USE OF REPRESENTATIVES
TWENTY-FIFTH LEGISLATURE, 2010
STATE OF HAWAII

H.B. NO. 2990

A BILL FOR AN ACT

RELATING TO MEDICAID.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF HAWAII:

SECTION 1. The Hawaii Revised Statutes is amended by adding a new chapter to be appropriately designated and to read as follows:

"**CHAPTER**

MEDICAID

PART I. GENERAL PROVISIONS

§ -1 Definitions. Unless the context clearly requires a different meaning, when used in this chapter:

"Abused or neglected" means subjected to "harm," "imminent harm," or "threatened harm" as defined in section 587-2.

"Applicant" means the person for whose use and benefit application for services or public assistance is made.

"Critical access hospital" means a hospital located in the state that is included in Hawaii's rural health plan approved by the Federal Health Care Financing Administration and approved as a critical access hospital by the department of health as provided in Hawaii's rural health plan and as defined in 42 United States Code Section 1395i-4.

"Department" means the department of human services.

"Director" means the director of human services.

"Domiciliary care" means the provision of twenty-four-hour living accommodations and personal care services and appropriate medical care, as needed, to adults unable to care for themselves by persons unrelated to the recipient in private residences or other facilities. "Domiciliary care" does not include the provision of rehabilitative treatment services provided by special treatment facilities.

"Financial assistance" means public assistance, except for payments for medical care, social service payments, transportation assistance, and emergency assistance under section 346-65, including funds received from the federal government.

"Medical assistance" means payment for medical care or personal care services, including funds received from the federal government.

"Medical care" means all kinds of medical care, psychiatric care, dental care, and maternity care, including surgical care, hospital care, eye care (which includes optical appliances), materials, supplies, and all other appliances used in the care, treatment and rehabilitation of patients, and hospitalization.

"Provider" means any person or public or private institution, agency or business concern authorized by the department to provide health care, service or supplies to beneficiaries of medical assistance.

"Public assistance" means financial assistance to or for the benefit of persons whom the department has determined to be without sufficient means of support to maintain a standard consistent with chapter 346, payments to or on behalf of such persons for medical care, and social service payments as described under the Social Security Act.

"Recipient" means the person for whose use and benefit services are rendered or a grant of public assistance is made.

"Social services" means crisis intervention, counseling, case management, and support activities such as day care and chore services provided by the department staff, by purchase of service, or by cooperative agreement with other agencies to persons meeting specified eligibility requirements.

PART II. QUEST

§ -2 Establishment of medicaid 1115 waiver program. The department shall establish a medicaid section 1115 waiver program. The program shall provide health care services through managed care health plans contracted by the department to

individuals under the age of sixty-five who are not certified as blind or disabled, and meet other criteria established by the department. The program shall expand medical coverage to include populations previously ineligible for medicaid and contain costs by shifting from a fee-for-service delivery system to a managed care system. The department shall adopt rules to implement the program.

PART III. LONG-TERM CARE

A. Medicaid Home and Community-based Waiver Programs

§ -10 Definitions. For the purpose of this subpart:

"Comprehensive home and community-based services" means the provision of a broad range of services, not otherwise available under the approved medicaid state plan, which the waiver program individual needs to avoid institutionalization for an indefinite period of time.

"Critical access hospital" means a hospital located in the state that is included in Hawaii's rural health plan approved by the federal Health Care Financing Administration and approved as a critical access hospital by the department of health as provided in Hawaii's rural health plan and as defined in 42 United States Code Section 1395i-4.

"Home care agency" means an agency licensed by the State to do business in Hawaii that provides home care services such as personal care, personal assistance, chore, homemaker, and nursing services in the individual's home.

"Residential alternative" means a community-based residence authorized to admit waiver program individuals, such as an adult foster home, adult residential care home, domiciliary care home, or foster home for the developmentally disabled.

"Service plan" means a written plan that specifies the services, along with their frequency and their provider, necessary to maintain the individual in the community as a cost-effective alternative to institutionalization.

"Waiver program" means the medicaid home and community-based services programs under 42 United States Code Section 1396n.

§ -11 Establishment of medicaid home and community-based waiver programs. (a) Waiver programs shall be established and administered by the department of human services to provide comprehensive home and community-based services for aged, chronically ill, disabled, developmentally disabled, and mentally retarded individuals, who are certified as requiring acute, skilled nursing, intermediate care facility, or

intermediate care facility for the mentally retarded level of care.

(b) These services shall be furnished to individuals in the geographic areas of the State identified in the approved waiver program applications.

(c) Medicaid home and community-based waiver program expenditures shall not exceed the amount authorized by the Federal Health Care Financing Administration.

§ -12 Determination of eligibility for participation in a waiver program. (a) To qualify for participation in a waiver program, individuals shall:

(1) Be determined by the department of human services to be eligible for federally-funded medicaid assistance;

(2) Be certified by the department of human services, through the preadmission screening process, to be in need of acute, skilled nursing facility, intermediate care facility, or intermediate care facility for the mentally retarded level of care; and

(3) Choose to remain in the community with the provision of home and community-based waiver program services as an alternative to institutionalization.

(b) Individuals approved for a waiver program shall have the following:

(1) Comprehensive assessment of their health, functional, social, and environmental needs;

(2) Written service plan that addresses the necessary safeguards to protect the health and welfare of the individual, and reflects the individual's freedom of choice of providers and services;

(3) Budget based on the services defined in the service plan; and

(4) Periodic review of their health, functional, and financial status to ensure continued eligibility for waiver program services.

§ -13 Provision of services. (a) Services that maximize the individual's independence shall be provided in the individual's home, the home of a responsible relative or other adult, or a residential alternative setting.

(b) The program shall provide the services in the most economic manner feasible which is compatible with preserving quality of care through:

(1) Informal care providers, such as family members, friends, or neighbors who regularly provide specific

services without remuneration and not as a part of any organized volunteer activity;

(2) Individual providers hired and directed by the waiver program individual to provide specific approved services;

(3) Contracts with agency providers, such as home care agencies and public or private health and social service organizations;

(4) Contracts with individual providers, such as counselors, nurses, therapists, and residential alternative program operators who provide services for the waiver program; and

(5) Program personnel, such as social workers and nurses who are hired by the waiver program to provide specific services.

§ -14 Needs allowance; waiver program individuals. (a) There may be established a monthly needs allowance for individuals living in:

(1) Adult residential care home type I and type II facilities;

(2) Licensed developmental disabilities domiciliary homes as defined in section 321-15.9;

(3) Community care foster family homes as defined in section -18;

(4) Certified adult foster homes as defined in section 321-11.2;

(5) Domiciliary care as defined in section -1;

(6) A nursing facility as defined in section -28; or

(7) A community-based residence as part of the residential alternatives community care program.

(b) The needs allowance may be administered by the department of human services to pay for clothing and other personal miscellaneous needs, such as bus fare, personal postage costs, haircuts, and other costs of day-to-day living.

(c) The State's supplemental payment for a needs allowance under subsection (a) shall be increased by an amount necessary to bring the allowance up to $50 per month. The payment under this section shall be afforded to an individual notwithstanding that the individual is incapacitated; provided that the moneys may be spent on behalf of the client, with a written accounting, by the operator of the residence or facility.

§ -15 Rules. The department of human services shall adopt rules in accordance with chapter 91, for the purpose of this subpart.

§ -16 **Personnel exempt.** The department may employ civil service personnel in accordance with chapter 76 to service the waiver programs.

§ -17 **Medicaid reimbursement equity.** Not later than July 1, 2008, there shall be no distinction between hospital-based and nonhospital-based reimbursement rates for institutionalized long-term care under medicaid. Reimbursement for institutionalized intermediate care facilities and institutionalized skilled nursing facilities shall be based solely on the level of care rather than the location. This section shall not apply to critical access hospitals.

B. Home and Community-Based Case Management Agencies and Community Care Foster Family Homes

§ -18 **Definitions.** As used in this part:

"Assisted living facility" means an assisted living facility as defined in section 321-15.1.

"Certificate of approval" means the certificate issued by the department or its designee that authorizes a person, agency, or organization to operate a community care foster family home.

"Client" means any person who receives home and community-based case management services to reside in a community care

foster family home, expanded adult residential care home, or assisted living facility.

"Community care foster family home" or "home" means a home that, for the purposes of this subpart:

(1) Is regulated by the department in accordance with rules that are equitable in relation to rules that govern expanded adult residential care homes;

(2) Is issued a certificate of approval by the department or its designee to provide, for a fee, twenty-four-hour living accommodations, including personal care and homemaker services, for not more than two adults at any one time, at least one of whom shall be a medicaid recipient, who are at the nursing facility level of care, who are unrelated to the foster family, and are receiving the services of a licensed home and community-based case management agency; and

(3) Does not include expanded adult residential care homes or assisted living facilities, which shall continue to be licensed by the department of health.

"Designee" means a person, institution, organization, or agency authorized by the department to issue certificates of approval to community care foster family homes and to monitor

these homes for certificate compliance and quality assurance. The department's designee shall perform these functions for the department and shall not at the same time function as a home and community-based case management agency or a community care foster family home as defined in this section.

"Expanded adult residential care home" means any facility providing twenty-four-hour living accommodations, for a fee, to adults unrelated to the family, who require at least minimal assistance in the activities of daily living, personal care services, protection, and health care services, and who may need the professional health services provided in an intermediate or skilled nursing facility.

"Home and community-based case management agency" means any person, agency, or organization licensed by the department to provide, coordinate, and monitor comprehensive services to meet the needs of clients whom the agency serves in a community care foster family home or any medicaid clients in an expanded adult residential care home, or an assisted living facility.

"License" means an approval issued by the department or its authorized agents for a person, agency, or organization to operate as a home and community-based case management agency.

§ -19 **Applicability.** (a) This subpart shall apply to the demonstration project statewide.

(b) Community care foster family homes shall be required to reserve at least one bed for medicaid patients.

§ -20 **Home and community-based case management agency, authority over and evaluation of.** (a) Any person, agency, or organization engaged in providing, coordinating, or monitoring comprehensive services to clients in community care foster family homes, or medicaid clients in expanded adult residential care homes, and assisted living facilities, shall meet the standards of conditions, management, and competence set by the department and hold a license in good standing issued for this purpose by the department.

(b) The department shall adopt rules pursuant to chapter 91 relating to:

(1) Standards for the organization and administration of home and community-based case management agencies;

(2) Standards of conditions, management, and competence of home and community-based case management agencies;

(3) Procedures for obtaining and renewing a license from the department; and

(4) Minimum grievance procedures for clients of case management services.

(c) As a condition for obtaining a license, a person, agency, or organization shall comply with rules adopted under subsection (b)(1), (2), and (3), and satisfy the background check requirements under section -22. The department may deny a license if:

(1) An operator, employee, or new employee of the home and community-based case management agency has been convicted of a crime other than a minor traffic violation involving a fine of $50 or less;

(2) The department finds that the criminal history record of an operator, employee, or new employee poses a risk to the health, safety, or well-being of adults receiving care in community care foster family homes, expanded adult residential care homes, or assisted living facilities;

(3) An operator, employee, or new employee of the home and community-based case management agency is a perpetrator of abuse as defined in section 346-222; or

(4) The holder of or an applicant for a home and community-based case management agency license, or one

of its employees, has a certificate of approval to operate a community care foster family home, or a license from the department of health to operate an adult residential care home, expanded adult residential care home, or assisted living facility.

(d) Upon approval of any home and community-based case management agency, the department or its authorized agents shall issue a license, which shall continue in force for one year, or for two years if a home and community-based case management agency has been licensed for at least one year and is in good standing pursuant to standards adopted by the department, unless sooner revoked for cause. The department or its authorized agents shall renew the license only if, after an annual or biennial evaluation, the agency continues to meet the standards established by the department.

(e) The department shall evaluate the home and community-based case management agency to determine compliance with the requirements established under this section:

(1) Annually or biennially; or

(2) Upon receipt of a complaint that the home and community-based case management agency is in violation of the requirements established under this section.

(f) The department may suspend or revoke a license if the department deems that the agency is unwilling or unable to comply with the rules adopted under this section; provided that:

(1) Upon suspension or revocation of a license, the home and community-based case management agency shall no longer be licensed and shall immediately notify the agency's clients and community care foster family homes, expanded adult residential care homes, and assisted living facilities in which the agency is providing services to clients;

(2) A home and community-based case management agency whose license has been suspended or revoked may appeal the suspension or revocation to the department through its established process, but the appeal shall not stay the suspension or revocation;

(3) A suspended or revoked license may be reinstated if the department deems that the agency is willing and able to comply with the rules adopted under this section; and

(4) A revoked license shall be restored only after a new application is made and reviewed under this subpart.

(g) Any home and community-based case management agency shall be subject to investigation by the department at any time and in the manner, place, and form as provided in the department's rules.

(h) The department shall adopt standard forms of contract that the home and community-based case management agency shall use with each of its clients, community care foster family homes, expanded adult residential care homes, and assisted living facilities.

(i) The department shall establish a review board consisting of three operators of community care foster family homes and three operators of expanded adult residential care homes. The review board shall monitor referrals and placements of clients by each home and community-based case management agency on a monthly basis. Each home and community-based case management agency shall be required to provide monthly reports to the review board.

(j) The home and community-based case management agency shall have a fiduciary duty to each client it serves.

(k) A home and community-based case management agency shall not enter into an agreement that requires a community care foster family home to accept that agency's clients exclusively.

§ -21 Community care foster family home, authority over and evaluation of. (a) Any person in any household who wants to take in, for a fee, any adult who is at the nursing facility level of care and who is unrelated to anyone in the household, for twenty-four-hour living accommodations, including personal care and homemaker services, may do so only after the household meets the required standards established for certification and obtains a certificate of approval from the department or its designee.

(b) The department shall adopt rules pursuant to chapter 91 relating to:

(1) Standards of conditions and competence for the operation of community care foster family homes;

(2) Procedures for obtaining and renewing a certificate of approval from the department; and

(3) Minimum grievance procedures for clients of community care foster family home services.

(c) As a condition for obtaining a certificate of approval, community care foster family homes shall comply with rules adopted under subsection (b) and satisfy the background check requirements under section -22. The department or its designee may deny a certificate of approval if:

(1) An operator or other adult residing in the community care foster family home, except for adults receiving care, has been convicted of a crime other than a minor traffic violation involving a fine of $50 or less;

(2) The department or its designee finds that the criminal history record of an operator or other adult residing in the home, except for adults receiving care, poses a risk to the health, safety, or well-being of adults in care; or

(3) An operator or other adult residing in the community care foster family home, except for adults receiving care, is a perpetrator of abuse as defined in section 346-222.

(d) Upon approval of a community care foster family home, the department or its designee shall issue a certificate of approval that shall continue in force for one year, or for two years if a community care foster family home has been certified for at least one year and is in good standing pursuant to standards adopted by the department, unless sooner suspended or revoked for cause. The department or its designee shall renew the certificate of approval only if, after an annual or biennial

evaluation, the home continues to meet the standards required for certification.

(e) Any community care foster family home shall be subject to investigation by the department or its designee at any time and in the manner, place, and form as provided in procedures to be established by the department.

(f) The department or its designee may suspend or revoke a certificate of approval if the department or its designee deems that a community care foster family home is unwilling or unable to comply with the rules adopted under subsection (b); provided that:

(1) The suspension or revocation shall be immediate when conditions exist that constitute an imminent danger to life, health, or safety of adults receiving care;

(2) A community care foster family home whose certificate of approval has been suspended or revoked shall immediately notify its clients and their case managers;

(3) A community care foster family home whose certificate of approval has been suspended or revoked may appeal to the department through its established process, but

the appeal shall not stay the suspension or revocation;

(4) A suspended or revoked certificate of approval may be reinstated if the department or its designee deems that the home is willing and able to comply with the rules adopted under subsection (b); and

(5) A revoked certificate of approval shall be restored only after a new application for a certificate of approval is submitted to the department or its designee and approved.

(g) Any community care foster family home shall be subject to monitoring and evaluation by the department or its designee for certification compliance and quality assurance on an annual or biennial basis.

§ -22 Background checks. (a) The department shall develop standards to ensure the reputable and responsible character of operators and employees of the home and community-based case management agencies and operators and other adults, except for adults in care, residing in community care foster family homes as defined in this subpart.

(b) An applicant for a home and community-based case management agency license and operators, employees, and new

employees of a home and community-based case management agency shall:

(1) Be subject to criminal history record checks in accordance with section 846-2.7;

(2) Be subject to adult abuse perpetrator checks, if the individual has direct contact with a client. For the purposes of this section, "adult abuse perpetrator check" means a search to determine whether an individual is known to the department as a perpetrator of abuse as defined in section 346-222, by means of a search of the individual's name and birth date in the department's adult protective service file; and

(3) Provide consent to the department to conduct an adult abuse perpetrator check and to obtain other criminal history record information for verification.

(c) New employees of the home and community-based case management agency shall be fingerprinted within five working days of employment, for the purpose of complying with the criminal history record check requirement.

(d) The department or its designee shall obtain criminal history record information through the Hawaii criminal justice data center on applicants for home and community-based case

management agency licenses, and operators, employees, and new employees of home and community-based case management agencies. The Hawaii criminal justice data center may assess the applicants and operators, employees, and new employees a reasonable fee for each criminal history record check conducted. The information obtained shall be used exclusively for the stated purpose for which it was obtained and shall be subject to federal laws and regulations as may be now or hereafter adopted.

(e) The department shall make a name inquiry into the criminal history records and the adult protective service file for the first two years a home and community-based case management agency is licensed and annually or biennially thereafter depending on the licensure status of the home and community-based case management agency.

(f) An applicant for a certificate of approval as a community care foster family home and operators and other adults residing in a community care foster family home shall:

(1) Be subject to criminal history record checks in accordance with section 846-2.7;

(2) Be subject to adult abuse perpetrator checks, if the individual has direct contact with a client. For the purposes of this section, "adult abuse perpetrator

check" means a search to determine whether an individual is known to the department as a perpetrator of abuse as defined in section 346-222, by means of a search of the individual's name and birth date in the department's adult protective service file; and

(3) Provide consent to the department to conduct an adult abuse perpetrator check and to obtain other criminal history record information for verification.

(g) The department or its designee shall obtain criminal history record information through the Hawaii criminal justice data center on applicants for certificates of approval as community care foster family homes and operators and other adults residing in community care foster family homes, except for adults receiving care. The Hawaii criminal justice data center may assess the applicants and operators and other adults a reasonable fee for each criminal history record check conducted. The information obtained shall be used exclusively for the stated purpose for which it was obtained and shall be subject to federal laws and regulations as may be now or hereafter adopted.

(h) The department or its designee shall make a name inquiry into the criminal history records and the adult

protective service file for the first two years a community care foster family home is certified and annually or biennially thereafter depending on the certification status of the community care foster family home.

§ -23 **Penalty.** Any person violating this subpart or any rule made pursuant to this subpart shall be fined not more than $500.

§ -24 **Exemptions.** As provided in sections 383-7, 392-5, and 393-5, "employment" for the purposes of the Hawaii employment security law, temporary disability insurance law, and Hawaii prepaid health care law, shall not include domestic in-home and community-based services for persons with developmental disabilities and mental retardation under the medicaid home and community based services program pursuant to Title 42 Code of Federal Regulations Sections 440.180 and 441.300, and Title 42 Code of Federal Regulations, Part 434, Subpart A, as amended, and identified as chore, personal assistance and habilitation, residential habilitation, supported employment, respite, and skilled nursing services, as the terms are defined and amended from time to time by the department of human services, performed by an individual whose services are contracted by a recipient of social service payments and who voluntarily agrees in writing to

be an independent contractor of the recipient of social service payments unless the individual is an employee and not an independent contractor of the recipient of social service payments under the Federal Unemployment Tax Act.

C. Adult Residential Care Homes

§ -25 Adult residential care homes expanded admissions. (a) Adult residential care homes may admit an individual who has been living immediately prior to admission in the individual's own home, a hospital, or other care setting, and who has been either:

(1) Admitted to a medicaid waiver program and determined by the department of human services to require nursing facility level care to manage the individual's physical, mental, and social functions; or

(2) A private-paying individual certified by a physician or advanced practice registered nurse as needing a nursing facility level of care.

(b) The department of health shall adopt rules in accordance with chapter 91 to expand admissions to adult residential care homes by level of care and to define and standardize these levels of care. The rules and standards shall provide for appropriate and adequate requirements for knowledge

and training of adult residential care home operators and their employees.

§ -26 Adult residential care homes; licensing. (a) All adult residential care homes shall be licensed to ensure the health, safety, and welfare of the individuals placed therein. The department shall conduct unannounced visits, other than the inspection for relicensing, to every licensed adult residential care home and expanded adult residential care home on an annual basis and at such intervals as determined by the department to ensure the health, safety, and welfare of each resident. Unannounced visits may be conducted during or outside regular business hours. All inspections relating to follow-up visits, visits to confirm correction of deficiencies, or visits to investigate complaints or suspicion of abuse or neglect shall be conducted unannounced during or outside regular business hours. Annual inspections for relicensing may be conducted during regular business hours or at intervals determined by the department. Annual inspections for relicensing shall be conducted with notice, unless otherwise determined by the department.

(b) The director of health shall adopt rules regarding adult residential care homes in accordance with chapter 91 that shall be designed to:

(1) Protect the health, safety, and civil rights of persons residing in facilities regulated;

(2) Provide for the licensing of adult residential care homes; provided that the rules shall allow group living in two categories of adult residential care homes as licensed by the department of health:

(A) Type I allowing five or fewer residents; provided that up to six residents may be allowed at the discretion of the department to live in a type I home; provided further that the primary caregiver or home operator is a certified nurse aide who has completed a state-approved training program and other training as required by the department; and

(B) Type II allowing six or more residents, including but not limited to the mentally ill, elders, persons with disabilities, the developmentally disabled, or totally disabled persons who are not related to the home operator or facility staff;

(3) Comply with applicable federal laws and regulations of Title XVI of the Social Security Act, as amended; and

(4) Provide penalties for the failure to comply with any rule.

For the purposes of this subsection:

"Developmentally disabled" means a person with developmental disabilities as defined under section 333F-1.

"Elder" has the same meaning as defined under section 356D-1.

"Mentally ill" means a mentally ill person as defined under section 334-1.

"Persons with disabilities" means persons having a disability under section 515-2.

"Totally disabled person" has the same meaning as a person totally disabled as defined under section 235-1.

(c) The department of health may provide for the training of and consultations with operators and staff of any facility licensed under this section, in conjunction with any licensing thereof, and shall adopt rules to ensure that adult residential care home operators shall have the needed skills to provide proper care and supervision in a home environment as required under department of health rules.

(d) The department of health shall establish a standard admission policy and procedure which shall require the provision of information that includes the appropriate medical and personal history of the patient as well as the level of care needed by the patient prior to the patient's referral and admission to any adult residential care home facility. The department of health shall develop appropriate forms and patient summaries for this purpose.

(e) The department of health shall maintain an inventory of all facilities licensed under this section and shall maintain a current inventory of vacancies therein to facilitate the placement of individuals in such facilities.

(f) The department of health shall develop and adopt a social model of health care to ensure the health, safety, and welfare of individuals placed in adult residential care homes. The social model of care shall provide for aging in place and be designed to protect the health, safety, civil rights, and rights of choice of the persons to reside in a nursing facility or in home- or community-based care.

(g) Any fines collected by the department of health for violations of this section shall be deposited into the office of health care assurance special fund.

§ -27 **Expanded adult residential care homes; licensing.** (a) All expanded adult residential care homes shall be licensed to ensure the health, safety, and welfare of the individuals placed therein.

(b) The director of health shall adopt rules regarding expanded adult residential care homes in accordance with chapter 91 that shall implement a social model of health care designed to:

(1) Protect the health, safety, civil rights, and rights of choice of residents in a nursing facility or in home- or community-based care;

(2) Provide for the licensing of expanded adult residential care homes for persons who are certified by the department of human services, a physician, advanced practice registered nurse, or registered nurse case manager as requiring skilled nursing facility level or intermediate care facility level of care who have no financial relationship with the home care operator or facility staff; provided that the rules shall allow group living in the following two categories of expanded adult residential care homes as licensed by the department of health:

(A) A type I home shall consist of five or fewer residents with no more than two nursing facility level residents; provided that more nursing facility level residents may be allowed at the discretion of the department of health; and provided further that up to six residents may be allowed at the discretion of the department to live in a type I home; provided that the primary caregiver or home operator is a certified nurse aide who has completed a state-approved training program and other training as required by the department; and

(B) A type II home shall consist of six or more residents, with no more than twenty per cent of the home's licensed capacity as nursing facility level residents; provided that more nursing facility level residents may be allowed at the discretion of the department of health;

provided further that the department of health shall exercise its discretion for a resident presently residing in a type I or type II home, to allow the resident to remain as an additional nursing facility

level resident based upon the best interests of the resident. The best interests of the resident shall be determined by the department of health after consultation with the resident, the resident's family, primary physician, case manager, primary caregiver, and home operator;

(3) Comply with applicable federal laws and regulations of Title XVI of the Social Security Act, as amended; and

(4) Provide penalties for the failure to comply with any rule.

(c) The department of health may provide for the training of and consultations with operators and staff of any facility licensed under this section, in conjunction with any licensing thereof, and shall adopt rules to ensure that expanded adult residential care home operators shall have the needed skills to provide proper care and supervision in a home environment as required under department of health rules.

(d) The department of health shall establish a standard admission policy and procedure which shall require the provision of information that includes the appropriate medical and personal history of the patient as well as the level of care needed by the patient prior to the patient's referral and

admission to any expanded adult residential care home facility. The department of health shall develop appropriate forms and patient summaries for this purpose.

(e) The department of health shall maintain an inventory of all facilities licensed under this section and shall maintain a current inventory of vacancies therein to facilitate the placement of individuals in such facilities.

D. Nursing Facility Tax

§ -28 Definitions. As used in this subpart, unless the context otherwise requires:

"Nursing facility" means a nursing facility licensed under sections 321-9 and 321-11 and any intermediate care facility for the mentally retarded persons licensed under sections 321-9 and 321-11.

"Nursing facility income" means the total compensation received for furnishing nursing facility services, including all receipts from "ancillary services" (as defined in 42 Code of Federal Regulations 413.53(b)) to the provision of nursing facility services, and receipts from items supplied in connection with these services. "Nursing facility income" shall not include the following:

(1) Compensation received from services covered by Title XVIII of the Federal Social Security Act (including copayments and deductibles received from beneficiaries of the medicare program);

(2) Income from an affiliated entity that operates as a prepaid health maintenance organization;

(3) Settlements from third party payors for services delivered or items supplied prior to the effective date of this Act (such as settlements of cost reports or decisions on rate reconsideration requests);

(4) Income from services provided by separately licensed units (such as distinct part intermediate care facilities for the mentally retarded);

(5) Income from the provision of adult day health and adult day care programs;

(6) Income from the provision of home health agency services;

(7) Income from the provision of "nursing homes without walls" programs;

(8) Income from the provision of inpatient hospital services;

(9) Income from grants, bequests, donations, endowments, or investments; or

(10) Amounts of taxes imposed by chapter 237 or this subpart and passed on, collected, and received from the consumer as part of nursing facility income.

"Operator" means any person operating a nursing facility, whether as owner or proprietor, or as lessee, sublessee, mortgagee in possession, licensee, or otherwise, or engaging or continuing in any service business that involves the actual furnishing of nursing facility services.

§ -29 Imposition of tax and rates. (a) There is levied and shall be assessed and collected during each quarter a tax in the amount of six per cent of all nursing facility income.

(b) Each nursing facility operator shall pay to the State the tax imposed by this section as provided by this subpart.

(c) The tax imposed by this section shall not apply to an individual facility determined by the department to be financially distressed, pursuant to the rulemaking authority authorized by this subpart; provided that this exemption does not cause the tax to fail to qualify as permissible under Section 1903(w) of the Federal Social Security Act.

(d) Each operator of a nursing facility shall identify separately the tax imposed by this section in all invoices or statements to persons whose payments result in nursing facility income. Notwithstanding the foregoing, the amount that a beneficiary of the medicaid program is required to contribute toward his or her care shall not be changed as a result of the tax imposed by this section.

(e) The taxes imposed by this section shall terminate at the end of the month following the time at which the taxes no longer qualify as permissible under Section 1903(w) of the Federal Social Security Act; but not before July 1, 1997.

§ -30 Return and payments; penalties. (a) On or before the fifteenth day of February, May, August, and November, or for fiscal year taxpayers on or before the forty-fifth day after the close of the fiscal quarter, every operator taxable under this subpart during the preceding calendar or fiscal quarter shall file a sworn return with the director in such form as the director shall prescribe, together with a remittance for the amount of the tax in the form of cash, bank draft, cashier's check, money order, or certificate of deposit. In lieu of the remittance, the operator may request withholding from payments made to the operator by the department under section -31.

Sections 237-30 and 237-32 shall apply to returns and penalties made under this subpart to the same extent as if the sections were set forth specifically in this section.

(b) Notwithstanding subsection (a), the director, for good cause, may permit an operator to file the operator's return required under this section and make payments thereon, on a semiannual basis during the calendar or fiscal year, the return and payment to be made on or before the last day of the calendar month after the close of each six-month period, to wit: for calendar year operators, on July 31 and January 31 or, for fiscal year operators, on or before the last day of the seventh month following the beginning of the fiscal year and on or before the last day of the month following the close of the fiscal year; provided that the director is satisfied that the grant of the permit will not unduly jeopardize the collection of the taxes due thereon and the operator's total tax liability for the calendar or fiscal year under this subpart will not exceed $1,000.

The director, for good cause, may permit an operator to make quarterly payments based on the operator's estimated quarterly or semiannual liability; provided that the operator files a reconciliation return at the end of each quarter or at

the end of each six-month period during the calendar or fiscal year, as provided in this section.

(c) If an operator filing the operator's return on a semiannual basis, as provided in this section, becomes delinquent in either the filing of the operator's return or the payment of the taxes due thereon, or if the liability of an operator, who possesses a permit to file the operator's return and make payments on a semiannual basis, exceeds $1,000 in taxes during the calendar or fiscal taxable year, or if the director determines that any such semiannual filing of a return would unduly jeopardize the proper administration of this subpart, including the assessment or collection of the taxes, the director, at any time, may revoke an operator's permit, in which case the operator then shall be required to file the operator's return and make payments thereon as provided in subsection (a).

(d) Section 232-2 shall apply to the annual return, but not to a quarterly or semiannual return.

§ -31 Withholding. As an option to making payments under section -30, the department and the operator in writing may agree that the department will withhold all or part of the amount of taxes owing for a quarter from Medicaid payments owed by the department to the operator. All reports by the

department to the federal government or to the operator, of medicaid payments made to the operator by the department shall include any amount withheld to satisfy the tax obligation imposed by this subpart.

§ -32 Annual return. On or before the twentieth day of the fourth month following the close of the calendar or fiscal taxable year, every operator who has become liable for the payment of the taxes under this subpart during the preceding tax year shall file a return summarizing that operator's liability under this subpart for the year, in such form as the director prescribes. The operator shall transmit to the Honolulu office of the department with the return, a remittance covering the residue of the tax chargeable to the operator, if any. The return shall be signed by the operator, if made by an individual, or by the president, vice-president, secretary, or treasurer of a corporation, if made on behalf of a corporation. If made on behalf of a partnership, firm, society, unincorporated association, group, hui, joint venture, joint stock company, corporation, trust estate, decedent's estate, trust, or other entity, any individual delegated by the entity shall sign the return on behalf of the operator. If for any reason it is not practicable for the individual operator to sign

the return, it may be done by any duly authorized agent. The department, for good cause shown, may extend the time for making the return on the application of any operator and grant such reasonable additional time within which to make the return as the department may deem advisable.

Section 232-2 shall apply to the annual return, but not to a quarterly or semiannual return.

§ -33 Assessment of tax upon failure to make return; limitation period; exceptions; extension by agreement. (a) If any operator fails to make a return as required by this subpart, the director shall make an estimate of the tax liability of the operator from any information the director obtains, and according to the estimate so made, assess the taxes, interest, and penalty due the State from the operator; give notice of the assessment to the operator; and make demand upon the operator for payment. The assessment shall be presumed to be correct until and unless, upon an appeal duly taken as provided in section -35, the contrary shall be clearly proved by the operator assessed. The burden of proof upon the appeal shall be upon the operator assessed to disprove the correctness of assessment.

(b) After a return is filed under this subpart the director shall cause the return to be examined, and may make such further audits or investigations as the director considers necessary. If the director determines that there is a deficiency with respect to the payment of any tax due under this subpart, the director shall assess the taxes and interest due the State, give notice of the assessment to the persons liable, and make demand upon the persons for payment.

(c) Except as otherwise provided by this section, the amount of taxes imposed by this chapter shall be assessed or levied within three years after the annual return was filed, or within three years of the due date prescribed for the filing of the return, whichever is later. No proceeding in court without assessment for the collection of any such taxes shall be begun after the expiration of the period. Where the assessment of the tax imposed by this subpart has been made within the period of limitation applicable thereto, the tax may be collected by levy or by a proceeding in court under chapter 231; provided that the levy is made or the proceeding was begun within fifteen years after the assessment of the tax. For any tax that has been assessed prior to July 1, 2009, the levy or proceeding shall be barred after June 30, 2024.

Notwithstanding any other provision to the contrary in this section, the limitation on collection after assessment in this section shall be suspended for the period:

(1) The taxpayer agrees to suspend the period;

(2) The assets of the taxpayer are in control or custody of a court in any proceeding before any court of the United States or any state, and for six months thereafter;

(3) An offer in compromise under section 231-3(10) is pending; and

(4) During which the taxpayer is outside the state if the period of absence is for a continuous period of at least six months; provided that if at the time of the taxpayer's return to the State the period of limitations on collection after assessment would expire before the expiration of six months from the date of the taxpayer's return, the period shall not expire before the expiration of the six months.

(d) In the case of a false or fraudulent return with intent to evade tax, or a failure to file the annual return, the tax may be assessed or levied at any time; provided that the

burden of proof with respect to the issues of falsity or fraud and intent to evade tax shall be upon the State.

(e) Where, before the expiration of the period prescribed in subsection (c) for assessments or in section -34 for credits and refunds, both the department and the operator have consented in writing to the assessment or levy of the tax after the date fixed by subsection (c) or the credit or refund of the tax after the date fixed by section -34, the tax may be assessed or levied, or the overpayment, if any, may be credited or refunded at any time prior to the expiration of the period agreed upon. The period so agreed upon may be extended by subsequent agreements in writing made before the expiration of the period previously agreed upon.

§ -34 **Overpayment; refunds.** Upon application by an operator, if the director determines that any tax, interest, or penalty has been paid more than once, or has been erroneously or illegally collected or computed, the tax, interest, or penalty shall be credited by the director on any taxes then due from the operator under this subpart. The director shall refund the balance to the operator or the operator's successors, administrators, executors, or assigns in accordance with section 231-23. As to all tax payments for which a refund or credit is

not authorized under this section (including, without prejudice to the generality of the foregoing, cases of unconstitutionality), the remedies provided by appeal or under section 40-35 are exclusive. No credit or refund shall be allowed for any tax imposed by this subpart, unless a claim for the credit or refund is filed as follows:

(1) If an annual return is timely filed, or is filed within three years after the date prescribed for filing the annual return, then the credit or refund shall be claimed within three years after the date the annual return was filed or the date prescribed for filing the annual return, whichever is later; and

(2) If an annual return is not filed, or is filed more than three years after the date prescribed for filing the annual return, a claim for credit or refund shall be filed within:

(A) Three years after the payment of the tax; or

(B) Three years after the date prescribed for the filing of the annual return, whichever is later.

The preceding limitation shall not apply to a credit or refund pursuant to an appeal, provided for in section -35.

§ -35 **Appeals.** Any operator aggrieved by any assessment of the tax imposed by this subpart for any quarter or any year, may appeal from the assessment in the manner and within the time and in all other respects, as provided in the case of income tax appeals by section 235-114.

§ -36 **Records to be kept; examination; penalties.** (a) Every operator shall keep, in the English language, within the state, and preserve for a period of three years, suitable records relating to nursing facility income taxed under this subpart, and such other books, records of account, and invoices as may be required by the department. All such books, records, and invoices shall be open for examination at any time by the department or the department of taxation, or the authorized representative thereof. For the purposes of determining the amount of taxes due under this subpart, every operator shall keep its books and records of account on the accrual basis.

(b) Any operator violating this section shall be guilty of a misdemeanor; and any officer, director, president, secretary, or treasurer of a corporation who permits, aids, or abets the corporation to violate this section shall likewise be guilty of a misdemeanor. The penalty for this misdemeanor shall be that prescribed by section 231-34 for individuals, corporations, or

officers of corporations, as the case may be, for violation of that section.

§ -37 Disclosure of returns unlawful; destruction of returns. (a) All tax returns and return information required to be filed under this subpart, and the report of any investigation of the return or of the subject matter of the return, shall be confidential. It shall be unlawful for any person or any officer or employee of the State to intentionally make known information imparted by any tax return or return information filed pursuant to this subpart, or any report of any investigation of the return or of the subject matter of the return, or to wilfully permit any such return, return information, or report so made, or any copy thereof, to be seen or examined by any person; provided that for tax purposes only the operator, the operator's authorized agent, or persons with a material interest in the return, return information, or report may examine the same. Unless otherwise provided by law, persons with a material interest in the return, return information, or report shall include:

(1) Trustees;

(2) Partners;

(3) Persons named in a board resolution or a one per cent shareholder in the case of a corporate return;

(4) The person authorized to act for a corporation in dissolution;

(5) A shareholder of an S corporation;

(6) The personal representative, trustee, heir, or beneficiary of an estate or trust in the case of the estate's or decedent's return;

(7) The committee, trustee, or guardian of any person in paragraphs (1) to (6) who is incompetent;

(8) The trustee in bankruptcy or receiver, and the attorney-in-fact of any person in paragraphs (1) to (7);

(9) Persons duly authorized by the State in connection with their official duties; and

(10) Any duly accredited tax official of the United States or any state or territory.

Any violation of this subsection shall be a misdemeanor. Nothing in this subsection shall prohibit the publication of statistics so classified as to prevent the identification of particular reports or returns and the items of the reports or returns.

(b) The department may destroy the quarterly or semiannual returns filed pursuant to section -30, or any of them, upon the expiration of three years after the end of the calendar or fiscal year in which the taxes so returned accrued.

§ -38 **Collection by suit; injunction.** The department may collect taxes due and unpaid under this subpart, together with all accrued penalties, by action in assumpsit or other appropriate proceedings in the district or circuit court of the judicial circuit in which the taxes arose, regardless of the amount. After delinquency has continued for sixty days, the department may proceed in the circuit court of the judicial circuit in which the nursing facility income is taxed to obtain an injunction restraining the further furnishing of nursing facility services until full payment is made of all taxes, penalties, and interest due under this subpart.

§ -39 **Application of taxes.** The taxes imposed by this subpart shall be in addition to any other taxes imposed by any other laws of the State; provided that if it is held by any court of competent jurisdiction that the taxes imposed by this subpart may not legally be imposed in addition to any other tax or taxes imposed by any other law or laws with respect to the same property and the use thereof, then this subpart shall be

deemed not to apply to the property and the use thereof under the specific circumstances, but the other laws shall be given full effect with respect to the property and use.

§ -40 Administration and enforcement; rules. (a) The director shall administer and enforce this subpart. With respect to:

(1) The examinations of books and records, and operators and other persons;

(2) Procedures and powers upon failure or refusal by an operator to make a return or proper return; and

(3) The general administration of this chapter;

the director shall have all rights, powers, and duties conferred by chapters 231 and 237 with respect to powers and duties or with respect to taxes imposed under chapter 237. Without restriction upon these rights and powers, section 237-8 and sections 237-36 to 237-41 are made applicable to and with respect to taxes, operators, department officers, and other persons, and the matters and things affected or covered by this subpart, insofar as these sections are not inconsistent with this subpart, in the same manner, as nearly as may be, as in similar cases covered by chapter 237.

(b) The director may adopt rules under chapter 91 to carry out this subpart.

(c) The department may contract with the department of taxation for assistance in implementing and administering this subpart.

§ -41 Taxes; allowable reimbursement costs. All taxes paid pursuant to this subpart shall be deemed allowable and reimbursable costs for federal medicaid reimbursement purposes. The department shall make appropriate adjustments to the methods and standards for reimbursing nursing facilities under section 346-14 by a medicaid state plan amendment which shall become effective on federal approval. In the case of any program involving federal medicaid participation, the adjustment shall take effect no earlier than the effective date of any federally-approved medicaid state plan amendment containing any such adjustment.

§ -42 Evasion of tax, etc.; penalties. It shall be unlawful:

(1) For any operator to:

(A) Refuse to make the return required in section -32;

(B) Make any false or fraudulent return or false statement in any return, with intent to defraud the State or to evade the payment of any tax imposed by this subpart; and

(C) For any reason to aid or abet another in any attempt to evade the payment of any tax imposed by this subpart; or

(2) For the president, vice-president, secretary, or treasurer of any corporation to make or permit to be made for any corporation or association any false return, or any false statement in any return required by this subpart, with the intent to evade the payment of any tax imposed by this subpart.

Any person violating this section or section 231-34 in relation to the tax imposed by this subpart, shall be punished as provided in section 231-34. Any corporation for which a false return, or return containing a false statement is made, shall be fined in the amount provided in section 231-34.

PART IV. PHARMACEUTICALS

A. State Pharmacy Assistance Program

§ -43 Definitions. As used in this part:

"Asset test" means the asset limits for eligibility in the state pharmacy assistance program as defined by the Medicare Modernization Act and any amendments thereto.

"Contractor" means the person, partnership, or corporate entity that has an approved contract with the department to administer the state pharmacy assistance program as established under this subpart.

"Enrollee" means a resident of this State who meets the conditions specified in this subpart and in department rules relating to eligibility for participation in the state pharmacy assistance program and whose application for enrollment in the state pharmacy assistance program has been approved by the department.

"Federal poverty level" means the federal poverty level updated annually in the Federal Register by the United States Department of Health and Human Services under the authority of Title 42 United States Code Section 9902(2).

"Full coverage prescription drug benefit" means a federally approved prescription drug plan that offers a zero co-payment benefit for medicaid dual eligibles under the medicare part D drug benefit.

"Liquid assets" means assets used in the eligibility determination process as defined by the Medicare Modernization Act.

"Medicaid dual eligible" means a person who is eligible for both medicaid and medicare as defined by the Medicare Modernization Act.

"Medicare Modernization Act" means the federal Medicare Prescription Drug, Improvement and Modernization Act of 2003.

"Medicare part D prescription drug benefit" means the federal prescription benefit provided under the Medicare Modernization Act.

"Prescription drug plan" means a plan provided by non-governmental entities under contract with the Federal Centers for Medicare and Medicaid Services to provide prescription benefits under the Medicare Modernization Act.

"Resident" means a person who lives within this state and has a fixed place of residence in this state, with the present intent of maintaining a permanent home in this state for the indefinite future.

§ -44 State pharmacy assistance program. (a) There is established within the department the state pharmacy assistance program. Provided that there are no federally approved

prescription drug plans available in the state that provide a full coverage prescription drug benefit, the state pharmacy assistance program may coordinate the prescription drug coverage with the federal medicare part D prescription drug benefit, including related supplies, as determined by the department, to each resident who meets the eligibility requirements as outlined in section -45.

(b) The department may provide enrollment assistance to eligible individuals into the state pharmacy assistance program.

(c) The department shall allow any willing prescription drug plan approved by the federal Centers for Medicare and Medicaid Services to provide the coordination of benefits between the State's medicare prescription drug program and the medicare part D drug benefit.

(d) The department may administer the state pharmacy assistance program or contract with a third party or parties in accordance with chapter 103F to administer any single component or combination of components of the state pharmacy assistance program, including outreach, eligibility, enrollment, claims, administration, rebate negotiations and recovery, and redistribution, to coordinate the prescription drug benefits of

the state pharmacy assistance program and the federal medicare part D drug benefit.

(e) Any contract with third parties to administer any component of the state pharmacy assistance program shall be established either at no cost to the State, or on a contingency-fee basis and with no up-front costs to the State, as may be negotiated by the department.

(f) Any contract with third parties to administer any component of the state pharmacy assistance program shall prohibit the contractor from receiving any compensation or other benefits from any pharmaceutical manufacturer participating in the state pharmacy assistance program.

(g) A prescription drug manufacturer or labeler that sells prescription drugs in the state may enter into a rebate agreement with the department. The rebate agreement may be agreed upon by the manufacturer or the labeler to make rebate payments to the department each calendar quarter or according to a schedule established by the department.

(h) The department or contractor may negotiate the amount of the rebate required from a manufacturer or labeler in accordance with this part.

(i) The department or contractor may take into consideration the rebate calculated under the medicaid rebate program pursuant to Title 42 United States Code Section 1396r-8, the average wholesale price of prescription drugs, and any other cost data related to prescription drug prices and price discounts.

(j) The department or contractor shall use their best efforts to obtain the best possible rebate amount.

(k) The department may prescribe the application and enrollment procedures for prospective enrollees.

(l) The department shall conduct ongoing quality assurance activities similar to those used in the State's medicaid program.

§ -45 Eligibility. (a) All residents of the State shall be eligible to participate in the state pharmacy assistance program; provided that the applicant:

(1) Is a resident of Hawaii;

(2) Is sixty-five years or older, or is disabled and receiving a social security benefit;

(3) Has a household income at or below one hundred fifty per cent of the federal poverty level;

(4) Meets the asset test; and

(5) Is not a member of a retirement plan who is receiving a benefit from the Medicare Modernization Act.

(b) State pharmacy assistance program applicants who are enrolled in any other public assistance program providing pharmaceutical benefits, other than the Medicare Modernization Act and medicaid, shall be ineligible for the state pharmacy assistance program as long as they receive pharmaceutical benefits from that other public assistance program, unless the applicant is eligible for medicare. Residents who qualify for, or are enrolled in, the Rx plus program shall be eligible for the state pharmacy assistance program; provided that they meet all other state pharmacy assistance program requirements.

(c) State pharmacy assistance program applicants who are enrolled in a private sector plan or insurance providing payments for prescription drugs shall be ineligible to receive benefits from the state pharmacy assistance program.

§ -46 Benefits. (a) For persons meeting the eligibility requirements in section -45, the state pharmacy assistance program may pay all or some of the co-payments required under the federal medicare part D pharmacy benefit program, subject to the sufficiency of funds in the state

pharmacy assistance program special fund, as determined by the department.

(b) The state pharmacy assistance program is the payor of last resort subject to the sufficiency of funds in the state pharmacy assistance program special fund, as determined by the department.

(c) The state pharmacy assistance program shall be funded with state appropriations, including funds derived from revenues to the State from rebates paid by pharmaceutical manufacturers pursuant to section -44(g), and with savings resulting from medicare prescription drug coverage for the medicaid dual eligible population.

§ -47 Special fund. (a) There is established within the state treasury to be administered by the department, the state pharmacy assistance program special fund, into which shall be deposited:

(1) All moneys received from manufacturers that pay rebates as provided in section -44(g);

(2) Appropriations made by the legislature to the fund; and

(3) Any other revenues designated for the fund.

(b) Moneys in the state pharmacy assistance program special fund may be used for:

(1) Reimbursement payments to participating pharmacies for co-payments required under the federal medicare part D pharmacy benefit program as provided to state pharmacy assistance program participants;

(2) The costs of administering the state pharmacy assistance program, including salary and benefits of employees, computer costs, and contracted services as provided in section -44(d); and

(3) Any other purpose deemed necessary by the department for the purpose of operating and administering the state pharmacy assistance program.

All interest on special fund balances shall accrue to the special fund. Upon dissolution of the state pharmacy assistance program special fund, any unencumbered moneys in the fund shall lapse to the general fund.

(c) The department shall expend all revenues received from rebates paid by pharmaceutical manufacturers pursuant to section -44(g) to pay for the benefits to enrollees in the state pharmacy assistance program, the costs of administering the program, and reimbursement of medicaid pharmaceutical costs.

§ -48 **Administrative rules.** The department shall adopt rules pursuant to chapter 91 necessary for the purposes of this part.

§ -49 **Annual reports.** The department shall report the enrollment and financial status of the state pharmacy assistance program to the legislature no later than twenty days prior to the convening of each regular session, beginning with the 2006 regular session.

B. Preauthorization Exemptions

§ -50 **Findings.** The legislature finds that:

(1) Patients who are medicaid recipients and who suffer from the human immunodeficiency virus, acquired immune deficiency syndrome, hepatitis C, or who are in need of immunosuppressives as a result of organ transplants, have the least means available to obtain proper medications required to control their illnesses;

(2) These medicaid recipients, if not promptly treated and maintained on effective medications, will, by the very nature of their illnesses, suffer greatly and may require increased medical care, including prolonged

hospitalization, resulting in increased costs to these patients and society as a whole;

(3) Failure to promptly treat a patient with the human immunodeficiency virus, acquired immune deficiency syndrome, or hepatitis C, and failure to use effective immunosuppressives during and after organ transplants, may result in increased suffering by the patients, the early or unnecessary loss of the patients' lives, increased cost of medical care, and increased emotional, physical, financial, and societal costs;

(4) It is ethically imperative that the physicians who treat medicaid recipient patients with human immunodeficiency virus, acquired immune deficiency syndrome, or hepatitis C, or patients who are in need of immunosuppressives before, during, and after transplant operations, have the unfettered ability to promptly medically intervene in treating these patients and to continue proven medications for those patients;

(5) The procedure of requiring preauthorization of medicaid recipients before dispensing medications for the treatment of human immunodeficiency virus,

acquired immune deficiency syndrome, hepatitis C, and immunosuppressives needed for transplant patients, is unduly arduous, difficult, and too time-consuming for practitioners with large numbers of these patients who require immediate treatment to avoid permanent injury and other undesirable consequences; and

(6) The imposition of a "first fail" plan before a physician can adjust or change a medication not on the approved list of medications is medically unsound. The condition of a seriously ill patient suffering from the human immunodeficiency virus, acquired immune deficiency syndrome, or hepatitis C, or who is in need of transplant immunosuppressives, will generally not remain stable for long without prompt treatment. If these persons are not more promptly and effectively treated, a significant probability exists that there will be a substantial increase in health care costs and hospitalizations, thereby increasing medical costs to the State.

§ -51 Preauthorization exemption for certain physicians and physician assistants. Any physician or physician assistant licensed in this State who treats a medicaid recipient patient

suffering from the human immunodeficiency virus, acquired immune deficiency syndrome, or hepatitis C, or who is a patient in need of transplant immunosuppressives, may prescribe any medications approved by the United States Food and Drug Administration and that are eligible pursuant to the Omnibus Budget Reconciliation Rebates Act and necessary to treat the condition, without having to comply with the requirements of any preauthorization procedure established by any other provision of this chapter.

PART V. INSURANCE MANDATES

§ -52 Insurance commissioner to implement this part. This part shall be administered by the insurance commissioner pursuant to the insurance commissioner's powers and duties under chapter 431 or any other law.

§ -53 Insurers prohibited from taking medicaid status into account. Any health insurer (including a self-insured plan, a group health plan as defined in Section 607(1) of the Employee Retirement Income Security Act of 1974, a health service benefit plan, a mutual benefit society, a fraternal benefit society, a health maintenance organization, a managed care organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service) is

prohibited, in enrolling an individual or in making any payments for benefits to the individual or on the individual's behalf, from taking into account that the individual is eligible for or is provided medical assistance under Title 42 United States Code Section 1396a (Section 1902 of the Social Security Act) herein referred to as medicaid, for this State, or any other state.

§ -54 State's right to third party payments. To the extent that payment has been made under the state plan for medical assistance for health care items or services furnished to an individual in any case where another party has a legal liability to make payment for such assistance, the State is considered to have acquired the rights of the individual to payment by the other party for those health care items or services.

§ -55 Insurer requirements. Any health insurer as identified in section -53 shall:

(1) Provide, with respect to individuals who are eligible for, or are provided, medical assistance under Title 42 United States Code Section 1396a (Section 1902 of the Social Security Act), as amended, upon the request of the State, information to determine during what period the individual or the individual's spouse or

dependents may be or may have been covered by a health insurer and the nature of the coverage that is or was provided by the health insurer, including the name, address, and identifying number of the plan in a manner prescribed by the State;

(2) Accept the State's right of recovery and the assignment to the State of any right of an individual or other entity to payment from the party for a health care item or service for which payment has been made for medical assistance under Title 42 United States Code Section 1396a (Section 1902 of the Social Security Act);

(3) Respond to any inquiry by the State regarding a claim for payment for any health care item or service that is submitted not later than three years after the date of the provision of the health care item or service; and

(4) Agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim, the type or format of the claim form, or a failure to present proper documentation at the point-of-sale that is the basis of the claim, if:

(A) The claim is submitted by the State within the three-year period beginning on the date on which the health care item or service was furnished; and

(B) Any action by the State to enforce its rights with respect to the claim is commenced within six years of the State's submission of the claim.

§ -56 **Coverage of children.** (a) No insurer shall deny enrollment of a child under the health plan of the child's parent for the following grounds:

(1) The child was born out of wedlock;

(2) The child is not claimed as a dependent on the parent's federal tax return; or

(3) The child does not reside with the parent or in the insurer's service area.

(b) Where a child has health coverage through an insurer of a noncustodial parent the insurer shall:

(1) Provide such information to the custodial parent as may be necessary for the child to obtain benefits through that coverage;

(2) Permit the custodial parent (or the provider, with the custodial parent's approval) to submit claims for

covered services without the approval of the noncustodial parent; and

(3) Make payments on claims submitted in accordance with paragraph (2) directly to the custodial parent, the provider, or the state medicaid agency.

(c) Where a parent is required by a court or administrative order to provide health coverage for a child, and the parent is eligible for family coverage, as defined in section 431:10A-103, and reciprocal beneficiary family coverage, as defined in section 431:10A-601, the insurer shall be required:

(1) To permit the parent to enroll, under the family coverage or reciprocal beneficiary family coverage, a child who is otherwise eligible for the coverage without regard to any enrollment season restrictions;

(2) If the parent is enrolled but fails to make application to obtain coverage for the child, to enroll the child under family coverage or reciprocal beneficiary family coverage upon application of the child's other parent, the state agency administering the medicaid program, or the state agency

administering the child support enforcement program; and

(3) Not to disenroll (or eliminate coverage of) the child unless the insurer is provided satisfactory written evidence that:

(A) The court or administrative order is no longer in effect; or

(B) The child is or will be enrolled in comparable health coverage through another insurer that will take effect not later than the effective date of disenrollment.

(d) An insurer may not impose requirements on a state agency, which has been assigned the rights of an individual eligible for medical assistance under medicaid and covered for health benefits from the insurer, that are different from requirements applicable to an agent or assignee of any other individual so covered.

§ -57 **Employer obligations.** Where a parent is required by a court or administrative order to provide health coverage, which is available through an employer doing business in this state, the employer is required:

(1) To permit the parent to enroll under family coverage, as defined in section 431:10A-103 or reciprocal beneficiary family coverage, as defined in section 431:10A-601, any child who is otherwise eligible for coverage without regard to any enrollment season restrictions;

(2) If the parent is enrolled but fails to make application to obtain coverage of the child, to enroll the child under family coverage or reciprocal beneficiary family coverage upon application by the child's other parent, by the state agency administering the medicaid program, or by the state agency administering the child support enforcement program;

(3) Not to disenroll (or eliminate coverage of) any such child unless the employer is provided satisfactory written evidence that:

(A) The court or administrative order is no longer in effect;

(B) The child is or will be enrolled in comparable coverage which will take effect no later than the effective date of disenrollment; or

(C) The employer has eliminated family health coverage or reciprocal beneficiary family coverage for all of its employees; and

(4) To withhold from the employee's compensation the employee's share (if any) of premiums for health coverage and to pay this amount to the insurer.

§ -58 Recoupment of amounts spent on child medical care. The department of the attorney general may garnish the wages, salary, or other employment income of, and withhold amounts from state tax refunds to, any person who:

(1) Is required by court or administrative order to provide coverage of the cost of health services to a child eligible for medical assistance under medicaid; and

(2) Has received payment from a third party for the costs of such services but has not used the payments to reimburse either the other parent or guardian of the child or the provider of the services,

to the extent necessary to reimburse the department for its costs, but claims for current and past due child support shall take priority over these claims.

§ -59 Requirements for coverage of an adopted child. (a) In any case in which a group health plan provides coverage for dependent children of participants or beneficiaries, the plan shall provide benefits to dependent children placed with participants or beneficiaries for adoption under the same terms and conditions as apply to the natural, dependent children of the participants and beneficiaries, irrespective of whether the adoption has become final.

(b) A group health plan may not restrict coverage under the plan of any dependent child adopted by a participant or beneficiary, or placed with a participant or beneficiary for adoption, solely on the basis of a preexisting condition of the child at the time that the child would otherwise become eligible for coverage under the plan, if the adoption or placement for adoption occurs while the participant or beneficiary is eligible for coverage under the plan.

(c) As used in this section:

"Child" means, in connection with any adoption, or placement for adoption, of the child, an individual who has not attained the age of eighteen as of the date of such adoption or placement for adoption.

"Placement for adoption" means the assumption and retention by a person of a legal obligation for total or partial support of a child in anticipation of the adoption of the child. The child's placement with a person terminates upon the termination of such legal obligation.

PART VI. FINANCING AND ENFORCEMENT

A. General Provisions

§ -60 Medical care payments. (a) The department shall adopt rules under chapter 91 concerning payment to providers of medical care. The department shall determine the rates of payment due to all providers of medical care, and pay such amounts in accordance with the requirements of the appropriations act and the Social Security Act, as amended. Payments to critical access hospitals for services rendered to medicaid beneficiaries shall be calculated on a cost basis using medicare reasonable cost principles.

(b) Rates of payment to providers of medical care who are individual practitioners, including doctors of medicine, dentists, podiatrists, psychologists, osteopaths, optometrists, and other individuals providing services, shall be based upon the Hawaii medicaid fee schedule. The amounts paid shall not exceed the maximum permitted to be paid individual practitioners

or other individuals under federal law and regulation, the medicare fee schedule for the current year, the state limits as provided in the appropriation act, or the provider's billed amount.

The appropriation act shall indicate the percentage of the medicare fee schedule for the year 2000 to be used as the basis for establishing the Hawaii medicaid fee schedule. For any subsequent adjustments to the fee schedule, the legislature shall specify the extent of the adjustment in the appropriation act.

(c) In establishing the payment rates for other noninstitutional items and services, the rates shall not exceed the current medicare payment, the state limits as provided in the appropriation act, the rate determined by the department, or the provider's billed amount.

(d) Payments to health maintenance organizations and prepaid health plans with which the department executes risk contracts for the provision of medical care to eligible public assistance recipients may be made on a prepaid basis. The rate of payment per participating recipient shall be fixed by contract, as determined by the department and the health maintenance organization or the prepaid health plan, but shall

not exceed the maximum permitted by federal rules and shall be less than the federal maximum when funds appropriated by the legislature for such contracts require a lesser rate. For purposes of this subsection, "health maintenance organizations" are entities approved as such, and "prepaid health plans" are entities designated as such by the Department of Health and Human Services; and "risk" means the possibility that the health maintenance organization or the prepaid health plan may incur a loss because the cost of providing services may exceed the payments made by the department for services covered under the contract.

(e) The department shall prepare each biennial budget request for a medical care appropriation based upon the most current Hawaii medicaid fee schedule available at the time the request is prepared.

The director shall submit a report to the legislature on or before January 1 of each year indicating an estimate of the amount of money required to be appropriated to pay providers at the maximum rates permitted by federal and state rules in the upcoming fiscal year.

§ -61 Interdepartmental transfer of funds; federal grants and allotments. The governor may transfer funds from the department of health to the department of human services and from the department of human services to the department of labor and industrial relations to obtain additional federal funds for medical assistance under Title XIX of the Social Security Act, as amended, and the work incentive program. The governor may also transfer funds from one department to another for the purpose of obtaining federal matching grants and allotments; provided that the state moneys have been appropriated for the purpose for which federal grants and allotments may be obtained.

§ -62 Comptroller's acceptance of vouchers. The requirements of section 40-56 and section 40-57 to the contrary notwithstanding, the comptroller may, if satisfied as to the adequacy of related internal controls and audit trails, issue warrants for original warrant vouchers without accompanying original bills for payments to vendors of the Hawaii state medicaid program. Whenever the comptroller has given the comptroller's approval for the issuance of warrants under this section without accompanying original bills, the original bills shall be retained by the expending agency vouchering the payment, and shall be made available for authorized referencing,

for the period prescribed by section 40-10 for the retention of vouchers, documents and other records or papers before destruction. For purposes of this section, the definition of original bills shall also include computer magnetic tape, computer listings, computer output microfilm, microfiche, and manually produced microfilm.

§ -63 Medicaid contracts; nonprofits and for-profits; reporting requirements. (a) All nonprofit or for-profit medicaid healthcare insurance contractors, within one hundred and eighty days following the close of each fiscal year, shall submit an annual report to the department of human services, the insurance division of the department of commerce and consumer affairs, and the legislature. The report shall be attested to by a plan executive located within the state and shall be made accessible to the public.

The report shall be based on contracts administered in the State and shall include:

(1) An accounting of expenditures of MedQuest contract payments for the contracted services, including the percentage of payments:

(A) For medical services;

(B) For administrative costs;

(C) Held in reserve; and

(D) Paid to shareholders;

(2) Employment information including:

(A) Total number of full-time employees hired for the contracted services;

(B) Total number of employees located in the state and the category of work performed; and

(C) The compensation provided to each of the five highest paid Hawaii employees and to each of the five highest paid employees nationwide, and a description of each position;

(3) Descriptions of any on-going state or federal sanction proceedings, prohibitions, restrictions, on-going civil or criminal investigations, and descriptions of past sanctions or resolved civil or criminal cases, within the past five years and related to the provision of medicare or medicaid services by the contracting entity, to the extent allowed by law;

(4) Descriptions of contributions to the community, including the percentage of revenue devoted to Hawaii community development projects and health

enhancements; provided that contracted services shall not be included in the percentage calculation; and

(5) A list of any management and administrative service contracts for MedQuest services made in Hawaii and outside of the state, including a description of the purpose and cost of those contracts.

(b) The department of human services shall include in all medicaid healthcare insurance plan contracts, the annual reporting requirements of subsection (a).

(c) Any contract under this section shall be governed by the laws of the State of Hawaii.

(d) Within ninety days of receipt of the reports required by this section, the department of human services shall provide a written analysis and comparative report to the legislature.

§ -64 Maintenance and availability of records; penalty. (a) To enable another provider to determine the proper course of treatment in emergencies and in order to determine whether a provider is genuinely entitled to reimbursement and to protect the medicaid program against fraud and abuse, each provider of health care, service or supplies under the state medicaid program shall maintain, and keep for a period of three years, such records as are necessary to disclose fully the type and

extent of health care, service or supplies provided to medicaid recipients. The department may identify the types of records necessary to be kept by promulgation of appropriate rules.

(b) No provider shall refuse or fail to make available at the provider's place of business or appropriate location, during normal business hours, or, if the appropriate representative agrees, at the mutual convenience of the parties, immediate access to all records required to be maintained under this section or rules promulgated hereunder and all diagnostic devices concerning or used for the provision of health care, service or supplies to a medicaid recipient to any duly authorized representative of the attorney general's office or the department of human services acting in the course and scope of the duly authorized representative's employment; such diagnostic devices may be examined and tested and such records may be retained by said duly authorized representative for a reasonable period of time for the purpose of examination, audit, copying, testing or photographing. This subsection shall supersede any other provision of the Hawaii Revised Statutes to the contrary notwithstanding.

(c) Whenever a provider without reasonable justification fails to keep adequate supporting records as required by this

section or rules promulgated hereunder or fails to make them available as required by this section, the director of human services shall suspend the provider during the period of noncompliance with this section, and no payment may be made to such provider with respect to any item or service furnished by such provider during the period of suspension. A provider shall receive notice and be provided an opportunity for a hearing in compliance with regulations of the department of human services for such suspension.

(d) Wilful refusal or failure to make records available as provided in subsection (b) of this section is a misdemeanor."

§ -65 Administrative inspections and warrants. (a) Issuance and execution of administrative inspection warrants shall be as follows:

(1) A judge of the circuit court, or any district judge within the judge's jurisdiction, and upon proper oath or affirmation showing probable cause, may issue warrants for the purpose of conducting administrative inspections authorized by this chapter or rules hereunder, and seizures of the property appropriate to the inspections. For purposes of the issuance of administrative inspection warrants, probable cause

exists upon showing a valid public interest in the effective enforcement of this chapter or rules hereunder, sufficient to justify administrative inspection of the area, premises, building, conveyance or records in the circumstances specified in the application for the warrant;

(2) A warrant shall issue only upon an affidavit of an individual having knowledge of the facts alleged, sworn to before the judge and establishing the grounds for issuing the warrant. If the judge is satisfied that grounds for the issuance exist or that there is probable cause to believe they exist, the judge shall issue a warrant identifying the area, premises, building, conveyance or records to be inspected, the purpose of the inspection, and, if appropriate, the type of property to be inspected, if any. The warrant shall:

(A) State the grounds for its issuance and the name of each person whose affidavit has been taken in support thereof;

(B) Be directed to a person authorized by the attorney general or the director of human services to execute it;

(C) Command the person to whom it is directed to inspect the area, premises, building, conveyance or records identified for the purpose specified and, if appropriate, use reasonable force in conducting the inspection authorized by the warrant and direct the seizure of the property specified;

(D) Identify the item or types of property to be seized, if any;

(E) Direct that it be served during normal business hours and designate the judge to whom it shall be returned;

(3) A warrant issued pursuant to this section must be executed and returned within ten days of its date unless, upon a showing of a need for additional time, the court orders otherwise. If property is seized pursuant to a warrant, a copy shall be given to the person from whom or from whose premises the property is taken, together with a receipt for the property

taken. The return of the warrant shall be made promptly, accompanied by a written inventory of any property taken. The inventory shall be made in the presence of the person executing the warrant and of the person from whose possession or premises the property was taken, if present, or in the presence of at least one credible person other than the person executing the warrant. A copy of the inventory shall be delivered to the person from whom or from whose premises the property was taken and to the applicant for the warrant;

(4) The judge who has issued a warrant shall attach thereto a copy of the return and all papers returnable in connection therewith and file them with the clerk of the issuing court.

(b) The designated representative of the attorney general or the department may make administrative inspections of provider premises in accordance with the following provisions:

(1) For purposes of this section only, "provider premises" means:

(A) Places where providers are required to keep records; and

(B) Places where providers conduct business related to their receipt of payments from the medicaid program for healthcare, service or supplies.

(2) When authorized by an administrative inspection warrant issued pursuant to subsection (a) the representative upon presenting the warrant and appropriate credentials to the owner, operator, or agent in charge, may enter providers premises for the purpose of conducting an administrative inspection.

(3) When authorized by an administrative inspection warrant, the representative may:

(A) Inspect and copy records required by this chapter to be kept;

(B) Retain records required by this chapter to be kept for a reasonable period of time, not to exceed forty-eight hours, for the purpose of examination, audit, copying, testing or photographing;

(C) Inspect, examine and test diagnostic devices used in the provision of health care, service or supplies to a medicaid recipient;

(D) Inventory any stock of any substance used in the provision of health care, service or supplies to a medicaid recipient and to obtain samples thereof;

(E) Inspect, examine and test, within reasonable limits and in a reasonable manner, provider premises and equipment as necessary to assure compliance with this chapter.

(4) This section does not prevent the inspection without a warrant of property, books and records pursuant to an administrative subpoena issued in accordance with law, nor does it prevent entries and administrative inspections, including seizures of property, without a warrant:

(A) If the owner, operator, or agent in charge of the provider premises consents;

(B) In situations presenting imminent danger to health or safety;

(C) In situations involving inspection of conveyances if there is reasonable cause to believe that the mobility of the conveyance makes it impracticable to obtain a warrant;

(D) In all other situations in which a warrant is not constitutionally required.

B. Federally Qualified Health Centers

§ -66 Medicaid overpayment recovery. The director shall recover medicaid overpayments made to providers. Medicaid overpayments shall be recovered due to a provider's ineligibility, noncovered service, noncovered drug, lack of prior authorization when a service requires one, incorrect payment allowance identified through any post payment review, or claims processing error. The director may recover overpayments through recoupment, tax offset under sections 231-51 to 231-59, and circuit court judgment. Nothing in this section shall limit the director's authority to recover overpayments through all other lawful means.

§ -67 Enforcement of decisions regarding medicaid overpayment recovery; judgment rendered thereon. (a) The director may file in the circuit court in the jurisdiction in which the medicaid overpayment occurred a certified copy of:

(1) A decision of the director assessing a medicaid overpayment against a provider from which no appeal has been taken within the time allowed therefor;

(2) A decision of the director assessing a medicaid overpayment against a provider from which an appeal has been taken but in which no order has been made by the director, the administrative appeals officer, or the court that the appeal shall operate as a supersedeas or stay;

(3) A decision of the administrative appeals officer assessing a medicaid overpayment against a provider from which no appeal has been taken within the time allowed therefor; or

(4) A decision of the administrative appeals officer assessing a medicaid overpayment against a provider from which an appeal has been taken but in which no order has been made by the administrative appeals officer or the court that the appeal shall operate as a supersedeas or stay.

The court shall render a judgment in accordance with the decision and notify the parties thereof. The judgment shall have the same effect, and all proceedings in relation thereto shall thereafter be the same, as though the judgment had been rendered in an action duly heard and determined by the court, except that there shall be no appeal therefrom.

(b) In all cases in which an appeal from the decision has been taken within the time provided, but in which the director, the administrative appeals officer, or the court has not issued an order that the appeal shall operate as a supersedeas or stay, the decree or judgment of the circuit court shall provide that the decree or judgment shall become void if the decision or award of the director or administrative appeals officer, as the case may be is later set aside.

(c) As used in this section, the term "administrative appeals officer" means the director's designated subordinate appointed to contested case hearings pursuant to chapter 91, and this chapter.

B. Federally Qualified Health Centers

§ -68 Federally qualified health centers; rural health clinics; reimbursement. (a) Notwithstanding any law or waiver to the contrary, federally qualified health centers and rural health clinics, as defined in Section 1905(1) of the Social Security Act (42 U.S.C. 1396 et seq.), shall be reimbursed in accordance with Section 1902(bb) of the Social Security Act, as that section was originally added in 2000 by section 702(b) of Public Law 106-554 and as amended in 2001 by section 2(b)(1) of Public Law 107-121, and services of federally qualified health

centers and rural health clinics shall remain mandatory services as provided in Sections 1902(a)(10)(A) and 1905(a)(2)(B) and (C) of the Social Security Act.

(b) Reimbursement rates paid to federally qualified health centers may be adjusted if costs exceed 1.75 per cent for changes related to the intensity, duration, or amount of service provided, facilities, regulatory requirements, or other extraordinary circumstances; provided that the federally qualified health center shall submit to the department an adjusted cost report covering a period of the previous two years. The director shall review the filing within a period of sixty days. The period may be extended by the director for an additional period not to exceed thirty days upon written notice to the filer. A filing shall be deemed to be approved unless disapproved by the director within the initial filing period or any extension thereof.

(c) The State may terminate the reimbursement methodology set forth in this section only in the event that changes in the relevant sections of the Social Security Act prohibit this reimbursement methodology.

§ -69 Centers for Medicare and Medicaid Services approval. The department shall implement sections -70, -

71, and -72, subject to approval of the Hawaii medicaid state plan by the Centers for Medicare and Medicaid Services.

§ -70 Federally qualified health centers and rural health clinics; reconciliation of managed care supplemental payments. (a) Federally qualified health centers or rural health clinics that provide services under a contract with a medicaid managed care organization shall receive estimated quarterly state supplemental payments for the cost of furnishing such services that are an estimate of the difference between the payments the federally qualified health center or rural health clinic receives from medicaid managed care organizations and payments the federally qualified health center or rural health clinic would have received under the Benefits Improvement and Protection Act of 2000 prospective payment system methodology. Not more than one month following the beginning of each calendar quarter and based on the receipt of federally qualified health center or rural health clinic submitted claims during the prior calendar quarter, federally qualified health centers or rural health clinics shall receive the difference between the combination of payments the federally qualified health center or rural health clinic receives from estimated supplemental quarterly payments and payments received from medicaid managed

care organizations and payments the federally qualified health center or rural health clinic would have received under the Benefits Improvement and Protection Act of 2000 prospective payment system methodology. Balances due from the federally qualified health center shall be recouped from the next quarter's estimated supplemental payment.

(b) The federally qualified health center or rural health clinic shall file an annual settlement report summarizing patient encounters within one hundred fifty days following the end of a calendar year in which supplemental payments are received from the department. The total amount of supplemental and medicaid managed care organization payments received by the federally qualified health center or rural health clinic shall be reviewed against the amount that the actual number of visits provided under the federally qualified health center's or rural health clinic's contract with the medicaid managed care organization would have yielded under the prospective payment system. The department shall also receive financial records from the medicaid managed care organization. As part of this review, the department may request additional documentation from the federally qualified health center or rural health clinic and the medicaid managed care organization to resolve differences

between medicaid managed care organization and provider records. Upon conclusion of the review, the department shall calculate a final payment that is due to or from the participating federally qualified health center or rural health clinic. The department shall notify the participating federally qualified health center or rural health clinic of the balance due to or from the federally qualified health center or rural health clinic. The notice of program reimbursement shall include the department's calculation of the balance due to or from the federally qualified health center or rural health clinic.

(c) For the purposes of this section, the payments received from medicaid managed care organizations exclude payments for non-prospective payment system services, managed care risk pool accruals, distributions, or losses, or any pay-for-performance bonuses or other forms of incentive payments such as quality improvement recognition grants and awards.

(d) An alternative supplemental managed care payment methodology other than the one set forth herein may be implemented as long as the alternative payment methodology is consented to in writing by the federally qualified health center or rural health clinic to which the methodology applies.

§ -71 Federally qualified health center or rural health clinic; adjustment for changes to scope of services. (a) Prospective payment system rates may be adjusted for any increases or decreases in the scope of services furnished by a participating federally qualified health center or rural health clinic, provided that:

(1) The federally qualified health center or rural health clinic notifies the department in writing of any changes to the scope of services and the reasons for those changes within sixty days of the effective date of the changes;

(2) The federally qualified health center or rural health clinic submits data, documentation, and schedules that substantiate any changes in services and the related adjustment of reasonable costs following medicare principles of reimbursement; and

(3) The federally qualified health center or rural health clinic proposes a projected adjusted rate within one hundred fifty days of the changes to the scope of services.

(b) This proposed projected adjusted rate is subject to departmental approval. The proposed projected adjusted rate

shall be calculated based on a consolidated basis where the federally qualified health center or rural health clinic takes all costs for the center that would include both the costs included in the base rate, as well as the additional costs; provided that the federally qualified health center or rural health clinic calculated the baseline prospective payment system rate based on total consolidated costs. A net change in the federally qualified health center's or rural health clinic's rate shall be calculated by subtracting the federally qualified health center's or rural health clinic's previously assigned prospective payment system rate from its projected adjusted rate.

(c) Within one hundred twenty days of its receipt of the projected adjusted rate and all additional documentation requested by the department, the department shall notify the federally qualified health center or rural health clinic of its acceptance or rejection of the projected adjusted rate. Upon approval by the department, the federally qualified health center or rural health clinic shall be paid the projected rate, which shall be effective from the date of the change in scope of services through the date that a rate is calculated based upon

the first full fiscal year that includes the change in scope of services.

(d) The department shall review the calculated rate of the first full fiscal year cost report if the change of scope of service is reflected in more than six months of the report. For those federally qualified health centers or rural health clinics in which the change of scope of services is in effect for six months or less of the cost report fiscal year, review of the next full fiscal year cost report also is required. The department shall review the calculated inflated weighted average rate of these two cost reports. The total costs of the first year report shall be adjusted to the Medical Economic Index of the second year report. Each report shall be weighted based upon number of patient encounters.

(e) Upon receipt of the cost reports, the prospective payment system rate shall be adjusted following a review by the fiscal agent of the cost reports and documentation. Adjustments shall be made for payments for the period from the effective date of the change in scope of services through the date of the final adjustment of the prospective payment system rate.

(f) For the purposes of prospective payment system rate adjustment, a change in scope of services provided by a

federally qualified health center or rural health clinic means the following:

(1) The addition of a new service, such as adding dental services or any other medicaid covered service, that is not incorporated in the baseline prospective payment system rate or a deletion of a service that is incorporated in the baseline prospective payment system rate;

(2) A change in service resulting from amended regulatory requirements or rules;

(3) A change in service resulting from relocation;

(4) A change in type, intensity, duration, or amount of service resulting from a change in applicable technology and medical practice used;

(5) An increase in service intensity, duration, or amount of service resulting from changes in the types of patients served, including but not limited to populations with human immunodeficiency virus, acquired immunodeficiency syndrome, or other chronic diseases, or homeless, elderly, migrant, or other special populations;

(6) A change in service resulting from a change in the provider mix of a federally qualified health center or a rural health clinic or one of its sites;

(7) Any changes in the scope of a project approved by the Federal Health Resources and Services Administration where the change affects a covered service; or

(8) Changes in operating costs due to capital expenditures associated with a modification of the scope of any of the services, including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the federally qualified health center or rural health clinic.

(g) No change in costs, in and of itself, shall be considered a scope of service change unless the cost is allowable under medicaid principles of reimbursement and the net change in the federally qualified health center's or rural health clinic's per visit rate equals or exceeds three per cent for the affected federally qualified health center or rural health clinic site. For federally qualified health centers or rural health clinics that filed consolidated cost reports for multiple sites to establish their baseline prospective payment system rates, the net change of three per cent shall be applied

to the average per visit rate of all the sites of the federally qualified health center or rural health clinic for purposes of calculating the costs associated with a scope of service change. For the purposes of this section, "net change" means the per visit change attributable to the cumulative effect of all increases or decreases for a particular fiscal year.

(h) All references in this section to "fiscal year" shall be construed to be references to the fiscal year of the individual federally qualified health center or rural health clinic, as the case may be.

§ -72 Federally qualified health center or rural health clinic visit. (a) Services eligible for prospective payment system reimbursement are those services that are furnished by a federally qualified health center or rural health clinic that are:

(1) Within the legal authority of a federally qualified health center to deliver, as defined in section 1905 of the Social Security Act;

(2) Actually provided by the federally qualified health center, either directly or under arrangements;

(3) Covered benefits under the medicaid program, as defined in section 4231 of the State Medicaid Manual and the Hawai'i medicaid state plan;

(4) Provided to a recipient eligible for medicaid benefits;

(5) Delivered exclusively by health care professionals, including physicians, physician's assistants, nurse practitioners, nurse midwives, clinical social workers, clinical psychologists, and other persons acting within the lawful scope of their license or certificate to provide services;

(6) Provided at the federally qualified health center's practice site, a hospital emergency room, in an inpatient setting, at the patient's place of residence, including long term care facilities, or at another medical facility; and

(7) Within the scope of services provided by the State under its fee-for-service medicaid program and its health QUEST program, on and after August 1994, and as amended from time to time.

(b) Contacts with one or more health professionals and multiple contacts with the same health professional that take

place on the same day and at a single location constitute a single encounter, except when one of the following conditions exists:

(1) After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment; or

(2) The patient makes one or more visits for other services such as dental or behavioral health. Medicaid may pay for a maximum of one visit per day for each of these services in addition to one medical visit.

(c) A federally qualified health center or rural health clinic that provides prenatal services, delivery services, and post natal services may elect to bill the managed care organization for all such services on a global payment basis. Alternatively, it may bill for prenatal and post natal services separately from delivery services and be paid the per visit prospective payment system reimbursement for prenatal and post natal visits. In this case, it may bill the managed care organization separately for inpatient delivery services that are not eligible for prospective payment system reimbursement.

§ -73 **Appeal.** A federally qualified health center or rural health clinic may appeal a decision made by the department if the medicaid impact is $10,000 or more, whereupon the opportunity for an administrative hearing under chapter 91 shall be afforded. Any federally qualified health center or rural health clinic aggrieved by the final decision and order shall be entitled to judicial review in accordance with chapter 92 or may submit the matter to binding arbitration pursuant to chapter 658A.

§ -74 **Hawaii qualified health centers.** If the QUEST program is implemented, the department shall provide a supplemental capitation program for the uninsured with enabling services based on an annual cost-based determination to all federally qualified health center, (FQHC), FQHC look-alike, or need health clinic designated as a Hawaii qualified health center under section 321-1.6, (HQHCs) and to any nonprofit entity having a majority of Hawaii qualified health centers as board members.

For the purposes of this section, "enabling services" includes enabling services as defined by federally qualified health center standards. The department shall have the administrative flexibility to expend funds through QUEST

contracts, through a modified voucher system, or through chapter 42D. Hawaii qualified health centers receiving these supplemental payments shall reconcile their costs on an annual basis.

C. Medicaid Fraud

§ -75 Medicaid fraud unit. There is established in the department of the attorney general a medicaid fraud unit.

The unit shall employ such attorneys, auditors, investigators, and other personnel as necessary to promote the effective and efficient conduct of the unit's activities. Except for the attorneys, all other employees of the medicaid fraud unit shall be subject to chapter 76.

The purpose of the medicaid fraud unit shall be to conduct a statewide program for the investigation and prosecution of medicaid fraud cases and violations of all applicable state laws relating to the providing of medical assistance and the activities of providers of such assistance. The medicaid fraud unit may also review and take appropriate action on complaints of abuse and neglect of patients of health care facilities receiving payments under the state plan for medical assistance and may provide for collection or referral for collection of

overpayments made under the state plan for medical assistance that are discovered by the unit in carrying out its activities.

§ -76 Medicaid investigations recovery fund; established. There is established in the state treasury the medicaid investigations recovery fund as a special fund, and which is to be administered by the department of the attorney general, into which shall be deposited all funds that have been recovered as a result of medicaid fraud settlements. Moneys from this special fund shall be used to support a portion of operating expenses of the medicaid fraud unit within the department of the attorney general."

SECTION 2. Section 231-51, Hawaii Revised Statutes, is amended to read as follows:

"**§231-51 Purpose.** The purpose of sections 231-52 to 231-59 is to permit the retention of state income tax refunds of those persons who owe a debt to the State, who are delinquent in the payment of child support pursuant to section 576D-1, who have defaulted on an education loan note held by the United Student Aid Funds, Inc., who owe federal income taxes to the United States Treasurer, or who receive a medicaid overpayment subject to recovery under section [~~346-59.6.~~] -61."

SECTION 3. Section 231-52, Hawaii Revised Statutes, is amended by amending the definition of "debt" to read as follows:

""Debt" includes:

(1) Any delinquency in periodic court-ordered or administrative-ordered payments for child support pursuant to section 576D-1, in an amount equal to or exceeding the sum of payments which would become due over a one-month period;

(2) Any liquidated sum exceeding $25 which is due and owing any claimant agency, regardless of whether there is an outstanding judgment for that sum, and whether the sum has accrued through contract, subrogation, tort, operation of law, or judicial or administrative judgment or order;

(3) Any defaulted education loan note held by the United Student Aid Funds, Inc. incurred under the federal Higher Education Act of 1965 (Public Law 89-329, 79 Stat. 1219), as amended;

(4) Any federal income taxes due and owing to the United States Treasurer; or

(5) Any medicaid overpayment under section [~~346-59.6.~~] -61."

SECTION 4. Section 237-24.7, Hawaii Revised Statutes, is amended to read as follows:

"**§237-24.7 Additional amounts not taxable.** In addition to the amounts not taxable under section 237-24, this chapter shall not apply to:

(1) Amounts received by the operator of a hotel from the owner of the hotel or from a time share association, and amounts received by the suboperator of a hotel from the owner of the hotel, from a time share association, or from the operator of the hotel, in amounts equal to and which are disbursed by the operator or suboperator for employee wages, salaries, payroll taxes, insurance premiums, and benefits, including retirement, vacation, sick pay, and health benefits. As used in this paragraph:

"Employee" means employees directly engaged in the day-to-day operation of the hotel and employed by the operator or suboperator.

"Hotel" means an operation as defined in section 445-90 or a time share plan as defined in section 514E-1.

"Operator" means any person who, pursuant to a written contract with the owner of a hotel or time share association, operates or manages the hotel for the owner or time share association.

"Owner" means the fee owner or lessee under a recorded lease of a hotel.

"Suboperator" means any person who, pursuant to a written contract with the operator, operates or manages the hotel as a subcontractor of the operator.

"Time share association" means an "association" as that term is defined in section 514E-1;

(2) Amounts received by the operator of a county transportation system operated under an operating contract with a political subdivision, where the political subdivision is the owner of the county transportation system. As used in this paragraph:

"County transportation system" means a mass transit system of motorized buses providing regularly scheduled transportation within a county.

"Operating contract" or "contract" means a contract to operate and manage a political

subdivision's county transportation system, which provides that:

(A) The political subdivision shall exercise substantial control over all aspects of the operator's operation;

(B) The political subdivision controls the development of transit policy, service planning, routes, and fares; and

(C) The operator develops in advance a draft budget in the same format as prescribed for agencies of the political subdivision. The budget must be subject to the same constraints and controls regarding the lawful expenditure of public funds as any public sector agency, and deviations from the budget must be subject to approval by the appropriate political subdivision officials involved in the budgetary process.

"Operator" means any person who, pursuant to an operating contract with a political subdivision, operates or manages a county transportation system.

"Owner" means a political subdivision that owns or is the lessee of all the properties and facilities of the county transportation system (including buses, real estate, parking garages, fuel pumps, maintenance equipment, office supplies, etc.), and that owns all revenues derived therefrom;

(3) Surcharge taxes on rental motor vehicles imposed by chapter 251 and passed on and collected by persons holding certificates of registration under that chapter;

(4) Amounts received by the operator of orchard properties from the owner of the orchard property in amounts equal to and which are disbursed by the operator for employee wages, salaries, payroll taxes, insurance premiums, and benefits, including retirement, vacation, sick pay, and health benefits. As used in this paragraph:

"Employee" means an employee directly engaged in the day-to-day operations of the orchard properties and employed by the operator.

"Operator" means a producer who, pursuant to a written contract with the owner of the orchard

property, operates or manages the orchard property for the owner where the property contains an area sufficient to make the undertaking economically feasible.

"Orchard property" means any real property that is used to raise trees with a production life cycle of fifteen years or more producing fruits or nuts having a normal period of development from the initial planting to the first commercially saleable harvest of not less than three years.

"Owner" means a fee owner or lessee under a recorded lease of orchard property;

(5) Taxes on nursing facility income imposed by chapter [~~346E~~] ____ and passed on and collected by operators of nursing facilities;

(6) Amounts received under property and casualty insurance policies for damage or loss of inventory used in the conduct of a trade or business located within the [~~State~~] state or a portion thereof that is declared a natural disaster area by the governor pursuant to section 209-2;

(7) Amounts received as compensation by community organizations, school booster clubs, and nonprofit organizations under a contract with the chief election officer for the provision and compensation of precinct officials and other election-related personnel, services, and activities, pursuant to section 11-5;

(8) Interest received by a person domiciled outside the [~~State~~] state from a trust company (as defined in section 412:8-101) acting as payment agent or trustee on behalf of the issuer or payees of an interest bearing instrument or obligation, if the interest would not have been subject to tax under this chapter if paid directly to the person domiciled outside the [~~State~~] state without the use of a paying agent or trustee; provided that if the interest would otherwise be taxable under this chapter if paid directly to the person domiciled outside the [~~State,~~] state, it shall not be exempt solely because of the use of a Hawaii trust company as a paying agent or trustee;

(9) Amounts received by a management company from related entities engaged in the business of selling interstate or foreign common carrier telecommunications services

in amounts equal to and which are disbursed by the management company for employee wages, salaries, payroll taxes, insurance premiums, and benefits, including retirement, vacation, sick pay, and health benefits. As used in this paragraph:

"Employee" means employees directly engaged in the day-to-day operation of related entities engaged in the business of selling interstate or foreign common carrier telecommunications services and employed by the management company.

"Management company" means any person who, pursuant to a written contract with a related entity engaged in the business of selling interstate or foreign common carrier telecommunications services, provides managerial or operational services to that entity.

"Related entities" means:

(A) An affiliated group of corporations within the meaning of [~~section~~] Section 1504 (with respect to affiliated group defined) of the federal Internal Revenue Code of 1986, as amended;

(B) A controlled group of corporations within the meaning of [~~section~~] Section 1563 (with respect to definitions and special rules) of the Federal Internal Revenue Code of 1986, as amended;

(C) Those entities connected through ownership of at least eighty per cent of the total value and at least eighty per cent of the total voting power of each such entity (or combination thereof), including partnerships, associations, trusts, S corporations, nonprofit corporations, limited liability partnerships, or limited liability companies; and

(D) Any group or combination of the entities described in paragraph (C) constituting a unitary business for income tax purposes;

whether or not the entity is located within or without the [~~State~~] state or licensed under this chapter; and

(10) Amounts received as grants under section 206M-15."

SECTION 5. Section 328C-1, Hawaii Revised Statutes, is amended by amending to definition of "needy person" to read as follows:

""Needy person" means any natural person who lacks the means to obtain adequate or proper pharmaceuticals or health care supplies, as determined by a practitioner at a Hawaii qualified health center, established under section [~~346-41.5,~~] -9, to be in need of service."

SECTION 6. Section 346-53, Hawaii Revised Statutes, is amended by amending subsections (c) and (d) to read as follows:

"(c) The director, pursuant to chapter 91, shall determine the rate of payment for domiciliary care, including care provided in licensed developmental disabilities domiciliary homes, community care foster family homes, and certified adult foster homes, to be provided to recipients who are eligible for Federal Supplementary Security Income or public assistance, or both. The director shall provide for level of care payment as follows:

(1) Beginning on July 1, 2008, for adult residential care homes classified as facility type I, licensed developmental disabilities domiciliary homes as defined under section 321-15.9, community care foster

family homes as defined under section [~~346-331,~~] ___-18, and certified adult foster homes as defined under section 321-11.2, the state supplemental payment shall not exceed $651.90; and

(2) Beginning on July 1, 2008, for adult residential care homes classified as facility type II, the state supplemental payment shall not exceed $759.90.

If the operator does not provide the quality of care consistent with the needs of the individual to the satisfaction of the department, the department may remove the recipient to another facility.

The department shall handle abusive practices under this section in accordance with chapter 91.

Nothing in this subsection shall allow the director to remove a recipient from an adult residential care home or other similar institution if the recipient does not desire to be removed and the operator is agreeable to the recipient remaining, except where the recipient requires a higher level of care than provided or where the recipient no longer requires any domiciliary care.

(d) On July 1, 2006, and thereafter, as the department determines a need, the department shall authorize a payment, as

allowed by federal law, for resident clients receiving supplemental security income in adult residential care home type I and type II facilities, licensed developmental disabilities domiciliary homes as defined under section 321-15.9, community care foster family homes as defined under section [~~346-331,~~] -18, and certified adult foster homes as defined under section 321-11.2, when state funds appropriated for the purpose of providing payments under subsection (c) for a specific fiscal year are not expended fully within a period that meets the requirements of the department's maintenance of effort agreement with the Social Security Administration.

The payment shall be made with that portion of state funds identified in this subsection that has not been expended.

The department shall determine the rate of payment to ensure compliance with its maintenance of effort agreement with the Social Security Administration."

SECTION 7. Section 346-34, Hawaii Revised Statutes, is amended by amending subsection (g) to read as follows:

"(g) No person shall knowingly transfer assets from that person's name to another person's or entity's name for the purpose of qualifying for public assistance under this chapter or chapter [~~346D.~~] ___. It shall be prima facie evidence of

such a transfer if there was a transfer of assets for less than fair market value of the assets within the federally required time period, or "lookback" period, from the date of the application for public assistance."

SECTION 8. Section 576D-10, Hawaii Revised Statutes, is amended by amending subsections (e) through (g) to read as follows:

"(e) Any alternative arrangement for direct payment shall provide that either parent may void the arrangement at any time and apply for services from the agency to act as agent to receive payments from the obligor parent. The alternative arrangement for direct payment also shall provide that, if the subject dependents of the obligor parent commence receiving public assistance[~~,~~] including but not limited to public assistance from the department of human services under chapter 346[~~,~~] or , foster care under section 571-48, Title IV-E or Title XIX of the [~~federal~~] Federal Social Security Act (42 U.S.C. §1396), or if either parent applies for services from the agency, the agency may immediately void the direct payment arrangement by sending written notice by regular mail to the custodial and obligor parents at their last known addresses, as disclosed in the alternative arrangement agreement.

(f) The alternative arrangement for direct payment agreement shall include the most recent addresses of the custodial and obligor parent. If the obligor parent alleges direct payment of child support to the custodial parent after the subject dependents of the court-approved alternative arrangement become recipients of public assistance, including but not limited to public assistance from the department of human services under chapter 346[~~,~~] or , foster care under [~~section~~] Section 571-48, Title IV-E or Title XIX of the [~~federal~~] Federal Social Security Act (42 U.S.C. §1396), or after the custodial parent applies for services from the agency, and after receiving proper notification of the change of payee to the agency, then the obligor shall have the burden of proving that the child support payments were made by presenting written evidence, including but not limited to canceled checks or receipts.

(g) No alternative arrangement for direct payment shall be approved where the obligor or the custodial parent is receiving services under Title IV-D or where the dependents of the obligor receive public assistance, including but not limited to public assistance from the department of human services under chapter 346[~~,~~] or , foster care under [~~section~~] Section 571-48, Title

IV-E or Title XIX of the [~~federal~~] Federal Social Security Act (42 U.S.C. §1396), or where the obligor owes child support for a period during which public assistance was provided to the child or children by the department of human services."

SECTION 9. Section 846-2.7, Hawaii Revised Statutes, is amended by amending subsection (b) to read as follows:

"(b) Criminal history record checks may be conducted by:

(1) The department of health on operators of adult foster homes or developmental disabilities domiciliary homes and their employees, as provided by section 333F-22;

(2) The department of health on prospective employees, persons seeking to serve as providers, or subcontractors in positions that place them in direct contact with clients when providing non-witnessed direct mental health services as provided by section 321-171.5;

(3) The department of health on all applicants for licensure for, operators for, and prospective employees, and volunteers at one or more of the following: skilled nursing facility, intermediate care facility, adult residential care home, expanded adult residential care home, assisted living facility,

home health agency, hospice, adult day health center, special treatment facility, therapeutic living program, intermediate care facility for the mentally retarded, hospital, rural health center and rehabilitation agency, and, in the case of any of the above-related facilities operating in a private residence, on any adult living in the facility other than the client as provided by section 321-15.2;

(4) The department of education on employees, prospective employees, and teacher trainees in any public school in positions that necessitate close proximity to children as provided by section 302A-601.5;

(5) The counties on employees and prospective employees who may be in positions that place them in close proximity to children in recreation or child care programs and services;

(6) The county liquor commissions on applicants for liquor licenses as provided by section 281-53.5;

(7) The department of human services on operators and employees of child caring institutions, child placing organizations, and foster boarding homes as provided by section 346-17;

(8) The department of human services on prospective adoptive parents as established under section 346-19.7;

(9) The department of human services on applicants to operate child care facilities, prospective employees of the applicant, and new employees of the provider after registration or licensure as provided by section 346-154;

(10) The department of human services on persons exempt pursuant to section 346-152 to be eligible to provide child care and receive child care subsidies as provided by section 346-152.5;

(11) The department of human services on operators and employees of home and community-based case management agencies and operators and other adults, except for adults in care, residing in foster family homes as provided by section [~~346-335;~~] ___-22;

(12) The department of human services on staff members of the Hawaii youth correctional facility as provided by section 352-5.5;

(13) The department of human services on employees, prospective employees, and volunteers of contracted

providers and subcontractors in positions that place them in close proximity to youth when providing services on behalf of the office or the Hawaii youth correctional facility as provided by section 352D-4.3;

(14) The judiciary on employees and applicants at detention and shelter facilities as provided by section 571-34;

(15) The department of public safety on employees and prospective employees who are directly involved with the treatment and care of persons committed to a correctional facility or who possess police powers including the power of arrest as provided by section 353C-5;

(16) The department of commerce and consumer affairs on applicants for private detective or private guard licensure as provided by section 463-9;

(17) Private schools and designated organizations on employees and prospective employees who may be in positions that necessitate close proximity to children; provided that private schools and designated organizations receive only indications of the states from which the national criminal history record information was provided pursuant to section 302C-1;

(18) The public library system on employees and prospective employees whose positions place them in close proximity to children as provided by section 302A-601.5;

(19) The State or any of its branches, political subdivisions, or agencies on applicants and employees holding a position that has the same type of contact with children, vulnerable adults, or persons committed to a correctional facility as other public employees who hold positions that are authorized by law to require criminal history record checks as a condition of employment as provided by section 78-2.7;

(20) The department of human services on licensed adult day care center operators, employees, new employees, subcontracted service providers and their employees, and adult volunteers as provided by section 346-97;

(21) The department of human services on purchase of service contracted and subcontracted service providers and their employees serving clients of the adult and community care services branch, as provided by section 346-97;

(22) The department of human services on foster grandparent program, retired and senior volunteer program, senior companion program, and respite companion program participants as provided by section 346-97;

(23) The department of human services on contracted and subcontracted service providers and their current and prospective employees that provide home and community-based services under Section 1915(c) of the Social Security Act (Title 42 United States Code Section 1396n(c)), or under any other applicable section or sections of the Social Security Act for the purposes of providing home and community-based services, as provided by section 346-97;

(24) The department of commerce and consumer affairs on proposed directors and executive officers of a bank, savings bank, savings and loan association, trust company, and depository financial services loan company as provided by section 412:3-201;

(25) The department of commerce and consumer affairs on proposed directors and executive officers of a nondepository financial services loan company as provided by section 412:3-301;

(26) The department of commerce and consumer affairs on the original chartering applicants and proposed executive officers of a credit union as provided by section 412:10-103;

(27) The department of commerce and consumer affairs on:

(A) Each principal of every non-corporate applicant for a money transmitter license; and

(B) The executive officers, key shareholders, and managers in charge of a money transmitter's activities of every corporate applicant for a money transmitter license,

as provided by section 489D-9;

(28) The department of commerce and consumer affairs on applicants for licensure and persons licensed under title 24;

(29) The Hawaii health systems corporation on:

(A) Employees;

(B) Applicants seeking employment;

(C) Current or prospective members of the corporation board or regional system board; or

(D) Current or prospective volunteers, providers, or contractors,

in any of the corporation's health facilities as provided by section 323F-5.5;

[~~+~~] (30) [~~+~~] The department of commerce and consumer affairs on an applicant for a mortgage loan originator's license as provided by chapter 454F; and

[~~+~~] (31) [~~+~~] Any other organization, entity, or the State, its branches, political subdivisions, or agencies as may be authorized by state law."

SECTION 10. Section 28-91, Hawaii Revised Statutes, is repealed.

["~~[§28-91] Medicaid fraud unit. There is established in the department of the attorney general a medicaid fraud unit.~~

~~The unit shall employ such attorneys, auditors, investigators, and other personnel as necessary to promote the effective and efficient conduct of the unit's activities. Except for the attorneys, all other employees of the medicaid fraud unit shall be subject to chapter 76.~~

~~The purpose of the medicaid fraud unit shall be to conduct a statewide program for the investigation and prosecution of medicaid fraud cases and violations of all applicable state laws relating to the providing of medical assistance and the activities of providers of such assistance. The medicaid fraud~~

~~unit may also review and take appropriate action on complaints of abuse and neglect of patients of health care facilities receiving payments under the state plan for medical assistance and may provide for collection or referral for collection of overpayments made under the state plan for medical assistance that are discovered by the unit in carrying out its activities.~~"]

SECTION 11. Section 28-91.5, Hawaii Revised Statutes, is repealed.

["~~[§28-91.5] Medicaid investigations recovery fund; established.~~ There is established in the state treasury the ~~medicaid investigations recovery fund as a special fund, and which is to be administered by the department of the attorney general, into which shall be deposited all funds that have been recovered as a result of medicaid fraud settlements. Moneys from this special fund shall be used to support a portion of operating expenses of the medicaid fraud unit within the department of the attorney general.~~"]

SECTION 12. Section 40-57.5, Hawaii Revised Statutes, is repealed.

["~~§40-57.5 Comptroller's acceptance of vouchers for the Hawaii state medicaid program.~~ The requirements of section 40-

~~56 and section 40-57 to the contrary notwithstanding, the comptroller may, if satisfied as to the adequacy of related internal controls and audit trails, issue warrants for original warrant vouchers without accompanying original bills for payments to vendors of the Hawaii state medicaid program. Whenever the comptroller has given the comptroller's approval for the issuance of warrants under this section without accompanying original bills, the original bills shall be retained by the expending agency vouchering the payment, and shall be made available for authorized referencing, for the period prescribed by section 40-10 for the retention of vouchers, documents and other records or papers before destruction. For purposes of this section, the definition of original bills shall also include computer magnetic tape, computer listings, computer output microfilm, microfiche, and manually produced microfilm.~~"]

SECTION 13. Section 103F-107, Hawaii Revised Statutes, is repealed.

["~~[§103F-107] Medicaid contracts; nonprofits and for-profits; reporting requirements.~~ (a) ~~All nonprofit or for-profit medicaid healthcare insurance contractors, within one hundred and eighty days following the close of each fiscal year,~~

~~shall submit an annual report to the department of human services, the insurance division of the department of commerce and consumer affairs, and the legislature. The report shall be attested to by a plan executive located within the State and shall be made accessible to the public.~~

~~The report shall be based on contracts administered in the State and shall include:~~

~~(1) An accounting of expenditures of MedQuest contract payments for the contracted services, including the percentage of payments:~~

~~(A) For medical services;~~

~~(B) For administrative costs;~~

~~(C) Held in reserve; and~~

~~(D) Paid to shareholders;~~

~~(2) Employment information including:~~

~~(A) Total number of full-time employees hired for the contracted services;~~

~~(B) Total number of employees located in the State and the category of work performed; and~~

~~(C) The compensation provided to each of the five highest paid Hawaii employees and to each of the~~

~~five highest paid employees nationwide, and a description of each position;~~

~~(3) Descriptions of any on-going state or federal sanction proceedings, prohibitions, restrictions, on-going civil or criminal investigations, and descriptions of past sanctions or resolved civil or criminal cases, within the past five years and related to the provision of medicare or medicaid services by the contracting entity, to the extent allowed by law;~~

~~(4) Descriptions of contributions to the community, including the percentage of revenue devoted to Hawaii community development projects and health enhancements; provided that contracted services shall not be included in the percentage calculation; and~~

~~(5) A list of any management and administrative service contracts for MedQuest services made in Hawaii and outside of the State, including a description of the purpose and cost of those contracts.~~

~~(b) The department of human services shall include in all medicaid healthcare insurance plan contracts, the annual reporting requirements of subsection (a).~~

~~(c) Any contract under this section shall be governed by the laws of the State of Hawaii.~~

~~(d) Within ninety days of receipt of the reports required by this section, the department of human services shall provide a written analysis and comparative report to the legislature.~~"]

SECTION 14. Section 321-15.6, Hawaii Revised Statutes, is repealed.

["~~§321-15.6 Adult residential care homes; licensing. (a) All adult residential care homes shall be licensed to ensure the health, safety, and welfare of the individuals placed therein. The department shall conduct unannounced visits, other than the inspection for relicensing, to every licensed adult residential care home and expanded adult residential care home on an annual basis and at such intervals as determined by the department to ensure the health, safety, and welfare of each resident. Unannounced visits may be conducted during or outside regular business hours. All inspections relating to follow-up visits, visits to confirm correction of deficiencies, or visits to investigate complaints or suspicion of abuse or neglect shall be conducted unannounced during or outside regular business hours. Annual inspections for relicensing may be conducted during regular business hours or at intervals determined by the~~

~~department. Annual inspections for relicensing shall be conducted with notice, unless otherwise determined by the department.~~

~~(b) The director shall adopt rules regarding adult residential care homes in accordance with chapter 91 that shall be designed to:~~

~~(1) Protect the health, safety, and civil rights of persons residing in facilities regulated;~~

~~(2) Provide for the licensing of adult residential care homes; provided that the rules shall allow group living in two categories of adult residential care homes as licensed by the department of health:~~

~~(A) Type I allowing five or fewer residents; provided that up to six residents may be allowed at the discretion of the department to live in a type I home; provided further that the primary caregiver or home operator is a certified nurse aide who has completed a state-approved training program and other training as required by the department; and~~

~~(B) Type II allowing six or more residents, including but not limited to the mentally ill, elders,~~

~~persons with disabilities, the developmentally disabled, or totally disabled persons who are not related to the home operator or facility staff;~~

~~(3) Comply with applicable federal laws and regulations of Title XVI of the Social Security Act, as amended; and~~

~~(4) Provide penalties for the failure to comply with any rule.~~

~~For the purposes of this subsection:~~

~~"Developmentally disabled" means a person with developmental disabilities as defined under section 333F-1.~~

~~"Elder" has the same meaning as defined under section 356D-1.~~

~~"Mentally ill" means a mentally ill person as defined under section 334-1.~~

~~"Persons with disabilities" means persons having a disability under section 515-2.~~

~~"Totally disabled person" has the same meaning as a person totally disabled as defined under section 235-1.~~

~~(c) The department may provide for the training of and consultations with operators and staff of any facility licensed under this section, in conjunction with any licensing thereof, and shall adopt rules to ensure that adult residential care home~~

~~operators shall have the needed skills to provide proper care and supervision in a home environment as required under department rules.~~

~~(d) The department shall establish a standard admission policy and procedure which shall require the provision of information that includes the appropriate medical and personal history of the patient as well as the level of care needed by the patient prior to the patient's referral and admission to any adult residential care home facility. The department shall develop appropriate forms and patient summaries for this purpose.~~

~~(e) The department shall maintain an inventory of all facilities licensed under this section and shall maintain a current inventory of vacancies therein to facilitate the placement of individuals in such facilities.~~

~~(f) The department shall develop and adopt a social model of health care to ensure the health, safety, and welfare of individuals placed in adult residential care homes. The social model of care shall provide for aging in place and be designed to protect the health, safety, civil rights, and rights of choice of the persons to reside in a nursing facility or in home or community based care.~~

~~(g) Any fines collected by the department of health for violations of this section shall be deposited into the office of health care assurance special fund.~~"]

SECTION 15. Section 321-15.61, Hawaii Revised Statutes, is repealed.

["~~[§321-15.61] Adult residential care homes expanded admissions.~~ ~~(a) Adult residential care homes may admit an individual who has been living immediately prior to admission in the individual's own home, a hospital, or other care setting, and who has been either:~~

~~(1) Admitted to a medicaid waiver program and determined by the department of human services to require nursing facility level care to manage the individual's physical, mental, and social functions; or~~

~~(2) A private paying individual certified by a physician or advanced practice registered nurse as needing a nursing facility level of care.~~

~~(b) The department of health shall adopt rules in accordance with chapter 91 to expand admissions to adult residential care homes by level of care and to define and standardize these levels of care. The rules and standards shall provide for appropriate and adequate requirements for knowledge~~

~~and training of adult residential care home operators and their employees.~~"]

SECTION 16. Section 321-15.62, Hawaii Revised Statutes, is repealed.

["~~**§321-15.62 Expanded adult residential care homes; licensing.** (a) All expanded adult residential care homes shall be licensed to ensure the health, safety, and welfare of the individuals placed therein.~~

~~(b) The director of health shall adopt rules regarding expanded adult residential care homes in accordance with chapter 91 that shall implement a social model of health care designed to:~~

~~(1) Protect the health, safety, civil rights, and rights of choice of residents in a nursing facility or in home or community-based care;~~

~~(2) Provide for the licensing of expanded adult residential care homes for persons who are certified by the department of human services, a physician, advanced practice registered nurse, or registered nurse case manager as requiring skilled nursing facility level or intermediate care facility level of care who have no financial relationship with the home~~

~~care operator or facility staff; provided that the rules shall allow group living in the following two categories of expanded adult residential care homes as licensed by the department:~~

~~(A) A type I home shall consist of five or fewer residents with no more than two nursing facility level residents; provided that more nursing facility level residents may be allowed at the discretion of the department; and provided further that up to six residents may be allowed at the discretion of the department to live in a type I home; provided that the primary caregiver or home operator is a certified nurse aide who has completed a state approved training program and other training as required by the department; and~~

~~(B) A type II home shall consist of six or more residents, with no more than twenty per cent of the home's licensed capacity as nursing facility level residents; provided that more nursing facility level residents may be allowed at the discretion of the department;~~

~~provided further that the department shall exercise its discretion for a resident presently residing in a type I or type II home, to allow the resident to remain as an additional nursing facility level resident based upon the best interests of the resident. The best interests of the resident shall be determined by the department after consultation with the resident, the resident's family, primary physician, case manager, primary caregiver, and home operator;~~

~~(3) Comply with applicable federal laws and regulations of Title XVI of the Social Security Act, as amended; and~~

~~(4) Provide penalties for the failure to comply with any rule.~~

~~(c) The department may provide for the training of and consultations with operators and staff of any facility licensed under this section, in conjunction with any licensing thereof, and shall adopt rules to ensure that expanded adult residential care home operators shall have the needed skills to provide proper care and supervision in a home environment as required under department rules.~~

~~(d) The department shall establish a standard admission policy and procedure which shall require the provision of information that includes the appropriate medical and personal history of the patient as well as the level of care needed by the patient prior to the patient's referral and admission to any expanded adult residential care home facility. The department shall develop appropriate forms and patient summaries for this purpose.~~

~~(e) The department shall maintain an inventory of all facilities licensed under this section and shall maintain a current inventory of vacancies therein to facilitate the placement of individuals in such facilities.~~"]

SECTION 17. Section 346-40, Hawaii Revised Statutes, is repealed.

["~~**§346-40 Maintenance and availability of records; penalty.** (a) To enable another provider to determine the proper course of treatment in emergencies and in order to determine whether a provider is genuinely entitled to reimbursement and to protect the medicaid program against fraud and abuse, each provider of health care, service or supplies under the state medicaid program shall maintain, and keep for a period of three years, such records as are necessary to disclose~~

~~fully the type and extent of health care, service or supplies provided to medicaid recipients. The department may identify the types of records necessary to be kept by promulgation of appropriate rules.~~

~~(b) No provider shall refuse or fail to make available at the provider's place of business or appropriate location, during normal business hours, or, if the appropriate representative agrees, at the mutual convenience of the parties, immediate access to all records required to be maintained under this section or rules promulgated hereunder and all diagnostic devices concerning or used for the provision of health care, service or supplies to a medicaid recipient to any duly authorized representative of the attorney general's office or the department of human services acting in the course and scope of the duly authorized representative's employment; such diagnostic devices may be examined and tested and such records may be retained by said duly authorized representative for a reasonable period of time for the purpose of examination, audit, copying, testing or photographing. This subsection shall supersede any other provision of the Hawaii Revised Statutes to the contrary notwithstanding.~~

~~(c) Whenever a provider without reasonable justification fails to keep adequate supporting records as required by this section or rules promulgated hereunder or fails to make them available as required by this section, the director of human services shall suspend the provider during the period of noncompliance with this section, and no payment may be made to such provider with respect to any item or service furnished by such provider during the period of suspension. A provider shall receive notice and be provided an opportunity for a hearing in compliance with regulations of the department of human services for such suspension.~~

~~(d) Wilful refusal or failure to make records available as provided in subsection (b) of this section is a misdemeanor.~~"]

SECTION 18. Section 346-41.5, Hawaii Revised Statutes, is repealed.

["~~**§346-41.5 Hawaii qualified health centers.** If the QUEST program is implemented, the department shall provide a supplemental capitation program for the uninsured with enabling services based on an annual cost based determination to all Hawaii qualified health centers (HQHCs) and to any nonprofit entity having a majority of Hawaii qualified health centers as board members.~~

~~For the purposes of this section, "enabling services" includes enabling services as defined by federally qualified health center standards. The department shall have the administrative flexibility to expend funds through QUEST contracts, through a modified voucher system, or through chapter 42D. Hawaii qualified health centers receiving these supplemental payments shall reconcile their costs on an annual basis.~~"]

SECTION 19. Section 346-42, Hawaii Revised Statutes, is repealed.

["~~**§346-42 Administrative inspections and warrants.** (a) Issuance and execution of administrative inspection warrants shall be as follows:~~

~~(1) A judge of the circuit court, or any district judge within the judge's jurisdiction, and upon proper oath or affirmation showing probable cause, may issue warrants for the purpose of conducting administrative inspections authorized by this chapter or rules hereunder, and seizures of the property appropriate to the inspections. For purposes of the issuance of administrative inspection warrants, probable cause exists upon showing a valid public interest in the~~

~~effective enforcement of this chapter or rules hereunder, sufficient to justify administrative inspection of the area, premises, building, conveyance or records in the circumstances specified in the application for the warrant;~~

~~(2) A warrant shall issue only upon an affidavit of an individual having knowledge of the facts alleged, sworn to before the judge and establishing the grounds for issuing the warrant. If the judge is satisfied that grounds for the issuance exist or that there is probable cause to believe they exist, the judge shall issue a warrant identifying the area, premises, building, conveyance or records to be inspected, the purpose of the inspection, and, if appropriate, the type of property to be inspected, if any. The warrant shall:~~

~~(A) State the grounds for its issuance and the name of each person whose affidavit has been taken in support thereof;~~

~~(B) Be directed to a person authorized by the attorney general or the director of human services to execute it;~~

~~(C) Command the person to whom it is directed to inspect the area, premises, building, conveyance or records identified for the purpose specified and, if appropriate, use reasonable force in conducting the inspection authorized by the warrant and direct the seizure of the property specified;~~

~~(D) Identify the item or types of property to be seized, if any;~~

~~(E) Direct that it be served during normal business hours and designate the judge to whom it shall be returned;~~

~~(3) A warrant issued pursuant to this section must be executed and returned within ten days of its date unless, upon a showing of a need for additional time, the court orders otherwise. If property is seized pursuant to a warrant, a copy shall be given to the person from whom or from whose premises the property is taken, together with a receipt for the property taken. The return of the warrant shall be made promptly, accompanied by a written inventory of any property taken. The inventory shall be made in the~~

~~presence of the person executing the warrant and of the person from whose possession or premises the property was taken, if present, or in the presence of at least one credible person other than the person executing the warrant. A copy of the inventory shall be delivered to the person from whom or from whose premises the property was taken and to the applicant for the warrant;~~

~~(4) The judge who has issued a warrant shall attach thereto a copy of the return and all papers returnable in connection therewith and file them with the clerk of the issuing court.~~

~~(b) The designated representative of the attorney general or the department may make administrative inspections of provider premises in accordance with the following provisions:~~

~~(1) For purposes of this section only, "provider premises" means:~~

~~(A) Places where providers are required to keep records; and~~

~~(B) Places where providers conduct business related to their receipt of payments from the medicaid program for health care, service or supplies.~~

~~(2) When authorized by an administrative inspection warrant issued pursuant to subsection (a) the representative upon presenting the warrant and appropriate credentials to the owner, operator, or agent in charge, may enter providers premises for the purpose of conducting an administrative inspection.~~

~~(3) When authorized by an administrative inspection warrant, the representative may:~~

~~(A) Inspect and copy records required by this chapter to be kept;~~

~~(B) Retain records required by this chapter to be kept for a reasonable period of time, not to exceed forty eight hours, for the purpose of examination, audit, copying, testing or photographing;~~

~~(C) Inspect, examine and test diagnostic devices used in the provision of health care, service or supplies to a medicaid recipient;~~

~~(D) Inventory any stock of any substance used in the provision of health care, service or supplies to a medicaid recipient and to obtain samples thereof;~~

~~(E) Inspect, examine and test, within reasonable limits and in a reasonable manner, provider premises and equipment as necessary to assure compliance with this chapter.~~

~~(4) This section does not prevent the inspection without a warrant of property, books and records pursuant to an administrative subpoena issued in accordance with law, nor does it prevent entries and administrative inspections, including seizures of property, without a warrant:~~

~~(A) If the owner, operator, or agent in charge of the provider premises consents;~~

~~(B) In situations presenting imminent danger to health or safety;~~

~~(C) In situations involving inspection of conveyances if there is reasonable cause to believe that the mobility of the conveyance makes it impracticable to obtain a warrant;~~

~~(D) In all other situations in which a warrant is not constitutionally required.~~"]

SECTION 20. Section 346-53.6, Hawaii Revised Statutes, is repealed.

["~~[§346-53.6] Federally qualified health centers; rural health clinics; reimbursement.~~ ~~(a) Notwithstanding any law or waiver to the contrary, federally qualified health centers and rural health clinics, as defined in section 1905(1) of the Social Security Act (42 U.S.C. 1396 et seq.), shall be reimbursed in accordance with section 1902(bb) of the Social Security Act, as that section was originally added in 2000 by section 702(b) of Public Law 106-554 and as amended in 2001 by section 2(b)(1) of Public Law 107-121, and services of federally qualified health centers and rural health clinics shall remain mandatory services as provided in sections 1902(a)(10)(A) and 1905(a)(2)(B) and (C) of the Social Security Act.~~

~~(b) Reimbursement rates paid to federally qualified health centers may be adjusted if costs exceed 1.75 per cent for changes related to the intensity, duration, or amount of service provided, facilities, regulatory requirements, or other extraordinary circumstances; provided that the federally qualified health center shall submit to the department an adjusted cost report covering a period of the previous two years. The director shall review the filing within a period of sixty days. The period may be extended by the director for an additional period not to exceed thirty days upon written notice~~

~~to the filer. A filing shall be deemed to be approved unless disapproved by the director within the initial filing period or any extension thereof.~~

~~(c) The State may terminate the reimbursement methodology set forth in this section only in the event that changes in the relevant sections of the Social Security Act prohibit this reimbursement methodology.~~"]

SECTION 21. Section 346-53.61, Hawaii Revised Statutes, is repealed.

["~~**[§346-53.61] Centers for Medicare and Medicaid Services approval.** The department shall implement sections 346-53.62, 346-53.63, and 346-53.64, subject to approval of the Hawaii medicaid state plan by the Centers for Medicare and Medicaid Services.~~"]

SECTION 22. Section 346-53.62, Hawaii Revised Statutes, is repealed.

["~~**[§346-53.62] Federally qualified health centers and rural health clinics; reconciliation of managed care supplemental payments.** (a) Federally qualified health centers or rural health clinics that provide services under a contract with a medicaid managed care organization shall receive estimated quarterly state supplemental payments for the cost of~~

~~furnishing such services that are an estimate of the difference between the payments the federally qualified health center or rural health clinic receives from medicaid managed care organizations and payments the federally qualified health center or rural health clinic would have received under the Benefits Improvement and Protection Act of 2000 prospective payment system methodology. Not more than one month following the beginning of each calendar quarter and based on the receipt of federally qualified health center or rural health clinic submitted claims during the prior calendar quarter, federally qualified health centers or rural health clinics shall receive the difference between the combination of payments the federally qualified health center or rural health clinic receives from estimated supplemental quarterly payments and payments received from medicaid managed care organizations and payments the federally qualified health center or rural health clinic would have received under the Benefits Improvement and Protection Act of 2000 prospective payment system methodology. Balances due from the federally qualified health center shall be recouped from the next quarter's estimated supplemental payment.~~

~~(b) The federally qualified health center or rural health clinic shall file an annual settlement report summarizing~~

~~patient encounters within one hundred fifty days following the end of a calendar year in which supplemental payments are received from the department. The total amount of supplemental and medicaid managed care organization payments received by the federally qualified health center or rural health clinic shall be reviewed against the amount that the actual number of visits provided under the federally qualified health center's or rural health clinic's contract with the medicaid managed care organization would have yielded under the prospective payment system. The department shall also receive financial records from the medicaid managed care organization. As part of this review, the department may request additional documentation from the federally qualified health center or rural health clinic and the medicaid managed care organization to resolve differences between medicaid managed care organization and provider records. Upon conclusion of the review, the department shall calculate a final payment that is due to or from the participating federally qualified health center or rural health clinic. The department shall notify the participating federally qualified health center or rural health clinic of the balance due to or from the federally qualified health center or rural health clinic. The notice of program reimbursement shall include the department's~~

~~calculation of the balance due to or from the federally qualified health center or rural health clinic.~~

~~(c) For the purposes of this section, the payments received from medicaid managed care organizations exclude payments for non prospective payment system services, managed care risk pool accruals, distributions, or losses, or any pay-for-performance bonuses or other forms of incentive payments such as quality improvement recognition grants and awards.~~

~~(d) An alternative supplemental managed care payment methodology other than the one set forth herein may be implemented as long as the alternative payment methodology is consented to in writing by the federally qualified health center or rural health clinic to which the methodology applies.~~"]

SECTION 23. Section 346-53.63, Hawaii Revised Statutes, is repealed.

["~~[§346-53.63] Federally qualified health center or rural health clinic; adjustment for changes to scope of services.~~ (a) ~~Prospective payment system rates may be adjusted for any increases or decreases in the scope of services furnished by a participating federally qualified health center or rural health clinic, provided that:~~

~~(1) The federally qualified health center or rural health clinic notifies the department in writing of any changes to the scope of services and the reasons for those changes within sixty days of the effective date of the changes;~~

~~(2) The federally qualified health center or rural health clinic submits data, documentation, and schedules that substantiate any changes in services and the related adjustment of reasonable costs following medicare principles of reimbursement; and~~

~~(3) The federally qualified health center or rural health clinic proposes a projected adjusted rate within one hundred fifty days of the changes to the scope of services.~~

~~(b) This proposed projected adjusted rate is subject to departmental approval. The proposed projected adjusted rate shall be calculated based on a consolidated basis where the federally qualified health center or rural health clinic takes all costs for the center that would include both the costs included in the base rate, as well as the additional costs, provided that the federally qualified health center or rural health clinic calculated the baseline prospective payment system~~

~~rate based on total consolidated costs. A net change in the federally qualified health center's or rural health clinic's rate shall be calculated by subtracting the federally qualified health center's or rural health clinic's previously assigned prospective payment system rate from its projected adjusted rate.~~

~~(c) Within one hundred twenty days of its receipt of the projected adjusted rate and all additional documentation requested by the department, the department shall notify the federally qualified health center or rural health clinic of its acceptance or rejection of the projected adjusted rate. Upon approval by the department, the federally qualified health center or rural health clinic shall be paid the projected rate, which shall be effective from the date of the change in scope of services through the date that a rate is calculated based upon the first full fiscal year that includes the change in scope of services.~~

~~(d) The department shall review the calculated rate of the first full fiscal year cost report if the change of scope of service is reflected in more than six months of the report. For those federally qualified health centers or rural health clinics in which the change of scope of services is in effect for six~~

~~months or less of the cost report fiscal year, review of the next full fiscal year cost report also is required. The department shall review the calculated inflated weighted average rate of these two cost reports. The total costs of the first year report shall be adjusted to the Medical Economic Index of the second year report. Each report shall be weighted based upon number of patient encounters.~~

~~(e) Upon receipt of the cost reports, the prospective payment system rate shall be adjusted following a review by the fiscal agent of the cost reports and documentation. Adjustments shall be made for payments for the period from the effective date of the change in scope of services through the date of the final adjustment of the prospective payment system rate.~~

~~(f) For the purposes of prospective payment system rate adjustment, a change in scope of services provided by a federally qualified health center or rural health clinic means the following:~~

~~(1) The addition of a new service, such as adding dental services or any other medicaid covered service, that is not incorporated in the baseline prospective payment system rate or a deletion of a service that is~~

~~incorporated in the baseline prospective payment system rate;~~

~~(2) A change in service resulting from amended regulatory requirements or rules;~~

~~(3) A change in service resulting from relocation;~~

~~(4) A change in type, intensity, duration, or amount of service resulting from a change in applicable technology and medical practice used;~~

~~(5) An increase in service intensity, duration, or amount of service resulting from changes in the types of patients served, including but not limited to populations with human immunodeficiency virus, acquired immunodeficiency syndrome, or other chronic diseases, or homeless, elderly, migrant, or other special populations;~~

~~(6) A change in service resulting from a change in the provider mix of a federally qualified health center or a rural health clinic or one of its sites;~~

~~(7) Any changes in the scope of a project approved by the federal Health Resources and Services Administration where the change affects a covered service; or~~

~~(8) Changes in operating costs due to capital expenditures associated with a modification of the scope of any of the services, including new or expanded service facilities, regulatory compliance, or changes in technology or medical practices at the federally qualified health center or rural health clinic.~~

~~(g) No change in costs, in and of itself, shall be considered a scope of service change unless the cost is allowable under medicaid principles of reimbursement and the net change in the federally qualified health center's or rural health clinic's per visit rate equals or exceeds three per cent for the affected federally qualified health center or rural health clinic site. For federally qualified health centers or rural health clinics that filed consolidated cost reports for multiple sites to establish their baseline prospective payment system rates, the net change of three per cent shall be applied to the average per visit rate of all the sites of the federally qualified health center or rural health clinic for purposes of calculating the costs associated with a scope of service change. For the purposes of this section, "net change" means the per visit change attributable to the cumulative effect of all increases or decreases for a particular fiscal year.~~

~~(h) All references in this section to "fiscal year" shall be construed to be references to the fiscal year of the individual federally qualified health center or rural health clinic, as the case may be.~~"]

SECTION 24. Section 346-53.64, Hawaii Revised Statutes, is repealed.

["~~[§346-53.64] Federally qualified health center or rural health clinic visit.~~ (a) ~~Services eligible for prospective payment system reimbursement are those services that are furnished by a federally qualified health center or rural health clinic that are:~~

~~(1) Within the legal authority of a federally qualified health center to deliver, as defined in section 1905 of the Social Security Act;~~

~~(2) Actually provided by the federally qualified health center, either directly or under arrangements;~~

~~(3) Covered benefits under the medicaid program, as defined in section 4231 of the State Medicaid Manual and the Hawaii medicaid state plan;~~

~~(4) Provided to a recipient eligible for medicaid benefits;~~

~~(5) Delivered exclusively by health care professionals, including physicians, physician's assistants, nurse practitioners, nurse midwives, clinical social workers, clinical psychologists, and other persons acting within the lawful scope of their license or certificate to provide services;~~

~~(6) Provided at the federally qualified health center's practice site, a hospital emergency room, in an inpatient setting, at the patient's place of residence, including long term care facilities, or at another medical facility; and~~

~~(7) Within the scope of services provided by the State under its fee for service medicaid program and its health QUEST program, on and after August 1994, and as amended from time to time.~~

~~(b) Contacts with one or more health professionals and multiple contacts with the same health professional that take place on the same day and at a single location constitute a single encounter, except when one of the following conditions exists:~~

~~(1) After the first encounter, the patient suffers illness or injury requiring additional diagnosis or treatment; or~~

~~(2) The patient makes one or more visits for other services such as dental or behavioral health. Medicaid may pay for a maximum of one visit per day for each of these services in addition to one medical visit.~~

~~(c) A federally qualified health center or rural health clinic that provides prenatal services, delivery services, and post-natal services may elect to bill the managed care organization for all such services on a global payment basis. Alternatively, it may bill for prenatal and post natal services separately from delivery services and be paid the per visit prospective payment system reimbursement for prenatal and post natal visits. In this case, it may bill the managed care organization separately for inpatient delivery services that are not eligible for prospective payment system reimbursement.~~"]

SECTION 25. Section 346-53.65, Hawaii Revised Statutes, is repealed.

["~~**[§346-53.65] Appeal.** A federally qualified health center or rural health clinic may appeal a decision made by the~~

~~department if the medicaid impact is $10,000 or more, whereupon the opportunity for an administrative hearing under chapter 91 shall be afforded. Any federally qualified health center or rural health clinic aggrieved by the final decision and order shall be entitled to judicial review in accordance with chapter 92 or may submit the matter to binding arbitration pursuant to chapter 658A.~~"]

SECTION 26. Section 346-59, Hawaii Revised Statutes, is repealed.

~~["**§346-59 Medical care payments.** (a) The department shall adopt rules under chapter 91 concerning payment to providers of medical care. The department shall determine the rates of payment due to all providers of medical care, and pay such amounts in accordance with the requirements of the appropriations act and the Social Security Act, as amended. Payments to critical access hospitals for services rendered to medicaid beneficiaries shall be calculated on a cost basis using medicare reasonable cost principles.~~

~~(b) Rates of payment to providers of medical care who are individual practitioners, including doctors of medicine, dentists, podiatrists, psychologists, osteopaths, optometrists, and other individuals providing services, shall be based upon~~

~~the Hawaii medicaid fee schedule. The amounts paid shall not exceed the maximum permitted to be paid individual practitioners or other individuals under federal law and regulation, the medicare fee schedule for the current year, the state limits as provided in the appropriation act, or the provider's billed amount.~~

~~The appropriation act shall indicate the percentage of the medicare fee schedule for the year 2000 to be used as the basis for establishing the Hawaii medicaid fee schedule. For any subsequent adjustments to the fee schedule, the legislature shall specify the extent of the adjustment in the appropriation act.~~

~~(c) In establishing the payment rates for other noninstitutional items and services, the rates shall not exceed the current medicare payment, the state limits as provided in the appropriation act, the rate determined by the department, or the provider's billed amount.~~

~~(d) Payments to health maintenance organizations and prepaid health plans with which the department executes risk contracts for the provision of medical care to eligible public assistance recipients may be made on a prepaid basis. The rate of payment per participating recipient shall be fixed by~~

~~contract, as determined by the department and the health maintenance organization or the prepaid health plan, but shall not exceed the maximum permitted by federal rules and shall be less than the federal maximum when funds appropriated by the legislature for such contracts require a lesser rate. For purposes of this subsection, "health maintenance organizations" are entities approved as such, and "prepaid health plans" are entities designated as such by the Department of Health and Human Services, and "risk" means the possibility that the health maintenance organization or the prepaid health plan may incur a loss because the cost of providing services may exceed the payments made by the department for services covered under the contract.~~

~~(c) The department shall prepare each biennial budget request for a medical care appropriation based upon the most current Hawaii medicaid fee schedule available at the time the request is prepared.~~

~~The director shall submit a report to the legislature on or before January 1 of each year indicating an estimate of the amount of money required to be appropriated to pay providers at the maximum rates permitted by federal and state rules in the upcoming fiscal year.~~"]

SECTION 27. Section 346-59.6, Hawaii Revised Statutes, is repealed.

["~~§346-59.6 Medicaid overpayment recovery. The director shall recover medicaid overpayments made to providers. Medicaid overpayments shall be recovered due to a provider's ineligibility, noncovered service, noncovered drug, lack of prior authorization when a service requires one, incorrect payment allowance identified through any post-payment review, or claims processing error. The director may recover overpayments through recoupment, tax offset under sections 231-51 to 231-59, and circuit court judgment. Nothing in this section shall limit the director's authority to recover overpayments through all other lawful means.~~"]

SECTION 28. Section 346-59.7, Hawaii Revised Statutes, is repealed.

["~~[§346-59.7] Enforcement of decisions regarding medicaid overpayment recovery; judgment rendered thereon.~~ ~~(a) The director may file in the circuit court in the jurisdiction in which the medicaid overpayment occurred a certified copy of:~~

~~(1) A decision of the director assessing a medicaid overpayment against a provider from which no appeal has been taken within the time allowed therefor;~~

~~(2) A decision of the director assessing a medicaid overpayment against a provider from which an appeal has been taken but in which no order has been made by the director, the administrative appeals officer, or the court that the appeal shall operate as a supersedeas or stay;~~

~~(3) A decision of the administrative appeals officer assessing a medicaid overpayment against a provider from which no appeal has been taken within the time allowed therefor; or~~

~~(4) A decision of the administrative appeals officer assessing a medicaid overpayment against a provider from which an appeal has been taken but in which no order has been made by the administrative appeals officer or the court that the appeal shall operate as a supersedeas or stay.~~

~~The court shall render a judgment in accordance with the decision and notify the parties thereof. The judgment shall have the same effect, and all proceedings in relation thereto shall thereafter be the same, as though the judgment had been rendered in an action duly heard and determined by the court, except that there shall be no appeal therefrom.~~

~~(b) In all cases in which an appeal from the decision has been taken within the time provided, but in which the director, the administrative appeals officer, or the court has not issued an order that the appeal shall operate as a supersedeas or stay, the decree or judgment of the circuit court shall provide that the decree or judgment shall become void if the decision or award of the director or administrative appeals officer, as the case may be is later set aside.~~

~~(c) As used in this section, the term "administrative appeals officer" means the director's designated subordinate appointed to contested case hearings pursuant to chapter 91, and this chapter.~~"]

SECTION 29. Part XIV of Chapter 346, Hawaii Revised Statutes, is repealed.

SECTION 30. Part XV of Chapter 346, Hawaii Revised Statutes, is repealed.

SECTION 31. Part XVI of Chapter 346, Hawaii Revised Statutes, is repealed.

SECTION 32. Chapter 346D, Hawaii Revised Statutes, is repealed.

SECTION 33. Chapter 346E, Hawaii Revised Statutes, is repealed.

SECTION 34. Chapter 431L, Hawaii Revised Statutes, is repealed.

SECTION 35. Statutory material to be repealed is bracketed and stricken. New statutory material is underscored.

SECTION 36. This Act shall take effect upon its approval; provided that sections -5, -6, and -7 as established in section 1 of this Act shall take effect upon approval of the

H.B. NO. 2990

Hawaii medicaid state plan by the Centers for Medicare and Medicaid Services.

INTRODUCED BY: John M. Mizuno

JAN 27 2010

H.B. NO. 2995

Report Title:
Medicaid

Description:
Recodifies current Hawaii Medicaid statutes under a new Medicaid Chapter.

The summary description of legislation appearing on this page is for informational purposes only and is not legislation or evidence of legislative intent.