
A BILL FOR AN ACT

RELATING TO MEDICAID.

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

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

4 "CHAPTER

5 MEDICAID

6 PART I. GENERAL PROVISIONS

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

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

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

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



1 "Department" means the department of human services.

2 "Director" means the director of human services.

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

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

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

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



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

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

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

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

18 **PART II. QUEST**

19 **§ -2 Establishment of medicaid 1115 waiver program.** The
20 department shall establish a medicaid section 1115 waiver
21 program. The program shall provide health care services through
22 managed care health plans contracted by the department to



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

8 **PART III. LONG-TERM CARE**

9 A. Medicaid Home and Community-based Waiver Programs

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

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

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



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

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

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

13 "Waiver program" means the medicaid home and community-
14 based services programs under 42 United States Code Section
15 1396n.

16 § -11 Establishment of medicaid home and community-based
17 waiver programs. (a) Waiver programs shall be established and
18 administered by the department of human services to provide
19 comprehensive home and community-based services for aged,
20 chronically ill, disabled, developmentally disabled, and
21 mentally retarded individuals, who are certified as requiring
22 acute, skilled nursing, intermediate care facility, or



1 intermediate care facility for the mentally retarded level of
2 care.

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

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

9 § -12 Determination of eligibility for participation in
10 a waiver program. (a) To qualify for participation in a waiver
11 program, individuals shall:

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

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

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



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

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

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

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

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

14 § -13 Provision of services. (a) Services that
15 maximize the individual's independence shall be provided in the
16 individual's home, the home of a responsible relative or other
17 adult, or a residential alternative setting.

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

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



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

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

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

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

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

16 § -14 Needs allowance; waiver program individuals. (a)

17 There may be established a monthly needs allowance for
18 individuals living in:

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

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



- 1 (3) Community care foster family homes as defined in
2 section -18;
- 3 (4) Certified adult foster homes as defined in section
4 321-11.2;
- 5 (5) Domiciliary care as defined in section -1;
- 6 (6) A nursing facility as defined in section -28; or
- 7 (7) A community-based residence as part of the residential
8 alternatives community care program.

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

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

20 § -15 Rules. The department of human services shall
21 adopt rules in accordance with chapter 91, for the purpose of
22 this subpart.



1 § -16 **Personnel exempt.** The department may employ civil
2 service personnel in accordance with chapter 76 to service the
3 waiver programs.

4 § -17 **Medicaid reimbursement equity.** Not later than
5 July 1, 2008, there shall be no distinction between hospital-
6 based and nonhospital-based reimbursement rates for
7 institutionalized long-term care under medicaid. Reimbursement
8 for institutionalized intermediate care facilities and
9 institutionalized skilled nursing facilities shall be based
10 solely on the level of care rather than the location. This
11 section shall not apply to critical access hospitals.

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

14 § -18 **Definitions.** As used in this part:

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

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

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



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

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

- 5 (1) Is regulated by the department in accordance with
6 rules that are equitable in relation to rules that
7 govern expanded adult residential care homes;
- 8 (2) Is issued a certificate of approval by the department
9 or its designee to provide, for a fee, twenty-four-
10 hour living accommodations, including personal care
11 and homemaker services, for not more than two adults
12 at any one time, at least one of whom shall be a
13 medicaid recipient, who are at the nursing facility
14 level of care, who are unrelated to the foster family,
15 and are receiving the services of a licensed home and
16 community-based case management agency; and
- 17 (3) Does not include expanded adult residential care homes
18 or assisted living facilities, which shall continue to
19 be licensed by the department of health.

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



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

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

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

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



1 § -19 Applicability. (a) This subpart shall apply to
2 the demonstration project statewide.

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

5 § -20 Home and community-based case management agency,
6 authority over and evaluation of. (a) Any person, agency, or
7 organization engaged in providing, coordinating, or monitoring
8 comprehensive services to clients in community care foster
9 family homes, or medicaid clients in expanded adult residential
10 care homes, and assisted living facilities, shall meet the
11 standards of conditions, management, and competence set by the
12 department and hold a license in good standing issued for this
13 purpose by the department.

14 (b) The department shall adopt rules pursuant to chapter
15 91 relating to:

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

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

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



- 1 (4) Minimum grievance procedures for clients of case
2 management services.
- 3 (c) As a condition for obtaining a license, a person,
4 agency, or organization shall comply with rules adopted under
5 subsection (b) (1), (2), and (3), and satisfy the background
6 check requirements under section -22. The department may
7 deny a license if:
- 8 (1) An operator, employee, or new employee of the home and
9 community-based case management agency has been
10 convicted of a crime other than a minor traffic
11 violation involving a fine of \$50 or less;
- 12 (2) The department finds that the criminal history record
13 of an operator, employee, or new employee poses a risk
14 to the health, safety, or well-being of adults
15 receiving care in community care foster family homes,
16 expanded adult residential care homes, or assisted
17 living facilities;
- 18 (3) An operator, employee, or new employee of the home and
19 community-based case management agency is a
20 perpetrator of abuse as defined in section 346-222; or
- 21 (4) The holder of or an applicant for a home and
22 community-based case management agency license, or one



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

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

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

19 (1) Annually or biennially; or

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



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

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

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

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

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



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

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

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

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

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



1 § -21 Community care foster family home, authority over
2 and evaluation of. (a) Any person in any household who wants
3 to take in, for a fee, any adult who is at the nursing facility
4 level of care and who is unrelated to anyone in the household,
5 for twenty-four-hour living accommodations, including personal
6 care and homemaker services, may do so only after the household
7 meets the required standards established for certification and
8 obtains a certificate of approval from the department or its
9 designee.

10 (b) The department shall adopt rules pursuant to chapter
11 91 relating to:

- 12 (1) Standards of conditions and competence for the
13 operation of community care foster family homes;
- 14 (2) Procedures for obtaining and renewing a certificate of
15 approval from the department; and
- 16 (3) Minimum grievance procedures for clients of community
17 care foster family home services.

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



- 1 (1) An operator or other adult residing in the community
2 care foster family home, except for adults receiving
3 care, has been convicted of a crime other than a minor
4 traffic violation involving a fine of \$50 or less;
- 5 (2) The department or its designee finds that the criminal
6 history record of an operator or other adult residing
7 in the home, except for adults receiving care, poses a
8 risk to the health, safety, or well-being of adults in
9 care; or
- 10 (3) An operator or other adult residing in the community
11 care foster family home, except for adults receiving
12 care, is a perpetrator of abuse as defined in section
13 346-222.
- 14 (d) Upon approval of a community care foster family home,
15 the department or its designee shall issue a certificate of
16 approval that shall continue in force for one year, or for two
17 years if a community care foster family home has been certified
18 for at least one year and is in good standing pursuant to
19 standards adopted by the department, unless sooner suspended or
20 revoked for cause. The department or its designee shall renew
21 the certificate of approval only if, after an annual or biennial



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

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

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

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

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

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



1 the appeal shall not stay the suspension or
2 revocation;
3 (4) A suspended or revoked certificate of approval may be
4 reinstated if the department or its designee deems
5 that the home is willing and able to comply with the
6 rules adopted under subsection (b); and
7 (5) A revoked certificate of approval shall be restored
8 only after a new application for a certificate of
9 approval is submitted to the department or its
10 designee and approved.

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

15 § -22 Background checks. (a) The department shall
16 develop standards to ensure the reputable and responsible
17 character of operators and employees of the home and community-
18 based case management agencies and operators and other adults,
19 except for adults in care, residing in community care foster
20 family homes as defined in this subpart.

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



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

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

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

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

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

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



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

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

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

- 18 (1) Be subject to criminal history record checks in
19 accordance with section 846-2.7;
- 20 (2) Be subject to adult abuse perpetrator checks, if the
21 individual has direct contact with a client. For the
22 purposes of this section, "adult abuse perpetrator



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

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

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

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



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

5 § -23 Penalty. Any person violating this subpart or any
6 rule made pursuant to this subpart shall be fined not more than
7 \$500.

8 § -24 Exemptions. As provided in sections 383-7, 392-
9 5, and 393-5, "employment" for the purposes of the Hawaii
10 employment security law, temporary disability insurance law, and
11 Hawaii prepaid health care law, shall not include domestic in-
12 home and community-based services for persons with developmental
13 disabilities and mental retardation under the medicaid home and
14 community based services program pursuant to Title 42 Code of
15 Federal Regulations Sections 440.180 and 441.300, and Title 42
16 Code of Federal Regulations, Part 434, Subpart A, as amended,
17 and identified as chore, personal assistance and habilitation,
18 residential habilitation, supported employment, respite, and
19 skilled nursing services, as the terms are defined and amended
20 from time to time by the department of human services, performed
21 by an individual whose services are contracted by a recipient of
22 social service payments and who voluntarily agrees in writing to



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

5 C. Adult Residential Care Homes

6 § -25 Adult residential care homes expanded admissions.

7 (a) Adult residential care homes may admit an individual who
8 has been living immediately prior to admission in the
9 individual's own home, a hospital, or other care setting, and
10 who has been either:

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

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

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



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

3 § -26 Adult residential care homes; licensing. (a) All
4 adult residential care homes shall be licensed to ensure the
5 health, safety, and welfare of the individuals placed therein.
6 The department shall conduct unannounced visits, other than the
7 inspection for relicensing, to every licensed adult residential
8 care home and expanded adult residential care home on an annual
9 basis and at such intervals as determined by the department to
10 ensure the health, safety, and welfare of each resident.
11 Unannounced visits may be conducted during or outside regular
12 business hours. All inspections relating to follow-up visits,
13 visits to confirm correction of deficiencies, or visits to
14 investigate complaints or suspicion of abuse or neglect shall be
15 conducted unannounced during or outside regular business hours.
16 Annual inspections for relicensing may be conducted during
17 regular business hours or at intervals determined by the
18 department. Annual inspections for relicensing shall be
19 conducted with notice, unless otherwise determined by the
20 department.



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

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

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

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

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



- 1 (3) Comply with applicable federal laws and regulations of
- 2 Title XVI of the Social Security Act, as amended; and
- 3 (4) Provide penalties for the failure to comply with any
- 4 rule.

5 For the purposes of this subsection:

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

8 "Elder" has the same meaning as defined under section 356D-
9 1.

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

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

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

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



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

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

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

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



1 § -27 Expanded adult residential care homes; licensing.

2 (a) All expanded adult residential care homes shall be licensed
3 to ensure the health, safety, and welfare of the individuals
4 placed therein.

5 (b) The director of health shall adopt rules regarding
6 expanded adult residential care homes in accordance with chapter
7 91 that shall implement a social model of health care designed
8 to:

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

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



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

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

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



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

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

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

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

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



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

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

8 D. Nursing Facility Tax

9 § -28 Definitions. As used in this subpart, unless the
10 context otherwise requires:

11 "Nursing facility" means a nursing facility licensed under
12 sections 321-9 and 321-11 and any intermediate care facility for
13 the mentally retarded persons licensed under sections 321-9 and
14 321-11.

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



- 1 (1) Compensation received from services covered by Title
2 XVIII of the Federal Social Security Act (including
3 copayments and deductibles received from beneficiaries
4 of the medicare program);
- 5 (2) Income from an affiliated entity that operates as a
6 prepaid health maintenance organization;
- 7 (3) Settlements from third party payors for services
8 delivered or items supplied prior to the effective
9 date of this Act (such as settlements of cost reports
10 or decisions on rate reconsideration requests);
- 11 (4) Income from services provided by separately licensed
12 units (such as distinct part intermediate care
13 facilities for the mentally retarded);
- 14 (5) Income from the provision of adult day health and
15 adult day care programs;
- 16 (6) Income from the provision of home health agency
17 services;
- 18 (7) Income from the provision of "nursing homes without
19 walls" programs;
- 20 (8) Income from the provision of inpatient hospital
21 services;



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

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

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

11 § -29 Imposition of tax and rates. (a) There is levied
12 and shall be assessed and collected during each quarter a tax in
13 the amount of six per cent of all nursing facility income.

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

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



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

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

12 § -30 Return and payments; penalties. (a) On or before
13 the fifteenth day of February, May, August, and November, or for
14 fiscal year taxpayers on or before the forty-fifth day after the
15 close of the fiscal quarter, every operator taxable under this
16 subpart during the preceding calendar or fiscal quarter shall
17 file a sworn return with the director in such form as the
18 director shall prescribe, together with a remittance for the
19 amount of the tax in the form of cash, bank draft, cashier's
20 check, money order, or certificate of deposit. In lieu of the
21 remittance, the operator may request withholding from payments
22 made to the operator by the department under section -31.



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

4 (b) Notwithstanding subsection (a), the director, for good
5 cause, may permit an operator to file the operator's return
6 required under this section and make payments thereon, on a
7 semiannual basis during the calendar or fiscal year, the return
8 and payment to be made on or before the last day of the calendar
9 month after the close of each six-month period, to wit: for
10 calendar year operators, on July 31 and January 31 or, for
11 fiscal year operators, on or before the last day of the seventh
12 month following the beginning of the fiscal year and on or
13 before the last day of the month following the close of the
14 fiscal year; provided that the director is satisfied that the
15 grant of the permit will not unduly jeopardize the collection of
16 the taxes due thereon and the operator's total tax liability for
17 the calendar or fiscal year under this subpart will not exceed
18 \$1,000.

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



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

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

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

18 § -31 Withholding. As an option to making payments
19 under section -30, the department and the operator in writing
20 may agree that the department will withhold all or part of the
21 amount of taxes owing for a quarter from Medicaid payments owed
22 by the department to the operator. All reports by the



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

5 § -32 Annual return. On or before the twentieth day of
6 the fourth month following the close of the calendar or fiscal
7 taxable year, every operator who has become liable for the
8 payment of the taxes under this subpart during the preceding tax
9 year shall file a return summarizing that operator's liability
10 under this subpart for the year, in such form as the director
11 prescribes. The operator shall transmit to the Honolulu office
12 of the department with the return, a remittance covering the
13 residue of the tax chargeable to the operator, if any. The
14 return shall be signed by the operator, if made by an
15 individual, or by the president, vice-president, secretary, or
16 treasurer of a corporation, if made on behalf of a corporation.
17 If made on behalf of a partnership, firm, society,
18 unincorporated association, group, hui, joint venture, joint
19 stock company, corporation, trust estate, decedent's estate,
20 trust, or other entity, any individual delegated by the entity
21 shall sign the return on behalf of the operator. If for any
22 reason it is not practicable for the individual operator to sign



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

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

8 § -33 Assessment of tax upon failure to make return;
9 limitation period; exceptions; extension by agreement. (a) If
10 any operator fails to make a return as required by this subpart,
11 the director shall make an estimate of the tax liability of the
12 operator from any information the director obtains, and
13 according to the estimate so made, assess the taxes, interest,
14 and penalty due the State from the operator; give notice of the
15 assessment to the operator; and make demand upon the operator
16 for payment. The assessment shall be presumed to be correct
17 until and unless, upon an appeal duly taken as provided in
18 section -35, the contrary shall be clearly proved by the
19 operator assessed. The burden of proof upon the appeal shall be
20 upon the operator assessed to disprove the correctness of
21 assessment.



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

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



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

4 (1) The taxpayer agrees to suspend the period;
5 (2) The assets of the taxpayer are in control or custody
6 of a court in any proceeding before any court of the
7 United States or any state, and for six months
8 thereafter;

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

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

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



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

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

14 § -34 **Overpayment; refunds.** Upon application by an
15 operator, if the director determines that any tax, interest, or
16 penalty has been paid more than once, or has been erroneously or
17 illegally collected or computed, the tax, interest, or penalty
18 shall be credited by the director on any taxes then due from the
19 operator under this subpart. The director shall refund the
20 balance to the operator or the operator's successors,
21 administrators, executors, or assigns in accordance with section
22 231-23. As to all tax payments for which a refund or credit is



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

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

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

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

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

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



1 § -35 Appeals. Any operator aggrieved by any assessment
2 of the tax imposed by this subpart for any quarter or any year,
3 may appeal from the assessment in the manner and within the time
4 and in all other respects, as provided in the case of income tax
5 appeals by section 235-114.

6 § -36 Records to be kept; examination; penalties. (a)
7 Every operator shall keep, in the English language, within the
8 state, and preserve for a period of three years, suitable
9 records relating to nursing facility income taxed under this
10 subpart, and such other books, records of account, and invoices
11 as may be required by the department. All such books, records,
12 and invoices shall be open for examination at any time by the
13 department or the department of taxation, or the authorized
14 representative thereof. For the purposes of determining the
15 amount of taxes due under this subpart, every operator shall
16 keep its books and records of account on the accrual basis.

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



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

3 § -37 Disclosure of returns unlawful; destruction of
4 returns. (a) All tax returns and return information required
5 to be filed under this subpart, and the report of any
6 investigation of the return or of the subject matter of the
7 return, shall be confidential. It shall be unlawful for any
8 person or any officer or employee of the State to intentionally
9 make known information imparted by any tax return or return
10 information filed pursuant to this subpart, or any report of any
11 investigation of the return or of the subject matter of the
12 return, or to wilfully permit any such return, return
13 information, or report so made, or any copy thereof, to be seen
14 or examined by any person; provided that for tax purposes only
15 the operator, the operator's authorized agent, or persons with a
16 material interest in the return, return information, or report
17 may examine the same. Unless otherwise provided by law, persons
18 with a material interest in the return, return information, or
19 report shall include:

20 (1) Trustees;

21 (2) Partners;



- 1 (3) Persons named in a board resolution or a one per cent
- 2 shareholder in the case of a corporate return;
- 3 (4) The person authorized to act for a corporation in
- 4 dissolution;
- 5 (5) A shareholder of an S corporation;
- 6 (6) The personal representative, trustee, heir, or
- 7 beneficiary of an estate or trust in the case of the
- 8 estate's or decedent's return;
- 9 (7) The committee, trustee, or guardian of any person in
- 10 paragraphs (1) to (6) who is incompetent;
- 11 (8) The trustee in bankruptcy or receiver, and the
- 12 attorney-in-fact of any person in paragraphs (1) to
- 13 (7);
- 14 (9) Persons duly authorized by the State in connection
- 15 with their official duties; and
- 16 (10) Any duly accredited tax official of the United States
- 17 or any state or territory.

18 Any violation of this subsection shall be a misdemeanor.

19 Nothing in this subsection shall prohibit the publication of
20 statistics so classified as to prevent the identification of
21 particular reports or returns and the items of the reports or
22 returns.



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

5 § -38 **Collection by suit; injunction.** The department
6 may collect taxes due and unpaid under this subpart, together
7 with all accrued penalties, by action in assumpsit or other
8 appropriate proceedings in the district or circuit court of the
9 judicial circuit in which the taxes arose, regardless of the
10 amount. After delinquency has continued for sixty days, the
11 department may proceed in the circuit court of the judicial
12 circuit in which the nursing facility income is taxed to obtain
13 an injunction restraining the further furnishing of nursing
14 facility services until full payment is made of all taxes,
15 penalties, and interest due under this subpart.

16 § -39 **Application of taxes.** The taxes imposed by this
17 subpart shall be in addition to any other taxes imposed by any
18 other laws of the State; provided that if it is held by any
19 court of competent jurisdiction that the taxes imposed by this
20 subpart may not legally be imposed in addition to any other tax
21 or taxes imposed by any other law or laws with respect to the
22 same property and the use thereof, then this subpart shall be



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

4 § -40 Administration and enforcement; rules. (a) The
5 director shall administer and enforce this subpart. With
6 respect to:

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

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

11 (3) The general administration of this chapter;

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



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

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

6 § -41 Taxes; allowable reimbursement costs. All taxes
7 paid pursuant to this subpart shall be deemed allowable and
8 reimbursable costs for federal medicaid reimbursement purposes.
9 The department shall make appropriate adjustments to the methods
10 and standards for reimbursing nursing facilities under section
11 346-14 by a medicaid state plan amendment which shall become
12 effective on federal approval. In the case of any program
13 involving federal medicaid participation, the adjustment shall
14 take effect no earlier than the effective date of any federally-
15 approved medicaid state plan amendment containing any such
16 adjustment.

17 § -42 Evasion of tax, etc.; penalties. It shall be
18 unlawful:

19 (1) For any operator to:

20 (A) Refuse to make the return required in section

21 -32;



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

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

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

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

19 **PART IV. PHARMACEUTICALS**

20 A. State Pharmacy Assistance Program

21 § -43 Definitions. As used in this part:



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

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

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

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

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



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

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

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

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

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

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

20 § -44 State pharmacy assistance program. (a) There is
21 established within the department the state pharmacy assistance
22 program. Provided that there are no federally approved



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

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

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

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



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

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

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

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

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



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

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

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

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

14 § -45 Eligibility. (a) All residents of the State
15 shall be eligible to participate in the state pharmacy
16 assistance program; provided that the applicant:

- 17 (1) Is a resident of Hawaii;
- 18 (2) Is sixty-five years or older, or is disabled and
19 receiving a social security benefit;
- 20 (3) Has a household income at or below one hundred fifty
21 per cent of the federal poverty level;
- 22 (4) Meets the asset test; and



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

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

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

17 § -46 Benefits. (a) For persons meeting the
18 eligibility requirements in section -45, the state pharmacy
19 assistance program may pay all or some of the co-payments
20 required under the federal medicare part D pharmacy benefit
21 program, subject to the sufficiency of funds in the state



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

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

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

13 § -47 Special fund. (a) There is established within
14 the state treasury to be administered by the department, the
15 state pharmacy assistance program special fund, into which shall
16 be deposited:

- 17 (1) All moneys received from manufacturers that pay
18 rebates as provided in section -44(g);
19 (2) Appropriations made by the legislature to the fund;
20 and
21 (3) Any other revenues designated for the fund.



- 1 (b) Moneys in the state pharmacy assistance program
2 special fund may be used for:
- 3 (1) Reimbursement payments to participating pharmacies for
4 co-payments required under the federal medicare part D
5 pharmacy benefit program as provided to state pharmacy
6 assistance program participants;
- 7 (2) The costs of administering the state pharmacy
8 assistance program, including salary and benefits of
9 employees, computer costs, and contracted services as
10 provided in section -44(d); and
- 11 (3) Any other purpose deemed necessary by the department
12 for the purpose of operating and administering the
13 state pharmacy assistance program.

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

- 18 (c) The department shall expend all revenues received from
19 rebates paid by pharmaceutical manufacturers pursuant to section
20 -44(g) to pay for the benefits to enrollees in the state
21 pharmacy assistance program, the costs of administering the
22 program, and reimbursement of medicaid pharmaceutical costs.



1 § -48 **Administrative rules.** The department shall adopt
2 rules pursuant to chapter 91 necessary for the purposes of this
3 part.

4 § -49 **Annual reports.** The department shall report the
5 enrollment and financial status of the state pharmacy assistance
6 program to the legislature no later than twenty days prior to
7 the convening of each regular session, beginning with the 2006
8 regular session.

9 B. Preauthorization Exemptions

10 § -50 **Findings.** The legislature finds that:

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

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



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

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

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

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



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

7 (6) The imposition of a "first fail" plan before a
8 physician can adjust or change a medication not on the
9 approved list of medications is medically unsound.

10 The condition of a seriously ill patient suffering
11 from the human immunodeficiency virus, acquired immune
12 deficiency syndrome, or hepatitis C, or who is in need
13 of transplant immunosuppressives, will generally not
14 remain stable for long without prompt treatment. If
15 these persons are not more promptly and effectively
16 treated, a significant probability exists that there
17 will be a substantial increase in health care costs
18 and hospitalizations, thereby increasing medical costs
19 to the State.

20 § -51 Preauthorization exemption for certain physicians
21 and physician assistants. Any physician or physician assistant
22 licensed in this State who treats a medicaid recipient patient



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

9 **PART V. INSURANCE MANDATES**

10 **§ -52 Insurance commissioner to implement this part.**

11 This part shall be administered by the insurance commissioner
12 pursuant to the insurance commissioner's powers and duties under
13 chapter 431 or any other law.

14 **§ -53 Insurers prohibited from taking medicaid status**

15 **into account.** Any health insurer (including a self-insured
16 plan, a group health plan as defined in Section 607(1) of the
17 Employee Retirement Income Security Act of 1974, a health
18 service benefit plan, a mutual benefit society, a fraternal
19 benefit society, a health maintenance organization, a managed
20 care organization, a pharmacy benefit manager, or other party
21 that is, by statute, contract, or agreement, legally responsible
22 for payment of a claim for a health care item or service) is



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

7 § -54 State's right to third party payments. To the
 8 extent that payment has been made under the state plan for
 9 medical assistance for health care items or services furnished
 10 to an individual in any case where another party has a legal
 11 liability to make payment for such assistance, the State is
 12 considered to have acquired the rights of the individual to
 13 payment by the other party for those health care items or
 14 services.

15 § -55 Insurer requirements. Any health insurer as
 16 identified in section -53 shall:

- 17 (1) Provide, with respect to individuals who are eligible
- 18 for, or are provided, medical assistance under Title
- 19 42 United States Code Section 1396a (Section 1902 of
- 20 the Social Security Act), as amended, upon the request
- 21 of the State, information to determine during what
- 22 period the individual or the individual's spouse or



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

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

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

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



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

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

8 § -56 Coverage of children. (a) No insurer shall deny
9 enrollment of a child under the health plan of the child's
10 parent for the following grounds:

11 (1) The child was born out of wedlock;

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

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

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

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

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



1 covered services without the approval of the
2 noncustodial parent; and

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

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

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

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



1 administering the child support enforcement program;
2 and

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

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

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

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

18 § -57 **Employer obligations.** Where a parent is required
19 by a court or administrative order to provide health coverage,
20 which is available through an employer doing business in this
21 state, the employer is required:

- 1 (1) To permit the parent to enroll under family coverage,
2 as defined in section 431:10A-103 or reciprocal
3 beneficiary family coverage, as defined in section
4 431:10A-601, any child who is otherwise eligible for
5 coverage without regard to any enrollment season
6 restrictions;
- 7 (2) If the parent is enrolled but fails to make
8 application to obtain coverage of the child, to enroll
9 the child under family coverage or reciprocal
10 beneficiary family coverage upon application by the
11 child's other parent, by the state agency
12 administering the medicaid program, or by the state
13 agency administering the child support enforcement
14 program;
- 15 (3) Not to disenroll (or eliminate coverage of) any such
16 child unless the employer is provided satisfactory
17 written evidence that:
- 18 (A) The court or administrative order is no longer in
19 effect;
- 20 (B) The child is or will be enrolled in comparable
21 coverage which will take effect no later than the
22 effective date of disenrollment; or



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

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

7 § -58 Recoupment of amounts spent on child medical care.

8 The department of the attorney general may garnish the wages,
9 salary, or other employment income of, and withhold amounts from
10 state tax refunds to, any person who:

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

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

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



1 § -59 Requirements for coverage of an adopted child.

2 (a) In any case in which a group health plan provides coverage
3 for dependent children of participants or beneficiaries, the
4 plan shall provide benefits to dependent children placed with
5 participants or beneficiaries for adoption under the same terms
6 and conditions as apply to the natural, dependent children of
7 the participants and beneficiaries, irrespective of whether the
8 adoption has become final.

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

17 (c) As used in this section:

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



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

6 PART VI. FINANCING AND ENFORCEMENT

7 A. General Provisions

8 § -60 Medical care payments. (a) The department shall
9 adopt rules under chapter 91 concerning payment to providers of
10 medical care. The department shall determine the rates of
11 payment due to all providers of medical care, and pay such
12 amounts in accordance with the requirements of the
13 appropriations act and the Social Security Act, as amended.
14 Payments to critical access hospitals for services rendered to
15 medicaid beneficiaries shall be calculated on a cost basis using
16 medicare reasonable cost principles.

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



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

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

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

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



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

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

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

21

22



1 § -61 Interdepartmental transfer of funds; federal
2 grants and allotments. The governor may transfer funds from the
3 department of health to the department of human services and
4 from the department of human services to the department of labor
5 and industrial relations to obtain additional federal funds for
6 medical assistance under Title XIX of the Social Security Act,
7 as amended, and the work incentive program. The governor may
8 also transfer funds from one department to another for the
9 purpose of obtaining federal matching grants and allotments;
10 provided that the state moneys have been appropriated for the
11 purpose for which federal grants and allotments may be obtained.

12 § -62 Comptroller's acceptance of vouchers. The
13 requirements of section 40-56 and section 40-57 to the contrary
14 notwithstanding, the comptroller may, if satisfied as to the
15 adequacy of related internal controls and audit trails, issue
16 warrants for original warrant vouchers without accompanying
17 original bills for payments to vendors of the Hawaii state
18 medicaid program. Whenever the comptroller has given the
19 comptroller's approval for the issuance of warrants under this
20 section without accompanying original bills, the original bills
21 shall be retained by the expending agency vouchering the
22 payment, and shall be made available for authorized referencing,



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

7 § -63 Medicaid contracts; nonprofits and for-profits;
8 reporting requirements. (a) All nonprofit or for-profit
9 medicaid healthcare insurance contractors, within one hundred
10 and eighty days following the close of each fiscal year, shall
11 submit an annual report to the department of human services, the
12 insurance division of the department of commerce and consumer
13 affairs, and the legislature. The report shall be attested to
14 by a plan executive located within the state and shall be made
15 accessible to the public.

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

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

21 (A) For medical services;

22 (B) For administrative costs;



- 1 (C) Held in reserve; and
- 2 (D) Paid to shareholders;
- 3 (2) Employment information including:
 - 4 (A) Total number of full-time employees hired for the
 - 5 contracted services;
 - 6 (B) Total number of employees located in the state
 - 7 and the category of work performed; and
 - 8 (C) The compensation provided to each of the five
 - 9 highest paid Hawaii employees and to each of the
 - 10 five highest paid employees nationwide, and a
 - 11 description of each position;
- 12 (3) Descriptions of any on-going state or federal sanction
- 13 proceedings, prohibitions, restrictions, on-going
- 14 civil or criminal investigations, and descriptions of
- 15 past sanctions or resolved civil or criminal cases,
- 16 within the past five years and related to the
- 17 provision of medicare or medicaid services by the
- 18 contracting entity, to the extent allowed by law;
- 19 (4) Descriptions of contributions to the community,
- 20 including the percentage of revenue devoted to Hawaii
- 21 community development projects and health



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

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

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

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

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

15 § -64 Maintenance and availability of records; penalty.

16 (a) To enable another provider to determine the proper course
17 of treatment in emergencies and in order to determine whether a
18 provider is genuinely entitled to reimbursement and to protect
19 the medicaid program against fraud and abuse, each provider of
20 health care, service or supplies under the state medicaid
21 program shall maintain, and keep for a period of three years,
22 such records as are necessary to disclose fully the type and



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

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

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



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

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

12 § -65 Administrative inspections and warrants. (a)
13 Issuance and execution of administrative inspection warrants
14 shall be as follows:

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



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

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

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



- 1 (B) Be directed to a person authorized by the
- 2 attorney general or the director of human
- 3 services to execute it;
- 4 (C) Command the person to whom it is directed to
- 5 inspect the area, premises, building, conveyance
- 6 or records identified for the purpose specified
- 7 and, if appropriate, use reasonable force in
- 8 conducting the inspection authorized by the
- 9 warrant and direct the seizure of the property
- 10 specified;
- 11 (D) Identify the item or types of property to be
- 12 seized, if any;
- 13 (E) Direct that it be served during normal business
- 14 hours and designate the judge to whom it shall be
- 15 returned;
- 16 (3) A warrant issued pursuant to this section must be
- 17 executed and returned within ten days of its date
- 18 unless, upon a showing of a need for additional time,
- 19 the court orders otherwise. If property is seized
- 20 pursuant to a warrant, a copy shall be given to the
- 21 person from whom or from whose premises the property
- 22 is taken, together with a receipt for the property



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

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

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

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

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



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

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

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

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

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

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



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

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

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

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

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

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



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

3 B. Federally Qualified Health Centers

4 § -66 Medicaid overpayment recovery. The director
5 shall recover medicaid overpayments made to providers. Medicaid
6 overpayments shall be recovered due to a provider's
7 ineligibility, noncovered service, noncovered drug, lack of
8 prior authorization when a service requires one, incorrect
9 payment allowance identified through any post payment review, or
10 claims processing error. The director may recover overpayments
11 through recoupment, tax offset under sections 231-51 to 231-59,
12 and circuit court judgment. Nothing in this section shall limit
13 the director's authority to recover overpayments through all
14 other lawful means.

15 § -67 Enforcement of decisions regarding medicaid
16 overpayment recovery; judgment rendered thereon. (a) The
17 director may file in the circuit court in the jurisdiction in
18 which the medicaid overpayment occurred a certified copy of:

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



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

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

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

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



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

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

13 B. Federally Qualified Health Centers

14 § -68 Federally qualified health centers; rural health
15 clinics; reimbursement. (a) Notwithstanding any law or waiver
16 to the contrary, federally qualified health centers and rural
17 health clinics, as defined in Section 1905(1) of the Social
18 Security Act (42 U.S.C. 1396 et seq.), shall be reimbursed in
19 accordance with Section 1902(bb) of the Social Security Act, as
20 that section was originally added in 2000 by section 702(b) of
21 Public Law 106-554 and as amended in 2001 by section 2(b)(1) of
22 Public Law 107-121, and services of federally qualified health



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

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

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

21 § -69 Centers for Medicare and Medicaid Services
22 approval. The department shall implement sections -70, -



1 71, and -72, subject to approval of the Hawaii medicaid state
2 plan by the Centers for Medicare and Medicaid Services.

3 § -70 Federally qualified health centers and rural
4 health clinics; reconciliation of managed care supplemental
5 payments. (a) Federally qualified health centers or rural
6 health clinics that provide services under a contract with a
7 medicaid managed care organization shall receive estimated
8 quarterly state supplemental payments for the cost of furnishing
9 such services that are an estimate of the difference between the
10 payments the federally qualified health center or rural health
11 clinic receives from medicaid managed care organizations and
12 payments the federally qualified health center or rural health
13 clinic would have received under the Benefits Improvement and
14 Protection Act of 2000 prospective payment system methodology.
15 Not more than one month following the beginning of each calendar
16 quarter and based on the receipt of federally qualified health
17 center or rural health clinic submitted claims during the prior
18 calendar quarter, federally qualified health centers or rural
19 health clinics shall receive the difference between the
20 combination of payments the federally qualified health center or
21 rural health clinic receives from estimated supplemental
22 quarterly payments and payments received from medicaid managed



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

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



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

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

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



1 § -71 Federally qualified health center or rural health
2 clinic; adjustment for changes to scope of services. (a)
3 Prospective payment system rates may be adjusted for any
4 increases or decreases in the scope of services furnished by a
5 participating federally qualified health center or rural health
6 clinic, provided that:

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

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

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

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



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

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



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

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

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

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



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

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

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

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

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

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



- 1 (6) A change in service resulting from a change in the
2 provider mix of a federally qualified health center or
3 a rural health clinic or one of its sites;
- 4 (7) Any changes in the scope of a project approved by the
5 Federal Health Resources and Services Administration
6 where the change affects a covered service; or
- 7 (8) Changes in operating costs due to capital expenditures
8 associated with a modification of the scope of any of
9 the services, including new or expanded service
10 facilities, regulatory compliance, or changes in
11 technology or medical practices at the federally
12 qualified health center or rural health clinic.
- 13 (g) No change in costs, in and of itself, shall be
14 considered a scope of service change unless the cost is
15 allowable under medicaid principles of reimbursement and the net
16 change in the federally qualified health center's or rural
17 health clinic's per visit rate equals or exceeds three per cent
18 for the affected federally qualified health center or rural
19 health clinic site. For federally qualified health centers or
20 rural health clinics that filed consolidated cost reports for
21 multiple sites to establish their baseline prospective payment
22 system rates, the net change of three per cent shall be applied



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

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

11 § -72 Federally qualified health center or rural health
12 clinic visit. (a) Services eligible for prospective payment
13 system reimbursement are those services that are furnished by a
14 federally qualified health center or rural health clinic that
15 are:

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

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



- 1 (3) Covered benefits under the medicaid program, as
2 defined in section 4231 of the State Medicaid Manual
3 and the Hawaii medicaid state plan;
- 4 (4) Provided to a recipient eligible for medicaid
5 benefits;
- 6 (5) Delivered exclusively by health care professionals,
7 including physicians, physician's assistants, nurse
8 practitioners, nurse midwives, clinical social
9 workers, clinical psychologists, and other persons
10 acting within the lawful scope of their license or
11 certificate to provide services;
- 12 (6) Provided at the federally qualified health center's
13 practice site, a hospital emergency room, in an
14 inpatient setting, at the patient's place of
15 residence, including long term care facilities, or at
16 another medical facility; and
- 17 (7) Within the scope of services provided by the State
18 under its fee-for-service medicaid program and its
19 health QUEST program, on and after August 1994, and as
20 amended from time to time.
- 21 (b) Contacts with one or more health professionals and
22 multiple contacts with the same health professional that take



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

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

7 (2) The patient makes one or more visits for other
8 services such as dental or behavioral health.

9 Medicaid may pay for a maximum of one visit per day
10 for each of these services in addition to one medical
11 visit.

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



1 § -73 Appeal. A federally qualified health center or
2 rural health clinic may appeal a decision made by the department
3 if the medicaid impact is \$10,000 or more, whereupon the
4 opportunity for an administrative hearing under chapter 91 shall
5 be afforded. Any federally qualified health center or rural
6 health clinic aggrieved by the final decision and order shall be
7 entitled to judicial review in accordance with chapter 92 or may
8 submit the matter to binding arbitration pursuant to chapter
9 658A.

10 § -74 Hawaii qualified health centers. If the QUEST
11 program is implemented, the department shall provide a
12 supplemental capitation program for the uninsured with enabling
13 services based on an annual cost-based determination to all
14 federally qualified health center, (FQHC), FQHC look-alike, or
15 need health clinic designated as a Hawaii qualified health
16 center under section 321-1.6, (HQHCs) and to any nonprofit
17 entity having a majority of Hawaii qualified health centers as
18 board members.

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



1 contracts, through a modified voucher system, or through chapter
2 42D. Hawaii qualified health centers receiving these
3 supplemental payments shall reconcile their costs on an annual
4 basis.

5 C. Medicaid Fraud

6 § -75 Medicaid fraud unit. There is established in the
7 department of the attorney general a medicaid fraud unit.

8 The unit shall employ such attorneys, auditors,
9 investigators, and other personnel as necessary to promote the
10 effective and efficient conduct of the unit's activities.

11 Except for the attorneys, all other employees of the medicaid
12 fraud unit shall be subject to chapter 76.

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



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

3 § -76 Medicaid investigations recovery fund;
4 established. There is established in the state treasury the
5 medicaid investigations recovery fund as a special fund, and
6 which is to be administered by the department of the attorney
7 general, into which shall be deposited all funds that have been
8 recovered as a result of medicaid fraud settlements. Moneys
9 from this special fund shall be used to support a portion of
10 operating expenses of the medicaid fraud unit within the
11 department of the attorney general."

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

14 "§231-51 Purpose. The purpose of sections 231-52 to 231-
15 59 is to permit the retention of state income tax refunds of
16 those persons who owe a debt to the State, who are delinquent in
17 the payment of child support pursuant to section 576D-1, who
18 have defaulted on an education loan note held by the United
19 Student Aid Funds, Inc., who owe federal income taxes to the
20 United States Treasurer, or who receive a medicaid overpayment
21 subject to recovery under section [~~346-59.6-~~] -61."



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

3 "Debt" includes:

- 4 (1) Any delinquency in periodic court-ordered or
5 administrative-ordered payments for child support
6 pursuant to section 576D-1, in an amount equal to or
7 exceeding the sum of payments which would become due
8 over a one-month period;
- 9 (2) Any liquidated sum exceeding \$25 which is due and
10 owing any claimant agency, regardless of whether there
11 is an outstanding judgment for that sum, and whether
12 the sum has accrued through contract, subrogation,
13 tort, operation of law, or judicial or administrative
14 judgment or order;
- 15 (3) Any defaulted education loan note held by the United
16 Student Aid Funds, Inc. incurred under the federal
17 Higher Education Act of 1965 (Public Law 89-329, 79
18 Stat. 1219), as amended;
- 19 (4) Any federal income taxes due and owing to the United
20 States Treasurer; or
- 21 (5) Any medicaid overpayment under section [~~346-59.6.~~]

22 _____-61."



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

3 "§237-24.7 Additional amounts not taxable. In addition to
4 the amounts not taxable under section 237-24, this chapter shall
5 not apply to:

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

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

19 "Hotel" means an operation as defined in section
20 445-90 or a time share plan as defined in section
21 514E-1.



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

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

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

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

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

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

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



1 subdivision's county transportation system, which
2 provides that:

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

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

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

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



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

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

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

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

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



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

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

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

13 (5) Taxes on nursing facility income imposed by chapter
14 [346E] _____ and passed on and collected by operators
15 of nursing facilities;

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



- 1 (7) Amounts received as compensation by community
2 organizations, school booster clubs, and nonprofit
3 organizations under a contract with the chief election
4 officer for the provision and compensation of precinct
5 officials and other election-related personnel,
6 services, and activities, pursuant to section 11-5;
- 7 (8) Interest received by a person domiciled outside the
8 [State] state from a trust company (as defined in
9 section 412:8-101) acting as payment agent or trustee
10 on behalf of the issuer or payees of an interest
11 bearing instrument or obligation, if the interest
12 would not have been subject to tax under this chapter
13 if paid directly to the person domiciled outside the
14 [State] state without the use of a paying agent or
15 trustee; provided that if the interest would otherwise
16 be taxable under this chapter if paid directly to the
17 person domiciled outside the [~~State,~~] state, it shall
18 not be exempt solely because of the use of a Hawaii
19 trust company as a paying agent or trustee;
- 20 (9) Amounts received by a management company from related
21 entities engaged in the business of selling interstate
22 or foreign common carrier telecommunications services



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

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

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

17 "Related entities" means:

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



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

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

15 (D) Any group or combination of the entities
16 described in paragraph (C) constituting a
17 unitary business for income tax purposes;
18 whether or not the entity is located within or without
19 the [~~State~~] state or licensed under this chapter; and

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



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

4 "Needy person" means any natural person who lacks the
5 means to obtain adequate or proper pharmaceuticals or health
6 care supplies, as determined by a practitioner at a Hawaii
7 qualified health center, established under section [~~346-41.5,~~
8 -9, to be in need of service."

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

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

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



1 family homes as defined under section [~~346-331.7~~] ____ -
2 18, and certified adult foster homes as defined under
3 section 321-11.2, the state supplemental payment shall
4 not exceed \$651.90; and

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

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

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

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

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



1 allowed by federal law, for resident clients receiving
2 supplemental security income in adult residential care home type
3 I and type II facilities, licensed developmental disabilities
4 domiciliary homes as defined under section 321-15.9, community
5 care foster family homes as defined under section [~~346-331,~~
6 -18, and certified adult foster homes as defined under
7 section 321-11.2, when state funds appropriated for the purpose
8 of providing payments under subsection (c) for a specific fiscal
9 year are not expended fully within a period that meets the
10 requirements of the department's maintenance of effort agreement
11 with the Social Security Administration.

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

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

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

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



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

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

8 "(e) Any alternative arrangement for direct payment shall
9 provide that either parent may void the arrangement at any time
10 and apply for services from the agency to act as agent to
11 receive payments from the obligor parent. The alternative
12 arrangement for direct payment also shall provide that, if the
13 subject dependents of the obligor parent commence receiving
14 public assistance[7] including but not limited to public
15 assistance from the department of human services under chapter
16 346[7] or _____, foster care under section 571-48, Title IV-E or
17 Title XIX of the [~~federal~~] Federal Social Security Act (42
18 U.S.C. §1396), or if either parent applies for services from the
19 agency, the agency may immediately void the direct payment
20 arrangement by sending written notice by regular mail to the
21 custodial and obligor parents at their last known addresses, as
22 disclosed in the alternative arrangement agreement.



1 (f) The alternative arrangement for direct payment
2 agreement shall include the most recent addresses of the
3 custodial and obligor parent. If the obligor parent alleges
4 direct payment of child support to the custodial parent after
5 the subject dependents of the court-approved alternative
6 arrangement become recipients of public assistance, including
7 but not limited to public assistance from the department of
8 human services under chapter 346[7] or _____, foster care under
9 ~~[section]~~ Section 571-48, Title IV-E or Title XIX of the
10 ~~[federal]~~ Federal Social Security Act (42 U.S.C. §1396), or
11 after the custodial parent applies for services from the agency,
12 and after receiving proper notification of the change of payee
13 to the agency, then the obligor shall have the burden of proving
14 that the child support payments were made by presenting written
15 evidence, including but not limited to canceled checks or
16 receipts.

17 (g) No alternative arrangement for direct payment shall be
18 approved where the obligor or the custodial parent is receiving
19 services under Title IV-D or where the dependents of the obligor
20 receive public assistance, including but not limited to public
21 assistance from the department of human services under chapter
22 346[7] or _____, foster care under ~~[section]~~ Section 571-48, Title



1 IV-E or Title XIX of the [~~federal~~] Federal Social Security Act
2 (42 U.S.C. §1396), or where the obligor owes child support for a
3 period during which public assistance was provided to the child
4 or children by the department of human services."

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

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

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

11 (2) The department of health on prospective employees,
12 persons seeking to serve as providers, or
13 subcontractors in positions that place them in direct
14 contact with clients when providing non-witnessed
15 direct mental health services as provided by section
16 321-171.5;

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



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

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

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

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

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



- 1 (8) The department of human services on prospective
2 adoptive parents as established under section 346-
3 19.7;
- 4 (9) The department of human services on applicants to
5 operate child care facilities, prospective employees
6 of the applicant, and new employees of the provider
7 after registration or licensure as provided by section
8 346-154;
- 9 (10) The department of human services on persons exempt
10 pursuant to section 346-152 to be eligible to provide
11 child care and receive child care subsidies as
12 provided by section 346-152.5;
- 13 (11) The department of human services on operators and
14 employees of home and community-based case management
15 agencies and operators and other adults, except for
16 adults in care, residing in foster family homes as
17 provided by section [~~346-335,~~] -22;
- 18 (12) The department of human services on staff members of
19 the Hawaii youth correctional facility as provided by
20 section 352-5.5;
- 21 (13) The department of human services on employees,
22 prospective employees, and volunteers of contracted



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

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

7 (15) The department of public safety on employees and
8 prospective employees who are directly involved with
9 the treatment and care of persons committed to a
10 correctional facility or who possess police powers
11 including the power of arrest as provided by section
12 353C-5;

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

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



1 (18) The public library system on employees and prospective
2 employees whose positions place them in close
3 proximity to children as provided by section 302A-
4 601.5;

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

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

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



- 1 (22) The department of human services on foster grandparent
2 program, retired and senior volunteer program, senior
3 companion program, and respite companion program
4 participants as provided by section 346-97;
- 5 (23) The department of human services on contracted and
6 subcontracted service providers and their current and
7 prospective employees that provide home and community-
8 based services under Section 1915(c) of the Social
9 Security Act (Title 42 United States Code Section
10 1396n(c)), or under any other applicable section or
11 sections of the Social Security Act for the purposes
12 of providing home and community-based services, as
13 provided by section 346-97;
- 14 (24) The department of commerce and consumer affairs on
15 proposed directors and executive officers of a bank,
16 savings bank, savings and loan association, trust
17 company, and depository financial services loan
18 company as provided by section 412:3-201;
- 19 (25) The department of commerce and consumer affairs on
20 proposed directors and executive officers of a
21 nondepository financial services loan company as
22 provided by section 412:3-301;



1 (26) The department of commerce and consumer affairs on the
2 original chartering applicants and proposed executive
3 officers of a credit union as provided by section
4 412:10-103;

5 (27) The department of commerce and consumer affairs on:
6 (A) Each principal of every non-corporate applicant
7 for a money transmitter license; and
8 (B) The executive officers, key shareholders, and
9 managers in charge of a money transmitter's
10 activities of every corporate applicant for a
11 money transmitter license,
12 as provided by section 489D-9;

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

16 (29) The Hawaii health systems corporation on:
17 (A) Employees;
18 (B) Applicants seeking employment;
19 (C) Current or prospective members of the corporation
20 board or regional system board; or
21 (D) Current or prospective volunteers, providers, or
22 contractors,



1 in any of the corporation's health facilities as
 2 provided by section 323F-5.5; .
 3 [+] (30) [+] The department of commerce and consumer affairs on
 4 an applicant for a mortgage loan originator's license
 5 as provided by chapter 454F; and
 6 [+] (31) [+] Any other organization, entity, or the State, its
 7 branches, political subdivisions, or agencies as may
 8 be authorized by state law."

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

11 ~~["§28-91] Medicaid fraud unit. There is established in~~
 12 ~~the department of the attorney general a medicaid fraud unit.~~

13 ~~The unit shall employ such attorneys, auditors,~~
 14 ~~investigators, and other personnel as necessary to promote the~~
 15 ~~effective and efficient conduct of the unit's activities.~~

16 ~~Except for the attorneys, all other employees of the medicaid~~
 17 ~~fraud unit shall be subject to chapter 76.~~

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



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

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

10 ~~["§28-91.5 Medicaid investigations recovery fund,~~
11 ~~established. There is established in the state treasury the~~
12 ~~medicaid investigations recovery fund as a special fund, and~~
13 ~~which is to be administered by the department of the attorney~~
14 ~~general, into which shall be deposited all funds that have been~~
15 ~~recovered as a result of medicaid fraud settlements. Moneys~~
16 ~~from this special fund shall be used to support a portion of~~
17 ~~operating expenses of the medicaid fraud unit within the~~
18 ~~department of the attorney general."]~~

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

21 ~~["§40-57.5 Comptroller's acceptance of vouchers for the~~
22 ~~Hawaii state medicaid program. The requirements of section 40-~~



1 ~~56 and section 40-57 to the contrary notwithstanding, the~~
2 ~~comptroller may, if satisfied as to the adequacy of related~~
3 ~~internal controls and audit trails, issue warrants for original~~
4 ~~warrant vouchers without accompanying original bills for~~
5 ~~payments to vendors of the Hawaii state medicaid program.~~
6 ~~Whenever the comptroller has given the comptroller's approval~~
7 ~~for the issuance of warrants under this section without~~
8 ~~accompanying original bills, the original bills shall be~~
9 ~~retained by the expending agency vouchering the payment, and~~
10 ~~shall be made available for authorized referencing, for the~~
11 ~~period prescribed by section 40-10 for the retention of~~
12 ~~vouchers, documents and other records or papers before~~
13 ~~destruction. For purposes of this section, the definition of~~
14 ~~original bills shall also include computer magnetic tape,~~
15 ~~computer listings, computer output microfilm, microfiche, and~~
16 ~~manually produced microfilm."]~~

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

19 ["~~§103F-107~~ ~~Medicaid contracts, nonprofits and for-~~
20 ~~profits, reporting requirements.~~ (a) ~~All nonprofit or for-~~
21 ~~profit medicaid healthcare insurance contractors, within one~~
22 ~~hundred and eighty days following the close of each fiscal year,~~



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

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

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

11 ~~(A) For medical services,~~

12 ~~(B) For administrative costs,~~

13 ~~(C) Held in reserve, and~~

14 ~~(D) Paid to shareholders,~~

15 ~~(2) Employment information including:~~

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

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

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



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

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

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

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

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



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

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

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

8 ~~["§321 15.6 Adult residential care homes; licensing. (a)~~
9 ~~All adult residential care homes shall be licensed to ensure the~~
10 ~~health, safety, and welfare of the individuals placed therein.~~
11 ~~The department shall conduct unannounced visits, other than the~~
12 ~~inspection for relicensing, to every licensed adult residential~~
13 ~~care home and expanded adult residential care home on an annual~~
14 ~~basis and at such intervals as determined by the department to~~
15 ~~ensure the health, safety, and welfare of each resident.~~
16 ~~Unannounced visits may be conducted during or outside regular~~
17 ~~business hours. All inspections relating to follow up visits,~~
18 ~~visits to confirm correction of deficiencies, or visits to~~
19 ~~investigate complaints or suspicion of abuse or neglect shall be~~
20 ~~conducted unannounced during or outside regular business hours.~~
21 ~~Annual inspections for relicensing may be conducted during~~
22 ~~regular business hours or at intervals determined by the~~



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

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

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

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

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

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



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

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

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

8 ~~For the purposes of this subsection:~~

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

11 ~~"Elder" has the same meaning as defined under section 356D-~~
12 ~~1.~~

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

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

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

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



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

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

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

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



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

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

6 ~~["§321-15.61] Adult residential care homes expanded~~
7 ~~admissions. (a) Adult residential care homes may admit an~~
8 ~~individual who has been living immediately prior to admission in~~
9 ~~the individual's own home, a hospital, or other care setting,~~
10 ~~and who has been either:~~

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

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

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



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

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

5 ~~["§321-15.62 Expanded adult residential care homes,~~
6 ~~licensing. (a) All expanded adult residential care homes shall~~
7 ~~be licensed to ensure the health, safety, and welfare of the~~
8 ~~individuals placed therein.~~

9 ~~(b) The director of health shall adopt rules regarding~~
10 ~~expanded adult residential care homes in accordance with chapter~~
11 ~~91 that shall implement a social model of health care designed~~
12 ~~to:~~

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

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



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

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

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



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

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

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

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



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

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

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

15 ~~["§346-40 Maintenance and availability of records;~~
16 ~~penalty. (a) To enable another provider to determine the~~
17 ~~proper course of treatment in emergencies and in order to~~
18 ~~determine whether a provider is genuinely entitled to~~
19 ~~reimbursement and to protect the medicaid program against fraud~~
20 ~~and abuse, each provider of health care, service or supplies~~
21 ~~under the state medicaid program shall maintain, and keep for a~~
22 ~~period of three years, such records as are necessary to disclose~~



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

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



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

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

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

16 ~~["§346-41.5 Hawaii qualified health centers. If the QUEST~~
17 ~~program is implemented, the department shall provide a~~
18 ~~supplemental capitation program for the uninsured with enabling~~
19 ~~services based on an annual cost based determination to all~~
20 ~~Hawaii qualified health centers (HQHCs) and to any nonprofit~~
21 ~~entity having a majority of Hawaii qualified health centers as~~
22 ~~board members.~~



1 ~~For the purposes of this section, "enabling services"~~
2 ~~includes enabling services as defined by federally qualified~~
3 ~~health center standards. The department shall have the~~
4 ~~administrative flexibility to expend funds through QUEST~~
5 ~~contracts, through a modified voucher system, or through chapter~~
6 ~~42D. Hawaii qualified health centers receiving these~~
7 ~~supplemental payments shall reconcile their costs on an annual~~
8 ~~basis."]~~

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

11 ~~["§346-42 Administrative inspections and warrants. (a)~~
12 ~~Issuance and execution of administrative inspection warrants~~
13 ~~shall be as follows:~~

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



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

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

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

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



- 1 ~~(C) Command the person to whom it is directed to~~
2 ~~inspect the area, premises, building, conveyance~~
3 ~~or records identified for the purpose specified~~
4 ~~and, if appropriate, use reasonable force in~~
5 ~~conducting the inspection authorized by the~~
6 ~~warrant and direct the seizure of the property~~
7 ~~specified;~~
- 8 ~~(D) Identify the item or types of property to be~~
9 ~~seized, if any;~~
- 10 ~~(E) Direct that it be served during normal business~~
11 ~~hours and designate the judge to whom it shall be~~
12 ~~returned;~~
- 13 ~~(3) A warrant issued pursuant to this section must be~~
14 ~~executed and returned within ten days of its date~~
15 ~~unless, upon a showing of a need for additional time,~~
16 ~~the court orders otherwise. If property is seized~~
17 ~~pursuant to a warrant, a copy shall be given to the~~
18 ~~person from whom or from whose premises the property~~
19 ~~is taken, together with a receipt for the property~~
20 ~~taken. The return of the warrant shall be made~~
21 ~~promptly, accompanied by a written inventory of any~~
22 ~~property taken. The inventory shall be made in the~~



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

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

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

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

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

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



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

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

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

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

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

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



- 1 ~~(E) Inspect, examine and test, within reasonable~~
- 2 ~~limits and in a reasonable manner, provider~~
- 3 ~~premises and equipment as necessary to assure~~
- 4 ~~compliance with this chapter.~~
- 5 ~~(4) This section does not prevent the inspection without a~~
- 6 ~~warrant of property, books and records pursuant to an~~
- 7 ~~administrative subpoena issued in accordance with law,~~
- 8 ~~nor does it prevent entries and administrative~~
- 9 ~~inspections, including seizures of property, without a~~
- 10 ~~warrant.~~
- 11 ~~(A) If the owner, operator, or agent in charge of the~~
- 12 ~~provider premises consents,~~
- 13 ~~(B) In situations presenting imminent danger to~~
- 14 ~~health or safety,~~
- 15 ~~(C) In situations involving inspection of conveyances~~
- 16 ~~if there is reasonable cause to believe that the~~
- 17 ~~mobility of the conveyance makes it impracticable~~
- 18 ~~to obtain a warrant,~~
- 19 ~~(D) In all other situations in which a warrant is not~~
- 20 ~~constitutionally required."]~~

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

22 repealed.



1 ~~["§346-53.6] Federally qualified health centers, rural~~
2 ~~health clinics, reimbursement. (a) Notwithstanding any law or~~
3 ~~waiver to the contrary, federally qualified health centers and~~
4 ~~rural health clinics, as defined in section 1905(1) of the~~
5 ~~Social Security Act (42 U.S.C. 1396 et seq.), shall be~~
6 ~~reimbursed in accordance with section 1902(bb) of the Social~~
7 ~~Security Act, as that section was originally added in 2000 by~~
8 ~~section 702(b) of Public Law 106-554 and as amended in 2001 by~~
9 ~~section 2(b)(1) of Public Law 107-121, and services of federally~~
10 ~~qualified health centers and rural health clinics shall remain~~
11 ~~mandatory services as provided in sections 1902(a)(10)(A) and~~
12 ~~1905(a)(2)(B) and (C) of the Social Security Act.~~

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



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

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

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

10 ~~["§346 53.61] Centers for Medicare and Medicaid Services~~
11 ~~approval. The department shall implement sections 346 53.62,~~
12 ~~346 53.63, and 346 53.64, subject to approval of the Hawaii~~
13 ~~medicaid state plan by the Centers for Medicare and Medicaid~~
14 ~~Services."]~~

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

17 ~~["§346 53.62] Federally qualified health centers and~~
18 ~~rural health clinics; reconciliation of managed care~~
19 ~~supplemental payments. (a) Federally qualified health centers~~
20 ~~or rural health clinics that provide services under a contract~~
21 ~~with a medicaid managed care organization shall receive~~
22 ~~estimated quarterly state supplemental payments for the cost of~~



1 ~~furnishing such services that are an estimate of the difference~~
2 ~~between the payments the federally qualified health center or~~
3 ~~rural health clinic receives from medicaid managed care~~
4 ~~organizations and payments the federally qualified health center~~
5 ~~or rural health clinic would have received under the Benefits~~
6 ~~Improvement and Protection Act of 2000 prospective payment~~
7 ~~system methodology. Not more than one month following the~~
8 ~~beginning of each calendar quarter and based on the receipt of~~
9 ~~federally qualified health center or rural health clinic~~
10 ~~submitted claims during the prior calendar quarter, federally~~
11 ~~qualified health centers or rural health clinics shall receive~~
12 ~~the difference between the combination of payments the federally~~
13 ~~qualified health center or rural health clinic receives from~~
14 ~~estimated supplemental quarterly payments and payments received~~
15 ~~from medicaid managed care organizations and payments the~~
16 ~~federally qualified health center or rural health clinic would~~
17 ~~have received under the Benefits Improvement and Protection Act~~
18 ~~of 2000 prospective payment system methodology. Balances due~~
19 ~~from the federally qualified health center shall be recouped~~
20 ~~from the next quarter's estimated supplemental payment.~~

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



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



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

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

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

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

16 [~~§346-53.63~~] ~~Federally qualified health center or rural~~
17 ~~health clinic; adjustment for changes to scope of services. (a)~~
18 ~~Prospective payment system rates may be adjusted for any~~
19 ~~increases or decreases in the scope of services furnished by a~~
20 ~~participating federally qualified health center or rural health~~
21 ~~clinic, provided that:~~



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

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

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

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



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

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

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



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

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

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

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



- 1 ~~incorporated in the baseline prospective payment~~
- 2 ~~system rate;~~
- 3 ~~(2) A change in service resulting from amended regulatory~~
- 4 ~~requirements or rules;~~
- 5 ~~(3) A change in service resulting from relocation;~~
- 6 ~~(4) A change in type, intensity, duration, or amount of~~
- 7 ~~service resulting from a change in applicable~~
- 8 ~~technology and medical practice used;~~
- 9 ~~(5) An increase in service intensity, duration, or amount~~
- 10 ~~of service resulting from changes in the types of~~
- 11 ~~patients served, including but not limited to~~
- 12 ~~populations with human immunodeficiency virus,~~
- 13 ~~acquired immunodeficiency syndrome, or other chronic~~
- 14 ~~diseases, or homeless, elderly, migrant, or other~~
- 15 ~~special populations;~~
- 16 ~~(6) A change in service resulting from a change in the~~
- 17 ~~provider mix of a federally qualified health center or~~
- 18 ~~a rural health clinic or one of its sites;~~
- 19 ~~(7) Any changes in the scope of a project approved by the~~
- 20 ~~federal Health Resources and Services Administration~~
- 21 ~~where the change affects a covered service; or~~



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

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



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

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

7 ~~["§346-53.64] Federally qualified health center or rural~~
 8 ~~health clinic visit. (a) Services eligible for prospective~~
 9 ~~payment system reimbursement are those services that are~~
 10 ~~furnished by a federally qualified health center or rural health~~
 11 ~~clinic that are:~~

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

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

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

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



- 1 ~~(5) Delivered exclusively by health care professionals,~~
2 ~~including physicians, physician's assistants, nurse~~
3 ~~practitioners, nurse midwives, clinical social~~
4 ~~workers, clinical psychologists, and other persons~~
5 ~~acting within the lawful scope of their license or~~
6 ~~certificate to provide services;~~
- 7 ~~(6) Provided at the federally qualified health center's~~
8 ~~practice site, a hospital emergency room, in an~~
9 ~~inpatient setting, at the patient's place of~~
10 ~~residence, including long term care facilities, or at~~
11 ~~another medical facility; and~~
- 12 ~~(7) Within the scope of services provided by the State~~
13 ~~under its fee for service medicaid program and its~~
14 ~~health QUEST program, on and after August 1994, and as~~
15 ~~amended from time to time.~~
- 16 ~~(b) Contacts with one or more health professionals and~~
17 ~~multiple contacts with the same health professional that take~~
18 ~~place on the same day and at a single location constitute a~~
19 ~~single encounter, except when one of the following conditions~~
20 ~~exists:~~



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

4 ~~(2) The patient makes one or more visits for other~~
5 ~~services such as dental or behavioral health.~~

6 ~~Medicaid may pay for a maximum of one visit per day~~
7 ~~for each of these services in addition to one medical~~
8 ~~visit.~~

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

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

21 ~~["§346-53.65] Appeal. A federally qualified health~~
22 ~~center or rural health clinic may appeal a decision made by the~~



1 ~~department if the medicaid impact is \$10,000 or more, whereupon~~
2 ~~the opportunity for an administrative hearing under chapter 91~~
3 ~~shall be afforded. Any federally qualified health center or~~
4 ~~rural health clinic aggrieved by the final decision and order~~
5 ~~shall be entitled to judicial review in accordance with chapter~~
6 ~~92 or may submit the matter to binding arbitration pursuant to~~
7 ~~chapter 658A."]~~

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

10 [~~"§346-59 Medical care payments. (a) The department~~
11 ~~shall adopt rules under chapter 91 concerning payment to~~
12 ~~providers of medical care. The department shall determine the~~
13 ~~rates of payment due to all providers of medical care, and pay~~
14 ~~such amounts in accordance with the requirements of the~~
15 ~~appropriations act and the Social Security Act, as amended.~~
16 ~~Payments to critical access hospitals for services rendered to~~
17 ~~medicaid beneficiaries shall be calculated on a cost basis using~~
18 ~~medicare reasonable cost principles.~~

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



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

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

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

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



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

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

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



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

3 [~~"§346-59.6 Medicaid overpayment recovery. The director
4 shall recover medicaid overpayments made to providers. Medicaid
5 overpayments shall be recovered due to a provider's
6 ineligibility, noncovered service, noncovered drug, lack of
7 prior authorization when a service requires one, incorrect
8 payment allowance identified through any post payment review, or
9 claims processing error. The director may recover overpayments
10 through recoupment, tax offset under sections 231-51 to 231-59,
11 and circuit court judgment. Nothing in this section shall limit
12 the director's authority to recover overpayments through all
13 other lawful means."~~]

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

16 [~~"[§346-59.7] Enforcement of decisions regarding medicaid
17 overpayment recovery; judgment rendered thereon. (a) The
18 director may file in the circuit court in the jurisdiction in
19 which the medicaid overpayment occurred a certified copy of:
20 (1) A decision of the director assessing a medicaid
21 overpayment against a provider from which no appeal
22 has been taken within the time allowed therefor,~~



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

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

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

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



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

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

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

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

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

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

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



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

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

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



- 1 Hawaii medicaid state plan by the Centers for Medicare and
- 2 Medicaid Services.
- 3

INTRODUCED BY:

John M. Pardo

JAN 27 2010



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.

