

APPENDICES

A – E

Appendix A
Written Questions Format
QEXA RFP

Applicant Name	Date Submitted	Question #	RFP Section #	RFP Page #	Paragraph #	Question

APPENDIX B RISK SHARE PROGRAM

Objective of the Program: The State acknowledges that due to circumstances beyond the control of the health plans and the State, the established capitation rates may not be appropriate for the services to be provided. Even with utilization data and experience serving the ABD enrollees, it is difficult for the plans and the State to accurately predict the actual performance or utilization of services by the enrolled population. It is possible that more recipients will utilize more services than estimated. Conversely, it is also possible that more recipients will utilize substantially less services than estimated.

To address the unknown risk to the health plans and the State, the DHS will implement a risk share program. The risk share program will be applied when there is an overall impact on the program such that there is a significant differential between the total funds provided to the plans for health care and the aggregate health care expenses of the plans. It is not intended to protect any one health plan from poor performance due to ineffective management of utilization, or the inability to negotiate effective and economical contracts. The risk share program cannot be activated by a single plan.

Conceptual Framework: Under the risk share program, the DHS will share in a significant difference between the capitated revenues and the actual costs experienced by the totality of the plans. Six (6) months following the end of the fiscal year (by December 31), using the financial reports provided by the participating health plans, a simple profit and loss statement will be developed for the health services portion of the QExA program. The health care services portion of the capitation revenues is assumed to be 94%. Actual administrative expenses will not be included in the computation since the intent of the program is to adjust for unknown risk associated with providing the health services to the enrolled population.

Following the computation of the aggregate profit and loss statement, a net loss or gain percentage will be computed based upon the total capitations paid to the plans for health care. If the loss percentage is within a 5% risk corridor, there will be no loss sharing between the DHS and the health plans and the health plans will absorb all of the loss. If the aggregate loss is outside of this risk corridor, the DHS will share equally in the loss exceeding the risk corridor up to the risk share limit of \$5,000,000. If there is an aggregate gain exceeding 3%, the DHS will share equally in the gain between 3% and 5%. The DHS will recover all gains exceeding 5%.

If there is to be risk sharing, each health plan would be compensated individually based on the number of eligible months. Using an example of a net loss of 7%, with the risk corridor at 5%, the 2% difference would be shared equally between the DHS and the health plans up to \$5,000,000. Since the DHS and the health plans share equally in the loss, the amount to be remitted back to the health plans is 1% of the total capitations

paid to the health plans for health care. Only health plans experiencing an actual loss will benefit from the risk share program.

Similarly, if there is a net gain of 7%, there will be profit sharing for the 4% difference beyond the 3% corridor. The first 2% difference will be shared equally between the DHS and the plans. The second 2% will be returned to the State. Only health plans experiencing an actual gain above the 3% corridor will be required to reimburse the State.

The individual amounts to be remitted to the plans or to the State will be distributed based on eligible months. The following formula will be used to determine the aggregate gain/loss*:

Σ Total revenue (based on capitations paid to each plan for the health care portion)

Less: Σ Net health care expenses (based on the actual experience for health care)

Equals: Net profit/loss (for the health care services provided to QUEST and QUEST-Net populations)

The net profit/loss divided by the total revenue will provide a percentage of the profit/loss which will be compared to the risk corridor established by the DHS.

* The following definitions apply:

Total Revenue is the sum of all capitation payments made to each health plan during the fiscal year. Total Revenue for Health Care is defined as Total Revenue times 94%.

Net Health Care Expenses will be based on the actual service expenses less any reimbursements from third party reimbursements. The expenses will be taken from the financial reports provided by the health plans for the year ended June 30. DHS recognizes that the financial reports are due within 45 days from the end of the reporting period and that some data may not be available at the time the reports are submitted. Therefore, prior to compiling the profit/loss statement for the risk share program, the plans will be requested to update their prior year's report for any adjustments. The report will be due to the DHS by January 15.

All net expenses for all health plans will be summed to determine the total net expenses for care.

Examples: The following examples illustrate how the Risk Share Program would be applied in aggregate and individually to the plans

Example 1: Aggregate Program Calculation for Loss

Plan	Recipient Months	Capitation Paid (total)	Medical Portion %	Medical Portion \$	Medical Expenses	Net Profit (Loss)	Gain (Loss) Percentage
A	205,200	102,600,000	94%	96,444,000	106,618,842	-10,174,842	-10.55%
B	<u>154,800</u>	<u>77,400,000</u>	94%	<u>72,756,000</u>	<u>79,122,150</u>	<u>-6,366,150</u>	<u>-8.75%</u>
	360,000	180,000,000		169,200,000	185,740,992	-16,540,992	-9.78%

Total Capitations Paid to the Plans for Care	169,200,000
Total Expenses Related to Care	<u>185,740,992</u>
Net Loss	16,540,992
Loss Percentage for the Program	9.78%
Risk corridor is 5%	<u>-5.00%</u>
% of loss to be shared equally between plans and DHS	4.78%
% to be returned to plans (50/50 share)	2.39%

Since in aggregate, the program experienced a loss greater than the 5% corridor, the risk share program will be implemented.

Example 2: Distribution to the Plans

The plans and DHS share equally in the loss over 5% (i.e., in this example 4.78%). The total amount to be returned to the plans is calculated based on 2.39% of the services portion of the capitations received by the plan experiencing a loss (2.39% x \$169,200,000 = \$4,043,880). A per capita amount to be returned can be calculated using the total amount to be returned divided by the total number of recipient months served by the plans experiencing a loss (which could be a single plan). In this example, the per capita amount would be \$11.23 per recipient month (\$4,043,880 / 360,000). As long as the \$5,000,000 limit was not reached, the calculation would be computed as follows: Each plan with a loss will receive \$11.23 per recipient month. Plan A would receive \$2,304,396 (205,200 x 11.23); and Plan B would receive \$1,738,404 (154,800 x

11.23). A plan would not receive any payment from the Risk Share Program if it did not actually experience a loss.

If the limit of \$5 million had been exceeded, each plan with a loss will receive a pro rata share of the \$5,000,000 based on the plan's recipient months. Plan A would receive \$2.85 million (57% x 5,000,000); and Plan B would receive \$2.15 million (43% x 5,000,000).

Example 3: Aggregate Calculation of Gain

If there is a net gain, the net gain percentage will be computed and distributed among the plans exceeding the 3% allowable gain.

Plan	Recipient Months	Capitation Paid (total)	Medical Portion %	Medical Portion \$	Medical Expenses	Net Profit (Loss)	Gain (Loss) Percentage
A	205,200	102,600,000	94%	96,444,000	92,142,598	4,301,402	4.46%
B	154,800	77,400,000	94%	72,756,000	66,404,401	6,351,599	8.73%
	360,000	180,000,000		169,200,000	158,546,999	10,653,001	6.30%

Total Capitations Paid to the Plans for Care	169,200,000
Total Expenses Related to Care	<u>158,546,999</u>
Net Gain	10,653,001

Gain Percentage for the Program 6.30%

Risk corridor is 3% 3.00%

Since in aggregate, the program experienced a gain greater than the 3% corridor, the risk share program will be implemented.

Example 4: Plan Specific Calculations

The plans and DHS share equally in the gain between 3% and 5% and any gain at or over 5% is returned to the State. If a plan has a gain over 5%, the maximum amount that the plan will be allowed to retain will be 4%. The gain allocation would be applied only to plans which experienced a gain over 3%. In this example, Plan A had a gain of 4.46% and would return half of the gain in excess of 3%, or 0.73% ([4.46 – 3.00] / 2). Plan A would retain \$3,597,361 and would return \$704,041 to DHS. Plan B had a gain of 8.73% and would be allowed to retain 4%. Plan B would retain \$2,910,240 and would return \$3,441,359 to DHS. If a plan has a gain of less than 3% or a loss, they would not may any payment to the state under the gain sharing provision.

Appendix C
Aged, Blind, or Disabled Population- Dual Eligible and Total Population
Distribution by Age and Island
August 2007

	≤ 21 years of age		22 to 64 years of age		≥ 65 years of age		Total	
	Dual Eligible	Total	Dual Eligible	Total	Dual Eligible	Total	Dual Eligible	Total
Hawaii	4	599	1,314	3,536	2,197	2,268	3,515	6,403
Kauai	1	157	322	779	799	828	1,122	1,764
Lanai	0	5	6	16	40	41	46	62
Maui	5	223	597	1,297	1,085	1,128	1,687	2,648
Molokai	1	35	54	140	99	103	154	278
Oahu	11	1,507	4,690	10,935	12,770	13,654	17,471	26,096
Total	22	2,526	6,983	16,703	16,990	18,022	23,995	37,251

APPENDIX D.1
PERSONS WITH SERIOUS MENTAL ILLNESS/SERIOUS AND PERSISTENT
MENTAL ILLNESS
Adult Mental Health Division

CATEGORY I: Continuing Services

AMHD continuing services are designated to promote treatment, psychosocial rehabilitation services and other community supports based on the understanding that SPMI are generally life-long, with an individualized course of recovery which may include relapse and remission.

Population Focus: Persons with SPMI who do not have access to other appropriate mental health services including those with co-occurring substance use disorders, and those with and without SPMI who are detained or committed by civil, family or criminal state courts on account of mental illness (or disease), disorder or defect (collectively, “mental illness”).

A. Eligibility Criteria for Consumers Who Participate Voluntarily in Services: To be eligible for AMHD funded services, the person must meet the following criteria:

1. **Age:** Eighteen (18) years or older; and
2. **Eligibility Assessment:** The consumer has participated in an AMHD approved clinical eligibility assessment sufficient to establish an included diagnosis of mental illness and serious functional impairment; and
3. **Diagnoses:** The consumer has one of the following included diagnoses:
 - a. **Included Diagnoses:** Primary diagnosis listed below based on DSM-IV-TR:
 1. Schizophrenia and Other Psychotic Disorders
 - a. 295.xx Schizophrenia
 - i) .30 Paranoid Type
 - ii) .10 Disorganized Type
 - iii) .20 Catatonic Type
 - iv) .90 Undifferentiated Type
 - v) .60 Residual Type
 - b. Schizoaffective Disorder
 - c. Delusional Disorder
 2. Mood Disorders
 - a. Depressive Disorders
 - i) 296.xx Major Depressive Disorder
 1. .3x Recurrent
 - b. Bipolar Disorders
 - i) 296.xx Bipolar I Disorder
 1. .0x Single Manic Episode
 2. .4x Most Recent Episode Hypomanic
 3. .40 Most Recent Episode Manic
 4. .6x Most Recent Episode Mixed

- 5. .5x Most Recent Episode Depressed
 - 6. .7x Most Recent Episode Unspecified
 - ii) 296.89 Bipolar II Disorder
- 3. Anxiety Disorders
 - a. 300.21 Panic Disorder With Agoraphobia
 - b. 300.3 Obsessive-Compulsive Disorder
 - c. 309.81 Posttraumatic Stress Disorder
- 4. Personality Disorders
 - a. 301.83 Borderline Personality Disorder
- 5. Substance-Related Disorders that do not resolve in thirty (30) days
 - a. Alcohol Use Disorders
 - i) 291.x Alcohol- Induced Psychotic Disorder
 - 1. .5 With Delusions
 - 2. .3 With Hallucinations
 - b. Amphetamine (or Amphetamine-Like)- Related Disorders
 - i) Amphetamine- Induced Disorders
 - 1. 292.xx Amphetamine- Induced Psychotic Disorder
 - a. .11 With Delusions
 - b. .12 With Hallucinations
 - c. Cannabis- Induced Disorders
 - i) 292.xx Cannabis- Induced Psychotic Disorder
 - 1. .11 With Delusions
 - 2. .12 With Hallucinations
 - d. Cocaine-Induced Disorders
 - i) 292.xx Cocaine-Induced Psychotic Disorder
 - 1. .11 With Delusions
 - 2. .12 With Hallucinations
 - e. Hallucinogen-Related Disorders
 - i) Hallucinogen-Induced Disorders
 - 1. 292.xx Hallucinogen-Induced Psychotic Disorders
 - a. .11 With Delusions
 - b. .12 With Hallucinations
 - f. Inhalant-Related Disorders
 - i) Inhalant- Induced Disorders
 - 1. 292.xx Inhalant-Induced Psychotic Disorders
 - a. .11 With Delusions
 - b. .12 With Hallucinations
 - g. Opioid-Related Disorders
 - i) Opioid-Induced Disorders
 - 1. 292.xx Opioid -Induced Psychotic Disorders
 - a. .11 With Delusions
 - b. .12 With Hallucinations
 - h. Phencyclidine (Or Phencyclidine-Like)-Related Disorders
 - i) Phencyclidine-Induced Disorders
 - 1. 292.xx Phencyclidine -Induced Psychotic Disorders
 - a. .11 With Delusions

- b. .12 With Hallucinations
 - i. Sedative-, Hypnotic-, Or Anxiolytic-Related Disorders
 - i) Sedative-, Hypnotic-, Or Anxiolytic -Induced Disorders
 - 1. 292.xx Sedative-, Hypnotic-, Or Anxiolytic -Induced Psychotic Disorders
 - a. .11 With Delusions
 - b. .12 With Hallucinations
 - j. Other (Or Unknown) Substance-Induced Disorders
 - i) Other (Or Unknown) Substance -Induced Disorders
 - 1. 292.xx Other (Or Unknown) Substance -Induced Psychotic Disorders
 - a. .11 With Delusions
 - b. .12 With Hallucinations
- 6. Co-occurring Disorders: Consumers with SPMI and substance use, or SPMI and developmental disability may be eligible for AMHD services as follows:
 - a. SPMI and Substance Use. Persons with a primary diagnosis identified in the Policy as an “included diagnosis” or mood disorder in addition to a substance use disorder, are eligible for AMHD Category I Continuing Services for both the SPMI and the substance use disorder. Consumers with a primary diagnosis of a substance induced psychotic disorder that does not resolve within thirty (30) days of first assessment are eligible for AMHD Services; and
 - b. SPMI and Developmental Disability. Consumers with a DSM-IV TR diagnosis of mild mental retardation (317) in addition to a SPMI as defined by this Policy, are eligible for AMHD funded services. Other developmental disability and mental retardation diagnoses (318.00, 318.10, 319.00) are excluded from AMHD eligibility.
- b. **Excluded Diagnoses:** Unless an included diagnosis listed above is also present, persons with the following disorders are excluded from eligibility for AMHD services. Note: if a specific DSM code is not noted in the list below, the entire DSM category is excluded. The excluded diagnoses are as follows:

Delirium, Dementia, Amnesic and Other Cognitive Disorders;

Disorders Usually First Diagnoses in Infancy, Childhood, and Adolescence;

Substance Related Disorders, except Substance Induced Psychosis as noted above;

Acute Stress Disorder (308.3);

Panic Disorder Without Agoraphobia (300.01);

Specific Phobia (300.29);
Social Phobia (300.23);
Generalized Anxiety Disorder (300.02);
Paranoid Personality Disorder (301.0);
Schizoid Personality Disorder (301.20);
Schizotypal Personality Disorder (301.22);
Histrionic Personality Disorder (301.50);
Narcissistic Personality Disorder (301.81);
Avoidant Personality Disorder (301.82);
Dependent Personality Disorder (301.6);
Obsessive-Compulsive Personality Disorder (301.4);
Antisocial Personality Disorder (301.7);
Major Depression, single episode (296.2x);
Brief Psychotic Disorder (298.80);
Sexual and Gender Identity Disorders;
Eating Disorders;
Sleeping Disorders;
Factitious Disorders;
Impulse Control Disorders Not Elsewhere;
Classified Adjustment Disorders;
Other Conditions That May Be A Focus Of Clinical;
Attention Mental Disorders Due To A General Medical Condition; and
Traumatic Brain Injury.

4. **Duration:** The person has a persistent mental illness as demonstrated by the presence of the disorder for the last 12 months, or which is expected to endure for twelve (12) months or longer; or the person is at significant risk of

continuing in a pattern of either institutionalization or living in a severely dysfunctional way if needed mental health services are not provided; and

5. **Functional Impairment:** In addition to all of the above criteria, the person's SPMI will or has resulted in functional impairment that seriously interferes with the person's ability to function independently in an appropriate and effective manner. Serious impairment is determined and documented, as part of the assessment described above, by meeting at least one of the following criteria as described in LOCUS Adult Version 2000 by American Association of Community Psychiatrists, May 30, 2000.

- a. Serious deterioration of interpersonal interactions with consistently conflictual or otherwise disrupted relations with others, which may include impulsive or abusive behaviors.
- b. Significant withdrawal and avoidance of almost all social interaction.
- c. Consistent failure to maintain personal hygiene, appearance, and self care near usual standards.
- d. Serious disturbances in vegetative status such as weight change, disrupted sleep, or fatigue that threaten physical well being.
- e. Inability to perform close to usual standards in school, work, parenting, or other obligations and these responsibilities may be completely neglected on a frequent basis or for an extended period of time.

B. Eligibility Criteria For Adults Detained or Committed by Civil or Criminal State Courts

Adults may be detained for mental examination, or committed to certain psychiatric facilities or to the custody of the DOH Director for appropriate placement by the Family Courts, District Courts, and Circuit Courts of Hawaii's several judicial circuits in involuntary civil commitment proceedings, in criminal court proceedings, and in criminal court proceedings which result in involuntary civil commitment.

The court orders for involuntary civil commitment, criminal court commitment and criminal court proceedings which result in involuntary civil commitment override most of the eligibility determinations, set forth above, as explained in more detail below. Generally, persons subject to court orders for detention, commitment, or revocation of conditional release are eligible for AMHD Category I Continuing Services without meeting any of the eligibility

categories other than age. For purposes of this Policy, the relevant provisions of Hawaii law, on (1) involuntary civil commitment; (2) criminal court detention, commitment, conditional release and discharge; and (3) criminal proceedings which result in involuntary civil commitment, as well as a summary of the relevant eligibility criteria for each of these three types of commitment, are as follows:

1. **Involuntary Civil Commitment:**

a. **Statutory Authority:** Pursuant to chapter 334, part IV Hawaii Revised Statutes (H.R.S.) (1993 Supp 2001), the Family Court may commit a person to a psychiatric facility (a public or private hospital or part thereof which provides inpatient or outpatient care, custody, diagnosis, treatment or rehabilitation services for mentally ill persons or for persons habituated to the excessive use of drugs or alcohol or for intoxicated persons) for involuntary hospitalization if the court finds:

- (1) That the person is mentally ill or suffering from substance abuse;
- (2) That the person is imminently dangerous to self or others, is gravely disabled or is obviously ill; and
- (3) That the person is in need of care or treatment, or both, and there is no suitable alternative available through existing facilities and programs which would be less restrictive than hospitalization

Section 334-60.2 H.R.S. (1993).

b. **Eligibility Criteria**

1. **Age:** Eighteen (18) years or older;
2. **Assessment:** AMHD approved clinical eligibility assessment is necessary;
3. **Diagnosis:** Not needed to determine eligibility for AMHD funded services;
4. **Duration:** The person committed by the Family Court is eligible for AMHD for the duration of the commitment order, as extended by any recommitment order;
5. **Functional Level:** Not needed to determine eligibility for AMHD funded services.

2. **Criminal Court Detention, Commitment, Conditional Release and Discharge:**

Pursuant to chapter 704 H. R. S. (1993 Supp 2001), defendants in criminal proceedings in any of the Hawaii -Family Courts, District Courts or Circuit Courts are entitled to assert physical or mental disease, disorder, or defect excluding responsibility as an affirmative defense ("mental health defense"), section 704-402 H. R. S. (1993), and no person who as a result of a physical or mental disease, disorder, or defect lacks capacity to understand the proceedings against the

person or to assist in the person's own defense ("fitness to proceed") shall be tried, convicted, or sentenced for the commission of an offense so long as such incapacity endures, section 704-403 H.R.S. (1993). During a criminal prosecution in which fitness to proceed or a mental health defense is at issue, the defendant's legal status will be determined by order of the court, and may change pursuant to the court's orders as follows:

a. Statutory Authority:

- (1) **Section 704-404:** Examination. Criminal proceedings may be suspended while one or three qualified examiners determine defendant's fitness to proceed and/or penal responsibility for the offenses with which defendant is charged. "Penal responsibility" means (a) the extent, if any, to which the capacity of the defendant to appreciate the wrongfulness of the defendant's conduct or to conform the defendant's conduct to the requirements of law was impaired at the time of the conduct alleged, section 704-404(4)(c) H.R.S. (1993 Supp 2001), and (b) the capacity of the defendant to have a particular state of mind which is required to establish an element of the offense charged, section 704-404(4)(e) H.R.S. (1993 Supp 2001).
- (2) **Section 704-406(1):** Suspension of Criminal Proceedings while Defendant Remains Unfit to Proceed. If, after receiving the reports of the examiner or examiners, and taking whatever other evidence may be necessary, the court finds that the defendant lacks fitness to proceed, the court suspends the criminal prosecution and commits the defendant to the custody of the DOH Director to be placed in an appropriate institution for detention, care, and treatment. If, however, the defendant can be released without danger to self, or the person or property of others, the court releases defendant on certain conditions.
- (3) **Section 704-411(1)(a):** Trial or Plea Bargain After Defendant Regains Fitness to Proceed. After the court determines that defendant has regained fitness, the defendant may proceed to trial, and may assert a mental defense at trial. At the conclusion of the trial, defendant may be found not guilty (and released) or guilty (and sentenced), or acquitted on the ground of the mental defense. (Acquittal on account of a mental defense may also result by agreement of the parties and order of the court.) After acquittal on account of a mental defense, if the court determines that defendant presents a risk of danger to self or others, and is not a proper subject for conditional

release, the court orders defendant to be committed to the custody of the DOH Director to be placed in an appropriate institution for custody, care, and treatment. Defendants charged with misdemeanors or felonies not involving violence or attempted violence are entitled to be placed by the DOH Director in the least restrictive environment appropriate in light of defendant's treatment needs and the need to prevent harm to self and others.

- (4) Section 704-411(1)(b):** Conditional Release After Acquittal on Ground of Mental Defense. If the court finds that defendant is affected by physical or mental disease, disorder, or defect and that defendant presents a danger to self or others, but that defendant can be controlled adequately and given proper care, supervision, and treatment if defendant is released on conditions, the court orders defendant's release from custody on such conditions as the court deems necessary.
- (5) Section 704-411(1)(c):** Discharge From Custody After Acquittal. If the court finds that defendant is no longer affected by physical or mental disease, disorder, or defect, or if so affected that the defendant no longer presents a danger to self or others and is not in need of care, supervision, or treatment, the court orders the defendant discharged from custody.
- (6) Section 704-412(1):** DOH Director's Application for Conditional Release After Commitment. After the expiration of at least ninety (90) days following the order of commitment, the DOH Director applies for defendant's discharge or conditional release if the DOH Director is of the opinion that defendant may be discharged or released on condition without danger to self or to the person or property of others.
- (7) Section 704-412(2):** Defendant's Application for Conditional Release After Commitment. After the expiration of at least ninety (90) days following the order of commitment, the defendant may apply for an order of discharge or conditional release_
- (8) Section 704-413(1):** Rehospitalization of Conditionally Released Person. Persons released on conditions from custody of the DOH Director are subject to supervision by the courts through their probation officers. If a probation officer has probable cause to believe the person on conditional release has violated the conditions, the probation officer may order the person hospitalized for a maximum of seventy-two (72) hours, which period may be increased by the court after a hearing.

- (9) **Section 704-413(2):** Discharge from or Modification of Conditional Release Order. The person released on conditions may apply for discharge from supervision, or for modification of the conditions of release.
- (10) **Section 704-413(3):** Revocation of Conditional Release. If the court determines after a hearing that the conditions of release have not been fulfilled or that for the safety of self or others that the conditional release should be revoked, the court may modify the conditions of release, or order the person to be committed to the custody of the DOH Director.

b. Eligibility Criteria:

1. Detention

- (1) **Age:** Eighteen (18) years or older;
- (2) **Assessment:** Assessment sufficient to determine possible need for inpatient detention, care and treatment. Does not require face-to-face assessment in emergent circumstances.
- (3) **Diagnosis:** The person detained for examination is eligible for AMHD funded services with or without an included diagnosis;
- (4) **Duration:** The person detained for examination is eligible for AMHD funded services for the duration of the commitment order, and for the period of any extension of that order.
- (5) **Functional Level:** The person detained for examination is eligible for AMHD funded services with or without functional limitations.

2. Commitment

- (1) **Age:** Eighteen (18) years or older;
- (2) **Assessment:** No eligibility assessment prior to admission to psychiatric facility is necessary.
- (3) **Diagnosis:** The person acquitted and committed is eligible for AMHD funded services with or without an included diagnosis;
- (4) **Duration:** The person acquitted and committed is eligible for AMHD funded services until discharged or released on conditions;
- (5) **Functional Level:** The person acquitted and committed is eligible for AMHD funded services with or without functional limitations.

3. Conditional Release

- (1) **Age:** Eighteen (18) years or older;

- (2) **Eligibility Assessment:** No eligibility assessment necessary;
- (3) **Diagnosis:** The person released on conditions is eligible for AMHD funded services with or without an included diagnosis;
- (4) **Duration:** The person released on conditions is eligible for AMHD funded services until discharged or until revocation of conditional release;
- (5) **Functional Level:** The person released on conditions is eligible for AMHD funded services with or without functional limitations..

4. Discharge

- (1) **Age:** Eighteen (18) years or older;
- (2) **Eligibility Assessment:** No eligibility assessment necessary prior to discharge; however, following discharge, person discharged will need an eligibility assessment prior to receiving continuing services on a voluntary basis;
- (3) **Diagnosis:** No diagnosis necessary prior to discharge; however, following discharge, person discharged must present with an included diagnosis to be eligible for continuing services on a voluntary basis;
- (4) **Duration:** Not applicable prior to discharge; however, following discharge, person discharged will need to meet duration requirements for continuing services on a voluntary basis;
- (5) **Functional Level:** Determination of functional level not applicable prior to discharge; however, following discharge person will need to meet functional level requirements for continuing services on a voluntary basis.

3. Criminal Proceedings Which Result in Involuntary Civil Commitment:

- a. **Statutory Authority:** In three instances, defendant charged with an offense under the penal code may thereafter be civilly committed to the custody of the DOH Director, as follows:
 - (1) **Section 704-406(2):** In a criminal prosecution in which the defendant regains fitness to proceed, but the court decides that so much time has passed since the order finding the defendant unfit that it would be unjust to resume the proceeding, the court may dismiss the criminal charge and either discharge defendant, or after proof that defendant meets civil commitment criteria, order defendant committed to the custody of the DOH Director to be placed in an

- appropriate institution for detention, care, and treatment, or order the defendant released on conditions.
- (2) **Section 704-406(3):** In a criminal prosecution in which defendant probably will remain unfit to proceed, the court may dismiss the charge and release defendant, or subject defendant to involuntary civil commitment procedures. This option is available to the court whether defendant was detained for care and treatment, or placed on conditional release after the initial finding that defendant was not fit to proceed.
 - (3) **Section 706-608:** When a person is prosecuted for a class C felony, misdemeanor, or petty misdemeanor (as determined by reference to the Hawaii Penal Code), and is also a chronic alcoholic, narcotic addict, or person suffering from mental abnormality, and subject by law to involuntary hospitalization the court may order involuntary hospitalization provided it will substantially further the rehabilitation of defendant and will not jeopardize public safety.

b. Eligibility Criteria:

- (1) **Age:** Eighteen (18) years or older;
- (2) **Eligibility Assessment:** AMHD approved clinical eligibility assessment is necessary;
- (3) **Diagnosis:** Person civilly committed is eligible for AMHD funded inpatient services with or without an included diagnosis;
- (4) **Duration:** For the duration of the commitment order, and the duration of any recommitment order;
- (5) **Functional Level:** Person civilly committed is eligible for AMHD funded services with or without functional limitations.

CATEGORY II: Time Limited Services

Prompt, intensive and focused services designed to assess, stabilize and provide linkage to treatment, PSR services and other community supports, as appropriate.

Population Focus: Adults in need of emergent (within 24 hours) or urgent (within 24-72 hours) intervention who are (1) exhibiting symptoms of a mental health crisis; (2) persons suspected of having a primary mental illness with an associated situational crisis such as loss of residence or arrest, and (3) those for whom there is significant diagnostic uncertainty.

Criteria for Mental Health Crisis:

Age: Eighteen (18) years or older,

Eligibility Assessment: A brief telephone or face-to-face screening assessment to determine immediacy of needs is necessary;

Diagnoses: Exhibiting symptoms of significant psychological or behavioral distress; **Duration:** No durational requirement;

Functional Level: Some degree of functional limitation in the areas of self protection, risk of harm to self or others, impulse control, and social judgment.

Criteria for Situational Crisis:

Age: Eighteen (18) years or older;

Eligibility Assessment: Brief screening;

Diagnosis: Suspected of having a primary mental illness but exhibiting symptoms of significant clinical stress;

Duration: No durational requirement;

Functional Level:: Some degree of functional limitation expected to worsen because of situation.

Criteria for Diagnostic Uncertainty:

Age: Eighteen (18) year or older;

Eligibility Assessment: Completed an AMHD approved clinical eligibility assessment but eligibility based on diagnosis cannot be determined without further evaluation; **Diagnosis:** Uncertain, but may include:

Unspecified (300.9)

NOS

Diagnosis Deferred (799.9)

Provisional Diagnosis

Other Conditions That May Be A Focus Of Clinical Attention;

Duration: No durational requirement;

Functional Level: Not specified.

CATEGORY III: Disaster Services

Prompt, post-traumatic counseling, debriefing or education intended to relieve or prevent the development of psychological distress or dysfunction for persons who have experienced stress from a disaster.

Population Focus: Adults experiencing stress from a disaster are members of a community or social system which has recently undergone an event of significant community impact that is outside the range of usual human experience and that would be markedly distressing to almost anyone, provoking, or expected to provoke intense fear, terror, or helplessness such as serious threat to life or physical integrity, or sudden destruction of home or community infrastructure. Members of the community or social system affected by the disaster are considered appropriate candidates for prompt post-traumatic counseling, debriefing, or education intended to

relieve or prevent the development of psychological distress or dysfunction. Persons who meet these criteria include direct or indirect victims of:

1. Hurricane, flood, or other storm or weather related disaster;
2. Volcanic eruption, earthquake, landslide, or tsunami;
3. Forest, brush, or other wildfire;
4. Toxic or radioactive contamination, biohazard, bioterrorism, epidemic, or other environmental or public health disaster;
5. Building fire, or structural collapse;
6. Shipwreck, airline crash, or other mass transportation disaster;
7. Kidnapping, hostage taking, multiple homicide, or terrorism; or
8. Major business failure, or economic collapse.

Distress/Dysfunction: Members of the affected community or social system may be experiencing currently distressful symptoms or dysfunction as a result of the disaster, or are presumed to be at significant risk of future distress or dysfunction with might be averted or mitigated by prompt post-traumatic counseling, debriefing, or education.

Immediacy: The disaster has occurred within the past thirty (30) days. In the case of a major community-wide disaster which leaves behind continuing conditions of hardship and deprivation, the AMHD Chief may extend the thirty-day limit.

Community Impact: The disaster has had an impact on a community or social system larger than an individual or family. A disaster has been officially declared by the State of Hawaii or the United States, or the AMHD Chief has received and approved a request for disaster services from legitimate community leadership such as a school administrator, state or county official, or religious, social or business organization.

Accessibility to Mental Health Services: The community or social system has no access to appropriate disaster counseling, debriefing, or education through sources other than those provided by AMHD.

Age: Eighteen (18) year or older;

Eligibility Assessment: Screening

Diagnosis: Risk of future distress or dysfunction;

Duration: Not applicable;

Functional Impairment: Not applicable.

APPENDIX D.2
PERSONS WITH SERIOUS MENTAL ILLNESS
MQD

Definition

The seriously mentally ill are defined as persons who, as the result of a mental disorder, exhibit emotional, cognitive, or behavioral functioning which is so impaired as to interfere substantially with their capacity to remain in the community without supportive treatment or services of a long-term or indefinite duration. In these persons, mental disability is severe and persistent resulting in a long term limitation in their functional capacities for primary activities of daily living such as interpersonal relationships, self-care, homemaking, employment, and recreation.

Conditions such as mental retardation or substance abuse may cause similar problems or limitations, and are not to be included in this definition unless, in addition to one or more of these disorders, the person has a severe and persistent mental disorder.

Criteria

Assessment:

The person has undergone a comprehensive professional clinical assessment sufficient to establish a diagnosis of mental disorder and a quantitative functional assessment. The combination of diagnosis and level of functioning establishes eligibility for public services through a formula stated below.

Eligible Diagnoses:

The person meets the latest DSM edition criteria for mental disorder in Category I, II, or III.

CATEGORY I

- Schizophrenic Disorders (295.1, 295.2, 295.3, 295.6, 295.9)
- Delusional Disorders (297.1)
- Psychotic Disorders Not Elsewhere Classified
 - Schizo-affective Disorders (295.7)
 - Psychotic Disorders (298.9)
- Mood Disorders
 - Bipolar Disorders (296.4, 296.5, 296.6, 296.7)

- Depressive Disorders (296.2, 296.3)
- Substance Related Disorders Persisting Three Months After Detoxification and Stabilization
 - Psychotic Disorders (291.3, 291.5, 292.11, 292.12)
 - Mood Disorders (291.89 for mood only, 292.84)

CATEGORY II

- Mental Disorders Due to a General Medical Condition
 - Psychotic Disorder Due to a General Medical Condition with Delusions (293.81)
 - Psychotic Disorder Due to a General Medical Condition with Hallucinations (293.82)
 - Mood Disorders Due to a General Medical Condition (293.83)
- Anxiety Disorders
 - Panic Disorder with Agoraphobia (300.21)
 - Panic Disorder without Agoraphobia (300.01)
 - Post Traumatic Stress Disorder (309.81)
 - Obsessive Compulsive Disorder (300.3)
 - Alcohol induced anxiety disorder/mood disorder with depressive features (291.81)
- Personality Disorders (these conditions exempted from provisionally qualifying conditions)
 - Schizoid
 - Schizotypal
 - Borderline Personality Disorder (301.83)

CATEGORY III (these conditions exempted from provisionally qualify conditions)

- Other Disorders Not Listed Above and Not Excluded Below

PERSONS WITH A PROVISIONALLY QUALIFYING CONDITION

These persons are defined as those who have a substance abuse condition and are suspected to suffer from a qualifying condition due to their symptoms and functional limitations. These persons have on-going and recent substance abuse which prevents the clinician from making a definitive qualifying diagnosis.

Excluded Diagnoses:

Unless an eligible disorder listed above is also present, the following disorders are excluded from eligibility under the Adult Behavioral Health Managed Care Plan.

- Delirium, Dementia, and Amnesic and other Cognitive Disorders
- Disorders Usually First diagnosed in Infancy, Childhood or Adolescence, i.e., Mental Retardation, Pervasive Developmental Disorders, Learning Disorders, Motor Skills Disorder, Communication Disorders.
- Substance Included Disorders except as otherwise described above.
- Substance Dependence Disorders
- Psychotic Disorders Not Elsewhere Classified. Only the following diagnosis in this category is excluded:
 - Brief Psychotic Disorder (298.8)
- Sexual and Gender Identity Disorders
- Factitious Disorders
- Impulse Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Psychological Factors Affecting Medical Conditions
- V Codes

Comorbidity:

Patients with a substance abuse diagnosis must also meet the diagnostic criteria for an above accepted mental illness to be considered potentially SMI. Those patients who are suspected to suffer from a qualifying condition yet currently are using substances, thus precluding the clear determination of an eligible diagnosis will be provisionally accepted as suffering from a qualifying condition. For those individuals with a dual diagnosis of substance abuse and a severe and persistent mental disorder, the assessment will also need to include a rating using the most current American Society of Addiction medicine (ASAM) placement criteria. The assessment for dual diagnosis individuals must also include a history of the patient's past and present substance use sufficient to identify and describe its effects on cognitive, psychological, behavioral, and physiological function; a general medical and psychiatric history and psychiatric examination; a history of prior

psychiatric treatments and outcomes; a family and social history; screening of blood, breath, or urine for abused substances. This assessment will be considered if the available information is sufficient to document the patient's appropriateness for SMI status and support a determination. A copy of any recent hospital or treatment facility admission and discharge summaries will aid the MQD reviewer in making determination.

Patients with DD/MR in addition to an allowable diagnosis will have to be at worst in the mild range (317.00) for eligibility.

Impaired Level of Functioning:

Assessment of impaired role functioning is achieved by the administration of an instrument such as the Client Assessment Record (CAR). At the minimum the Global Assessment of Functioning (GAF) will be provided to the MQD reviewer. A GAF score below 50 will be considered as supportive of an impaired level of functioning in conjunction with the CAR calculated score by the MQD reviewer. If the CAR instrument was used by the provider, CAR scales would be limited to: Medical/Physical, Family/Living Situation, Interpersonal Relations, Role Performance, Socio-Legal, and Self-Care/Basic Needs. The person is assigned to one of the four following levels of impaired functioning:

Level A:

3 or more CAR scale scores of 40 and above or
4 or more CAR scale scores of 30 and above.

Level B:

2 or more CAR scale scores of 40 and above or
3 or more CAR scale scores of 30 and above.

Level C1:

1 CAR scale scores of 40 and above or
2 CAR scale scores of 30 and above.

Level C2:

Clinical evidence indicates that level functioning would rate at the C1 level or lower in the absence of treatment.

Eligibility Determination Formula:

1. a) The patient meets Diagnostic Category 1 and any of the Impaired Role Functioning Levels (A, B, C1 or C2).

- b) The patient meets Diagnostic Category II and Impaired Role Functioning Levels A or B.
 - c) The patient meets Diagnostic Category III and Impaired Role Functioning Level A.
2. As part of the assessment of chronic mental illness, documentation should be provided on historical duration of illness and disability and/or on the presence of risk factors making it likely that the disorder and disability will be present into the foreseeable future.
- a, b, or c above must have been present for at least 6 months or must have a 6 month minimal expected duration or must have a combined present and expected duration of 6 months.

Accessible Services:

The person with a clear SMI diagnosis is judged to be in need of a comprehensive planned package of supportive and treatment services requiring intensive case management and interdisciplinary supervision of long-term or indefinite duration. Those with a provisional diagnosis due to limited functioning secondary to substance abuse are judged to be in need of the above services for a limited-term duration in order to establish a clear SMI diagnosis.

APPENDIX D.3

EVALUATION PROCESS FOR DETERMINATION OF ELIGIBILITY FOR THE BEHAVIORAL HEALTH MANAGED CARE (BHMC) PLAN FOR SERIOUSLY MENTALLY ILL (SMI) ADULTS OR SERIOUS EMOTIONAL DIS (SED) CHILDREN

1) INPATIENTS

a) Individuals on Oahu

If, after reviewing relevant clinical information, the health plan or referring provider determines that a member meets the criteria for a Serious Mental Illness (SMI) or Serious Emotional Disturbance (SED), they should complete and fax to the MQD the referral form entitled Referral for Serious Mental Illness. This form is self-explanatory, must be completed entirely, and should be submitted at least two (2) working days before anticipated discharge to:

Medical Standards Branch (MSB)/MQD
ATTENTION: SMI Determinations
Fax #: 202-692-8131

If the patient is discharged in advance of his/her projected discharge date, please inform the MQD Psychiatric Consultant at 202-692-8115 and use the process described under “OUTPATIENTS.”

b) Individuals on Neighbor Islands

Use the process describe under “OUTPATIENTS”.

2) **OUTPATIENTS** - The health plan or referring provider should mail or fax to the MQD, the “Referral for SMI/SED” form, the forms for the assessment of Mental States and Functional Scales. In addition, to expedite the processing of SMI/SED referrals, it is asked that as much of the following information, as possible, be included;

- a) Personal history, family history, social history and history of drug use.
- b) Mental health history and educational history.
- c) History of past hospitalizations and other prior psychiatric care.
- d) Local hospital admissions and discharge summaries (including medical and psychiatric histories and physical examinations).
- e) Most current psychiatric and psychological assessments to include pertinent history, behavioral observation and presentation, diagnostic impression, reports of psychological/psychiatric testing, Global Assessment of Functioning (GAF) scores and substance abuse information using ASAM placement criteria (if applicable).
- f) Pre-signed option letters for patients who are or have Medicaid or Medicaid/Medicare insurance.

- 3) The Medical Directors of the health plan must review and sign all referrals for SMI/SED and any information (such as the assessment of mental state and functional scales) which may have been completed by health plan staff. Thus, the MQD will not make a determination that a member is SMI/SED (if referred by the plan) without the signature of the plan's Medical Director.
- 4) The MQD's psychiatric consultant will make a decision based on the information submitted.
- 5) The Referral Form with the MQD's decision will be returned to the health plan in most cases with seven (7) business days and not more than 30 days after receipt. The MQD makes one of the following four determinations:
 - a) SMI/SED- yes, full acceptance
 - b) Provisional SMI/SED- yes, provisional acceptance for limited period
 - c) SMI/SED- no
 - d) Additional Information Needed
- 6) Provisional SMI/SED are those individuals who have a substance abuse condition and are suspected to suffer from a qualifying condition due to their symptoms and functional limitations. These persons have on-going and recent substance abuse which prevents the clinician from making a definitive qualifying diagnosis.
- 7) If the member is determined to be SMI/SED or provisional SMI/SED, the BHMC plan will receive a copy of all pertinent information submitted by the referring provider. In addition, the MQD's Enrollment Call Center will be notified to add the member's eligibility status to the member's eligibility file.
- 8) If a member was not determined to be SMI/SED or if additional information is needed, the MQD will indicate the reason for this decision or the additional information needed on the referral form.
- 9) After a referral has been submitted to the MQD and before the referring provider is notified of a decision, the referring provider shall update the MQD in situations including but not limited to the following:
 - a) The patient was admitted to the hospital.
 - b) The patient has an urgent need for behavioral health managed care services.
 - c) The referring provider has not received a determination seven (7) working days or more after submission of the referral.

Additional clarification which applies to both INPATIENTS and OUTPATIENTS:

- 1) If no records of prior hospitalizations are available, outpatient treatment services will be considered by the MQD's Psychiatric consultant in determining whether a member has an SMI/SED diagnosis. The following criteria will be used for the determination: Treatment for at least 6 months or must have a 6 month minimal expected duration, or must have a combined present and expected duration of 6 months.
- 2) Those members with a qualifying condition will be accepted provisionally into the behavioral health managed care plan for six months to allow for a complete assessment and intensive case management. A case review by the BHMC will begin four months after enrollment for members in this category. Once an SMI/SEBD diagnosis is established the member will be changed to an SMI/SED category. If the member does not have an SMI/SED diagnosis the member will be disenrolled from the behavioral health managed care plan. It is the responsibility of the referring provider to determine the continued treatment needs of those recipients determined not to have an SMI/SED diagnosis and is in treatment for substance abuse at the time of disenrollment.
- 3) Do not refer the following types of members as they **DO NOT** meet **SMI/SED** requirements:
 - a) Adults with SMI/SED diagnosis or who (in the absence of a diagnosis) have documentation of displaying SMI/SED symptoms for less than a combined and expected duration of at least 6 months.
 - b) Adults whose serious mental illness is not expected to last more than 6 months.
 - c) Adults with substance abuse diagnosis (es) only and NO independent psychiatric diagnosis that would otherwise qualify for SMI/SED consideration. Referrals can be made for those adults with a substance abuse diagnosis and a probable SMI/SED diagnosis which is unclear due to the patients' recent and sustained substance abuse.
 - d) Adults with psychiatric diagnosis (es) and developmental disabilities (DD)/mental retardation (MR) (other than mild DD/MR); and
 - e) Patients with SMI/SED diagnosis (es) who are functioning well in the community.
- 4) To expedite processing, the MQD will return only the referral form to the health plan or Medicaid provider. If a provider wishes to have a determination reconsidered, all applicable information should be resubmitted. A decision on the reconsideration will be rendered within seven (7) working days of receipt in most cases and as stated in the RFP, not more than 30 days after receipt.
- 5) If a provider questions a determination, he/she should contact the MQD psychiatric consultant at 692-8115.

- 6) Other individuals such as psychiatrist and psychologists can also make referrals for SMI/SED evaluation.
- 7) If the referring provider needs clarification or has questions on SMI/SED referrals, contact the Medical Standards Branch at 202-692-8105.

APPENDIX D.4
CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE (SED)

Definition

For purposes of MQD, children with SED are persons

- ◆ Birth to age 18
- ◆ who currently or at any time during the past year have had a primary diagnosis of at least one of the following mental, behavioral or emotional disorders:

Pervasive Developmental Disorders (PDD)

299.0	Autistic disorder
300.0	Pervasive developmental disorder NOS

Anxiety Disorders of Childhood or Adolescence

309.21	Separation anxiety disorder
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Schizophrenia

295.2x	Catatonic
295.1x	Disorganized
295.3x	Paranoid
295.9x	Undifferentiated
295.6x	Residual

Delusional (Paranoid) Disorder

297.10	Delusional (Paranoid) disorder
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Psychotic Disorders Not Elsewhere Classified

295.70	Schizoaffective disorder
297.30	Share psychotic disorder (Folie a deux)
298.90	Psychotic disorder NOS

Bipolar Disorders

296.6x	Mixed
296.4x	Manic
296.5x	Depressed
301.13	Cyclothymia

Depressive Disorders

Major Depression	
296.2x	Single episode
296.3x	Recurrent
300.40	Dysthymia

Anxiety Disorders

300.30	Obsessive compulsive disorder
309.89	Post-traumatic stress disorder

Somatoform Disorder

300.11 Conversion disorder

Dissociative Disorders

300.14	Disassociative identity
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Impulse Control Not Elsewhere Classified

312.34	Intermittent explosive disorder
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Attention Deficit and Disruptive Behavior Disorders

313.81.1	Oppositional defiant disorder
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◆ that has resulted in functional impairment which substantially interferes with or limits the child's role or functioning in the family, school, or community activities as defined by MQD and CAMHD and measured by the Child and Adolescent Functional Assessment Scale (CAFAS) with a score of 120+.

◆ and who has had the above diagnosis or in the absence of a diagnosis has displayed related symptoms for the following duration:

- 6 months for recipients less than age 10 and one year for recipients greater than age 10.

APPENDIX E
COVERED PREVENTIVE SERVICES FOR ADULTS AND CHILDREN

The following is a listing of preventive services for which payments will be made by the health plan.

FOR ADULTS

The following are services for which payments will be made by the health plan as separate medical services, as components of separate medical services, or as components of the “evaluation and management” services rendered by the health plan’s providers. The services and periodicity are adapted from the 1996 U.S. Preventive Services Task Force.

Screening

1. Blood Pressure Measurement

Minimum: every single measurement, all ages and sexes
Periodicity: every 2 years if normal
(on basis of expert opinion) every 1 year or more frequently if abnormal

2. Weight/Height Measurement

Minimum: all ages and sexes; single measurement
Periodicity: (on basis of expert opinion) every 2 years

3. Total Cholesterol Measurement

Minimum: females age 45-65; single measurement
Males 35-65; single measurement
Periodicity: every 5 years
(there is insufficient evidence to recommend cholesterol measurement in younger adults with high cardiovascular disease risk factors or in older adults, however recommendation for screening may be made on other grounds. See U.S. Preventive Services Task Force. *Guide to Clinical Preventive Services, 2nd ed.* Baltimore: Wilkins & Wilkins, 1996)

4. Breast Cancer Screening

Minimum: age 50 – 69 mammography alone or mammography and clinical breast exam (CBE)
Periodicity: annual

Minimum: age 40 – 49; although there is insufficient evidence to recommend either mammography alone or mammography and CBE, the American Cancer Society, the American College of OB/Gyn, and the American Academy of Family Physicians, recommend

mammography every 1-2 years and CBE every year. If done at this frequency, the health plan shall reimburse providers.

Minimum: age 70-72; although there is insufficient evidence to recommend mammography screening, the health plan shall reimburse providers for providing every 1-2 years

5. Cervical Cancer Screening

Minimum: pap test and pelvic exam; all sexually active women or age 18-65
Periodicity: annual, decreasing to every 3 years after 3 successive normal annual tests

Since it may be difficult to assess accurately if there have been 3 successive normal annual tests, annual pap tests will be reimbursed by the health plan.

6. Colorectal Cancer Screening

Minimum: age 50 or older; single sigmoidoscopy or annual fecal occult blood test (FOBT)
Periodicity: annual FOBT, sigmoidoscopy at age 50 and then every 10 years

7. Prostate Cancer Screening

Not recommended for routine screening.

If screening is to be performed, digital rectal exam and prostate specific antigen (PSA) for age 50-70 is best evaluated approach but should be preceded by objective information about the potential benefits and harms of early detection.

8. Rubella Serology or Vaccination History

Minimum: women of child bearing age

9. Tuberculin Skin Testing

Minimum: the current methodology, schedule and priority (immigrants, TB contacts, food handlers, health care and school workers, etc.) established by the DOH

10. Health Education and Counseling

- a. Substance use, including alcohol
- b. Diet and exercise
- c. Injury prevention
- d. Sexual behavior
- e. Dental health
- f. Family violence
- g. Depression: there is insufficient evidence to recommend for or against the routine use of standardized questionnaires to screen for depression in asymptomatic patients
- h. Results and implications of screening listed above

Immunizations

1. Tetanus-diphtheria (Td) booster
2. Rubella (or evidence of immunity) for women of child-bearing age
3. Hepatitis B in high risk groups—household and sexual contacts of HBsAg positive person

Chemoprophylaxis

1. Multivitamin with folic acid – pregnant women and women actively trying to become pregnant
2. Counsel all peri and post menopausal women about the potential benefits and risk of hormone prophylaxis

FOR THE HIGH RISK POPULATION

Required preventive interventions are those provided for adults and listed above **and** the following:

Risk Factor	Intervention
Low-income; immigrants; alcoholics; TB contacts	PPD
Certain chronic medical conditions; institutionalized persons	PPD; pneumococcal vaccine; influenza vaccine
Health care/lab workers	PPD; hepatitis B and hepatitis A influenza vaccine
Family h/o skin cancer; fair skin	Avoid sun exposure
Blood product recipients	HIV screen; hepatitis B vaccine
Susceptible to measles, mumps or varicella	MMR; varicella vaccine
Previous pregnancy with neural tube defect	Folic acid 4.0 mg
Injection of street drug use	RPR/VDRL; PPD; HIV screen; hepatitis B & A vaccines
High risk sexual behavior	STD screens; hepatitis B & A vaccines

FOR PREGNANT WOMEN

The following are services for which the health plan must reimburse providers as separate medical services, components of separate medical services or as components of the maternity (vaginal/Cesarean section delivery; prenatal care; postpartum care) benefit.

1. Prenatal Laboratory Screening Tests

Including voluntary HIV testing and counseling and tests for alpha-fetoprotein, alone or in combination with other tests to screen for neural tube anomalies and chromosomal anomalies such as Down's syndrome. Prenatal laboratory screening tests covered include testing for gestational diabetes, rubella, GC, Chlamydia, pap

smear, Hepatitis B, blood typing and RH, urinalysis, complete blood count, etc. as currently recommended by the American College of Obstetrics and Gynecology (ACOG).

2. Prenatal Visits

Those meeting the periodicity and standards currently recommended by the ACOG.

3. Health Education and Screening

For conditions which could make a pregnancy “high-risk” such as smoking, alcohol and other substance abuse, depression, inadequate diet, psychosocial problems, signs of premature labor, other medical conditions, etc. and appropriate referrals including WIC and mental health providers. Other health education such as fetal development, breastfeeding, labor and delivery.

4. Diagnosis of Premature Labor

5. Diagnostic Amniocentesis, Diagnostic Ultrasound, Fetal Stress and Non-Stress Testing

6. Prenatal Vitamins Including Folic Acid

7. Hospital Stays

Up to 48 hours after vaginal delivery or 96 hours after Cesarean section delivery for health women with uncomplicated deliveries and postpartum stays following current guidelines of the American Academy of Pediatrics (AAP) or ACOG.

FOR CHILDREN

The following are services for which the health plan shall reimburse providers as separate medical services, as components of separate medical services, or as components of the EPSDT comprehensive evaluation.

1. Newborn Screening

Includes newborn hearing assessment, newborn laboratory screening—phenylketonuria, hypothyroidism, and other metabolic diseases as specified by the Department of Health (DOH) and currently in effect

2. Hospital Stays for Normal, Term, Healthy Newborns

Up to 48 hours after normal vaginal delivery or up to 96 hours after cesarean section delivery following current guidelines of the AAP and ACOG.

3. Other Age Appropriate Laboratory Screening Tests

Includes those currently in effect as recommended by the AAP, the Centers for Disease Control (CDC), and/or required by the Centers for Medicare & Medicaid

Services (CMS) for Medicaid recipients (for example, hemoglobin/hematocrit, blood lead level).

4. Screening to Assess Health Status

Includes age appropriate general physical and mental health, growth, development, and nutritional status. The periodicity schedule follows the AAP's Guidelines for Health Supervision currently in effect. Included, but not limited to the following:

- a. Initial/interval health history
- b. Height/weight/head circumference
- c. Blood pressure
- d. Developmental assessment using the Denver Developmental Screening Test of Developmental Inventory (MCDI), or any other acceptable method for developmental screening
- e. Behavioral assessment (including screening for substance abuse for ages 12+)
- f. Vision testing
- g. Hearing/language testing; audiometry
- h. Physical examination

5. Tuberculin Skin Testing

Using the method recommended by the DOH, following a schedule recommended by the Hawaii Chapter, AAP.

6. Immunizations

Following the standards and schedule of the Advisory Committee on Immunization Practices (ACIP) and the DOH currently in effect.

7. Age Appropriate Dental Referral and Oral Fluoride

8. Age Appropriate Health Education

Includes education to child and/or parent including dietary counseling, injury prevention, child maturation/development, behavior management, dental care, sexuality, family violence, STD, HIV, pregnancy, and depression. Provisions for children aged 12 years and older to be able to discuss sensitive issues alone with the provider or designated staff.