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State/Territory Name: Hawaii

State Plan Amendment (SPA) #: 21-0012

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 E. 12th St., Room 355
Kansas City, Missouri 64106

Medicaid and CHIP Operations Group

June 22, 2022

Judy Mohr Peterson, PhD
Med-QUEST Division Administrator
Office of the Director
Department of Human Services
PO Box 339
Honolulu, HI 96809-0339

Re: Hawaii State Plan Amendment (SPA) 21-0012

Dear Dr. Mohr Peterson:

The Centers for Medicare & Medicaid Services (CMS) reviewed your Medicaid State Plan Amendment (SPA) submitted under transmittal number (TN) 21-0012. This amendment clarifies pharmacy services under the other licensed practitioner benefit and identifies the reimbursement rate and methodology for these services.

We conducted our review of your submittal according to statutory requirements in Title XIX of the Social Security Act and implementing regulations. This letter is to inform you that Hawaii Medicaid SPA 21-0012 was approved on June 21, 2022, with an effective date of September 11, 2021.

If you have any questions, please contact Brian Zolynas at 415-744-3601 or via email at Brian.Zolynas@cms.hhs.gov.

Sincerely

James G. Scott, Director
Division of Program Operations

Enclosures

cc: Jodeen Enesa, Med-QUEST
Cori Kekina, Med-QUEST
Edie Mayeshiro, Med-QUEST

DEPARTMENT OF HEALTH & HUMAN SERVICES
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June 22, 2022

Judy Mohr Peterson, PhD
Med-QUEST Division Administrator
Office of the Director
Department of Human Services
PO Box 339
Honolulu, HI 96809-0339

Re: Hawaii State Plan Amendment (SPA) 21-0012

Dear Dr. Mohr Peterson:

We are issuing this letter as a companion to the Centers for Medicare and Medicaid Services' (CMS) approval of Hawaii's State Plan Amendment (SPA) 21-0012. SPA 21-0012 clarifies pharmacy services under the other licensed practitioner (OLP) benefit and identifies the reimbursement rate and methodology for these services. During our review of the SPA, CMS performed a review of the eyeglasses benefit and OLP benefit associated with the submitted SPA pages. Our comments concerning these benefits are as follows:

Eyeglasses Benefit

In the course of our review, we found that the amount, duration, and scope limitations for the optometrist services benefit, as identified on Supplement to Attachment 3.1-A and 3.1-B, page 2, item 6b, appear to include limitations for the eyeglasses benefit. Section 1905(a)(12) of the Social Security Act (the Act) and the Code of Federal Regulations (CFR) at 42 CFR 440.120(d) provide that the eyeglasses benefit means lenses, including frames, and other aids to vision prescribed by a physician skilled in diseases of the eye or an optometrist. Per 42 CFR 440.230(a) the state plan must specify the amount, duration, and scope of each service that it provides for; meaning each benefit must include a description of the amount, duration, and scope limitations that apply to that benefit. The eyeglasses benefit, as identified on Supplement to Attachment 3.1-A and 3.1-B, page 4, item 12d, only cross references item 6b and does not specify that the requirements of 42 CFR 440.120(d) are met. Furthermore, the eyeglasses benefit does not specify the amount, duration, and scope limitations that apply to the benefit as required by 42 CFR 440.230(a). Please revise the applicable state plan pages as follows:

1. Please revise the eyeglasses benefit service description to remove the cross reference to item 6b and confirm that the requirements of 42 CFR 440.120(d) are met.

2. Please move the eyeglasses benefit amount, duration, and scope limitations that begin on sentence four of item 6b to item 12d.

In addition, it appears that the limitations described in subsections 2, 3, and 4 on Supplement to Attachment 3.1-A and 3.1-B, page 2, item 6b cannot be exceeded based upon medical necessity. While a state may implement amount, duration and scope limitations on Medicaid benefits, when limitations are applied regardless of medical necessity, they are considered hard limitations and a sufficiency determination is necessary. From our records, we have concluded that a sufficiency determination has not previously occurred for these limitations. If the limitations are hard limits that cannot be exceeded by a medical necessity determination, the state will need to respond to the sufficiency questions in accordance with 42 CFR 440.230(b). Please see the attachment at the end of this letter.

Other Licensed Practitioner (OLP) Benefit

Medical care, or any other type of remedial care recognized under state law, furnished by licensed practitioners within the scope of practice according to state law is defined in the Social Security Act (the Act) at section 1905(a)(6). The Code of Federal Regulations (CFR) at 42 CFR 440.60 provides additional details for licensed practitioners other than physicians' services. Hawaii State plan amendment HI-21-0012 proposes to add licensed pharmacists to Attachment 3.1-A and 3.1-B under item 6d. Throughout the review process, the state worked with CMS to appropriately cover licensed pharmacists. However, during our review, CMS noticed other changes that need to be made to comport with the rules of this benefit. Hawaii opted for a companion letter to be issued with the approval of HI-21-0012.

3. Attachment 3.1-A (and 3.1-B respectively), item 6d.1 includes Services of a licensed psychologist within the scope of practice according to state law. The state indicates the following limitations:
   a. Testing is limited to a maximum of 4 hours once every 12 months or to 6 hours, if a comprehensive test is justified.
   b. Prior authorization is required for all psychological testing except for tests that are requested by the department's professional staff.

Please assure that the testing limitations can be exceeded if determined medically necessary by the state for individuals under the age of 21 pursuant to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit. If the limitations are hard limits that cannot be exceeded by a medical necessity determination for adults, the state will need to respond to the sufficiency questions in accordance with 42 CFR 440.230(b).

4. The state has included two additional paragraphs after the testing limitations described above that reads: *"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."

The language above may be better placed in the Rehabilitative services section of the Medicaid State plan, under item 13.d because the state has included a definition of SAT services and a list of licensed practitioners who are qualified to provide the services. The state has also included reimbursement and medical necessity language which are not a part of the OLP benefit and should be included in Attachment 4.19-B instead of 3.1-A/B.

Alternatively, if the state's intent is to cover the listed practitioners (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 and all of the practitioners are licensed, OLP is still an option. CMS is available to provide additional technical assistance upon request by the state.

Sufficiency Questions for the Eyeglasses and Other Licensed Practitioner Benefits

42 CFR 440.230(b) sets forth the requirement that services must be sufficient in amount, duration, and scope to reasonably achieve its purpose. The sufficiency of optional services should be demonstrated by ensuring that the proposed limitation meets the needs of at least 90% of beneficiaries that utilize the service. Please provide data to support that the limitations meet the needs of at least 90% of beneficiaries that utilize the services by responding to the questions below:

1. **BACKGROUND** - What is the reason for this limitation? If the reason for the limitation is duplication of services, abuse or inappropriate utilization, please provide the evidence that supports this reasoning. What other approaches/initiatives/processes have you tried or considered to address this matter?

2. **DATA SUPPORT** - With respect to existing limitations and using data within the last 12 months, what percentage of Medicaid beneficiaries utilized the maximum amount of the service? Please provide this information for the following eligibility groups:

   a. Aged, Blind and Disabled

   b. Non-Dually Eligible Adults (for analyses of services for which Medicare would not be primary payer, otherwise the analysis would include dually eligible individuals)

   c. Pregnant Women

d. Parents/Caretakers /Other Non-Disabled Adults

e. Adult expansion group, if applicable

3. **CLINICAL SUPPORT** - If the data requested above is not available, or is not relevant to demonstrating the sufficiency of the limited benefit, please indicate support for this proposed scope of services through clinical literature or evidence-based practice guidelines, or describe your consultation with your provider community or others that resulted in an assurance that this proposed scope of services has meaningful clinical merit to achieve its intended purpose.

4. **EXCEPTIONS** - Are there any exemptions to the proposed limitations? If so, how was this exemption determined to be appropriate? Does the state have a process for granting other exemptions if similar circumstances warrant? (e.g., if there is an exemption for individuals with one condition because their needs are greater, is there a process for other individuals with conditions that result in greater needs to request an exemption?) Can additional services beyond the proposed limit be provided based on a determination of medical necessity? That is, will there be an exception or prior authorization process for beneficiaries that require services beyond the limitation?

5. **BENEFICIARY IMPACT** - Please describe what will or is likely to occur to beneficiaries who will be impacted by this limitation. If the limit cannot be exceeded based on a determination of medical necessity:

   a. How will those affected by the limitation obtain the medical services they need beyond the stated limits?

   b. Will beneficiaries be billed and expected to pay for any care that may not be covered? Or, instead will the provider or practitioner be expected to absorb the costs of the provided services?

   c. Will beneficiaries be reassessed to determine need for the service prior to the plan amendment's effective date?

   d. If the beneficiary's covered services are being reduced, will the beneficiary be notified of their appeals rights per 42 CFR 431.206?

6. **DELIVERY SYSTEM** - Will the proposed limitation apply to services performed through managed care contracts, fee-for-service (FFS) or both? If applied in managed care, indicate whether or not the capitation rates will be adjusted to reflect the change.

7. **TRACKING** - How is the limitation tracked? Will both providers and beneficiaries be informed in advance so they know they have reached the limit? Please summarize the process.

CMS welcomes the opportunity to work with you and your staff to resolve these issues. Please contact Brian Zolynas at (415) 744-3601 or by email at Brian.Zolynas@cms.hhs.gov if you have any questions.

Sincerelv

James G. Scott, Director
Division of Program Operations

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 21 — 0012

2. STATE: Hawaii

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

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
~~10/01/2021~~ 9/11/21

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
~~§42 CFR 483.60~~ 42 CFR 447

7. FEDERAL BUDGET IMPACT
a. FFY 2021 $0.00
b. FFY 2022 $0.00

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Supplement to Attachment 3.1-A and 3.1-B pg 2
Attachment 4.19-B pg. 1

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Supplement to Attachment 3.1-A and 3.1-B pg 2
Attachment 4.19-B pg. 1

10. SUBJECT OF AMENDMENT
COVID-19 Vaccine and Pharmacy Services

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

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME
Judy Mohr Peterson, PhD

14. TITLE
Med-QUEST Division Administrator

15. DATE SUBMITTED
09/30/2021

16. RETURN TO
State of Hawaii
Department of Human Services
Office of the Director
P.O. Box 339
Honolulu, Hawaii 96809-0339

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED
September 30, 2021

18. DATE APPROVED
June 21, 2022

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL
September 11, 2021

20. SIGNATURE OF REGIONAL OFFICIAL

21. TYPED NAME
James G. Scott

22. TITLE
Director, Division of Program Operations

23. REMARKS
Boxes 4 and 6: State authorized pen and ink change on 04/25/2022.

Instructions on Back

6b. Routine eye exams provided by qualified optometrists are authorized once in a one-year period for individuals under twenty-one years of age and once in a two-year period for adults age twenty-one years and older. Visit done more frequently maybe 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 agetwenty-one and older. Medical justification required for bifocal lenses.
2) Trifocal lenses are covered only for those currently wearing these lensessatisfactorily 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 correctionshall be fitted with ready made half glasses instead of bifocals.

6d. Service of Other Providers:

1) Services of a licensed Psychologist within the scope of practice according to state law are provided with the following limitations:

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

b. 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.

2) Services provided by a licensed Pharmacist within their scope of practice according to state law.

State: Hawaii

NONINSTITUTIONAL ITEMS AND SERVICES:

1. HAWAII MEDICAID FEE SCHEDULE:

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers. (ex. case management for persons with chronic mental illness). The Hawaii Medicaid Fee Schedule was updated on September 11, 2021 and made effective for services rendered on or after that date. The Hawaii Medicaid Fee Schedule is based on a combination of sixty percent of the 2006 to current Medicare Fee Schedules as applicable. Services not covered by Medicare in 2006 are paid at sixty percent of the Medicare Fee Schedule on the first year in which the code/service is covered by Medicare, whichever is later. The Medicaid Fee Schedule is located at https://medquest.hawaii.gov/en/plans-providers/fee-for-service/fee-schedules.html

Reimbursement rates, except as specified below and other parts of this Attachment, for providers of medical care who are individual practitioners and other providing non-institutional items and services shall not exceed the maximum permitted under federal laws and regulations and shall be the lower of the Medicare Fee Schedule, as described above, the Hawaii Medicaid Fee Schedule or the provider's billed amount.

These services include:

(a) Physician services;

(1) Payment shall be sixty per cent of the 2006 Medicare Fee Schedule for physician services.
(2) The methodology for the calculation of enhanced payments for certain primary care physician services delivered to Medicaid recipients is described in Supplement 2 to Attachment 4.19-B. The reimbursement rates are published and located at https://medquest.hawaii.gov/en/plans-providers/fee-for-service/fee-schedules.html

(b) Podiatric services;

(c) Optometric services;

(d) Other licensed practitioner services (other than those provided by a licensed pharmacist) including nurse midwife, and pediatric nurse practitioner, advanced practice registered nurse in behavioral health are reimbursed at seventy-five per cent of the Medicaid reimbursement rate for a psychiatrist. Services provided by a licensed clinical social worker, marriage and family therapist, and licensed mental health counselor are reimbursed at seventy-five per cent of the Medicaid reimbursement rate for a psychologist.

1) Other licensed provider services includes services provided by licensed pharmacists (such as administration of vaccines). Payment for these services shall be made to the affiliated billing provider/Pharmacy, in accordance with the Hawaii Medicaid Fee Schedule located at https://medquest.hawaii.gov/en/plans-providers/fee-for-service/fee-schedules.html

(e) Physical therapy;

(f) Occupational therapy;

(g) Services for persons with speech, language, and hearing disorders;