Criteria for At-Risk Population

The "At-Risk" population is defined as those Hawaii Medicaid beneficiaries who do not meet criteria for nursing facility level of care (NF LOC) but are assessed to be at risk of deteriorating to the institutional level of care if certain long term services and supports (LTSS) are not provided. To be eligible, the individual must reside in his/her home (may live in home with daughter/son/guardian/friend or other family member), and cannot be residing in a facility, e.g. care home, foster home, hospital, nursing facility, hospice facility. Individuals who reside in a community shelter (e.g. YMCA, YWCA, IHS) may receive At-Risk services appropriate for their living environment as determined by the health plan. If services are provided by the community shelter (e.g. meals or cleaning of room), then the health plan shall not provide these services.

Individuals who do meet NF LOC and/or are receiving services in a facility do not qualify for inclusion in the At-Risk population. The At-Risk population also does not include individuals who meet the LOC criteria for intermediate care facility for persons with intellectual disabilities (ICF/ID) or are receiving services in the Developmental Disabilities or Intellectual Disabilities (DD/ID) 1915(c) waiver.

Eligible Medicaid beneficiaries shall receive At-Risk services through their QUEST Expanded Access (QExA) health plan. A Medicaid beneficiary who meets At-Risk criteria may be eligible to receive the following home and community based services: home-delivered meals, Personal Emergency Response System (PERS), personal assistance (levels I and II), adult day care, adult day health, and skilled nursing services. Eligibility for specific services will be based on the functional assessment score through the newly revised DHS 1147.

The Health Services Advisory Group (HSAG) is responsible for approving the functional assessment score. To meet criteria for the At-Risk population, the lower limit for At-Risk is five functional points. However, HSAG may approve At-Risk criteria with lower than five functional points if need is demonstrated. The DHS 1147 must include additional documentation to support the functional status and needs. Health plans shall provide services based on medical necessity and needs of the member, regardless of the point score. Needs of the member include but are not limited to age, frailty, natural supports, cognition, and behavioral status. The health plan must consider natural support systems when identifying needs of the member and determining at-risk services.

The following array of services are available with guidelines provided for three levels of services:

I	5 to 7 functional points	▪ Home-delivered meals* ▪ PERS
II	8 to 10 functional points	▪ Home-delivered meals ** ▪ PERS ▪ Personal assistance (level I)
III	Greater than 10 functional points	▪ Home-delivered meals** ▪ PERS ▪ Personal assistance (both level I and II) ▪ Adult day care ▪ Adult day health ▪ Skilled nursing services

*If home-delivered meals are not available in the area where the individual resides, the health plan may substitute personal assistance level I for meal preparation.

**As meal preparation is included as part of personal care (chore) services, an individual receiving personal care services cannot simultaneously receive home-delivered meals.

Based on current available funding, DHS will have service limits and enact waitlists as described below:

- Home-delivered meals or PERS: No service limits.
- Personal assistance (level I or II), adult day care, adult day health, and skilled nursing services: Service limit of 2,500 individuals (split evenly between ʻOhana Health Plan and UnitedHealthcare Community Plan). Receipt of any of the identified services goes towards the service limit. A waitlist will be maintained should the number of eligible individuals seeking services exceed the service limit.
- Waitlists shall be managed based upon needs of the member.

- QExA health plans may provide HCBS services to individuals who do not meet At-Risk criteria. However, this is at the health plan's discretion and these individuals will not be counted towards their service limit.

Additional documentation required to support meeting At-Risk criteria:

In addition to the functional assessment scores, the DHS 1147 must contain documented evidence or examples of the individual's situation, functional deficits, and limitations, and must demonstrate how he/she would benefit from the LTSS. For example, the "comments" should describe one or more of the following:

- Caregiver support system is unable to provide 24/7 supervision and recipient cannot be left alone during day (e.g. family/caregiver support system works outside home during day).

- The individual requires assistance with medically necessary tasks (due to memory, mental status/behavior, or physical limitations), such as insulin administration or basic wound care.

- The individual requires assistance with IADLs, such as house cleaning, laundry, grocery shopping, or meal preparation, because of memory, mental status/behavior, or physical limitations.

- The individual may be unsteady and may have fallen previously, but is able to get self to restroom and/or change own incontinence pads.

Maximum length of approval is for a one-year period, based on individual needs, and may be renewed if medically necessary. The review and approval of an individual as meeting At-Risk criteria will be based upon information contained on the DHS 1147 only (assessment, functional scores and needs, comments, etc.); DHS 1147A and DHS 1147E will not be reviewed for At-Risk population criteria.