Table of Contents

State/Territory Name: Hawaii

State Plan Amendment (SPA) #: 11-007

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES Centers for Medicare & Medicaid Services

Region IX
Division of Medicaid & Children's Health Operations
90 Seventh Street, Suite 5-300 (5W)
San Francisco, CA 94103-6706

FEB 17 2012

Patricia McManaman
Director, Department of Human Services
P.O. Box 339
Honolulu, HI 96809-0339

Dear Ms. McManaman:

I am writing to inform you that Hawaii's State Plan Amendment (SPA) No. 11-007 has been approved. Following a request for additional information, this SPA was re-submitted to my office on November 23, 2011, and proposes amendments to Hawaii's approved Title XIX State Plan to eliminate certain optional services for Hawaii's QUEST beneficiaries, as well as to impose an inpatient service limitation on this population. All of HI 11-007's proposed service reductions and limitations remain in compliance with Section 1905(a) of the Social Security Act, as well as 42 CFR Part 440.

The approval is effective July 1, 2012 as requested. Attached are copies of the new State Plan pages to be incorporated within your approved State plan.

Changes are reflected in the following sections of your approved State plan:

- Section 3, page 19c and 20c
- Attachment 3.1-A, pages 1, 7 and 11
- Attachment 3.1-B, pages 2, 6 and 10
- Supplement to Attachment 3.1-A and 3.1-B, pages 1-1.2, 1.7, 2-2.1, 3.a., 3.1, 3.4-3.5, 4-5
- Supplement 3 to Attachment 3.1-A and 3.1-B, pages 1-6

If you have any questions, please contact Tom Schenck at (415) 744-3589, or tom.schenck@cms.hhs.gov.

Sincerely,

[redacted]

Gloria Nagle, Ph.D., MPA
Associate Regional Administrator
Division of Medicaid & Children's Health Operations

cc: Kenneth Fink, Med-QUEST Administrator
Mary Rydell, CMS Pacific Area Representative

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 11-007

2. STATE: HAWAII

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) MEDICAL ASSISTANCE

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
~~January~~ 1, 2012 (tws)
July

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
Section 1905(a) of the Social Security Act
42 CFR Part 440

7. FEDERAL BUDGET IMPACT: (tws)
FFY 2012 (2nd, 3rd and 4th quarter): ~~($15,187,114)~~ ($944,919)
FFY 2013: ~~($20,249,485)~~ ($2,834,756)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Section 3, Page 19c and 20c (tws)
Attachment 3.1-A, pages ~~1, 3a to 7 and 11~~ 1, 7, 11
Attachment 3.1-B, pages ~~2, 3 to 6 and page 10~~ 2, 6, 10
~~Supplement 1 to Attachment 3.1-A and 3.1-B, page 1~~
Supplement to Attachment 3.1-A and 3.1-B, pages ~~1.a to 1.1, 1.7, 2, 2.1, 3.1, 3.4 to 4~~ 1-1.2, 1.7, 2-2.1, 3.a., 3.1, 3.4-3.5, 4-5
Supplement 3 to Attachment 3.1-A and 3.1-B, pages 1 to ~~7~~ 6

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
(tws)
Attachment 3.1-A, pages ~~1, 3a to 7 and 11~~ 1, 7, 11
Attachment 3.1-B, pages ~~2, 3 to 6 and page 10~~ 2, 6, 10
Supplement to Attachment 3.1-A and 3.1-B, pages ~~1.1, 1.7, 2, 2.1, 3.1, 3.4 to 4~~ 1-1.2, 1.7, 2-2.1, 3.a., 3.1, 3.4-3.5, 4-5
section 3: Page 19c & 20c
Supplement 3 to Attachment 3.1-A & 3.1-B, Pages 1-7

10. SUBJECT OF AMENDMENT:
The amendment will facilitate preparation for expansion under the Patient Protection and Affordable Care Act, P.L. 111-148 and remediates the State's projected substantial Medicaid general fund shortfall.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED: AS APPROVED BY GOVERNOR

12. SIGNATURE OF STATE AGENCY OFFICIAL:
[redacted]

13. TYPED NAME:
PATRICIA MCMANAMAN

14. TITLE:
DIRECTOR

15. DATE SUBMITTED:
JUN 30 2011

16. RETURN TO:
Med-QUEST Division
Program & Policy Development Office
P. O. Box 700190
Kapolei, Hawaii 96709-0190

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: July 7, 2011

18. DATE APPROVED: FEB 17 2012

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
July 1, 2012

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Gloria Nagle, Ph.D., MPA

22. TITLE: Associate Regional Administrator

23. REMARKS:
Pen and Ink Changes, boxes 4, 7, 8 and 9

FORM HCFA-179 (07-92)

State of Hawaii

Citation 3.1(a)(1) Amount, Duration, and Scope of Services: Categorically Needy (Continued)

1905(a)(26) and 1934

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

ATTACHMENT 3.1-A identifies the medical and remedial services provided to the categorically needy. (Note: Other programs to be offered to Categorically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Categorically Needy beneficiaries would also list the additional coverage – that is in excess of established service limits – for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

State of Hawaii

Citation 3.1(a)(1) Amount, Duration, and Scope of Services: Medically Needy (Continued)

1905(a)(26) and 1934

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

ATTACHMENT 3.1-B identifies services provided to each covered group of the medically needy. (Note: Other programs to be offered to Medically Needy beneficiaries would specify all limitations on the amount, duration and scope of those services. As PACE provides services to the frail elderly population without such limitation, this is not applicable for this program. In addition, other programs to be offered to Medically Needy beneficiaries would also list the additional coverage – that is in excess of established service limits – for pregnancy-related services for conditions that may complicate the pregnancy. As PACE is for the frail elderly population, this also is not applicable for this program.)

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*

*Description provided on attachment

State: Hawaii

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

14. 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.

15. 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: 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/Territory: 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): _____

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: Hawaii

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

Amount, Duration, and Scope of Medical and Remedial Care Services Provided To the Medically 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 service.

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

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. Inpatient services days are limited to:

   a. 30 inpatient days per benefit period for medical and/or surgical care; and,
   b. An additional 30 days per benefit year for inpatient behavioral health care.

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 dieticians

3. Laboratory and imaging services will be allowed when associated with a covered visit. 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. Service limitations do not apply to services received under EPSDT.

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;

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

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).

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. Optometrists' services are authorized only when provided under EPSDT and are subject to the following limitations:

1) Approval required for contact lenses, subnormal visual aids costing more than $50.00 and to replace glasses or contacts within 2 years. 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.

Eyeglasses are authorized only when provided under EPSDT.

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 c. 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.

7d. Physical and occupational therapy and services for speech, hearing and language disorders are authorized only when provided under EPSDT.

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. Clinical services, same limitations as #2 above.

(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. 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 and will follow all applicable Medicare guidelines, restrictions and limitations. 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.

These services are authorized only when provided under EPSDT.

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.

Prosthetic devices are authorized only when provided under EPSDT.

12d. Same as 6b.

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

- Psychological testing
- Neuropsychological testing
- Standardized Cognitive testing

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.

Individuals who are mentally retarded (MR) or developmentally delayed (DD) are not eligible for these services, including MR/DD individuals who are in Home & Community Based Waiver programs.

These services are to be provided by the following qualified mental health professionals: licensed psychiatrist, licensed psychologist, licensed clinical social worker (CSW) with

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.

State of HAWAII

I. Eligibility

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

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

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

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

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

Regular Post Eligibility

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

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

1. Allowances for the needs of the:

(A.) Individual (check one)

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

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

2. ___ The following dollar amount: $ _____
Note: If this amount changes, this item will be revised.
3. ___ The following formula is used to determine the needs allowance:

_____
_____

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

(B.) Spouse only (check one):

1. ___ SSI Standard
2. ___ Optional State Supplement Standard
3. ___ Medically Needy Income Standard
4. ___ The following dollar amount: $ _____
Note: If this amount changes, this item will be revised.
5. ___ The following percentage of the following standard that is not greater than the standards above: _____ % of _____ standard.
6. ___ The amount is determined using the following formula:

_____
_____

7. ___ Not applicable (N/A)

(C.) Family (check one):

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

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

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

_____

_____

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

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

Regular Post Eligibility

2. ___ 209(b) State, a State that is using more restrictive eligibility requirements than SSI. The State is using the post-eligibility rules at 42 CFR 435.735. Payment for PACE services is reduced by the amount remaining after deducting the following amounts from the PACE enrollee's income.

(a) **42 CFR 435.735** -- States using more restrictive requirements than SSI.

1. Allowances for the needs of the:
(A.) Individual (check one)
1. ___ The following standard included under the State plan (check one):
(a) ___ SSI
(b) ___ Medically Needy
(c) ___ The special income level for the institutionalized
(d) ___ Percent of the Federal Poverty Level ____%
(e) ___ Other (specify):
2. ___ The following dollar amount: $ _____
Note: If this amount changes, this item will be revised.
3. ___ The following formula is used to determine the needs allowance:

_____

_____

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

(B.) Spouse only (check one):

1. ___ The following standard under 42 CFR 435.121:

_____

2. ___ The Medically Needy Income Standard

_____

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

_____

_____

6. ___ Not applicable (N/A)

(C.) Family (check one):

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

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

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

_____

_____

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

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

Spousal Post Eligibility

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

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

(a) Allowances for the needs of the:

1. Individual (check one)

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

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

(B). ___ The following dollar amount: $ _____
Note: If this amount changes, this item will be revised.

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

_____

_____

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

_____

_____

_____

_____

_____

II. Rates and Payments

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

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

III. Enrollment and Disenrollment

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