HAWAII ADMINISTRATIVE RULES

TITLE 17

DEPARTMENT OF HUMAN SERVICES

SUBTITLE 12

MED-QUEST DIVISION

CHAPTER 1720

BENEFITS PACKAGE

Subchapter 6 Institutional Care Services

§17-1720-22 Institutional Care Services
§§17-1720-23 to 17-1720-25 (Reserved)

Subchapter 7 Dental Services

§17-1720-26 Dental Services
§§17-1720-27 to 17-1720-30 (Reserved)

Subchapter 8 Exclusions and limitations

§17-1720-31 Exclusions and limitations
§§17-1720-32 to 17-1720-34 (Reserved)

Historical Note: This chapter is based substantially upon repealed subchapter 7 of chapter 17-1721.1 and repealed subchapter 8 of chapter 17-1727.

The source note for subchapter 7 of chapter 17-1721.1 is: [Eff 01/31/09; am 06/25/12; R 09/30/13]

The source note for subchapter 8 of chapter 17-1727 is: [Eff 08/01/94; am 01/29/96; am 03/30/96; am 11/25/96; am 06/19/00; am 02/16/02; am 01/31/09; am 09/10/09; am 06/25/12; am 04/12/13; R 09/30/13]

SUBCHAPTER 1

GENERAL PROVISIONS

§17-1720-1 Purpose. This chapter describes covered services, exclusions and limitations provided to an enrollee by a participating health plan. [Eff 09/30/13; am and comp NOV 10 2016] (Auth: HRS §346-14; 42 C.F.R. §§430.25, 438.6, 440.210) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 438.6, 440.210)

§§17-1720-2 to 17-1720-4 (Reserved).

SUBCHAPTER 2

SCOPE AND CONTENT OF SERVICES

§17-1720-5 Purpose. This subchapter describes covered services provided by a participating health plan to an enrollee. [Eff 09/30/13; am and comp] (Auth: HRS §346-14; 42 C.F.R. §§430.25, 438.6, 440.210) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 438.6, 440.210)

§17-1720-6 Covered services. (a) The services minimally required to be provided by each participating health plan are described in section 17-1720-10 and shall be known as the standard benefits package.

(b) The standard benefits package is based on a twelve-month benefit period. Service limits are pro-rated for any benefit period less than twelve-months. If an enrollee changes health plans during a benefit period, the remaining unused service limits will be covered by the new health plan for the duration of the benefit period.

(c) Based on clinical eligibility and medical necessity, a participating health plan may provide services described in section 17-1720-14 to an enrollee.

(d) Based on level of care eligibility, the enrollee shall be provided services described in sections 17-1720-18 or 17-1720-22 by the health plan.

(e) A health plan may, at the health plan's option, or as otherwise required by the contract between the health plan and the department, or the state plan, provide medically necessary services which exceed the requirements of the standard benefits package. [Eff 09/30/13; am and comp NOV 10 2016] (Auth: HRS §346-14; 42 C.F.R. §§430.25, 438.6, 440.210) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 438.6, 440.210)

§§17-1720-7 to 17-1720-9 (Reserved).

SUBCHAPTER 3

STANDARD BENEFITS PACKAGE

§17-1720-10 Standard benefits package. Within a twelve-month benefit period, participating health plans shall provide the following medically necessary services which minimally include, but are not limited to, the following and which may require prior authorization and be subject to limitations as described in chapter 17-1737:

(1) Medical inpatient days for medically necessary inpatient hospital care related to medical care, surgery, post-stabilization, acute rehabilitation and behavioral health inpatient days for psychiatric care include, but are not limited to, the following:
   (A) Semi-private room and board and general nursing care for inpatient stays related to medical care, surgery, and psychiatric care;
   (B) Intensive care room and board and general nursing care for medical care and surgery;
   (C) Use of an operating room and related facilities, inpatient anesthesia, radiology, laboratory and other diagnostic services agreed upon by the plan medical director for medical care and surgery;
   (D) Drugs, dressings, blood derivatives and their administration, general medical supplies, and diagnostic and therapeutic procedures as prescribed by the attending physician; and

(E) Other ancillary services associated with hospital care except private duty nursing.

(2) Outpatient services include, but are not limited to, the following:

(A) Ambulatory surgical center procedures or outpatient hospital services;

(B) Behavioral health services;

(C) Bona fide emergency services, coverage shall be provided for bona fide emergency services including ground and air (fixed wing and rotor) ambulance for emergency transportation, emergency room services, and physician services in conjunction with the emergency room visits. Bona fide emergency room visits shall be restricted to those requiring services for emergency medical conditions;

(D) Diagnostic testing, including laboratory and radiology;

(E) Dialysis;

(F) Durable medical equipment including visual appliances, prosthetic devices, orthotics and medical supplies;

(G) Early and Periodic Screening, Diagnosis and Treatment services as described in chapters 17-1715 and 17-1715.1, for an enrollee under age twenty-one years who requires services that have either been exhausted or not described under section 17-1720-10;

(H) Family planning services to include family planning services rendered by a physician or nurse midwife, and family planning drugs, supplies and devices approved by the federal Food and Drug Administration;

(I) Habilitation services;

(J) Home health services;

(K) Hospice services;

(L)
(M) Pregnancy related, maternity and newborn care services;
(N) Medical services related to dental needs;
(O) Methadone management;
(P) Non-emergency transportation;
(P) Prescription or over-the-counter drugs with a prescription limited by a strict formulary and defined in the contract negotiated between the health plan and the department;
(Q) Other practitioner services;
(R) Out-of-State services;
(S) Physician services;
(T) Podiatry services;
(U) Preventative services;
(V) Rehabilitation services including physical, occupational, speech, and cognitive rehabilitation therapy;
(W) Sterilization services;
(X) Smoking cessation services;
(Y) Substance abuse treatment services;
(Z) Urgent care services;
(AA) Vaccinations; and
(BB) Vision and hearing services. [Eff 09/30/13; am and comp NOV 10 2016] (Auth: HRS §346-14; 42 C.F.R. §§430.25, 438.6, 440.210) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 438.6, 440.210)

§§17-1720-11 to 17-1720-13 (Reserved)

SUBCHAPTER 4

SPECIALIZED BEHAVIORIAL HEALTH SERVICES

§17-1720-14 Specialized behavioral health services. (a) In addition to services included in the standard benefits package under section 17-1720-10 and

based on clinical eligibility and medical necessity, the following specialized behavioral health services may be provided for an enrollee with a severe and persistent mental illness, serious mental illness, or requiring support for emotional and behavioral development:

(1) Biopsychosocial rehabilitation;
(2) Clubhouse;
(3) Community based residential programs;
(4) Crisis management;
(5) Crisis residential services;
(6) Financial management;
(7) Hospital-based residential services;
(8) Intensive case management;
(9) Intensive family intervention;
(10) Intensive outpatient hospital services;
(11) Peer Specialist;
(12) Substance abuse treatment provided by a licensed or a certified substance abuse counselor;
(13) Supportive employment;
(14) Supported housing; and
(15) Therapeutic living supports and therapeutic foster care supports.

(b) An enrollee who is age eighteen years or older and certified by an independent clinical evaluator as diagnosed with severe and persistent mental illness or serious mental illness shall receive behavioral health services through the adult mental health division within the department of health, the health plan in which the enrollee is enrolled or community care services program as determined by the department.

(c) An enrollee who is three to twenty years of age, and who is diagnosed with a severe emotional or behavioral disorder by an independent clinical evaluator, shall be referred to the child and adolescent mental health division within the department of health for behavioral health services. [Eff 09/30/13; am and comp NOV 10 2016] (Auth: HRS §346-14; 42 C.F.R. §430.25) (Imp: HRS §346-14; 42 C.F.R. §430.25

§§17-1720-15 to 17-1720-17 (Reserved).

SUBCHAPTER 5

HOME AND COMMUNITY BASED SERVICES

§17-1720-18 Home and Community Based Services (HCBS). (a) The participating health plan is not required to provide HCBS to an enrollee if:

(1) The enrollee chooses institutional services;

(2) The enrollee cannot be served safely in the community;

(3) There are no adequate or appropriate providers for needed services; or

(4) The cost of providing services in the home or community setting is expected to exceed the cost of providing care in an institution.

(b) The health plan must receive prior approval from the department or its designee prior to disapproving a request for HCBS.

(c) An enrollee must meet one of the following level of care criteria to receive home and community based services:

(1) At risk of deteriorating to institutional level of care; or

(2) At institutional level of care.

(d) The health plan shall provide HCBS services which minimally include, but are not limited to, the following and may require prior authorization:

(1) Adult day care services provided by a licensed facility maintained and operated by an enrollee, organization, or agency for the purpose of providing regular supportive care to four or more disabled adult participants, with or without charging a fee. Adult day care services include therapeutic, social, educational, recreational, and other activities. Adult day care staff members may not perform healthcare related services such as medication administration, tube

feedings, and other activities which require healthcare related training;

(2) Adult day health services provided by an organized program of therapeutic, social and health activities and services provided to enrollees with functional impairments, for the purpose of restoring or maintaining the enrollee's optimal capacity for self-care. Adult day health facilities are licensed in accordance with chapter 11-96 and subchapter 2 of chapter 11-94.1;

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

(4) Personal assistance services - Level I are provided to enrollees requiring assistance with instrumental activities of daily living in order to prevent a decline in the health status and maintain enrollees safely in their home and communities. These services are primarily companion or home maker/chore services. The services are for the Medicaid beneficiary, not for other members of the household;

(5) Personal assistance services - Level II are provided to enrollees requiring assistance with moderate/substantial to total assistance to perform activities of daily living and health maintenance activities.

(6) Personal emergency response system that is an electronic system placed in homes of high risk enrollees who live alone or are alone

significant parts of the day, have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision, to enable them to secure immediate help in the event of a physical, emotional, or environmental emergency; and

(7) Skilled nursing services are provided to enrollees requiring ongoing nursing care (in contrast to home health or part time, intermittent skilled nursing services). The service is provided by licensed nurses as described in chapter 16-89.

(e) The health plan shall provide the following services which minimally include, but are not limited to, the following and require prior authorization:

(1) The services included in subsection (d);

(2) Assisted living services that include personal care and supportive care services (such as homemaker services, chore services, attendant services, and meal preparation) that are furnished to enrollees who reside in an assisted living facility. Payment for room and board is prohibited;

(3) Community care foster family home services provided in a home that is certified by the department to provide, for a fee, twenty-four hour living accommodations, including personal care, supportive services (such as homemaker services, chore services and attendant care and companion services) and medication oversight (to the extent permitted under State law). Services shall be provided in a certified private home by a principal care provider who lives in the home for not more than three adults at any one time, at least two of whom shall be Medicaid recipients, and all of whom are at nursing facility level of care, are unrelated to the foster family, and are being monitored in the home by a licensed community case management agency. It does

not include expanded adult residential care homes and assisted living facilities, which shall continue to be licensed by the department of health;

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

(5) Counseling and training services that involve counseling for the enrollee, family or caregiver, and professional and paraprofessional caregivers to provide the necessary support to build and enhance coping skills, as well as training that may include, but not limited to, enrollee care training for enrollees, family and caregivers regarding the nature of the disease and the disease process; methods of transmission and infection control measures; biological, psychological care and special treatment needs-regimens; employer training for consumer directed services; instruction

about the treatment regimens; use of equipment specified in the service plan; employer skills updates as necessary to safely maintain the enrollee at home; crisis intervention; supportive counseling; family therapy; suicide risk assessments and intervention; death and dying counseling; anticipatory grief counseling; substance abuse counseling; and nutritional assessment and counseling;

(6) Environmental accessibility adaptations that are changes to the enrollee's living environment, but not including community care foster family homes and expanded adult residential care homes (E-ARCH), to promote safety or facilitate the enrollee's self-reliance by enabling the enrollee to perform basic activities of daily living. Modifications may include installation of ramps and handrails, widening of doorways, removal of other architectural barriers, bathroom modifications, electrical, plumbing or air conditioners and modifications to the telephone system which enable the enrollee to function with greater independence in the home, and without which the enrollee would require institutionalization. Window air conditioners may be installed when it is necessary for the health and safety of the enrollee. Excluded are those adaptations or improvements to the home that are of general utility, and are not direct medical or remedial services to the enrollee, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from these services. All services shall be provided in accordance with applicable State or local building codes;

(7) Home maintenance that is a service necessary to maintain a safe, clean and sanitary environment. Home maintenance services are

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

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

(9) Non-medical transportation that is the necessary transportation provided to and from facilities, resources, and appointments in order for the enrollee to receive the services included in the plan of care;

(10) Residential care services are personal care services, homemaker, chore, attendant care and companion services, and medication oversight (to the extent permitted by law)

provided in a licensed private home by a principle care provider who lives in the home. Residential care is furnished in a:

(A) Type I Expanded Adult Residential Care Home (EARCH), allowing not more than five residents provided that up to six residents may be allowed at the discretion of the department to live in a Type I home with not more than two of whom may be at a nursing facility level of care (NF LOC); or

(B) Type II EARCH, allowing six or more residents, no more than twenty percent of the home's licensed capacity may be enrollees meeting a NF LOC who receive these services in conjunction with residing in the home;

(11) Respite care services are provided to enrollees unable to care for themselves and are furnished on a short-term basis because of the absence of or need for relief for those persons normally providing the care. Respite may be provided at three (3) different levels: hourly, daily, and overnight; and

(12) Specialized medical equipment and supplies, including the purchase, rental, lease, warranty costs, installation, repairs and removal of devices, controls, or appliances, specified in a plan of care, that enable an enrollee to increase or maintain their abilities to perform activities of daily living, or to perceive, control, participate in, or communicate with the environment in which they live. [Eff 09/30/13; am and comp NOV 10 2016] (Auth: HRS §346-14; 42 C.F.R. §430.25) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§§17-1720-19 to 17-1720-21 (Reserved).

SUBCHAPTER 6

INSTITUTIONAL CARE SERVICES

§17-1720-22 Institutional care services. (a) Institutional care services are provided in a licensed nursing facility to an enrollee who is referred by a physician and may require prior authorization.

(b) Institutional care services shall be provided either directly by or under the general supervision of a licensed practical nurse or registered professional nurse.

(c) Institutional care services shall minimally include, but are not limited to:

(1) Activities of the enrollee's choice (including religious activities) that are designed to provide normal pursuits for physical and psychosocial well-being;

(2) Administration of medication and treatment;

(3) Basic nursing and treatment supplies include, but are not limited to: soap, skin lotion, alcohol, powder, applicators, tongue depressors, cotton ball, gauzes, adhesive tape, bandages, incontinent pads, V-pads, thermometers, blood pressure apparatus, plastic or rubber sheets, enema equipment, and douche equipment;

(4) Development, management, and evaluation of the written care plan based on physician orders that necessitate the involvement of skilled technical or professional personnel to meet the enrollee's care needs, promote recovery, and ensure the enrollee's health and safety;

(5) Durable medical equipment and supplies used but which are reusable include, but are not limited to: ice bag, hot water bottle, urinal, bedpan, commode, cane, crutch, walker, wheelchair, and side rail and traction equipment;

(6) Health education services provided by skilled technical or professional personnel to teach the enrollee self care, such as

gait training and self-administration of medications;

(7) Laundry service for items of enrollee's washable personal clothing;

(8) Nonrestorative or nonrehabilitative therapy, or both, provided by nursing staff;

(9) Observation and assessment of the enrollee's unstable condition that requires the skills and knowledge of skilled technical or professional personnel to identify and evaluate the enrollee's need for possible medical intervention, modification of treatment, or both, to stabilize the enrollee's condition;

(10) Review of the drug regimen of each institutionalized enrollee at least once a month by a licensed pharmacist, as required for a nursing facility to participate in Medicaid;

(11) Therapeutic diet and dietary supplements as ordered by the attending physician;

(12) Social services provided by qualified personnel;

(13) Room and board;

(14) Provision of and payment for, through contractual agreements with appropriate skilled technical or professional personnel, other medical and remedial services ordered by the attending physician which are not regularly provided by the provider. Other services that may be needed, such as transportation to realize the provision of services ordered by the attending physician, shall also be arranged through contractual agreements. The contractual agreement shall stipulate the responsibilities, functions, objectives, service fee, and other terms agreed to by the NF and the person or entity that contracts to provide the service; and

(15) Feeding assistance performed by a feeding assistant, nurse aide, or nurse. The feeding assistant must work under the supervision of a registered nurse or licensed practical nurse that is licensed to practice in Hawaii. [Eff 09/30/13; am and comp NOV 10 2016] (Auth: HRS §346-14; Pub. L. No. 100-203; 42 C.F.R. §§434.10, 440.40, 440.150, 483.1, 483.20) (Imp: Pub.

L. No. 100-203; 42 C.F.R. §§434.10, 440.40, 440.150, 483.1, 483.20)

§§17-1720-23 to 17-1720-25 (Reserved).

SUBCHAPTER 7

DENTAL SERVICES

§17-1720-26 Dental Services. (a) Required preventive dental services and medically necessary dental services shall only be provided on a fee-for-service basis under section 17-1737-75.

(b) The health plans shall coordinate with the department or its designee to refer an eligible individual to the department's dental third party administrator for non-medically related dental services. [Eff 09/30/13; am and comp NOV 10 2016] (Auth: HRS §346-14; 42 C.F.R. §430.25) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§§17-1720-27 to 17-1720-30 (Reserved).

SUBCHAPTER 8

EXCLUSIONS AND LIMITATIONS

§17-1720-31 Exclusions and limitations. A participating health plan shall not provide coverage for certain services, procedures, medications, supplies, equipment, or other items that are:

(1) Specifically excluded from coverage by State or federal requirements;
(2) Provided by providers not licensed or certified in the State to perform the service;
(3) Available without charge to the general public through a separate state or federally administered federally-funded program;

(4) Covered by a third party medical or liability insurance, including Medicare;
(5) Required to receive prior authorization but did not receive it;
(6) Experimental in nature and have not been approved by the United States Food and Drug Administration, or both;
(7) Elective and do not improve outcomes such as decreasing risk of morbidity or mortality;
(8) Without sufficient evidence of effectiveness or net benefits as determined by the department and not covered under the currently approved Medicaid State Plan, Medicaid waivers, or both;
(9) Comparatively effective to a tolerated lower cost alternative; or
(10) Otherwise determined by the department to be non-covered, excluded, or limited.

[Eff 09/30/13; am and comp NOV 10 2016]
(Auth: HRS §346-14; 42 C.F.R. §438.210)
(Imp: HRS §346-14; 42 C.F.R. §438.210)

§§17-1720-32 to 17-1720-34 (Reserved).