D. Definition of Services:

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

1. The case management provider must keep written documentation of his/her case management activities which includes assessment/reassessment, plan of care development, implementation and changes, advocacy, liaison, coordination of care and quality.

2. All records must be dated and signed.

3. All federal and state privacy and confidentiality requirements must be met.

E. Qualification of Providers:

1. The case management provider must be a Medicaid provider.

2. The case management provider must be an entity that employs licensed professional nurses and/or licensed physicians. The nurse must work with a physician. The physician may be an employer, a consultant to the nursing staff, an employee, or the recipient's physician.

3. In all cases, the primary case manager must be a licensed professional nurse or a licensed physician.

4. Although case management services may be provided by the staff of the entity, the licensed professional nurse and/or physician must supervise, consult, and/or advise the staff providing the activities.

5. The assessment of the patient's medical condition must be performed by a licensed professional nurse or licensed physician.

F. Freedom of Choice:

1. Eligible recipient will have free choice of the providers of case management services.

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

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

State/Territory: Hawaii

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

The following ambulatory services are provided.

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

*Description provided on attachment.

State: Hawaii

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

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

   ☒ Provided: ☐ No limitations ☒ With limitations*

2. a. Outpatient hospital services.

   ☒ Provided: ☐ No limitations ☒ With limitations*

   b. Rural health clinic services and other ambulatory services furnished by a rural health clinic (which are otherwise covered under the Plan).

   ☒ Provided: ☐ No limitations ☒ With limitations*

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

   ☒ Provided: ☐ No limitations ☒ With limitations*

3. Other laboratory and x-ray services.

   ☒ Provided: ☐ No limitations ☒ With limitations*

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

   ☒ Provided: ☐ No limitations ☒ With limitations*

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

   ☒ Provided

   c. Family planning services and supplies for individuals of childbearing age.

   ☒ Provided: ☐ No limitations ☒ With limitations*

*Description provided on attachment.

State/Territory: HAWAII

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

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

Provided: ___ No limitations X With limitations*

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

Provided: ___ No limitations X With limitations*

* Description provided on attachment.

State/Territory:	HAWAII

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

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

a. Podiatry Services

x Provided: ___ No limitations x With limitations

b. Optometirists' Services

x Provided: ___ No limitations x With limitations

c. Chiropractors' Services

___ Provided: ___ No limitations ___ With limitations

d. Other Practitioners' Services

x Provided: ___ No limitations x With limitations

7. Home Health Services

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

x Provided: ___ No limitations x With limitations

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

x Provided: ___ No limitations x With limitations

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

x Provided: ___ No limitations x With limitations

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

x Provided: ___ No limitations x With limitations

*Description provided on attachment.

State/Territory: Hawaii

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

8. Private duty nursing services.

[ ] Provided: [ ] No limitations [ ] With limitations*

9. Clinic services.

[X] Provided: [ ] No limitations [X] With limitations*

10. Dental services.

[X] Provided: [ ] No limitations [X] With limitations*

11. Physical therapy and related services.

a. Physical therapy.

[X] Provided: [ ] No limitations [X] With limitations*

b. Occupational therapy.

[X] Provided: [ ] No limitations [X] With limitations*

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

[X] Provided: [ ] No limitations [X] With limitations*

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

a. Prescribed drugs.

[X] Provided: [ ] No limitations [X] With limitations*

b. Dentures.

[X] Provided: [ ] No limitations [X] With limitations*

*Description provided on attachment.

State/Territory: Hawaii

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

c. Prosthetic devices.

[X] Provided: [ ] No limitations [ ] With limitations*

d. Eyeglasses.

[X] Provided: [ ] No limitations [ ] With limitations*

13. Other diagnostic, screening, preventive, and rehabilitative services, i.e., other than those provided elsewhere in this plan.

a. Diagnostic services.

[X] Provided: [ ] No limitations [X] With limitations*

b. Screening services.

[X] Provided: [X] No limitations [ ] With limitations*

c. Preventive services.

[X] Provided: [X] No limitations [ ] With limitations*

d. Rehabilitative services.

[X] Provided: [ ] No limitations [X] With limitations*

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

a. Inpatient hospital services.

[ ] Provided: [ ] No limitations [ ] With limitations*

b. Skilled nursing facility services.

[ ] Provided: [ ] No limitations [ ] With limitations*

*Description provided on attachment.

State/Territory: Hawaii

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

c. Intermediate care facility services

☐ Provided: ☐ No limitations ☐ With limitations*

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

☒ Provided: ☐ No limitations ☒ With limitations*

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

☐ Provided: ☐ No limitations ☐ With limitations*

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

☒ Provided: ☐ No limitations ☒ With limitations*

17. Nurse-midwife services.

☒ Provided: ☐ No limitations ☒ With limitations*

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

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

☐ No limitations ☒ With limitations*

*Description provided on attachment

State/Territory: _____

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

19. Case management services and Tuberculosis related services

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

X Provided: X With limitations*

___ Not provided.

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

___ Provided: ___ With limitations*

X Not provided.

20. Extended services for pregnant women.

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

X Provided: + ___ Additional coverage ++

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

X Provided: + ___ Additional coverage ++ ___ Not provided.

21. Certified pediatric or family nurse practitioners' services.

X Provided: ___ No limitations X With limitations*

___ Not provided.

\+ Attached is a list of major categories of services (e.g., inpatient hospital, physician, etc.) and limitations on them, if any, that are available as pregnancy-related services or services for any other medical condition that may complicate pregnancy.
Refer to Supplement to Attachment 3.1-A and 3.1-B

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

*Description provided on attachment.

State/Territory: HAWAII

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

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

/X/ Provided: / / No limitations /X/ With limitations*

/ / Not provided.

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

a. Transportation.

/X/ Provided: / / No limitations /X/ With limitations*

b. Services of Christian Science nurses.

/ / Provided: / / No limitations / / With limitations*

c. Care and services provided in Christian Science sanitoria.

/ / Provided: / / No limitations / / With limitations*

d. Skilled nursing facility services provided for patients under 21 years of age.

/X/ Provided: / / No limitations /X/ With limitations*

e. Emergency hospital services.

/X/ Provided: /X/ No limitations / / With limitations*

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

/ / Provided: / / No limitations / / With limitations*

State/Territory: HAWAII

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

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

___ Provided X Not Provided

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

___ Provided: ___ State Approved (Not Physician) Service Plan Allowed

___ Services Outside the Home Also Allowed

___ Limitations Described on Attachment

X Not provided.

State/Territory: Hawaii

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

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

☐ Election of PACE: By virtue of this submittal, the State elects PACE as an optional State Plan service.

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

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

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

Provided: ☐ No limitations ☐ With limitations ☒ None licensed or approved

Please describe any limitations: N/A

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

Provided: ☐ No limitations ☐ With limitations (please describe below)

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

Please describe any limitations: N/A

Please check all that apply:

☐ (a) Practitioners furnishing mandatory services described in another benefit category and otherwise covered under the State plan (i.e., physicians and certified nurse midwives).

☐ (b) Other licensed practitioners furnishing prenatal, labor and delivery, or postpartum care in a freestanding birth center within the scope of practice under State law whose services are otherwise covered under 42 CFR 440.60 (e.g., lay midwives, certified professional midwives (CPMs), and any other type of licensed midwife). *

☐ (c) Other health care professionals licensed or otherwise recognized by the State to provide these birth attendant services (e.g., doulas, lactation consultant, etc.).*

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

1. The utilization control committee of an acute hospital facility shall determine the medical necessity for admission and continued stay for all recipients. Extension of hospital stay shall be requested when a patient is awaiting placement in a long-term facility.

2a. Outpatient psychiatric services for substance abuse treatment (SAT) services that are medically necessary shall be provided with no limits on the number of visits. The providers for SAT services are psychiatrists, psychologists, licensed social workers in behavioral health, and advance practice registered nurses (APRN) in behavioral health. Setting where services will be delivered are in outpatient hospital/clinic including methadone clinics, and physician/provider offices. Only professional fees are paid when services are provided in an outpatient clinic setting and are paid at or below the Medicare fee schedule rate. SAT services that are medically necessary shall be reimbursed with the existing approved Medicaid Fee Schedule located in Attachment 4.19-B, Section 1., Hawaii Medicaid Fee Schedule, item (a) and (d) and Section 2., Medicaid Payment for Other Non-Institutional Items and Services are determined as Follows, item (i)., or PPS methodology.

2c. FQHC and RHC services are congruent with the general scope and limitations to services of Hawaii's Medicaid program.

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

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

3. Prior authorization is required for the following services:

Radiology:

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

Laboratory:

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

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

4a. Authorization by the Department's medical consultant is required for level of care and admission to a NF.

4b. All services listed under 1905(a) of the Social Security Act are available to EPSDT eligible individuals when medically necessary, even though the services are not covered in this plan. Services limitation may be exceeded when determined by the State to be medically necessary.

School-Based Health-Related Services (SBHRS):

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

SBHRS are defined below:

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

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

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

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

Physical Therapy: Therapy services are provided by:

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

Occupational Therapy: Therapy services are provided by:

- Occupational therapist registered (OTR) who is registered and licensed to practice in the State of Hawaii. Occupational therapist will meet the Federal requirements at 42 C.F.R. §440.110(b)(2);

- Certified occupational therapy assistant (COTA) who is a graduate of an accredited occupational therapy assistance program recognized by the American Medical Association and American Occupational Therapy Association with an Associate.

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

Auditory therapy: Therapy services are provided by:

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

Speech Language Therapy: Therapy services are provided by:

- Speech pathologist licensed to practice in the State of Hawaii and meets the Federal provider requirements at 42 C.F.R. §440.110(c). Providers or speech language therapy services will meet the Federal provider requirements at 42 C.F.R §440.110(c)(2);

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

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

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

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

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

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

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

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

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

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

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

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

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

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

4c. The limitation on family planning are:

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

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

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

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

5a. Physicians' services are limited to two visits a month for patients in NF except for acute episodes. Physician services do not extend to procedures or services considered to be experimental or unproven as determined by Medicare.

- Telehealth services: Telehealth services are the use of communication equipment to link health care practitioners and patients in different locations. Services shall be used in place of a face-to-face, "hands on" encounter for consultation, office visit, individual psychotherapy and pharmacologic management. These services may be provided to eligible individuals only if they are presented from an originating site located in either a:

(1) Rural Health Professional Shortage Area (HPSA) as defined by section 332(a)(1)(A) of the Public Health Act;

(2) In a county outside of a Metropolitan Statistical Area, as defined by Section 1886(d)(2)(D) of the Social Security Act; or

(3) From an entity that participates in a Federal telemedicine demonstration project that has been approved by the Secretary of Health and Human Services as of December 31, 2000.

Interactive audio and video telecommunication systems must be used. Interactive telecommunications systems must be multi-media communications that, at a minimum, include audio and video equipment, permitting real-time consultation among the patient, consulting practitioner, and referring practitioner. Telephones, facsimile machines, and electronic mail systems do not meet the requirements of interactive telecommunications system. As a condition of payment, the patient must be present and participating in the telehealth visit.

Transmission fees and items such as technical support, line charges, depreciation on equipment, etc. are not reimbursable services under telehealth.

An originating site is the location of an eligible individual at the time the service being furnished via a telecommunications system occurs. Originating sites authorized to furnish telehealth services are listed below:

(1) The office of a physician or practitioner;

(2) A hospital;

(3) A critical access hospital;

(4) A rural health clinic; and

(5) A federally qualified health center.

An exception to this provision is an entity participating in a Federal telehealth demonstration project that is approved by or is receiving funding from the Secretary of Health and Human Services as of December 31, 2000 or a substitute for a face-to-face service approved by the State. An entity participating in a Federal telehealth demonstration project qualifies as an originating site regardless of geographic location. Reimbursement is allowed when asynchronous "store and forward technology", in single or multi-media formats, is used as a substitute for an interactive telecommunications system.

A distant site is the site at which the physician or practitioner delivering the service is located at the time the service is provided via a telecommunications system.

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

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

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

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

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

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

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

1) Testing is limited to a maximum of 4 hours once every 12 months or to 6 hours, if a comprehensive test is justified.

2) Prior authorization is required for all psychological testing except for tests that are requested by the department's professional staff.

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

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

Smoking cessation counseling and pharmacotherapy recommended in the most current Public Health Service guideline shall be limited to two quit attempts per year. A minimum of four in person counseling sessions provided by trained and licensed providers practicing within their scope of practice shall constitute each quit attempt. Two effective components of counseling, practical counseling and social support delivered as part of the treatments is emphasized. Settings where services will be delivered are in outpatient hospital/clinics and physician/provider offices. Limits may be exceeded based on medical necessity.

Smoking cessation counseling services can be provided by the following licensed providers: psychologists, licensed clinical social workers in behavioral health, advance practice registered nurses (APRN), marriage and family therapists (MFT), and licensed mental health counselors (MHC) in behavioral health.

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

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

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

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

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

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

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

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

10. DENTAL SERVICES:

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

(1) Exclusions to dental services are:

(a) Orthodontic services, except following repair of cleft palate or other developmental defect or injury resulting in malalignment or malocclusion of the teeth in a child or when recommended by DOH's, crippled children branch.

(b) Fixed bridgework.

(c) Plaque control.

(d) Gold crowns and gold inlays.

(e) Procedures, appliances, or restoration solely for cosmetic purposes. Composite resin or acrylic restoration in posterior teeth and all primary teeth shall be considered purely cosmetic.

(f) Overdentures.

(g) Tooth preparation, temporary restorations, cement bases, impressions, or local anesthesia.

(2) Limitations to dental services provided are:

(a) X-rays.

(b) Dental work done under intravenous, inhalation or general anesthesia shall be allowed only once per treatment plan and limited to cases of medical necessity.

(c) Restorative dentistry limited to use of certain materials. Non-duplicated restorative procedures are allowed once per tooth every two years as needed in the treatment of fractured or carious teeth.

(d) Dental prostheses:

(i) Partial dentures are limited to fill the space due to the loss of one or more anterior teeth and to fill the space due to the loss of two or more posterior teeth exclusive of third molars.

(ii) Temporary dentures allowed only when teeth have been extracted recently with prior authorization and shall be subject to maximum benefits for dentures.

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

(iv) Dentures relines are limited to once per denture every two years.

(e) Topical application of fluoride is limited to individuals under age twenty-one.

(f) Sealants for occlusal surface of caries free permanent molar teeth only for children age six through fifteen.

(g) Anterior, molars and premolar root canal shall be covered for a maximum of once per tooth, with authorization, except in cases of poor prognosis possibly due to extensive root decay or bone loss or prior root canal therapy failure.

(h) Acrylic jackets and acrylic veneer crowns, if authorized, shall be limited to anterior teeth for a maximum of once per tooth.

(i) Except for emergency treatments, prior authorization is required for certain dental work.

(3) The above limitations will be exceeded based on a determination of medical necessity under the EPSDT provisions at 1905(r)(5).

(B) Individuals age 21 years and older — Dental Services:

(1) Emergency treatment shall include the following services:

(a) Relief of dental pain;

(b) Elimination of infection; and

(c) Treatment of acute injuries to the teeth or supporting structures of the orofacial complex.

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

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

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

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

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

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

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

The following excluded drugs are not covered:

(a) Used for cosmetic purposes or hair growth;

(b) With associated tests or monitoring purchased exclusively from the manufacturer or designee as a condition of sale;

(c) Which are classed as "less than effective" as described in Section 107(c)(3) of the Drug Amendments of 1962 or are identical, similar or related; and

(d) Agents used to promote fertility.

(2) The Medicaid agency provides coverage for the following excluded or otherwise restricted drugs or classes of drugs, or their medical uses to all Medicaid recipients, including full benefit dual eligible beneficiaries under the Medicare Prescription Drug Benefit – Part D.

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

The following excluded drugs are covered:

(a) Agent when used for anorexia, weight loss, weight gain (see specific drug categories below)

- Marinol

(b) Agents when used for symptomatic relief cough and colds (see specific drug categories below)

- Brompheniramine with pseudoephedrine (tablets, liquid)
- Chlorpheniramine (all forms)
- Diphenhydramine (all forms)
- Guaifenesin with or without dextromethorphan (all strength/liquid)
- Loratadine with or without a decongestant (for age 20 years old and younger; for age 61 years old and older; age 21 to 60 continue to require PA)*
- Pseudoephedrine (all forms)

(c) Prescription only vitamins and mineral products, except prenatal vitamins and fluoride (prior authorization required)

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

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

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

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

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

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

Schedule 3
Supplemental Rebate Calculation

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

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

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

(4) The maximum quantity of any medication to be paid equals the larger of a one month supply or one hundred units. The State may implement stricter quantity restrictions to help ensure proper utilization and reduce billing errors.

(5) In compliance with Section 1927(b)(2) of the Social Security Act, the fiscal agent is engaged to report to each manufacturer not later than sixty days after the end of each calendar quarter and in a form consistent with a standard reporting format established by the Secretary, information on the total number of dosage units of each covered outpatient drug dispensed under the plan during the quarter and shall promptly transmit a copy of such report to the Secretary as instructed by CMS.

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

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

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

Dentures are authorized only when provided under EPSDT.

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

12d. Same as 6b.

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

- Psychological testing
- Neuropsychological testing
- Standardized cognitive testing

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

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

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

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

Community Mental Health Rehabilitative Services:

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

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

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

The services are defined as follows:

1. **Crisis Management.** This service provides mobile assessment for individuals in an active state of crisis (24 hours per day, 7 days per week) and can occur in a variety of community settings including the consumer's home. Immediate response is required. Included in Crisis Management services are an assessment of risk, mental status, and medical stability, and immediate crisis resolution and de-escalation. If necessary, this may include referral to licensed psychiatrist, licensed psychologist, or to an inpatient acute care hospital. The presenting crisis situation may necessitate that the services be provided in the consumer's home or natural environment setting. Thus, crisis management services may be provided in the home, school, work environment or other community setting as well as in a health care setting. These services are provided through JCAHO, CARF, or COA accredited agencies. In addition, agencies must have staff that includes one or more qualified mental health professionals. If the services are provided by staff other than a qualified mental health professional, the staff must be supervised at a minimum by a qualified mental health professional.

2. **Crisis Residential Services.** Crisis Residential Services are short-term, interventions provided to individuals experiencing crisis to address the cause of the crisis and to avert or delay the need for acute psychiatric inpatient hospitalization or inpatient hospital based psychiatric care at levels of care below acute psychiatric inpatient. Crisis Residential Services are for individuals who are experiencing a period of acute stress that significantly impairs the capacity to cope with normal life circumstances. The program provides psychiatric services that address the psychiatric, psychological, and behavioral health needs of the individuals. Specific services are: psychiatric medical assessment, crisis stabilization and intervention, medication management and monitoring, individual, group and/or family counseling, and daily living skills training. Services are provided in a licensed residential program, licensed therapeutic group home or foster home setting. All crisis residential programs will have less than 16 beds. The services do not include payment for room and board. The staff providing crisis residential services must be qualified mental health professionals. If the services are provided by staff other than a qualified mental health professional, the staff must be supervised at a minimum by a qualified mental health professional.

3. **Biopsychosocial Rehabilitative Programs :** A therapeutic day rehabilitative social skill building service which allows individuals with serious mental illness to gain the necessary social and communication skills necessary to allow them to remain in or return to naturally occurring community programs.

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

4. **Intensive Family Intervention.** These are time limited intensive interventions intended to stabilize the living arrangement, promote reunification or prevent the utilization of out of home therapeutic resources (i.e. psychiatric hospital, therapeutic foster care, residential treatment facility) for children with serious emotional or behavioral disturbance or adults with serious mental illness. These services: 1) diffuse the current crisis, evaluate its nature and intervene to reduce the likelihood of a recurrence; 2) assess and monitor the service needs of the identified individual so that he/she can be safely maintained in the family; 3) ensure the clinical appropriateness of services provided; and 4) improve the individual's ability to care for self and the family's capacity to care for the individual. This service includes focused evaluations and assessments, crisis case management, behavior management, counseling, and other therapeutic rehabilitative mental health services toward improving the individual's ability to function in the family. Services are directed towards the identified individual within the family. Services can be provided in-home, school or other natural environment. Services are provided by a multidisciplinary team comprised of qualified mental health professionals. If the services are provided by staff other than that listed above, the staff must be supervised by one of the licensed disciplines noted above and at a minimum be a qualified mental health professional. Additionally, provider qualifications must be in compliance with requirements and standards of a national accreditation organization (JCAHO, CARF, COA).

5. **Therapeutic Living Supports and Therapeutic Foster Care Supports.** These are services covered in settings such as group living arrangements or therapeutic foster homes. Group living arrangements usually provide services for 3 to 6 individuals per home but not more than 15. Therapeutic foster homes provide services for a maximum of 15 individuals per home. Although these group living arrangements and therapeutic foster homes may provide 24 hour per day of residential care, only the therapeutic services provided are covered. There is no reimbursement of room and board charges. Covered

therapeutic supports are only available when the identified individual resides in a licensed group living arrangement or licensed therapeutic foster home. The identified individual must be either a child with serious emotional or behavioral disturbance or the adult with a serious mental illness. Services provided in therapeutic group homes and therapeutic foster homes include: supervision, monitoring and developing independence of activities of daily living and behavioral management, medication monitoring, counseling and training (individual, group, family), directed at the amelioration of functional and behavioral deficits and based on the individual's plan of care developed by a team of licensed and qualified mental health professionals. Services are provided in a licensed facility and are provided by a qualified mental health professional or staff under the supervision of a qualified mental health professional with 24-hour on-call coverage by a licensed psychiatrist or psychologist.

6. **Intensive outpatient hospital services.** These are outpatient hospital services for the purpose of providing stabilization of psychiatric impairments as well as enabling the individual to reside in the community or to return to the community from a more restrictive setting. Services are provided to an individual who is either a child with serious emotional or behavioral disturbance or an adult with a serious mental illness. In addition, the adult or child must meet at least two of the following criteria: 1) at high risk for acute inpatient hospitalization, homelessness or (for children) out-of-home placement because of their behavioral health condition; 2) exhibits inappropriate behavior that generates repeated encounters with mental health professionals, educational and social agencies, and/or the police; or 3) are unable to recognize personal danger, inappropriate social behavior, and recognize and control behavior that presents a danger to others. The goals of service are clearly identified in an individualized plan of care. The short term and long term goals and continuing care plan are established prior to admission through a comprehensive assessment of the consumer to include a severity-adjusted rating of each clinical issue and strength. Treatment is time-limited, ambulatory and active offering intensive, coordinated clinical services provided by a multi-disciplinary team. This service includes medication administration and a medication management plan. Services are available at least 20 hours per week. All services are provided by qualified mental health professionals, or by individuals under the supervision of a qualified mental health professional. Additionally, provider qualifications must be in compliance with requirements and standards of a national accreditation organization (JCAHO, CARF, COA). Registered nurses or licensed practical nurses must be available for nursing interventions and administration of medications. Licensed psychiatrists or psychologist must be actively involved in the development, monitoring, and modification of the plan of care. The services must be provided in the outpatient area or clinic of a licensed JCAHO certified hospital or other licensed facility that is Medicare certified for

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

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

13d. **Limitations continued**

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

13d. **Community Mental Health Rehabilitative Services (continued)**

8. **Substance Abuse Treatment (SAT) services**: SAT services furnished under §440.130(d) are provided by a qualified mental health professional to include but not limited to a licensed psychiatrist, licensed psychologist, licensed clinical social worker with experience in behavioral health, licensed advance practical nurse in behavioral health, licensed mental health counselor, or a licensed marriage and family therapist with experience with behavioral health or a substance abuse counselor certified by the State. SAT services shall be provided without limits on the number of visits when medically necessary; prior authorization is required, and monthly assessments are performed to ensure that services are medically necessary. SAT services are recommended by a physician or other licensed practitioner of the healing arts, within the scope of his or her practice under State law. The substance abuse provider assists an individual in achieving specific objectives of treatment or care for a substance use or mental health disorder through a face-to-face, one-to-one therapeutic relationship. Services are generally directed toward reducing psychosocial stress and teaching coping and problem-solving skills, using supportive and cognitive-behavioral approaches that restore a participant's best possible functional level.

9. **Peer support services:** Peer support services may be provided by a peer specialist certified by the State Department of Health, Adult Mental Health Division (AMHD) as part of their Hawaii certified peer specialist (HCPS) program or a program that meets the criteria established by the AMHD. Peer support services are provided without limits on the number of visits when medically necessary; prior authorization is required, and monthly assessments are performed to ensure that benefits are medically necessary. Peer support providers are self-identified consumers who are in recovery from mental illness and/or substance use disorders. Peer support providers meet the following minimum requirements for supervision, care coordination and training: 1) Supervision is provided by a mental health professional (as defined by the State); 2) Peer support services are coordinated within the context of a comprehensive, individualized plan of care that reflects the needs and preferences of the participant in achieving the specific, individualized goals that have measurable results and are specified in the service plan; 3) Training and Credentialing: Peer support providers must complete training and certification as defined by the State. The peer specialist must demonstrate the ability to support the recovery of others from mental illness and or substance use disorders. Peer support providers must complete ongoing continuing educational requirements.

Limitations (continued)

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

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

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

Services are not limited and must be authorized.

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

17. Limited to nurse midwives sponsored by a physician.

18. Authorization by the Department's medical consultant is required for services during a transitional period.

20.a. & b. Extended services to pregnant women includes all major categories of services provided for the categorically needy recipients, as long as the services are determined to be medically necessary and related to the pregnancy.

22. Prior authorization is required by the medical consultant for the provision of respiratory care services for ventilator-dependent individuals.

23. Nurse practitioner services shall be limited to the scope of practice a nurse practitioner is legally authorized to perform under State law.

24a. Except for emergencies, prior authorization is required for air transportation. Taxi service to obtain medical services may be authorized by the payment worker if there is not bus system, no means of transportation, etc.

24d. Must meet the skilled nursing level of care requested by a physician and approved by the department's medical consultant.

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

(1) In the context of inpatient and outpatient hospital services and physicians' services, provisions are made for specialists' services and consultation.

(2) Provision for transportation is made so that the required special medical services which are not available in communities where recipients reside may be obtained elsewhere.

(3) There is an arrangement under which the agency's medical consultant may call on a member of the local medical association for consultation on cases involving questions of over-utilization or appropriateness of services recommended or provided.

(4) NF standards are rigidly enforced jointly with the Department of Health. Both agencies provide consultation to such facilities to correct identified deficiencies or upgrade nursing care. A general surveillance is maintained by this agency to assure that such facilities continuously meet the required standards.

(5) Prospective reviews and prior authorization requirements are maintained so that determination may be made by this agency as to the appropriateness of recommended medical services.

(6) Periodic visits are made by the agency's representative to participating medical facilities to confer with the medical staff, review medical records and generally observe the services being provided recipients.

(7) Planning and development of statewide EPSDT services are done jointly with the physician-administrators of Title V programs and in consultation with the local pediatric society.

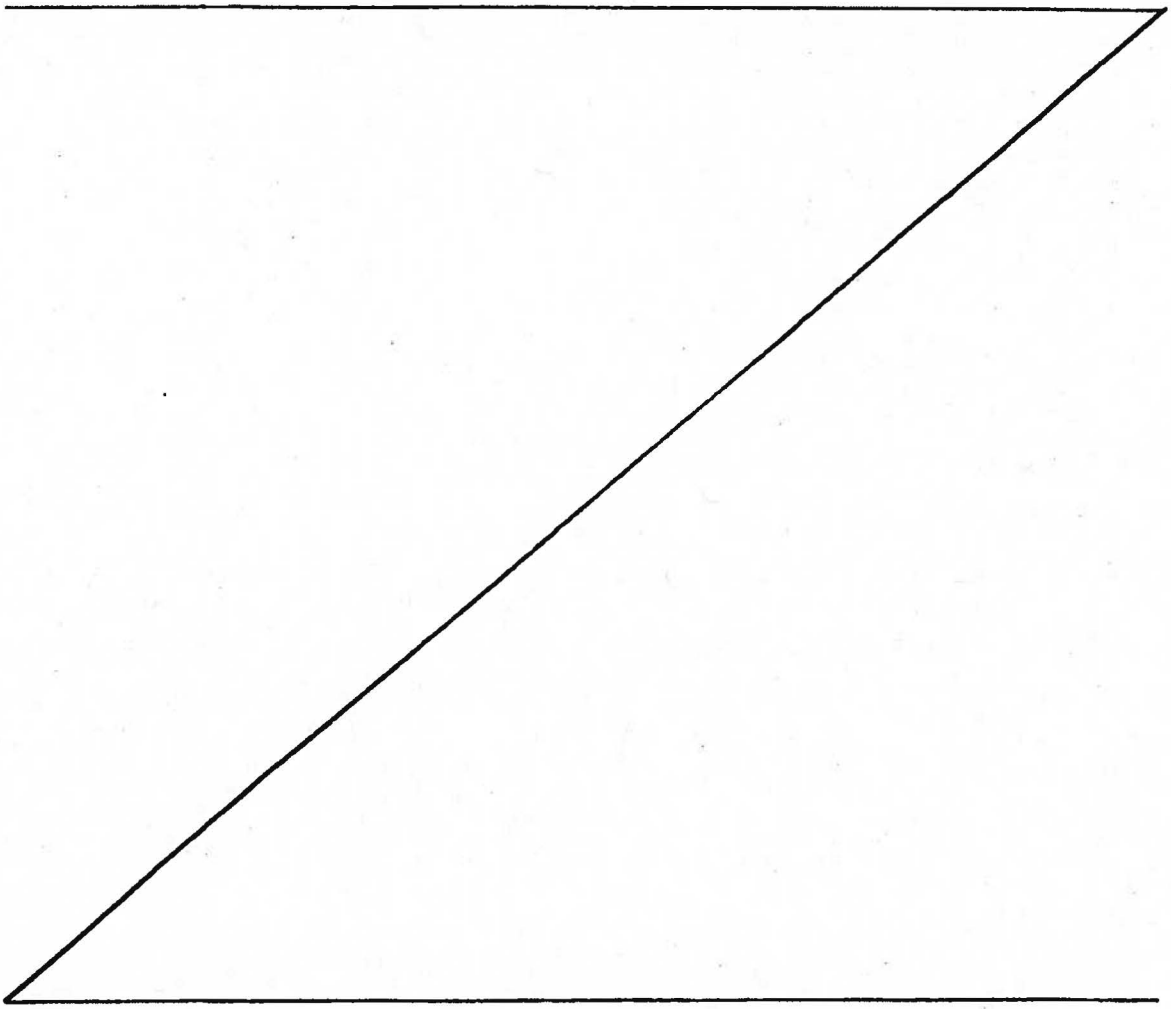
(8) Periodic on-site medical reviews are conducted by the agency's multi-disciplinary team at participating NF's to determine the adequacy of services and to evaluate the level of care required by recipients. Physician's patient certifications are examined and utilization review activities are monitored.

(9) Medical and remedial care and services which are unproven or of experimental nature are excluded under the program. Medicare's definition and guidelines are utilized in determining which procedures are experimental or unproven.

(10) Described below are the methods used to implement the nursing home reform provisions of OBRA '87.

A. PASARR Level I was provided on an interim basis by HCAD consultants. Effective September 1, 1989, LTC facilities assumed responsibility for Level I;

B. By interagency agreement, PASARR Level II determinations are performed by Mental Health Division and Developmental Disabilities Division of the Department of Health:



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

(1) Taxi transportuation is provided for recipients residing in areas not served by a bus system, or when travel by bus would be either hazardous or cause extreme hardship to a recipient who is ill or has a physical or ment . impairment.

(2) Ambulance service is provided in emergencies or when a recipient, due to the nature of his physical impairment, is unable to travel by taxi.

(3) Air transportation is provided when required specialized medical services are not available on the island of recipient's residence. Attendant's service is also made avilable when recommended by the attending physician or required by the airline.

(4) Out-of state transportation is provided when required specialized medical services are not available in the State. Attendant's service is also made available when recommended by the attending physician or required by the airline.

State/Territory: HAWAII

STANDARDS FOR THE COVERAGE OF ORGAN TRANSPLANT SERVICES

1. The standards for coverage of organ transplant services are applied equally to the categorically and medically needy individuals as described in ATTACHMENT 3.1-E, pages 2 through 7.

2. The guidelines for approving organ transplants for EPSDT eligible individuals which are not covered under this Plan are as follows:

   a. Shall have prior medical authorization

   b. Shall be performed at a Medicare certified facility

   c. Shall be an established non-experimental procedure

   d. Shall be medically necessary, specifically:

      i. The condition is life-threatening and unresponsive to other medical or surgical therapy, with a prognosis of six to twelve months of life.

      ii. There is significant reason to believe that the transplant will improve the quality of life of the patient.

      iii. There is significant reason to believe that the patient's medical status is adequate to tolerate the transplant procedure and follow-up medical and surgical care.

      iv. The initial or primary disease process is confined to the organ with no life threatening involvement of other organ systems and no anticipation that life threatening recurrence of the disease process will involve the transplanted organ or other organ systems.

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

(b) Kidney transplantations are covered under this program.

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

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

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

(f) Immunosuppressive therapy shall be covered as required.

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

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

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

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

(a) Indications of penetrating keratoplasty include:

(1) Corneal opacification that sufficiently obscures visibility (vision) through the anterior segment of the eye with at least light perception present. Causes for this problem include:

(A) Corneal injury and scarring;

(B) Corneal degeneration (from Fuch's or other dystrophy or from previous cataract or intraocular lens implantation, or both);

(C) Corneal degeneration from keratoconus or familial causes;

(D) Corneal infection (e.g., herpes); and

(2) Therapeutic graft for relief of pain with at least light perception vision present, from corneal degeneration because of inflammation with pain in the eye and useful vision still present.

(b) Indications of lemellar keratoplasty include:

(1) Superficial layer corneal scarring and deformity due to:

(A) Trauma;

(B) Degeneration;

(C) Infection; or

(D) Congenital deformity (anterior);

(2) Aphakia;

(3) High myopia;

(4) High refractive error;

(5) Keratoconus; and

(6) Recurrent pterygium.

(c) Conditions and limitations affecting corneal transplant include:

(1) A relative contraindication is intractable glaucoma in the eye under consideration for surgery;

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

§17-1737-93 Allogenic bone marrow transplant.

(a) Indications for allogenic bone marrow transplant include:

(1) Severe aplastic anemia unresponsive to usual therapy;

(2) Acute myelogenous leukemia in first remission;

(3) Acute lymphocytic leukemia in second remission; and

(4) Chronic leukemia after first year.

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

(1) Human leukocyte group A (HLA) histocompatible donor shall be available;

(2) Patient has no other major systemic disease which would result in poor potential for recovery (such as a heart condition, liver disease, kidney damage , brain lesions, cancer in other organs or lung disease);

(3) Patient shall have been properly evaluated by a qualified authorityin Hawaii and bone marrow transplant is recommended as a possible curative procedure or if palliative, with reasonable likelihood for prolongation of life and return to an active life;

(4) No active infection at the time of the procedure;

(5) No general medical contraindication for the procedure and anesthesia;

(6) Informed consent shall be obtained from the patient or the patient's representative; and

(7) Age restricted to fifty or under except when identical twin is histocompatible and then age limit may be fifty-five. [Eff 08/01/96] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §440.230; 42 U.S.C. §1396b(i))

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

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

(b) Conditions and limitations affecting kidney transplant include:

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

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

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L

Alternative Benefit Plan Populations **ABP1**

Identify and define the population that will participate in the Alternative Benefit Plan.

Alternative Benefit Plan Population Name: Adult group under Section 1902(a)(10)(A)(i)(VIII) of the Act

Identify eligibility groups that are included in the Alternative Benefit Plan's population, and which may contain individuals that meet any targeting criteria used to further define the population.

Eligibility Groups Included in the Alternative Benefit Plan Population:

	Eligibility Group:	Enrollment is mandatory or voluntary?	
+	Adult Group	Mandatory	X

Enrollment is available for all individuals in these eligibility group(s). Yes

Geographic Area

The Alternative Benefit Plan population will include individuals from the entire state/territory. Yes

Any other information the state/territory wishes to provide about the population (optional)

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130724

APR 15 2014

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L

OMB Expiration date: 10/31/2014

Voluntary Benefit Package Selection Assurances - Eligibility Group under Section 1902(a)(10)(A)(i)(VIII) of the Act **ABP2a**

The state/territory has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements. Therefore the state/territory is deemed to have met the requirements for voluntary choice of benefit package for individuals exempt from mandatory participation in a section 1937 Alternative Benefit Plan.	Yes

Explain how the state has fully aligned its benefits in the Alternative Benefit Plan using Essential Health Benefits and subject to 1937 requirements with its Alternative Benefit Plan that is the state's approved Medicaid state plan that is not subject to 1937 requirements.

All Hawaii state Medicaid plan services are included in the ABP. However, habilitation services, which are Essential Health Benefits (EHB) that are a required part of the ABP, are not a part of the traditional state Medicaid plan. In order to ensure that benefits are aligned across all populations, habilitation are provided through 1115(a)(2) authorities as costs not otherwise matchable.

PRA Disclosure Statement

V.20130807

APR 15 2014

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L

Selection of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package ABP3

Select one of the following:

- ○ The state/territory is amending one existing benefit package for the population defined in Section 1.
- ◉ The state/territory is creating a single new benefit package for the population defined in Section 1.

Name of benefit package: Hawaii Alternative Benefits Health Plan

Selection of the Section 1937 Coverage Option

The state/territory selects as its Section 1937 Coverage option the following type of Benchmark Benefit Package or Benchmark-Equivalent Benefit Package under this Alternative Benefit Plan (check one):

- ◉ Benchmark Benefit Package.
- ○ Benchmark-Equivalent Benefit Package.

The state/territory will provide the following Benchmark Benefit Package (check one that applies):

- ○ The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employee Health Benefit Program (FEHBP).
- ○ State employee coverage that is offered and generally available to state employees (State Employee Coverage):
- ○ A commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state/territory (Commercial HMO):
- ◉ Secretary-Approved Coverage.
  - ◉ The state/territory offers benefits based on the approved state plan.
  - ○ The state/territory offers an array of benefits from the section 1937 coverage option and/or base benchmark plan benefit packages, or the approved state plan, or from a combination of these benefit packages.
    - ◉ The state/territory offers the benefits provided in the approved state plan.
    - ○ Benefits include all those provided in the approved state plan plus additional benefits.
    - ○ Benefits are the same as provided in the approved state plan but in a different amount, duration and/or scope.
    - ○ The state/territory offers only a partial list of benefits provided in the approved state plan.
    - ○ The state/territory offers a partial list of benefits provided in the approved state plan plus additional benefits.

Please briefly identify the benefits, the source of benefits and any limitations:

Benefits in the Alternative Benefit Plan are the same as offered in the Hawaii Medicaid state plan with the following exception: habilitative services under the Cost Not Otherwise Matchable (CNOM) authority as described in the 1115 demonstration waiver is technically the authorization and source.

Selection of Base Benchmark Plan

Alternative Benefit Plan

The state/territory must select a Base Benchmark Plan as the basis for providing Essential Health Benefits in its Benchmark or Benchmark-Equivalent Package.

The Base Benchmark Plan is the same as the Section 1937 Coverage option. [No]

Indicate which Benchmark Plan described at 45 CFR 156.100(a) the state/territory will use as its Base Benchmark Plan:

- (●) Largest plan by enrollment of the three largest small group insurance products in the state's small group market.
- ( ) Any of the largest three state employee health benefit plans by enrollment.
- ( ) Any of the largest three national FEHBP plan options open to Federal employees in all geographies by enrollment.
- ( ) Largest insured commercial non-Medicaid HMO.

Plan name: [HMSA Preferred Provider Plan 2010]

Other Information Related to Selection of the Section 1937 Coverage Option and the Base Benchmark Plan (optional):

1. The state assures that all services in the base benchmark have been accounted for throughout the benefit chart found in ABP5.
2. The state assures the accuracy of all information in ABP5 depicting amount, duration and scope parameters of services authorized in the currently approved Medicaid state plan with the exception of the habilitative services under the Cost Not Otherwise Matchable (CNOM) authority as described in the 1115 demonstration waiver is technically the authorization and source.

PRA Disclosure Statement

V.20130801

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L

OMB Expiration date: 10/31/2014

Alternative Benefit Plan Cost-Sharing **ABP4**

☑ Any cost sharing described in Attachment 4.18-A applies to the Alternative Benefit Plan.

Attachment 4.18-A may be revised to include cost sharing for ABP services that are not otherwise described in the state plan. Any such cost sharing must comply with Section 1916 of the Social Security Act.

The Alternative Benefit Plan for individuals with income over 100% FPL includes cost-sharing other than that described in Attachment 4.18-A. | No

Other Information Related to Cost Sharing Requirements (optional):

PRA Disclosure Statement

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V.20130807

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L

Benefits Description **ABP5**

The state/territory proposes a "Benchmark-Equivalent" benefit package. No

Benefits Included in Alternative Benefit Plan

Enter the specific name of the base benchmark plan selected:

HMSA Preferred Provider Plan 2010

Enter the specific name of the section 1937 coverage option selected, if other than Secretary-Approved. Otherwise, enter "Secretary-Approved."

Secretary-Approved

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Alternative Benefit Plan

Essential Health Benefit 1: Ambulatory patient services — Collapse All ☐

Benefit Provided: Outpatient hospital services
Source: State Plan 1905(a) — Remove
Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: No limitations
Duration Limit: No limitations
Scope Limit: No limitations
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Other laboratory & x-ray services: X-ray services
Source: State Plan 1905(a) — Remove
Authorization: Prior Authorization
Provider Qualifications: Medicaid State Plan
Amount Limit: No limitations
Duration Limit: No limitations
Scope Limit: No limitations
Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:
Prior authorization is required for the following radiology services:
1. Magnetic resonance imaging (MRI);
2. Magnetic resonance angiography; and
3. Positron emission tomography (PET).

Benefit Provided: Physicians' services
Source: State Plan 1905(a)
Authorization: Authorization required in excess of limitation
Provider Qualifications: Medicaid State Plan
Amount Limit: Refer to the box below for "Amount Limit".
Duration Limit: Refer to the box below for "Duration Limit".
Scope Limit: Physician services do not extend to procedures or services considered to be experimental or unproven as determined by Medicare.

Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Amount and Duration Limit:
1. Physicians' services are limited to two visits a month for patients in nursing facilities except for acute episodes.

Benefit Provided:

Home health services - Nursing services

Source:

State Plan 1905(a)

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Refer to the box below for "Amount Limit".

Duration Limit:

Refer to the box below for "Duration Limit".

Scope Limit:

Services exceeding the parameters described above must be medically necessary and prior authorized by the medical consultant or its authorized representative.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Amount and Duration Limits:
1. One visit per day only.
2. Daily home visits are permitted for nursing services in the first two weeks of patient care if part of the written plan of care without the need for authorization/approval process, no more than three visits per week from the third week to the seventh week of care are permitted without the need for authorization/approval process; no more than one visit a week from the eighth week to the fifteenth week of care is permitted without the need for authorization/approval process. No more than one visit every other month from the sixteenth week of care is permitted without the need for authorization/approval process.

Benefit Provided:

Home health services - Home health aide

Source:

State Plan 1905(a)

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Refer to the box below for "Amount Limit".

Duration Limit:

Refer to the box below for "Duration Limit".

Scope Limit:

Services exceeding the parameters described above must be medically necessary and prior authorized by the medical consultant or its authorized representative.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Amount and Duration Limits:
1. One visit per day only.
2. Daily home visits are permitted for home health aide services in the first two weeks of patient care if part of the written plan of care without the need for authorization/approval process, no more than three visits per week from the third week to the seventh week of care are permitted without the need for

Alternative Benefit Plan

authorization/approval process; no more than one visit a week from the eighth week to the fifteenth week of care is permitted without the need for authorization/approval process. No more than one visit every other month from the sixteenth week of care is permitted without the need for authorization/approval process.

Remove

Benefit Provided:
Clinic services

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Refer to the box below for "Amount Limit".

Duration Limit:
Refer to the box below for "Duration Limit".

Scope Limit:
Refer to the box below for "Scope Limit".

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Amount; Duration and Scope Limits:
1. Limitations on the amount, duration or scope of clinic services are the same limitations as described for outpatient services listed in ABP 5.
2. Physicians that provide direction or supervision of other in the clinic, assume professional responsibility for the care of the patients.

Benefit Provided:
Diagnostic services

Source:
State Plan 1905(a)

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Refer to the box below for "Amount Limit".

Duration Limit:
Refer to the box below for "Duration Limit".

Scope Limit:
No limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Amount and Duration Limit
Psychological testing is limited to a maximum of 4 hours once every 12 months or to 6 hours, if a comprehensive test is justified. However, psychological testing exceeding the parameters must be medically necessary and be prior authorized.

Other
Diagnostic procedures or out-of-state procedures requiring authorization are:
1. Psychological testing except for tests that are requested by the department's professional staff;
2. Neuropsychological testing; and
3. Standardized Cognitive testing.

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Alternative Benefit Plan

Benefit Provided: Screening services

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: No limitations

Duration Limit: No limitations

Scope Limit: No limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Hospice care - at home

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: No limitations

Duration Limit: No limitations

Scope Limit: No limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

1. An individual under the age of 21 years may receive curative treatment concurrent with receiving hospice services.
2. Authorization by the department consultant is required during a transitional period. Transitional period means the time in which the recipient is transferred from one setting to other setting (e.g. inpatient hospital to home).

Benefit Provided: Nurse practitioners'

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: No limitations

Duration Limit: No limitations

Scope Limit: Nurse practitioner services shall be limited to the scope of practice of nurse practitioner is legally authorized to perform under State law.

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Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided: Other licensed practitioners

Source: State Plan 1905(a)

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: Refer to the box below for "Amount Limit".

Duration Limit: Refer to the box below for "Duration Limit".

Scope Limit: Refer to the box below for "Scope Limit".

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Services of a psychologist are provided with the following limitations:
1. Testing is limited to a maximum of 4 hours once every 12 months or to 6 hours, if a comprehensive test is justified. However, psychological testing exceeding the parameters must be medically necessary and be prior authorized.
2. Prior authorization is required for all psychological testing except for tests that are requested by the department's professional staff.

The providers for Substance Abuse Treatment (SAT) are psychologists, licensed clinical social workers in behavioral health, advance practice registered nurses, marriage and family therapists, and licensed mental health counselors in behavioral health. SAT services will be delivered are in outpatient hospitals/clinics including methadone clinics, and physician/provider offices.

SAT services that are medically necessary shall be provided with no limits on the number of visits in accordance with the parity law.

Benefit Provided: Personal care services

Source: Secretary-Approved Other

Remove

Authorization: Prior Authorization

Provider Qualifications: Other

Amount Limit: No limitations

Duration Limit: No limitations

Scope Limit: No limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Cost Not Other wise Matchable (CNOM) authority as described in the 1115 demonstration waiver is technically the authorization.

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Alternative Benefit Plan

Benefit Provided:
OP hospital - Termination of Pregnancy

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
No limitations

Duration Limit:
No limitations

Scope Limit:
Refer to the box below for "Scope Limit".

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Coverage for termination of a pregnancy is allowed when the pregnancy resulted from rape or incest, or in the case where a woman suffers from a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy, as certified by a physician that would place the woman in danger of death unless an abortion is performed.

Add

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Alternative Benefit Plan

☑ Essential Health Benefit 2: Emergency services — Collapse All ☐

Benefit Provided: Other Medical Svcs - Emergency hospital services

Source: State Plan 1905(a) — Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: No limitations

Duration Limit: No limitations

Scope Limit: No limitations.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Other Medical Svcs - Emergency Transportation

Source: State Plan 1905(a) — Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: No limitations

Duration Limit: No limitations

Scope Limit: No limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

APR 15 2014

Alternative Benefit Plan

☑ Essential Health Benefit 3: Hospitalization — Collapse All ☐

Benefit Provided: Inpatient hospital services

Source: State Plan 1905(a) — Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: No limitations

Duration Limit: No limitations

Scope Limit: No limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Hospice - Inpatient hospital

Source: State Plan 1905(a) — Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: No limitations

Duration Limit: No limitations

Scope Limit: No limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

1. An individual under the age of 21 years may receive curative treatment concurrent with receiving hospice services.
2. Authorization by the department consultant is required during a transitional period. Transitional period means the time in which the recipient is transferred from one setting to other setting (e.g. inpatient hospital to home).

Add

APR 15 2014

Alternative Benefit Plan

☑ Essential Health Benefit 4: Maternity and newborn care — Collapse All ☐

Benefit Provided: Inpatient hospital services - Maternity Care
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: No limitations
Duration Limit: No limitations
Scope Limit: No limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Nurse-midwife services
Source: State Plan 1905(a)
Remove

Authorization: None
Provider Qualifications: Medicaid State Plan
Amount Limit: No limitations
Duration Limit: No limitations
Scope Limit: Limited to nurse midwives sponsored by or under the supervision of a physician.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Physicians' services - Maternity care
Source: State Plan 1905(a)

Authorization: Authorization required in excess of limitation
Provider Qualifications: Medicaid State Plan
Amount Limit: Refer to the box below for "Amount Limit".
Duration Limit: Refer to the box below for "Duration Limit".
Scope Limit: Physician services do not extend to procedures or services considered to be experimental or unproven as determined by Medicare.

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Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Amount and Duration Limit:
Physicians' services are limited to two visits a month for patients in nursing facilities except for acute episodes.

Remove

Benefit Provided:
Other licensed practitioners - Maternity Care

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
No limitations

Duration Limit:
No limitations

Scope Limit:
No limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Nurse practitioners' - Maternity Care

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
No limitations.

Duration Limit:
No limitations.

Scope Limit:
Nurse practitioner services shall be limited to the scope of practice of nurse practitioner is legally authorized to perform under State law.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided:
Clinic services - Maternity Care

Source:
State Plan 1905(a)

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Refer to the box below for "Amount Limit".

Duration Limit:
Refer to the box below for "Duration Limit".

Alternative Benefit Plan

Scope Limit:

Refer to the box below for "Scope Limit". | Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Amount, Duration and Scope Limits:
1. Limitations on the amount, duration or scope of clinic services are the same limitations as described for outpatient services listed in ABP5.
2. Physicians that provide direction or supervision of other in the clinic, assume professional responsibility for the care of the patients.

Add

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Alternative Benefit Plan

☑ Essential Health Benefit 5: Mental health and substance use disorder services including behavioral health treatment

Collapse All ☐

Benefit Provided: OP hospital svcs - Mental/Behavioral Health OP

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: No limitations

Duration Limit: No limitations

Scope Limit: No limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: OP hospital svcs - Substance Abuse Disorder OP

Source: State Plan 1905(a)

Remove

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: No limitations

Duration Limit: No limitations

Scope Limit: No limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: IP hospital svcs - Mental/Behavioral Health IP

Source: State Plan 1905(a)

Authorization: None

Provider Qualifications: Medicaid State Plan

Amount Limit: No limitations

Duration Limit: No limitations

Scope Limit: Inpatient hospital services for mental or behavioral health will not be covered in an Institution for Mental Disease.

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Alternative Benefit Plan

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Remove

Benefit Provided:

IP hospital svcs - Substance Abuse Disorder IP

Source:

State Plan 1905(a)

Remove

Authorization:

None

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitations

Duration Limit:

No limitations

Scope Limit:

Inpatient hospital services for substance abuse disorder will not be covered in an Institution for Mental Disease.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

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Alternative Benefit Plan

☒ Essential Health Benefit 6: Prescription drugs

Benefit Provided:

Coverage is at least the greater of one drug in each U.S. Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

Prescription Drug Limits (Check all that apply.):	Authorization:	Provider Qualifications:
☒ Limit on days supply	Yes	State licensed
☐ Limit on number of prescriptions		
☒ Limit on brand drugs		
☒ Other coverage limits		
☒ Preferred drug list		

Coverage that exceeds the minimum requirements or other:

The State of Hawaii's ABP prescription drug benefit plan is the same as under the approved Medicaid state plan for prescribed drugs.

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Alternative Benefit Plan

☑ Essential Health Benefit 7: Rehabilitative and habilitative services and devices — Collapse All ☐

Benefit Provided: Home health services - Physical therapy

Source: State Plan 1905(a) — Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: No limitations

Duration Limit: No limitations

Scope Limit: Refer to the box below for "Scope Limit".

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Scope Limit:
1. Medically necessary physical services are limited to patients who are expected to improve in a reasonable period of time with therapy.
2. Provider qualifications meet the federal requirements under 42 C.F.R. 440.110.
3. Initial physical therapy evaluations do no require prior approval. However, physical therapy and re-evaluations require prior approval of the medical consultant providing diagnosis, recommended therapy include frequency and duration and for chronic cases, long term goals and a plan of care.

Benefit Provided: Home health services - Occupational therapy

Source: State Plan 1905(a) — Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: No limitations

Duration Limit: No limitations

Scope Limit: Refer to the box below for "Scope Limit".

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Scope Limit:
1. Medically necessary occupational therapy services are limited to patients who are expected to improve in a reasonable period of time with therapy.
2. Provider qualifications meet the federal requirements under 42 C.F.R. 440.110.
3. Initial occupational therapy evaluations do no require prior approval. However, occupational therapy and re-evaluations require prior approval of the medical consultant providing diagnosis, recommended therapy include frequency and duration and for chronic cases, long term goals and a plan of care.

Benefit Provided: Home health services - Speech/hearing/lang therapy

Source: State Plan 1905(a)

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Alternative Benefit Plan

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Remove

Amount Limit: No limitations

Duration Limit: No limitations

Scope Limit: Refer to the box below for "Scope Limit".

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Scope Limit:
1. Medically necessary speech, hearing and language therapy services are limited to patients who are expected to improve in a reasonable period of time with therapy.
2. Provider qualifications meet the federal requirements under 42 C.F.R. 440.110.
3. All speech, hearing and language evaluation and therapy require authorization by the medical consultant including rental or purchase of hearing aids.

Benefit Provided: Physical therapy

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: No limitations

Duration Limit: No limitations

Scope Limit: Refer to the box below for "Scope Limit".

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Scope Limit
1. Medically necessary physical services are limited to patients who are expected to improve in a reasonable period of time with therapy.
2. Physical services are only provided if rehabilitative.
3. Provider qualifications meet the federal requirements under 42 C.F.R. 440.110.

Benefit Provided: Occupational therapy

Source: State Plan 1905(a)

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: No limitations

Duration Limit: No limitations

Alternative Benefit Plan

Scope Limit:

Refer to the box below for "Scope Limit". | Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Scope Limit
1. Medically necessary occupational services are limited to patients who are expected to improve in a reasonable period of time with therapy.
2. Occupational services are only provided if rehabilitative.
3. Provider qualifications meet the federal requirements under 42 C.F.R. 440.110.

Benefit Provided:	Source:	
Speech/hearing/language therapy	State Plan 1905(a)	Remove

Authorization:	Provider Qualifications:
Prior Authorization	Medicaid State Plan
Amount Limit:	**Duration Limit:**
No limitations	No limitations

Scope Limit:

Refer to the box below for "Scope Limit".

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Scope Limit
1. Medically necessary services for speech, hearing & language disorder are limited to patients who are expected to improve in a reasonable period of time with therapy.
2. Services for speech, hearing & language disorder are only provided if rehabilitative.
3. Provider qualifications meet the federal requirements under 42 C.F.R. 440.110.

Benefit Provided:	Source:	
Habilitative services	Secretary-Approved Other	Remove

Authorization:	Provider Qualifications:
Prior Authorization	Medicaid State Plan
Amount Limit:	**Duration Limit:**
No limitations	No limitations

Scope Limit:

The following habilitative services are to develop or improve a skill or function not maximally learned or acquired by an individual due to a disabling condition: 1. P.T.; 2) O.T.; and 3) S.T.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Cost Not Otherwise Matchable (CNOM) authority as described in the 1115 demonstration waiver is technically the authorization and the source of the habiliative services provided for the Alternative Benefits Plan.

Alternative Benefit Plan

Benefit Provided: Nursing facility services

Source: State Plan 1905(a)

Remove

Authorization: Prior Authorization

Provider Qualifications: Medicaid State Plan

Amount Limit: 120 days

Duration Limit: Per year

Scope Limit: Authorization by the Department's medical consultant is required for level of care and admission to a nursing facility.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Benefit Provided: Home hlth svs (refer below for full benefit name)

Source: State Plan 1905(a)

Remove

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: $50.00 per item

Duration Limit: No limitations

Scope Limit: No limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Medical supplies, equipment and appliances suitable for use in the home require prior authorization by the department when the cost exceed $50.00 per item.

Benefit Name: Home health services - Medical supplies, equipment and appliances suitable for use in the home

Benefit Provided: Prosthetic devices

Source: State Plan 1905(a)

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: $50.00 per item

Duration Limit: No limitations.

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Scope Limit:

No limitations

Remove

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Prosthetic devices require prior authorization when the cost of purchase, repair or manufacture exceeds $50.00 per item.

Add

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Alternative Benefit Plan

☑ Essential Health Benefit 8: Laboratory services — Collapse All ☐

Benefit Provided:
Other laboratory and x-ray svcs - Lab work

Source:
State Plan 1905(a)

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
No limitations

Duration Limit:
No limitations

Scope Limit:
No limitations

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Prior authorization is required for the following:
1. Reference lab tests that cannot be done in Hawaii and not specifically billable by clinical labs in Hawaii;
2. Disease specific new technology lab tests; and
3. Chromosomal analysis.

Add

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Alternative Benefit Plan

☑ Essential Health Benefit 9: Preventive and wellness services and chronic disease management Collapse All ☐

The state/territory must provide, at a minimum, a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

Benefit Provided:
Smoking cessation counseling (OLP)

Source:
State Plan 1905(a)

Remove

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Refer to the box below for "Amount Limit".

Duration Limit:
Refer to the box below for "Duration Limit".

Scope Limit:
Refer to the box below for "Scope Limit".

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Amount and Duration Limits:
Smoking cessation counseling and pharmacotherapy recommended in the most current Public Health Service guideline shall be limited to two quit attempts year. A minimum of four in person counseling session provided by trained and licensed providers practicing within their scope of practice shall constitute each quit attempt.

Scope Limit:
1. Two effective components of counseling, practical counseling and social support delivered as part of the treatments is emphasized.
2. Setting where services will be delivered are in outpatient hospital or clinics and physician or provider offices.
3. Smoking cessation counseling services can be provided by the following licensed providers: psychologists, licensed clinical social workers in behavioral health, advance practice registered nurses, marriage and family therapist and licensed mental health counselors in behavioral health.

Other information:
Limits may be exceeded based on medical necessity.

Add

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Alternative Benefit Plan

☑ Essential Health Benefit 10: Pediatric services including oral and vision care — Collapse All ☐

Benefit Provided:
Medicaid State Plan EPSDT Benefits

Source:
State Plan 1905(a)

Remove

Authorization:
None

Provider Qualifications:
Medicaid State Plan

Amount Limit:
No limitations

Duration Limit:
No limitations

Scope Limit:
All services under 1905(a) of the Social Security Act are available to EPSDT eligible individuals when medically necessary, even if the services are not covered for adults in the Hawaii State Plan.

Other information regarding this benefit, including the specific name of the source plan if it is not the base benchmark plan:

Add

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Alternative Benefit Plan

☐ Other Covered Benefits from Base Benchmark

Collapse All ☐

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Alternative Benefit Plan

☒ Base Benchmark Benefits Not Covered due to Substitution or Duplication — Collapse All ☐

Base Benchmark Benefit that was Substituted: Primary Care Visit to Treat an Injury or Illness
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Primary care visits to treat an injury or illness were bundled, along with specialist visits and mapped to EHB 1 - Ambulatory patient services. Bundled services are duplication of physicians' services, diagnostic services and screening services in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Specialist Visit
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Specialist visits were bundled, along with primary care visits to treat an injury or illness and mapped to EHB 1 - Ambulatory patient services. Bundled services are duplication of physicians' services, diagnostic services and screening services in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Other Practitioner Office Visit
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Other practitioner office visits are mapped to EHB 1 - Ambulatory patient services. This service is a duplication of other licensed practitioner in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Outpatient Facility
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Outpatient facility is mapped to EHB 1 - Ambulatory patient services. This service is a duplication of outpatient hospital services in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Outpatient Surgery Physician/Surgical Services
Source: Base Benchmark
Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Outpatient surgery physician and surgical services were bundled, along with primary care visits to treat an injury or illness and specialist visits and mapped to EHB 1 - Ambulatory patient services. Bundled services are duplication of physicians' services, diagnostic services and screening services in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Hospice Services
Source: Base Benchmark

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Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Hospice services are to mapped to EHB 1 - Ambulatory patient services and EHB 3 - Hospitalization. This service is a duplication of hospice care in the existing state Medicaid plan.

Remove

Base Benchmark Benefit that was Substituted:

Non-Emergency Care When Traveling Outside the U.S.

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Non-emergency care when traveling outside the U.S. is mapped to EHB 1 - Ambulatory patient services. This service is a duplication of physicians' services in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted:

Infertility Treatment

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substitution: Infertility treatment is mapped to EHB 1 - Ambulatory patient services. Personal care services under the secretary approved authority were used for substitution purposes.

Base Benchmark Benefit that was Substituted:

Urgent Care Centers or Facilities

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Urgent care centers or facilities were bundled, along with outpatient facility and mapped to EHB 1 - Ambulatory patient services. Bundled services are duplication of physicians' services, other licensed practitioner services and clinic services in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted:

Home Health Care Services

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Home health care services - nursing and home health health aide services are mapped to EHB 1 - Ambulatory patient services and Home health care services - physical therapy, occupational therapy or speech pathology and audiology services are mapped to EHB 7 - Rehabilitative and habilitative services and devices. This service is a duplication of home health services in the existing state Medicaid plan.

Base Benchmark Plan: 150 visits per year.

Base Benchmark Benefit that was Substituted:

Emergency Room Services

Source:
Base Benchmark

Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Emergency room services are mapped to EHB 2 - Emergency services. This service is a duplication of other medical services: emergency hospital services in the existing state Medicaid plan.

Remove

Base Benchmark Benefit that was Substituted: Emergency Transportation/Ambulance

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Emergency transportation and ambulance is mapped to EHB 2 - Emergency services. This service is a duplication of other medical services: emergency transportation in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Inpatient Hospital Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Inpatient hospital services is mapped to EHB 3 - Hospitalization. This service is a duplication of inpatient hospital services in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Inpatient Physician and Surgical Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Inpatient physician and surgical services is mapped to EHB 3 - Hospitalization. This service is a duplication of inpatient hospital services in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Bariatric Surgery

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Bariatric surgery is mapped to EHB 3 - Hospitalization. This service is a duplication of inpatient hospital service in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Skilled Nursing Facility

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Skilled nursing facility is mapped to EHB 7 - Rehabilitative and habilitative services and devices. This service is a duplication of nursing facility services in the existing state Medicaid plan. Base Benchmark Plan: 120 days per year.

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: Prenatal and Postnatal Care

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Prenatal and postnatal care is mapped to EHB 4 - Maternity and newborn care. This service is a duplication of physicians' services, other licensed practitioner services, clinic services, nurse midwife services and nurse practitioner services in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Delivery & All Inpatient Svcs for Maternity Care

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Delivery & all inpatient services for maternity care is mapped to EHB 4 - Maternity and newborn care. These services are duplication of inpatient hospital services in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Mental/Behavioral Health Outpatient Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Mental and behavioral health outpatient services are mapped to EHB 5 - Mental health and substance use disorder, including behavioral health treatment. These services are a duplication of outpatient hospital services in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Mental/Behavioral Health Inpatient Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Mental and behavioral health inpatient services are mapped to EHB 5 - Mental health and substance use disorder, including behavioral health treatment. These services are a duplication of inpatient hospital services in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Substance Abuse Disorder Outpatient Services

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Substance abuse disorder outpatient services are mapped to EHB 5 - Mental health and substance use disorder, including behavioral health treatment. These services are a duplication of outpatient hospital services in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Substance Abuse Disorder Inpatient Services

Source: Base Benchmark

Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Substance abuse disorder inpatient services are mapped to EHB 5 - Mental health and substance use disorder, including behavioral health treatment. These services are a duplication of inpatient hospital services in the existing state Medicaid plan.

Remove

Base Benchmark Benefit that was Substituted: Generic Drugs

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Generic drugs are bundled, along with preferred brand drugs, non-preferred brand drugs and specialty drugs and mapped to EHB 6 - Prescription drugs. Bundled services are duplication of prescribed drugs in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Preferred Brand Drugs

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Preferred brand drugs are bundled, along with generic drugs, non-preferred brand drugs and specialty drugs and mapped to EHB 6 - Prescription drugs. Bundled services are duplication of prescribed drugs in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Non-preferred Brand Drugs

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Non-preferred brand drugs are bundled, along with generic drugs, preferred brand drugs and specialty drugs and mapped to EHB 6 - Prescription drugs. Bundled services are duplication of prescribed drugs in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Specialty Drugs

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Specialty drugs are bundled, along with generic drugs, preferred brand drugs and non-preferred brand drugs and mapped to EHB 6 - Prescription drugs. Bundled services are duplication of prescribed drugs in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted: Outpatient Rehabilitation Services

Source: Base Benchmark

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Outpatient rehabilitation services are mapped to EHB 7 - Rehabilitative and habilitative

services and devices. These services are duplication of physical therapy, occupational therapy and services for individuals with speech, hearing, and language disorders in the existing state Medicaid plan.

Remove

Base Benchmark Benefit that was Substituted:

Durable Medical Equipment

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Durable medical equipment is mapped to EHB 7 - Rehabilitative and habilitative services and devices. This benefit is a duplication of home health services - medical supplies, equipment and appliances suitable for use in the home in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted:

Hearing Aids

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Hearing aids are mapped to EHB 7 - Rehabilitative and habilitative services and devices. This benefit is a duplication of home health services - medical supplies, equipment and appliances suitable for use in the home in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted:

Diagnostic Test (X-Ray and Lab Work)

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: X-ray services is mapped to EHB1 - Ambulatory patient services and lab work is mapped to EHB 8 - Laboratory services. This service is a duplication of other laboratory and x-ray services in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted:

Imaging (CT/PET Scans, MRIs)

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Imaging is mapped to EHB1 - Ambulatory patient services. This service is a duplication of other laboratory and x-ray services in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted:

Preventive Care/Screening Immunization

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Preventive care or screening immunization is mapped to EHB 9 - Preventive and wellness services and chronic disease management. This service is a duplication of preventive services and smoking cessation counseling under other licensed practitioners in the existing state Medicaid plan.

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Alternative Benefit Plan

Base Benchmark Benefit that was Substituted:
Routine Eye Exam for Children

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Routine eye exams for children is mapped to mapped to EHB 10 - Pediatric services including dental and vision care. This service is a duplication of EPSDT in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted:
Eye Glasses for Children

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Eye glasses for children is mapped to EHB 10 - Pediatric services including dental and vision care. This service is a duplication of EPSDT in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted:
Dental Check-Up for Children

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Dental check-ups for children is mapped to EHB 10 - Pediatric services including dental and vision care. This service is a duplication of EPSDT in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted:
Reconstructive Surgery

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Reconstructive surgery is mapped to EHB 3 - Hospitalization. This service is a duplication of of inpatient hospital services in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted:
Cochlear Implants

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Cochlear implants is mapped to EHB 7 - Rehabilitative and habilitative services and devices. This service is a duplication of services for individuals with speech, hearing and language disorders in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted:
Transplant

Source:
Base Benchmark

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Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Transplant mapped to EHB 3 - Hospitalization. This service is a duplication of inpatient hospital services in the existing Medicaid plan.

Remove

Base Benchmark Benefit that was Substituted:

Prostate Cancer Screening

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Prostate cancer screening is mapped to EHB 9 - Preventive and wellness services and chronic disease management. This service is a duplication of preventive services in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted:

Diagnostic Test - Allergy Testing

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Allergy testing is mapped to EHB 1- Ambulatory patient services. This service is a duplication of diagnostic services in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted:

Other - Allergy Injection

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Allergy injections are mapped to EHB 1 - Ambulatory patient services. These services are are duplication of physician services, other licensed practitioner services and nurse practitioner services in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted:

DME - Orthotics and External Prosthetics

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Orthotics and External Prosthetics are mapped to EHB 7 - Rehabilitative and habilitative services and devices. Theses benefits are duplication of home health services - medical supplies, equipment and appliances suitable for use in the home and prosthetic devices in the existing state Medicaid plan.

Base Benchmark Benefit that was Substituted:

Other - Blood and blood products

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Blood and blood products are mapped to EHB 1 - Ambulatory patient services. This benefit is a duplication of outpatient hospital services in the existing Medicaid plan.

Alternative Benefit Plan

Base Benchmark Benefit that was Substituted: Other - Voluntary Sterilization

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Substitution: Voluntary sterilization is mapped to EHB 1 - Ambulatory patient services. Personal care services under a secretary approved authority were used for substitution purposes.

Base Benchmark Benefit that was Substituted: Other - Chemotherapy and Radiation Therapy

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Chemotherapy and radiation therapy is mapped to EHB 1 - Ambulatory patient services. This services is a duplication of outpatient hospital services in the existing Medicaid plan.

Base Benchmark Benefit that was Substituted: Other - Pulmonary Rehab

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Pulmonary rehab is mapped to EHB 1 - Ambulatory patient services. This service is a duplication of outpatient hospital services in the existing Medicaid plan.

Base Benchmark Benefit that was Substituted: Other - IV/Infusion therapy and Injectibles

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: IV/infusion therapy and injectibles are mapped to EHB 1 - Ambulatory patient services. These services are duplication of outpatient hospital services in the existing Medicaid plan.

Base Benchmark Benefit that was Substituted: Other - Hyperbaric Oxygen Therapy

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Hyperbaric oxygen therapy is mapped to EHB 1 - Ambulatory patient services. These services are duplication of outpatient hospital services in the existing Medicaid plan.

Base Benchmark Benefit that was Substituted: Other - Dialysis and Supplies

Source: Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Dialysis and supplies are mapped to EHB 1 - Ambulatory patient services. This benefit is a duplication of outpatient hospital services in the existing Medicaid plan.

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Alternative Benefit Plan

Base Benchmark Benefit that was Substituted:
Other - HIV/AIDS Treatment

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: HIV/AIDS treatments are mapped to EHB 1 - Ambulatory patient services. These services are duplication of outpatient hospital in the existing Medicaid plan.

Base Benchmark Benefit that was Substituted:
Other - Oxygen

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Oxygen is mapped to EHB 7 - Rehabilitative and habilitative services and devices. This benefit is a duplication of home health services - medical supplies, equipment and appliances suitable for use in the home in the existing Medicaid plan.

Base Benchmark Benefit that was Substituted:
Other - Diabetes Education and Counseling

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Diabetes education and counseling is mapped to EHB 9 - Preventive and wellness services and chronic diseases management. This benefit is a duplication of preventive services in the existing Medicaid plan.

Base Benchmark Benefit that was Substituted:
Other - Diagnosis and Treatment of Lymphadema

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Diagnosis and treatment of lymphadema is mapped to EHB 1 - Ambulatory patient services. This service is a duplication of outpatient hospital services in the existing Medicaid plan.

Base Benchmark Benefit that was Substituted:
Other - Coverage for Certain Clinical Trials

Source:
Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Coverage for certain clinical trials are mapped to EHB 1 - Ambulatory patient services. These services are duplication of outpatient hospital, physician services and other licensed practitioners in the existing Medicaid plan.

Base Benchmark Benefit that was Substituted:
Other - Medical Food

Source:
Base Benchmark

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Alternative Benefit Plan

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Medical foods are mapped to EHB 7 - Rehabilitative and habilitative services and devices. This benefit is a duplication of home health services - medical supplies, equipment and appliances suitable for use in the home in the existing Medicaid plan.

Remove

Base Benchmark Benefit that was Substituted:

Termination of Pregnancy

Source:

Base Benchmark

Remove

Explain the substitution or duplication, including indicating the substituted benefit(s) or the duplicate section 1937 benchmark benefit(s) included above under Essential Health Benefits:

Duplication: Termination of pregnancy is mapped to EHB 1 - Ambulatory patient services. This benefit is a duplication of outpatient hospital.

Add

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Alternative Benefit Plan

☒ Other Base Benchmark Benefits Not Covered — Collapse All ☐

Base Benchmark Benefit not Included in the Alternative Benefit Plan:
Routine Eye Exam (Adult)

Source:
Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:
This benefit is not considered an Essential Health Benefit.

Base Benchmark Benefit not Included in the Alternative Benefit Plan:
Termination of Pregnancy (Non-Hyde)

Source:
Base Benchmark

Remove

Explain why the state/territory chose not to include this benefit:
This benefit is not authorized under Title XIX of the Act and will not be covered under Medicaid other than when the pregnancy resulted from rape or incest, or in the case where a woman suffers from a physical disorder, injury or illness, including a life-endangering physical condition caused by or arising from the pregnancy, as certified by a physician that would place the woman in danger of death unless an abortion is performed.

Add

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Alternative Benefit Plan

☒ Other 1937 Covered Benefits that are not Essential Health Benefits — Collapse All ☐

Other 1937 Benefit Provided: Medical & surgical services furnished by a dentist

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: No limitations

Duration Limit: No limitaions

Scope Limit: Refer to the box below for "Scope Limit".

Other:

Scope Limit:
1. Medical and surgical services that will be covered must be related to the treatment of a medical condition such as acute pain, infection or fracture of the jaw and include examination of the oral cavity, required radiographs and complex oral surgical procedures.
2. Additional non-covered services may be covered as determined medically necessary by the department.

Other 1937 Benefit Provided: Other licensed practitioners - Optometrists' svc

Source: Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization: Authorization required in excess of limitation

Provider Qualifications: Medicaid State Plan

Amount Limit: One routine eye exams

Duration Limit: Every two years

Scope Limit: Refer to the box below for "Scope Limit".

Other:

Scope Limit:
1. Visit done more frequently may be prior authorized and covered when medically necessary. Emergency eye care shall be covered without prior authorization.
2. Approval required for contact lenses, subnormal visual aids costing more than $50.00 and to replace glasses or contacts within two years. Medical justification required for bifocal lenses.

Other 1937 Benefit Provided: Rural health clinic

Source: Section 1937 Coverage Option Benchmark Benefit Package

Authorization: Other

Provider Qualifications: Medicaid State Plan

Amount Limit: Refer below for "Amount Limit".

Duration Limit: Refer below for "Duration Limit".

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Alternative Benefit Plan

Scope Limit:

Refer below for "Scope Limit".

Remove

Other:

Amount, Duration and Scope Limit:
1. Rural health clinic services are congruent with the general scope and limitations to services of Hawaii's Medicaid program.
2. Rural health clinic services shall be delivered exclusively by the following health care professionals who are licensed by, and a resident of, the State of Hawaii:
a. Physician (Doctor of Medicine, Doctor of Osteopathy, Doctor of Dentistry, Doctor of Optometry and Doctor of Podiatry).
b. Physician Assistant.
c. Nurse Practitioner.
d. Nurse Midwife.
e. Visiting Nurse.
f. Clinical Social Worker.
g. Clinical Psychologist.
h. Licensed dietitian.

Other 1937 Benefit Provided:

Extended svs for pregnant women - Sixty day period

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitations

Duration Limit:

No limitations

Scope Limit:

Please refer below for "Scope Limit".

Other:

Scope Limit:
1. Pregnancy related and postpartum services for a sixty day period after the pregnancy ends and any remaining days in the month in which the 60th day fall.
2. Extended services to pregnant women includes all major categories of services as long as the services are determined to be medically necessary and related to the pregnancy.

Other 1937 Benefit Provided:

Transportation - Non-emergency

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitations

Duration Limit:

No limitations

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Alternative Benefit Plan

Scope Limit:

Taxi service to obtain medical services may be authorized by the payment worker if there is not bus system, no mean of transportation, etc.

Remove

Other:

Other 1937 Benefit Provided:

Extended svces for preg women - Med complication

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitations

Duration Limit:

No limitation

Scope Limit:

Extended services to pregnant women includes all major categories of services as long as the services are determined to be medically necessary and related to the pregnancy.

Other:

Other 1937 Benefit Provided:

Physician services - Routine Eye Exam (Adult)

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitations

Duration Limit:

No limitations

Scope Limit:

No limitations

Other:

Other 1937 Benefit Provided:

Nursing facility services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:
No limitations

Duration Limit:
No limitations

Remove

Scope Limit:
No limitations

Other:

Other 1937 Benefit Provided:
Case Management Services - Dual Diagnosis

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
No limitations

Duration Limit:
No limitations

Scope Limit:
Case management is to support, coordinate, link, monitor and review services and resources. Case management will assist eligible individuals under the plan in gaining access to needed medical, social, education and other services.

Other:
This target group is defined along three dimensions:
1. Diagnosis;
2. Level of disability which is likely to continue indefinitely;
3. Impaired role functioning which result in substantial functional limitations in three or more of the following areas of major life activity; self care, learning, mobility, self-direction, capacity for independent living, and economic sufficiency; and reflect the person's need for a combination and sequence of special, interdisciplinary or generic care, treatment, or other services which are of lifelong or of extended duration and are individually planned and coordinated.

Other 1937 Benefit Provided:
Case Management Services-DD/IID

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
No limitations

Duration Limit:
No limitations

Scope Limit:
Case management is to support, coordinate, link, monitor and review services and resources. Case management will assist eligible individuals under the plan in gaining access to needed medical, social, education and other services.

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Alternative Benefit Plan

Other:

Remove

Other 1937 Benefit Provided:
Case Management Services-Medically Fragile

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
No limitations

Duration Limit:
No limitations

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

Other:

Other 1937 Benefit Provided:
Intermediate care facility services for the IID

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
No limitations

Duration Limit:
No limitations

Scope Limit:
Authorization by the department's medical consultant for the recommended level of care required.

Other:

Other 1937 Benefit Provided:
Federally Qualified Health Center

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Other

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Refer below for "Amount Limit".

Duration Limit:
Refer below for "Duration Limit".

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Alternative Benefit Plan

Scope Limit:

Refer below for "Scope Limit".

Remove

Other:

Amount, Duration and Scope Limit:
1. Rural health clinic services are congruent with the general scope and limitations to services of Hawaii's Medicaid program.
2. Rural health clinic services shall be delivered exclusively by the following health care professionals who are licensed by, and a resident of, the State of Hawaii:
a. Physician (Doctor of Medicine, Doctor of Osteopathy, Doctor of Dentistry, Doctor of Optometry and Doctor of Podiatry).
b. Physician Assistant.
c. Nurse Practitioner.
d. Nurse Midwife.
e. Visiting Nurse.
f. Clinical Social Worker.
g. Clinical Psychologist.
h. Licensed dietitian.

Other 1937 Benefit Provided:

Family planning services and supplies

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitations

Duration Limit:

No limitations

Scope Limit:

Refer to the box below for "Scope Limit".

Other:

Scope Limit:
1. Hysterectomies are not covered when performed solely to render the person incapable of reproducing.
2. Sterilizations are not authorized for any person under age twenty-one years; institutionalized; or mentally incompetent. Informed consent shall be obtained prior to a sterilization procedure.

Other 1937 Benefit Provided:

Other licensed practitioners - Podiatry svcs

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

$100.00 per item

Duration Limit:

No limitations

Scope Limit:

No limitations

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Alternative Benefit Plan

Other:

Hospital inpatient services and appliances costing more than $100.00 require prior authorization by the department.

Remove

Other 1937 Benefit Provided:

Other licensed practitioners - Psychologists' svc

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Authorization required in excess of limitation

Provider Qualifications:

Medicaid State Plan

Amount Limit:

Refer to the box for "Amount Limit".

Duration Limit:

Refer to the box for "Duration Limit".

Scope Limit:

No limitations

Other:

Amount and Duration Limits:
Testing is limited to a maximum of four hours once every twelve months or to six hours every twelve months, if a comprehensive test is justified.

Other 1937 Benefit Provided:

Dental Services - Emergency Services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Other

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitations.

Duration Limit:

No limitations.

Scope Limit:

Emergency treatment shall include the following services:
1. Relief of dental pain.
2. Elimination of infections.
3. Treatment of acute injuries to the teeth supporting structures of the orofacial complex.

Other:

Other 1937 Benefit Provided:

Respiratory care services

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

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Alternative Benefit Plan

Amount Limit:
No limitations.

Duration Limit:
No limitations.

Remove

Scope Limit:
Prior authorization is required by the medical consultant for the provision of respiratory care services for ventilator-dependent individuals.

Other:

Other 1937 Benefit Provided:
Eyeglasses

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Authorization required in excess of limitation

Provider Qualifications:
Medicaid State Plan

Amount Limit:
One glasses or contacts

Duration Limit:
Every two years

Scope Limit:
Refer to the box below for "Scope Limit".

Other:
Scope Limit:
The following limitation apply:
1. Medical justification required for bifocal lenses.
2. Trifocal lenses are covered only for those currently wearing these lenses satisfactorily and for specific job requirements.
3. Bilateral plano glasses covered as safety glasses for person with one remaining eye.
4. Individuals with presbyopia who require no or minimal distance correction shall be fitted with ready made half glasses instead of bifocals.
5. Approval required when costing more than $50.00.

Other 1937 Benefit Provided:
Community Mental Health Rehab - Crisis Management

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
No limitations

Duration Limit:
No limitations

Scope Limit:
Refer below for "Scope Limit".

Other:
Scope Limit:

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1. Services will be available to recipients determined to need mental health and/or drug abuse/alcohol services.
2. Services must be recommended by a physician or other licensed practitioner to promote the maximum reduction and/or restoration of a recipient to his/her best possible functional level relevant to their diagnosis of mental illness and/or abuse of drugs/alcohol.
3. Services may be provided in the consumer's home or natural environment setting. Thus, crisis management services may be provided in the home, school, work environment or other community setting as well as in a health care setting.
4. Services are provided through JCAHO, CARF or COA accredited agencies.
5. Services must be provided by qualified mental health professionals.
6. Services provided by staff other than a qualified mental health professional, the must be supervised at a minimum by a qualified mental health professional.
7. Services will not be covered in an Institution for Mental Disease.

Other information:
1. Services provided must be part of the recipient's plan of care developed with the participation of a licensed psychiatrist or psychologist.

Remove

Other 1937 Benefit Provided:

Community Mental Health Rehab - Crisis Residential

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitations

Duration Limit:

No limitations

Scope Limit:

Refer below for "Scope Limit".

Other:

Scope Limit:
1. Services will be available to recipients determined to need mental health and/or drug abuse/alcohol services.
2. Services must be recommended by a physician or other licensed practitioner to promote the maximum reduction and/or restoration of a recipient to his/her best possible functional level relevant to their diagnosis of mental illness and/or abuse of drugs/alcohol.
3. Services are provided in a licensed residential program, licensed therapeutic group home or foster home setting.
4. Services do not include payment of room and board.
5. Services must be provided by qualified mental health professionals.
6. Services provided by staff other than a qualified mental health professional, the must be supervised at a minimum by a qualified mental health professional.
7. Services will not be covered in an Institution for Mental Disease (IMD).

Other information:
Services provided must be part of the recipient's plan of care developed with the participation of a licensed psychiatrist or psychologist.

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Other 1937 Benefit Provided:
Community Mental Health Rehab - Biopsychosocial

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
No limitations

Duration Limit:
No limitations

Scope Limit:
Refer below for "Scope Limit".

Other:

Scope Limit:
1. Services will be available to recipients determined to need mental health and/or drug abuse/alcohol services.
2. Services must be recommended by a physician or other licensed practitioner to promote the maximum reduction and/or restoration of a recipient to his/her best possible functional level relevant to their diagnosis of mental illness and/or abuse of drugs/alcohol.
3. Provider qualifications to provide these services are ensured by provider compliance with requirements and standards of a national accreditation organization (JCAHO, CARF or COA).
4. Services must be provided by qualified mental health professionals.
5. Services provided by staff other than a qualified mental health professional, the must be supervised at a minimum by a qualified mental health professional.
6. Services will not be covered in an Institution for Mental Disease.

Other information:
Services provided must be part of the recipient's plan of care developed with the participation of a licensed psychiatrist or psychologist.

Other 1937 Benefit Provided:
Community Mental Health Rehab - Intensive Family

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
No limitations

Duration Limit:
No limitations

Scope Limit:
Refer below for "Scope Limit".

Other:

Scope Limit:
1. Services will be available to recipients determined to need mental health and/or drug abuse/alcohol services.
2. Services must be recommended by a physician or other licensed practitioner to promote the maximum reduction and/or restoration of a recipient to his/her best possible functional level relevant to their diagnosis of mental illness and/or abuse of drugs/alcohol.

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3. Services are directed toward the identified individual within the family.
4. Services can be provided in-home, school or other natural environment.
5. Services are provided by a multidisciplinary team comprised of qualified mental health professionals.
6. Services provided by staff other than a qualified mental health professional, the must be supervised at a minimum by a qualified mental health professional.
7. Provider qualifications to provide these services are ensured by provider compliance with requirements and standards of a national accreditation organization (JCAHO, CARF or COA).
8. Services will not be covered in an Institution for Mental Disease.

Other information:
Services provided must be part of the recipient's plan of care developed with the participation of a licensed psychiatrist or psychologist.

Remove

Other 1937 Benefit Provided:

Community Mental Health Rehab - Therapeutic Living

Source:

Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitations

Duration Limit:

No limitations

Scope Limit:

Refer below for "Scope Limit".

Other:

Amount Limit:
1. Group living arrangements usually provide services for three to six individuals per home but not more than fifteen.
2. Therapeutic foster home provide services for a maximum of fifteen individuals per home.

Scope Limit:
1. Services will be available to recipients determined to need mental health and/or drug abuse/alcohol services.
2. Services must be recommended by a physician or other licensed practitioner to promote the maximum reduction and/or restoration of a recipient to his/her best possible functional level relevant to their diagnosis of mental illness and/or abuse of drugs/alcohol.
3. Only therapeutic services are covered.
4. No reimbursement of room and board charges.
5. Covered therapeutic supports are only available when the recipient resides in a licensed group living arrangement or licensed therapeutic foster home.
6. Recipients must be either a child with serious emotional or behavioral disturbance or the adult with a serious mental illness.
7. Service are provided in a licensed facility and provided by qualified mental health professionals or staff under the supervision of a qualified mental health professional with 24 hour on call covered by a licensed psychiatrist or psychologist.
8. Services will not be covered in an Institution for Mental Disease.

Other information:
1. Services provided must be part of the recipient's plan of care developed with the participation of a

licensed psychiatrist or psychologist.
2. Services provided under this benefit are covered in other settings.

Remove

Other 1937 Benefit Provided:
Community Mental Health Rehab - Intensive OP hosp

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Remove

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
Please refer below for "Amount Limit".

Duration Limit:
Please refer below for "Duration Limit".

Scope Limit:
Please refer below for "Scope Limit".

Other:

Amount and Duration Limits:
Services are available at least twenty hours per week.

Scope Limit:
1. Services will be available to recipients determined to need mental health and/or drug abuse/alcohol services.
2. Services must be recommended by a physician or other licensed practitioner to promote the maximum reduction and/or restoration of a recipient to his/her best possible functional level relevant to their diagnosis of mental illness and/or abuse of drugs/alcohol.
3. Provider qualifications to provide these services are ensured by provider compliance with requirements and standards of a national accreditation organization (JCAHO, CARF or COA).
4. Services must be provided by qualified mental health professionals.
5. Services provided by staff other than a qualified mental health professional, the must be supervised at a minimum by a qualified mental health professional.
6. Services must be provided in the outpatient are or clinic of a licensed JCAHO certified hospital or other licensed facility that is Medicare certified for coverage of partial hospitalization/day treatment.
7. These services area not provided to recipients in the inpatient hospital setting in and do not include acute inpatient hospital stays.

Other information:
Services provided must be part of the recipient's plan of care developed with the participation of a licensed psychiatrist or psychologist.

Other 1937 Benefit Provided:
Community Mental Health Rehab - Assertive Comm

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:
Prior Authorization

Provider Qualifications:
Medicaid State Plan

Amount Limit:
No limitations

Duration Limit:
No limitations

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Alternative Benefit Plan

Scope Limit:

Refer below for "Scope Limit".

Remove

Other:

Scope Limit:
1. Services will be available to recipients determined to need mental health and/or drug abuse/alcohol services.
2. Services must be recommended by a physician or other licensed practitioner to promote the maximum reduction and/or restoration of a recipient to his/her best possible functional level relevant to their diagnosis of mental illness and/or abuse of drugs/alcohol.
3. Provider qualifications to provide these services are ensured by provider compliance with requirements and standards of a national accreditation organization (JCAHO, CARF or COA).
4. Services must be provided by qualified mental health professionals.
5. Services provided by staff other than a qualified mental health professional, the must be supervised at a minimum by a qualified mental health professional.
6. Reimbursement for case management as a separate service is not allowed.
7. Reimbursement for biopsychosocial rehabilitation as a separate service is not allowed.
8. Services will not be covered in an Institution for Mental Disease.

Other information:
Services provided must be part of the recipient's plan of care developed with the participation of a licensed psychiatrist or psychologist.

Other 1937 Benefit Provided:

Community Mental Health Rehab - Peer support svcs

Source:
Section 1937 Coverage Option Benchmark Benefit Package

Authorization:

Prior Authorization

Provider Qualifications:

Medicaid State Plan

Amount Limit:

No limitations

Duration Limit:

No limitations

Scope Limit:

Refer below for "Scope Limit".

Other:

Scope Limit:
Peer support services may be provided by a peer specialist certified by the State Department of Health, Adult Mental Health Division (AMHD) as part of their Hawaii certified peer specialist program or a program that meets the criteria established by the AMHD.

Other information:
1. Peer support services are provided without limits on the number of visits when medically necessary; prior authorization is required, and monthly assessments are performed to ensure that benefits are medically necessary.
2. Peer support providers are self-identified consumers who are in recovery from mental illness and/or substance use disorders. Peer support providers meet the following minimum requirements for supervision, care coordination and training: 1) Supervision is provided by a mental health professional (as defined by the State); 2) Peer support services are coordinated within the context of a comprehensive, individualized plan of care that reflects the needs and preferences of the participant in achieving the specific,

individualized goals that have measurable results and are specified in the service plan; 3) Training and Credentialing: Peer support providers must complete training and certification as defined by the State. The peer must demonstrate the ability to support the recovery of others from mental illness and or substance use disorders. Peer support providers must complete ongoing continuing educational requirements.	Remove
	Add

Alternative Benefit Plan

☐ Additional Covered Benefits (This category of benefits is not applicable to the adult group under section 1902(a)(10)(A)(i)(VIII) of the Act.) Collapse All ☐

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130814

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Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L

OMB Expiration date: 10/31/2014

Benefits Assurances **ABP7**

EPSDT Assurances

If the target population includes persons under 21, please complete the following assurances regarding EPSDT. Otherwise, skip to the Prescription Drug Coverage Assurances below.

The alternative benefit plan includes beneficiaries under 21 years of age. Yes

☑ The state/territory assures that the notice to an individual includes a description of the method for ensuring access to EPSDT services (42 CFR 440.345).

☑ The state/territory assures EPSDT services will be provided to individuals under 21 years of age who are covered under the state/territory plan under section 1902(a)(10)(A) of the Act.

Indicate whether EPSDT services will be provided only through an Alternative Benefit Plan or whether the state/territory will provide additional benefits to ensure EPSDT services:

◉ Through an Alternative Benefit Plan.

○ Through an Alternative Benefit Plan with additional benefits to ensure EPSDT services as defined in 1905(r).

Other Information regarding how ESPDT benefits will be provided to participants under 21 years of age (optional):

Prescription Drug Coverage Assurances

☑ The state/territory assures that it meets the minimum requirements for prescription drug coverage in section 1937 of the Act and implementing regulations at 42 CFR 440.347. Coverage is at least the greater of one drug in each United States Pharmacopeia (USP) category and class or the same number of prescription drugs in each category and class as the base benchmark.

☑ The state/territory assures that procedures are in place to allow a beneficiary to request and gain access to clinically appropriate prescription drugs when not covered.

☑ The state/territory assures that when it pays for outpatient prescription drugs covered under an Alternative Benefit Plan, it meets the requirements of section 1927 of the Act and implementing regulations at 42 CFR 440.345, except for those requirements that are directly contrary to amount, duration and scope of coverage permitted under section 1937 of the Act.

☑ The state/territory assures that when conducting prior authorization of prescription drugs under an Alternative Benefit Plan, it complies with prior authorization program requirements in section 1927(d)(5) of the Act.

Other Benefit Assurances

☑ The state/territory assures that substituted benefits are actuarially equivalent to the benefits they replaced from the base benchmark plan, and that the state/territory has actuarial certification for substituted benefits available for CMS inspection if requested by CMS.

☑ The state/territory assures that individuals will have access to services in Rural Health Clinics (RHC) and Federally Qualified Health Centers (FQHC) as defined in subparagraphs (B) and (C) of section 1905(a)(2) of the Social Security Act.

☑ The state/territory assures that payment for RHC and FQHC services is made in accordance with the requirements of section 1902(bb) of the Social Security Act.

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Alternative Benefit Plan

- ☑ The state/territory assures that it will comply with the requirement of section 1937(b)(5) of the Act by providing, effective January 1, 2014, to all Alternative Benefit Plan participants at least Essential Health Benefits as described in section 1302(b) of the Patient Protection and Affordable Care Act.
- ☑ The state/territory assures that it will comply with the mental health and substance use disorder parity requirements of section 1937(b)(6) of the Act by ensuring that the financial requirements and treatment limitations applicable to mental health or substance use disorder benefits comply with the requirements of section 2705(a) of the Public Health Service Act in the same manner as such requirements apply to a group health plan.
- ☑ The state/territory assures that it will comply with section 1937(b)(7) of the Act by ensuring that benefits provided to Alternative Benefit Plan participants include, for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.
- ☑ The state/territory assures transportation (emergency and non-emergency) for individuals enrolled in an Alternative Benefit Plan in accordance with 42 CFR 431.53.
- ☑ The state/territory assures, in accordance with 45 CFR 156.115(a)(4) and 45 CFR 147.130, that it will provide as Essential Health Benefits a broad range of preventive services including: "A" and "B" services recommended by the United States Preventive Services Task Force; Advisory Committee for Immunization Practices (ACIP) recommended vaccines; preventive care and screening for infants, children and adults recommended by HRSA's Bright Futures program/project; and additional preventive services for women recommended by the Institute of Medicine (IOM).

PRA Disclosure Statement

V.20130807

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Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L

Service Delivery Systems **ABP8**

Provide detail on the type of delivery system(s) the state/territory will use for the Alternative Benefit Plan's benchmark benefit package or benchmark-equivalent benefit package, including any variation by the participants' geographic area.

Type of service delivery system(s) the state/territory will use for this Alternative Benefit Plan(s).

Select one or more service delivery systems:

☒ Managed care.

- ☒ Managed Care Organizations (MCO).
- ☐ Prepaid Inpatient Health Plans (PIHP).
- ☐ Prepaid Ambulatory Health Plans (PAHP).
- ☐ Primary Care Case Management (PCCM).

☒ Fee-for-service.

☐ Other service delivery system.

Managed Care Options

Managed Care Assurance

☑ The state/territory certifies that it will comply with all applicable Medicaid laws and regulations, including but not limited to sections 1903(m), 1905(t), and 1932 of the Act and 42 CFR Part 438, in providing managed care services through this Alternative Benefit Plan. This includes the requirement for CMS approval of contracts and rates pursuant to 42 CFR 438.6.

Managed Care Implementation

Please describe the implementation plan for the Alternative Benefit Plan under managed care including member, stakeholder, and provider outreach efforts.

No separate implementation plan will be required for the initiation of ABP under managed care as it will be subsumed under member, provider and other stakeholder outreach efforts.

MCO: Managed Care Organization

The managed care delivery system is the same as an already approved managed care program. Yes

The managed care program is operating under (select one):

- ○ Section 1915(a) voluntary managed care program.
- ○ Section 1915(b) managed care waiver.
- ○ Section 1932(a) mandatory managed care state plan amendment.
- ◉ Section 1115 demonstration.
- ○ Section 1937 Alternative (Benchmark) Benefit Plan state plan amendment.

Identify the date the managed care program was approved by CMS: Sep 24, 2013

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Alternative Benefit Plan

Describe program below:

QUEST Integration is a continuation and expansion of the state's ongoing demonstration, which is funded through Title XIX, Title XXI and the state. QUEST Integration used capitated managed care as a delivery system. QUEST Integration provides Medicaid State Plan benefits and additional benefits (including institutional and home and community-based long-term services and supports) based on medical necessity and clinical criteria to beneficiaries eligible under the state plan and to the demonstration populations. During the period between approval and implementation of the QUEST Integration managed care contract the state will continue operations under its QUEST and QExA programs.

Additional Information: MCO (Optional)

Provide any additional details regarding this service delivery system (optional):

Fee-For-Service Options

Indicate whether the state/territory offers traditional fee-for-service and/or services managed under an administrative services organization:

(•) Traditional state-managed fee-for-service

( ) Services managed under an administrative services organization (ASO) arrangement

Please describe this fee-for-service delivery system, including any bundled payment arrangements, pay for performance, fee-for-service care management models/non-risk, contractual incentives as well as the population served via this delivery system.

The fee-for-service program is a component within the state medical assistance program which reimburses providers for medical services.

An individual eligible for fee-for-service coverage under the medical assistance program includes:

(1) A child in receipt of foster care, kinship guardianship or adoption assistance, under age twenty-one who is a resident of the State, and placed in another state;
(2) A non-citizen ineligible for Medicaid assistance who receives emergency medical services;
(3) An individual who enters the State of Hawaii Organ and Tissue Transplant (SHOTT) program;
(4) An incarcerated individual who is admitted as an inpatient in a medical institution not on the grounds of the incarceration facility;
(5) An individual who receives a determination of eligibility on or after the start date of a new health plan contract period that is retroactive to a date prior to the start of the new health plan contract period with incurred services during the period from the effective date of coverage up to the start date of the new health plan contract period; or
(6) A medically needy individual who is not aged, blind or disabled.

Furthermore, while enrolled in a participating health plan, an individual is excluded from the fee-for-service program, except for the following additional services that may be provided on a fee-for-service basis, subject to approval by the department:
(1) ICF-ID institutional services;
(2) School-based health related services;
(3) Early intervention program services;
(4) Specialized behavioral health services;
(5) Abortion services under the Hyde amendment; and
(6) Dental services.

Additional Information: Fee-For-Service (Optional)

Provide any additional details regarding this service delivery system (optional):

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Alternative Benefit Plan

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V.20130718

Alternative Benefit Plan

OMB Control Number: 0938-1148
OMB Expiration date: 10/31/2014

Attachment 3.1-L

Employer Sponsored Insurance and Payment of Premiums	ABP9
The state/territory provides the Alternative Benefit Plan through the payment of employer sponsored insurance for participants with such coverage, with additional benefits and services provided through a Benchmark or Benchmark-Equivalent Benefit Package.	No
The state/territory otherwise provides for payment of premiums.	No

Other Information Regarding Employer Sponsored Insurance or Payment of Premiums:

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

APR 15 2014

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L

OMB Expiration date: 10/31/2014

General Assurances ABP 10

Economy and Efficiency of Plans

☑ The state/territory assures that Alternative Benefit Plan coverage is provided in accordance with Federal upper payment limit requirements and other economy and efficiency principles that would otherwise be applicable to the services or delivery system through which the coverage and benefits are obtained.

Economy and efficiency will be achieved using the same approach as used for Medicaid state plan services. Yes

Compliance with the Law

☑ The state/territory will continue to comply with all other provisions of the Social Security Act in the administration of the state/territory plan under this title.

☑ The state/territory assures that Alternative Benefit Plan benefits designs shall conform to the non-discrimination requirements at 42 CFR 430.2 and 42 CFR 440.347(e).

☑ The state/territory assures that all providers of Alternative Benefit Plan benefits shall meet the provider qualification requirements of the Base Benchmark Plan and/or the Medicaid state plan.

PRA Disclosure Statement

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V.20130807

APR 15 2014

Alternative Benefit Plan

OMB Control Number: 0938-1148

Attachment 3.1-L

OMB Expiration date: 10/31/2014

Payment Methodology **ABP11**

Alternative Benefit Plans - Payment Methodologies

☑ The state/territory provides assurance that, for each benefit provided under an Alternative Benefit Plan that is not provided through managed care, it will use the payment methodology in its approved state plan or hereby submits state plan amendment Attachment 4.19a, 4.19b or 4.19d, as appropriate, describing the payment methodology for the benefit.

An attachment is submitted.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 5 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

V.20130807

APR 15 2014

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: HAWAII

COORDINATION OF TITLE XIX WITH PART B OF TITLE XVIII

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

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

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

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

   / / Yes / / No

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

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

   / / Yes / / No

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

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

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

All groups specified above.

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

State: Hawaii

COORDINATION OF TITLE XIX WITH WIC

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

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

Dear

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

To obtain more information about the WIC program, call:

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

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

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

2. The information and referral notice is sent to all newly approved medicaid recipients involving pregnant women and situations involving children under age five. Breastfeeding or postpartum women would be included.

3. The information and referral notice is sent, no less than annually to all AFDC and medically needy AFDC-related cases, including the poverty level cases involving women and children. This is handled by HAWI.