DEPARTMENT OF HUMAN SERVICES

Amendments to Chapters 17-1700, 17-1721, 17-1721.1, 17-1727, 17-1728, 17-1728.1, 17-1732, 17-1735 and 17-1737

Hawaii Administrative Rules

1. Section 17-1700-2, Hawaii Administrative Rules, is amended by amending the definitions of "Hawaii QUEST or QUEST" and "QExA" to read as follows:

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""Hawaii QUEST or QUEST" means the demonstration project developed by the department which will deliver medical[, dental,] and behavioral health services, through health plans employing managed care concepts, to certain individuals formerly covered by public assistance programs including the aid to families with dependent children (AFDC) and related medical programs[, general assistance (GA), and the state health insurance program (SHIP).]."

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""QExA" means the QUEST expanded access program[.] that delivers medical and behavioral health services through health plans employing managed care concepts, to certain individuals who are aged, blind or disabled."

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2. Section 17-1700-2, Hawaii Administrative Rules, is amended by adding a new definition to read as follows:

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""QEx" means the QUEST Expanded program that delivers medical and behavioral health services through health plans employing managed care concepts, to certain individuals in accordance with the State plan under Title XIX, or in accordance with a demonstration project under Title XI of the Social Security Act."

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[Eff 08/01/94; am 01/29/96; am 01/31/09;
am] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §346-14)

3. Section 17-1721-2, Hawaii Administrative Rules, is amended by amending the definition of "Medically needy" to read as follows:

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""Medically needy" means aged, blind, or disabled individuals who are otherwise eligible for Medicaid, who are not <u>mandatory or optional</u> categorically needy, and whose income <u>is insufficient to meet their medical expenses</u> and resources are within limits set under the Medicaid State Plan."

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4. Section 17-1721-2, Hawaii Administrative Rules, is amended by adding new definitions to read as follows:

"<u>"Acute care services" means the short term medical treatment, usually in an acute care hospital, for patients having an acute illness or injury.</u>"

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"<u>"Contract" means a contract between a participating health plan and the department to provide QExA services.</u>"

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"<u>"Enrollment fee" means the amount an enrollee is responsible to pay that is equal to the spenddown amount for a medically needy individual or cost share amount for an individual receiving long term care services. A resident of an intermediate care facility for individuals with intellectual disabilities or a participant in the Medicaid waiver program for persons with developmental disabilities or intellectual disabilities are exempt from the enrollment fee.</u>"

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““Health plan” means a QExA health plan contracted by the State to provide health care services, through a managed care system, to individuals who are found eligible to participate in QExA and are enrolled in that health plan.”

““Health plan contract period” means the period of time under which a health plan is continuously operating under a contract including amendments without a new procurement.””

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““ICF-ID” means intermediate care facility for individuals with intellectual disabilities.”

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““Nursing facility level of care” means the determination that a member requires the services of licensed nurses in an institutional setting to carry out the physician’s planned regimen for total care. These services can be provided in the home or in community-based programs as a cost-neutral, least restrictive alternative to institutional care in a hospital or nursing home.”

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““State plan” or “Hawaii Medicaid state plan” is the document approved by the United States Department of Health and Human Services that defines how Hawaii operates its Medicaid program. The state plan addresses areas of state program administration, Medicaid eligibility criteria, service coverage, and provider reimbursement.”

5. Section 17-1721-2, Hawaii Administrative Rules, is amended by deleting the definitions "Cost-sharing related to Medicare Part D" and "Likely to remain".

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[““Cost-sharing related to Medicare Part D” means any premiums, deductibles, co-payments, co-insurance, and any cost incurred within the Part D coverage gap.”]

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[““Likely to remain” means that the attending or admitting physician, or the department or its designee, indicates that the individual is expected to reside in a nursing facility or a medical facility receiving nursing facility level of care for at least thirty consecutive days.”] [Eff 08/01/94; am 10/26/01; am 12/26/05;am 01/31/09; am] (Auth: HRS §346-14; 42 C.F.R §431.10) (Imp: HRS §§346-4; 346-29; 42 C.F.R. §§435.4; 435.1008; 42 U.S.C. §1396r-5)

6. Section 17-1721-8, Hawaii Administrative Rules, is amended by amending subsection (a) to read as follows:

“§17-1721-8 Medical assistance only for aged, blind, or disabled individuals. (a) Individuals who are certified as being aged, blind, or disabled shall be categorically eligible for medical assistance under one of the following coverage groups:

(1) The mandatory categorically needy coverage for the aged, blind, or disabled, whose members are eligible for or receive SSI payments or SSP payments, or both;
(2) The medically needy coverage for the aged, blind, or disabled, whose members are financially ineligible for SSI benefits, but whose income is insufficient to meet medical expenses;
(3) The optional categorically needy coverage for the aged or disabled, whose members are allowed to qualify under a higher assistance standard, as allowed under the provisions of 42 C.F.R. §435.230[(b)](c)(2)(vi); or
(4) The optional categorically needy coverage for individuals residing in the community who meet the requirements of 42 C.F.R. §435.217 as follows:
    (A) The individual would be eligible for Medicaid if institutionalized;
    (B) The individual does not have income that exceeds income standards for the:
        (i) Mandatory categorically needy,

(ii) Optional coverage of aged and disabled under the provisions of 42 C.F.R. §435.230[(b)](c)(2)(vi), or

(iii) Individuals in domiciliary care facilities;

(C) The individual has been determined to need home and community based services in order to remain in the community; or

(D) The individual may be covered under the terms of a home and community based waiver."

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[Eff 08/01/94; am 01/31/09; am] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§435.121, 435.210, 435.217, 435.330; 42 U.S.C. §1396(a) to (m))

7. Section 17-1721-14 Hawaii Administrative Rules, is amended by amending subsection (b) to read as follows:

"§17-1721-14 Personal reserve standard for aged, blind, or disabled individuals. ***

(b) For each additional family member, $250 shall be added to the SSI personal reserve standard for a couple and the resultant amount is the personal reserve standard for [the] a family[.] of applicable size." [Eff 08/01/94; am] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§435.840, 435.843, 435.845)

8. Section 17-1721-22 Hawaii Administrative Rules, is amended to read as follows:

"§17-1721-22 Standards of assistance for medically needy aged, blind, or disabled individuals. For individuals who meet the requirements in section 17-1721-8(a)(2), the medical assistance standards shall be equal to the [financial assistance payment standard] medically needy income standards for a family of [the same] applicable size." [Eff 08/01/94;

am] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §346-53; 42 C.F.R. §§435.119, 435.811 435.814, 435.831)

9. Section 17-1721-35 Hawaii Administrative Rules, is amended by amending subsection (c) to read as follows:

"§17-1721-35 General eligibility provisions.
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(c) Medically needy individuals who are disenrolled from a health plan for being two months in arrears of the payment of their enrollment fee are not eligible for coverage under this chapter unless the individual:

(1) Is no longer two full months in arrears in the payment of the enrollment fee; or

(2) Qualifies as a mandatory or optional categorically needy individual."
[Eff 08/01/94; am] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §346-53(e); 42 C.F.R. §§435.119, 435.812, 435.814, 435.831)

10. Section 17-1721-39, Hawaii Administrative Rules, is amended to read as follows:

"§17-1721-39 Provision of coverage. (a) [QExA health plans shall provide coverage for individuals] Individuals eligible under this [chapter,] section [except for] shall be provided coverage on a fee-for-service basis for services identified in chapter 17-1737:

(1) [Medically needy individuals who are not expected to incur expenses sufficient to satisfy their spenddown obligation for a consecutive three-month period;

(2) Individuals who are eligible for medical assistance for a period that is less than thirty days;

(3) Children] Blind or disabled children under age twenty-one years who are residents of the State, receive child welfare services or subsidized adoption from the department or court, and are placed in other states; [and]

[(4)](2) Individuals who enter the State of Hawaii organ and tissue transplant (SHOTT) program[.]; and

(3) Aged, blind or disabled incarcerated individuals who are admitted as an inpatient in a medical institution.

[(b) Individuals in subsection (a) will be provided coverage on a fee-for-service basis for the services identified in chapter 17-1737.

(c)](b) Individuals [enrolled in the Medicaid waiver program for persons] with developmental disabilities or [mental retardation (DD/MR)] intellectual disabilities (DD/ID) who are:

(1) Enrolled in the Medicaid waiver program for persons with DD/ID shall have their primary and acute care services covered by a QExA health plan, but shall have their HCBS benefits covered under fee-for-service;

(2) Admitted into an [and] intermediate care facility for [the mentally retarded (ICF/MR)] individuals with intellectual disabilities (ICF/ID) shall have their primary and acute care services covered by a QExA health plan but shall have their ICF/ID services [benefits] covered under fee-for-service.

[(d) Individuals who are enrolled in the Program for All-Inclusive Care for the Elderly (PACE) shall have all medical and long-term care services covered by the PACE program.

(e) Medically needy individuals who are disenrolled from a health plan for being two months in arrears of the payment of their enrollment fee are not eligible for coverage under this chapter unless the individual:

(1) Is no longer two full months in arrears in the payment of the enrollment fee; or
(2) Is a medically needy individual who is not expected to incur expenses sufficient to satisfy their spenddown obligation for a three-month period; or
(3) Qualifies as a mandatory categorically needy individual or an optional categorically needy individual under section 17-1721-8.]

(c) Individuals who receive a determination of eligibility on or after the start date of a new health plan contract period that is retroactive to a date prior to the start of the new health plan contract

period shall have services incurred during the period from the effective date of coverage up to the start date of the new health plan contract period covered on a fee-for-service basis.

(d) Individuals who receive a determination of eligibility for services incurred limited to a retroactive period and are not currently eligible shall have those services covered on a fee-for-service basis.

(e) As determined by the department on a case-by-case basis, an individual may be enrolled in a managed care program who otherwise would have had services covered on a fee-for-service basis."

[Eff 01/31/09; am] (Auth: HRS §346-14) (Imp: HRS§346-14)

11. Section 17-1721-43, Hawaii Administrative Rules, is amended by amending subsections and (e) to read as follows:

"§17-1721-43 Determination of the community spouse resource allowance. ***

(e) The provisions of subsections (a) through (d) [only] apply to an institutionalized individual [determined eligible] who qualifies for [home and community based services] long-term care services. [who qualify for Medicaid as a medically needy individual or under the provisions of 42 C.F.R. §435.217]." [Eff 08/01/94; am 01/31/09; am] (Auth: HRS §346-14; 42 C.F.R §431.10) (Imp: HRS §346-29; 42 U.S.C. §1396r-5, 42 U.S.C. §1315)

12. Section 17-1721-44, Hawaii Administrative Rules, is amended by amending subsection (b) to read as follows:

"§17-1721-44 Post-eligibility treatment of income for an institutionalized individual. ***

(b) An institutionalized individual's cost share is determined by deducting the following from the individual's income:

(1) A personal needs allowance of:
   (A) $50 for an individual residing in a nursing facility or medical facility receiving a nursing facility level of care;
   (B) One hundred percent of the FPL for a household of one for an individual residing in a private home in the community; or
   (C) The standard of assistance for the medically needy for a household of one for an individual residing in a community care foster family home.

(2) An amount for maintenance of the institutionalized individual's community spouse and dependent family member that shall be deducted first from the income of the institutionalized individual's income as follows:
   (A) The contribution from the institutionalized individual to the community spouse which shall be equal to the amount that the maximum community spouse maintenance needs allowance exceeds the [countable] gross monthly income of the community spouse. The maximum community spouse maintenance needs allowance is defined by federal statutes or regulations and is subject to increases by means of indexing, court order, or fair hearing decree;
   (B) The family allowance for each dependent family member, residing with the community spouse, [which] shall be equal to [the amount that] one third the amount of the spousal allowance in subparagraph (A) which exceeds the [amount of the] gross monthly income of that family member; or
   (C) The family allowance for [a] any or all dependent family [member] members

residing in the home of the institutionalized [individual's home,] individual [with no] without the community spouse [residing in the home, which] shall be equal to the [amount that the] medically needy standard of assistance [for the medically needy] for a family of equal size, which exceeds the [amount of the] total gross monthly income of the dependent family [member].

(3) Any incurred medical expenses as provided in section 17-1721-37, not covered by the medical assistance program excluding any unpaid portion of long-term care services that were not payable by Medicaid during a penalty period for the transfer of assets for less than fair market value established under the provisions of this chapter;

(4) Veterans Affairs benefits that have been reduced to $90 for pensioners with no dependents; and

(5) Veterans Affairs benefits for unusual medical expenses (UME)."

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[Eff 08/01/94; am 11/13/95; am 11/25/96; am 01/31/09; am] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§435.726, 435.733, 435.735, 435.831, 435.832; 38 U.S.C. §5503; 42 U.S.C. §§1396a(r), 1396r-5; 42 U.S.C. §1315)

13. Section 17-1721-51, Hawaii Administrative Rules, is amended by adding the definition of an "Immediate family member" to read as follows:

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""Immediate family member" means an individual, their spouse, natural or legal children, their siblings, their parents, and the spouses of these family members."

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[Eff 10/19/09; am] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396p(c))

14. Section 17-1721-52, Hawaii Administrative Rules, is amended by amending subsections (a) and (b) to read as follows:

"§17-1721-52 Penalty period for the transfer of an asset for less than fair market value. (a) An individual who requests medical assistance for coverage of long-term care services shall be assessed a penalty period for coverage of these services if the individual or the individual's spouse, transferred an asset for less than fair market value within the applicable look-back period. The length of the look-back period shall be[:

(1) Thirty-six months for an asset transferred prior to February 8, 2006;

(2) Sixty months for an asset transferred to an irrevocable trust prior to February 8, 2006; and Sixty] sixty months for an asset transferred on or after February 8, 2006.

(b) An asset that was transferred on or after the [look-back period] date of application shall be considered as follows:

(1) A penalty period shall be assessed if an individual transfers an asset after being determined eligible for coverage of long-term care services.

(2) A penalty period shall not be assessed for the transfer of an asset owned by the community spouse made after the individual has been determined eligible for coverage of long-term care services[.] with the exception of subsection (d); or sections 17-1721-53, 17-1721-54, 17-1721-55, or 17-1721-56."

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[Eff 10/19/09; am] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396p(c))

15. Section 17-1721-52, Hawaii Administrative Rules, is amended by amending subsection (d) to read as follows:

"§17-1721-52 Penalty period for the transfer of an asset for less than fair market value. ***

(d) The transfer provision shall apply to countable assets in chapter 17-1725 owned by the individual [and] or the individual's community spouse[,] or both and to the following exempt assets in chapter 17-1725:

(1) The home property;
(2) The value of basic maintenance items [of limited value] essential for day-to-day living including but not limited to clothing, furniture, and appliances [that exceeds $5,000];
(3) All [Motor] motor vehicles,[except for one vehicle designated for use by the individual or their spouse]with the exception of watercrafts or air transportation vehicles, including but not limited to, cars, trucks, vans, or motorcycles; [and]
(4) The equity value of a bona fide funeral or burial plan [that exceeds $1,500.] or agreement; and
(5) The burial space (including plots, vaults, and niches) including those designated for immediate family members."

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[Eff 10/19/09; am] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396p(c))

16. Section 17-1721-53, Hawaii Administrative Rules, is amended to read as follows:

"§17-1721-53 Treatment of annuities. (a) An individual who requires coverage of long-term care services or the [individual's] community spouse shall disclose whether or not the individual or the community spouse has any ownership interest in annuities on each application or at each recertification of Medicaid eligibility.

(1) An individual shall not be eligible for coverage of long-term care services if the institutionalized individual or the

[individual's] community spouse fails to disclose any interest in an annuity.

(2) The disclosure shall be required regardless of whether the annuity is irrevocable or treated as an asset in chapter 17-1725.

(b) The portion of the funds of an annuity purchased prior to February 8, 2006, that is not actuarially sound and is payable beyond the life expectancy of the annuitant shall be considered transferred.

(c) All funds used to purchase an annuity on or after February 8, 2006, by the institutionalized individual or the [individual's] community spouse shall be considered transferred if the department is not named as a remainder beneficiary in the first position, or in a position behind the community spouse and [dependent child of] the institutionalized [individual] individual's minor child under the age of twenty-one years or who is blind or disabled, for the amount of medical assistance paid on behalf of the [annuitant] institutionalized individual.

(1) The department shall notify the issuer of an annuity issued on or after February 8, 2006, of the right of the department to be a preferred remainder beneficiary.

(2) The issuer may inform other remainder beneficiaries of the department's remainder interest.

(d) Funds used to purchase an annuity on or after February 8, 2006, by the institutionalized individual or the [individual's] community spouse, or on behalf of the institutionalized individual or the [individual's] community spouse, shall not be considered transferred if:

(1) The annuity is considered:

(A) An individual retirement annuity that meets the requirements of section 408(b) of the IRC; or

(B) A deemed IRA under a qualified employer plan under section 408(q) of the IRC; or

(2) The annuity is purchased with proceeds from one of the following:

(A) A traditional IRA under section 408(a) of the IRC;

(B) An account or trust which is treated as a traditional IRA under section 408(c) of the IRC;

(C) A simplified retirement account under section 408(p) of the IRC;

(D) A simplified employee pension under section 408(k) of the IRC; or

(E) A Roth IRA under section 408A of the IRC; or

(3) The annuity meets all of the following requirements:

(A) Is actuarially sound as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration;

(B) Is irrevocable, [and] non-assignable and cannot be sold; [and]

(C) Makes equal payments throughout the term of the contract and does not defer payments or allow balloon payments;[.] and

(D) Cannot be cancelled upon the death of the institutionalized individual or the community spouse.

(e) Certain transactions or changes which occur on or after February 8, 2006, that affect the terms of a qualified annuity that was purchased by the institutionalized individual or the community spouse prior to February 8, 2006, shall be considered a transfer of asset which includes but is not limited to the:

(1) Course of payment made by the annuity;

(2) Treatment of income or principal of the annuity to include additions of principal, elective withdrawals or requests to change the distribution of the annuity; or

(3) Election to annuitize the contract.

(f) Routine changes or automatic events or both, made by the institutionalized individual or the community spouse for an annuity that was purchased prior to February 8, 2006, that are not considered a transfer of asset include:

(1) Routine changes to include, but are not limited to, notifications of address change, death, or divorce of a remainder beneficiary.

(2) Changes based on the terms of an annuity which existed prior to February 8, 2006, which do not require a decision, election or action to be effective.

(3) Changes that are beyond the control of the institutionalized individual or the community spouse to include, but are not limited to, changes in the law or the issuer's policies.

(g) Transactions or changes made for annuities purchased prior to February 8, 2006, that do not meet the criteria of subsection (f) of this section as well as a qualified annuity that is transferred to anyone except the community spouse or to another individual for the sole benefit of the community spouse, child or to a trust as described in section 1917(c)(2)(B) of the Social Security Act, shall be treated as a transfer of asset." [Eff 10/19/09; am] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396(a); 42 U.S.C. §1396p(c) and (e); 42 U.S.C. §1396r-5(c))

17. Section 17-1721-54, Hawaii Administrative Rules, is amended by amending subsection (a) to read as follows:

"§17-1721-54 Treatment of promissory notes, loans and mortgages. (a) The assets used by an individual who requires coverage of long-term care services or the individual's spouse, to secure a promissory note, loan or mortgage on or after February 8, 2006, shall not be considered transferred if all of

the following conditions apply to the promissory note, loan or mortgage:

(1) The repayment term is actuarially sound;
(2) Is irrevocable and cannot be sold;
(3) Equal payments are made throughout the term of the contract[;] with no deferral or balloon payments; and
(4) [Cannot] The balance cannot be cancelled upon the death of the institutionalized individual or the [individual's] community spouse."

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[Eff 10/19/09; am] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396p(c))

18. Section 17-1721-56, Hawaii Administrative Rules, is amended to read as follows:

"§17-1721-56 Treatment of the transfer of income. (a) A transfer of asset penalty period shall be assessed if the institutionalized individual or the [individual's] community spouse transferred:

(1) Lump sum payments received [income] in the month [it was received,]; or [transferred a right to receive income.]
(2) An entitled stream of income (disclaimed or voluntarily agreed).

(b) The penalty period for the transfer of income shall be calculated by dividing the amount of income by the statewide average monthly cost of nursing facility services assessed to a private patient at the time the individual requests coverage of long-term care services. Disposal of such lump sum payments or the entitled stream of income constitutes a transfer of asset.

(c) The amount of income used to calculate a penalty period shall be:

(1) The gross amount of the lump sum income transferred in the month it was received [by the individual]; or

(2) The total gross amount of income expected to be received [when the right to receive a single source of income was transferred.

(3) The total amount of income expected to be received] during the individual's lifetime when the [right to receive a] entitled stream of income was transferred[. The total amount of income] which is calculated by multiplying the annual amount of income expected to be received [by] during the individual's [life expectancy] lifetime based on the life expectancy tables established by the Social Security Administration's Office of the Actuary."

[Eff 10/19/09; am] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396p(c))

19. Section 17-1721-57, Hawaii Administrative Rules, is amended to read as follows:

"§17-1721-57 Transfer of assets that are not subject to the assessment of a penalty. A penalty period shall not be applied when:

(1) The asset transferred was the individual's home and title to the home was transferred to the [individual's]:
  (A) Spouse of such individual;
  (B) Child of such individual who is under age twenty-one[,] years, or a blind or disabled child;
  (C) A sibling of such individual who has an equity interest in the home, and has resided in the home for at least one year immediately prior to the date the individual [began receiving long-term care services] becomes an institutionalized individual; or
  (D) An adult child of such individual, other than a child described in paragraph (B), who has resided in the home with the individual for at least two years immediately prior to the date the individual [began receiving long-

term care services] becomes an institutionalized individual and who provided care which allowed the individual to reside at home.

(2) The asset, other than a home, was transferred:
   (A) To the individual's community spouse or to another individual or entity for the sole benefit of the community spouse;
   (B) From the community spouse to another individual or entity for the sole benefit of the community spouse;
   (C) To the individual's child who is under age twenty-one years [of age], a blind [child] or disabled child, or to a trust established after August 10, 1993, for the child; or
   (D) To a trust established after August 10, 1993, solely for the benefit of an individual under age sixty-five years [of age] who is disabled as defined in section 17-1721-6.

(3) The individual can substantiate that the individual intended to transfer the asset:
   (A) At either [at] fair market value, or for other valuable consideration[, or the] by providing substantiated evidence of attempts to dispose of the asset for fair market value, as well as evidence to support the value at which the asset was disposed; or
   (B) The asset was transferred exclusively for a purpose other than to qualify for medical assistance[.] by providing convincing evidence as to the specific purpose for which the asset was transferred.

(4) Circumstances that meet the requirements of this subsection include, but are not limited to:
   (A) The individual [was] who did not [receiving] require long-term care services at the time of the transfer;

(B) The individual was living independently at the time of the transfer;

(C) The individual did not have a pre-existing condition that could have led to the need for long-term care or assisted living services at the time of the transfer;

(D) The transfer was not within the individual's control (e.g. court ordered); or

(E) A diagnosis of a previously undetected disabling condition [leading] that led to the need for long-term care [eligibility] services occurred after the date of transfer.

[(4)](5) The asset transferred for less than fair market value has been returned.

(A) The returned asset must be evaluated for the impact on the individual's eligibility for Medicaid.

(B) If the entire transferred asset has been returned, the penalty period is negated. Coverage of long-term care services shall be provided for any portion of a penalty period that was applied prior to the return of the asset.

(C) If only a portion of the transferred asset has been returned, and the individual is eligible for [Medicaid,] coverage of long-term care services, the penalty period shall be recalculated based [on] upon the balance of the unreturned asset.

(i) The end date of the recalculated penalty period shall be applicable if it exceeds the amount of the penalty period already applied;

(ii) Coverage of long-term services shall be provided for the portion of the penalty period that exceeds

the end date of the recalculated penalty period." [Eff 10/19/09; am] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396p(c))

20. Section 17-1721-58, Hawaii Administrative Rules, is amended to read as follows:

"§17-1721-58 Determining a penalty period. (a) A penalty period shall be calculated by dividing the total uncompensated value of the asset transferred, by the statewide average monthly cost of nursing facility services assessed to a private patient at the time the individual requests and is determined eligible for the coverage of long-term care services.

(b) A penalty period that results in a partial [less than a whole] month penalty shall not be rounded down or disregarded.

(c) [A penalty period established for an asset that was transferred prior to February 8, 2006, shall be established for each month a non-exempted transfer occurred during the applicable look-back period specified in section 17-1721-52, and the following apply:

(1) Multiple transfers made in the same month shall be combined to establish a penalty period for that month;
(2) A penalty period shall commence on the first day of a month the asset was transferred; and
(3) A penalty period that would commence within the term of another penalty period shall commence at the end of the prior penalty period.

(d)] A penalty period established for an asset that was transferred, [on or after February 8, 2006,] shall be applied as follows:

(1) The value of [any asset] all non-exempt [transferred] transfers during the applicable look-back period specified in

subsection 17-1721-52(a)(3) shall be combined and a single penalty period shall be determined.

(2) A separate penalty period shall be determined for [each month] non-exempt [transfer] transfers which occurred [after] while a penalty is being applied for a previous transfer by an individual [was] determined eligible for coverage of long-term care services.

(3) The penalty period shall commence the later of:

(A) The [first day of the month the asset was transferred] date of request for long-term care services;

(B) The date the individual would be eligible for coverage of long-term care services but [for the imposition of] a penalty is being imposed under this subchapter; or

(C) The date a negative action can be taken in situations when timely notice of adverse action is required [to] for the individual [is required] currently receiving coverage of long-term care services.

(4) A penalty period that would commence within the term of another penalty period shall commence at the end of the prior penalty period.

[(e)](d) An established penalty period shall continue to run [even in periods where] , regardless of whether the penalized individual [subject to the penalty period is not] no longer is eligible for medical assistance, or is not receiving long-term care services.

[(f)](e) The department shall send a denial notice to an individual requesting coverage of long-term care services, or an adverse action notice to an individual who is receiving coverage for long-term care [coverage,] services when imposing a penalty

period. The notices shall meet the requirements of chapter 17-1713, and must inform the individual of:

(1) The type and amount of the transferred asset used to determine the penalty period;
(2) The length of the penalty period;
(3) The start and end date of the penalty period;
(4) The authority under the Hawaii administrative rules to impose the negative action; and
(5) The individual's right to request a hardship waiver of the penalty period.

[(g)](f) If the spouse of a penalized individual becomes eligible for coverage of long-term care services, the remaining penalty period may be allocated between [the individual and the spouse.] both spouses.

[(h)](g) If one of the spouses should die before completing the allocated penalty period, the remaining spouse shall be allocated the balance remaining for the deceased spouse." [Eff 10/19/09; am] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396p(c))

21. Section 17-1721-59, Hawaii Administrative Rules, is amended by amending subsections (d) and (e) to read as follows:

"§17-1721-59 Waiver of a transfer of asset penalty period due to undue hardship. ***

(d) The process for requesting and reviewing a waiver of a penalty period imposed for a transfer of asset due to undue hardship is as follows:

(1) The department shall send the individual a notice of denial or a notice of adverse action according to the requirements of chapter 17-1713 to inform the individual of the establishment of the penalty period and the individual's right to request a hardship waiver.
(2) The individual shall have twenty calendar days from the mailing of the denial or

adverse notice as specified in 17-1721-59(d)(1) to request a hardship waiver and provide all documentation to support the basis of [the] a hardship waiver request.

(3) The department shall make a determination [of] to grant a hardship waiver within ten business days after receiving the waiver request [for a waiver] and [the] supporting documentation.

(4) An individual who is denied a hardship waiver [request] shall be informed of the enforcement date of the penalty period and the right to request a fair hearing under chapter 17-1703.

(e) Nursing facilities may request a hardship waiver on behalf of [a] their resident [upon authorization] with the written consent of the resident or the resident's personal representative[.] and may represent the resident or the resident's personal representative throughout the appeals process."

[Eff 10/19/09; am] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396p(c))

22. Chapter §17-1721, Hawaii Administrative Rules, is amended by adding a new section to read as follows:

"§17-1721-61, Waiver of excess home equity due to undue hardship. (a) The denial for the coverage of long-term care services may be waived if the department determined that the imposition of ineligibility will cause the individual undue hardship.

(b) Undue hardship exists if the denial of coverage of long-term care services would deprive the individual of:

(1) Medical care such that the individual's life or health would be endangered; or

(2) Food, clothing, shelter, or other necessities of life.

(c) Undue hardship may be granted if the individual provides a written statement with

satisfactory evidence to the department of the legal inaccessibility of the excess home equity through any means provided by the individual, spouse, legal representative or authorized representative from the nursing facility.

(d) The process for requesting and reviewing a waiver of ineligibility due to excess home equity is as follows:

(1) The department shall send the individual a notice of denial or a notice of adverse action according to the requirements of chapter 17-1713 to inform the individual of ineligibility due to excess home equity and of the individual's right to request a hardship waiver.

(2) The individual shall have twenty calendar days from the mailing of the denial or adverse notice as specified in 17-1721-61(c) to request a hardship waiver and provide all documentation to support the basis of the hardship waiver request.

(3) The department shall make a determination whether to grant a hardship waiver within ten business days after receiving the waiver request and supporting documentation.

(4) An individual who is denied a hardship waiver shall be informed of the right to request a fair hearing under chapter 17-1703.

(e) Nursing facilities may request a hardship waiver on behalf of their resident with specific written consent of the resident or the resident's personal representative and may represent the resident or the resident's personal representative throughout the appeals process." [Eff] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §1396p(c))

23. Section 17-1721.1-2, Hawaii Administrative Rules, is amended by amending the definitions of "Benefit period," "Cost share," "Early periodic diagnosis, screening, and treatment program" or

"EPSDT,"" "Emergency medical condition," "Enrollee," "Enrollment fee," "Home and community based services," "ICF-MR" and "Medically needy" to read as follows:

***

""Benefit period" means the period from the first day of the month following the close of the annual plan change period and extending for [no more than twelve months thereafter, as] a period designated by the department."

***

""Cost share" means the share of monthly medical expenses for long-term care services for an institutionalized individual who is subject to post-eligibility treatment of income."

***

""Early and periodic screening, diagnosis[, screening,] and treatment program" or "EPSDT"" means early and periodic screening, [and diagnostic] diagnosis and treatment services, to identify physical or mental defects in recipients, and, to provide health care, treatment, and other measures to correct or ameliorate any defects and chronic condition discovered in accordance with section 1905r of the Social Security Act. EPSDT includes services to:

(1) Seek out recipients and their families and inform them of the benefits of prevention and the health services available;

(2) Help the recipient or family use health resources, including their own talents, effectively and efficiently; and

(3) Assure the problems identified are diagnosed and treated early, before they become more complex and their treatment more costly."

***

""Emergency medical condition" means the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain[)], psychiatric disturbances and/or symptoms of substance abuse) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the

absence of emergency services or immediate medical attention to result in:

(1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
(2) Serious impairment to body functions; [or]
(3) Serious dysfunction of any bodily organ or [Part] part;
(4) Serious harm to self or others due to an alcohol or drug abuse emergency;
(5) Injury to self or bodily harm to others; or
(6) With respect to a pregnant woman who is having contractions:
    (A) That there is inadequate time to effect a safe transfer to another hospital before delivery; or
    (B) That transfer may pose a threat to the health or safety of the woman or her unborn child."

""Enrollee" means an individual who has selected or [is] been assigned by the department to be a [enrollee] member of a participating health plan.

"Enrollment fee" means the amount an enrollee, [except for an enrollee who is a resident of an ICF-MR or a participant in the DD-MR waiver program,] is responsible to pay that is equal to the spenddown amount for a medically needy individual or cost share amount for an individual receiving long term care services. A resident of an intermediate care facility for individuals with intellectual disabilities or a participant in the Medicaid waiver program for persons with developmental disabilities or intellectual disabilities are exempt from the enrollment fee."

***

""Home and community based services" or "HCBS" [include, but are not limited to, adult day] means long-term care[, adult day health, assisted living, pediatric attendant care,] services provided to an individual residing in a community [care management agency (CCMA) services, community care foster family

home services, counseling and training activities, environmental accessibility adaptations, E-ARCH or residential care services, home delivered meals, home maintenance, medically fragile day] setting who is certified by the department to be at nursing facility level of care.[moving assistance, non-medical transportation, personal assistance services - level II, personal emergency response systems, private duty nursing, respite care, and specialized medical equipment and supplies.]"

"["ICF-MR"] "ICF-ID" means intermediate care facility for [the mentally retarded.] individuals with intellectual disabilities."

***

""Medically needy" means aged, blind, or disabled individuals who are otherwise eligible for Medicaid, who are not mandatory or optional categorically needy, [and] whose [income and] resources are within limits set under the Medicaid State Plan[.], but whose income exceeds the appropriate income standard and the excess may be reduced with incurred medical or remedial expenses or both to establish Medicaid eligibility."

***

24. Section 17-1721.1-2, Hawaii Administrative Rules, is amended by adding new definitions to read as follows:

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""Categorically needy" means aged, blind, or disabled individuals:

(1) Who are otherwise eligible for medical assistance and who meet the financial eligibility requirements for SSI or SSP or are considered under section 1619(b) of the Social Security Act to be SSI recipients; or
(2) Whose categorical eligibility for medical assistance is protected by statute."

***

""Community" means the place of residence of an individual receiving long-term care services that is not a nursing facility or a medical facility."

***

""Family" means any persons requesting or receiving medical assistance, any legally responsible parents or spouses, and any other legally responsible persons residing in the same household."

""Health plan contract period" means the period of time under which a health plan is continuously operating under a contract including amendments without a new procurement.""

***

""Income" means any monies received by an individual or family during a given month."

""Institutionalized individual" means an individual who is or is likely to be an inpatient at a medical facility receiving nursing facility level of care, or an inpatient at a nursing facility for a continuous period of institutionalization, or a recipient of home and community based services."

***

""Medical facility" means a facility which:

(1) Is organized to provide medical care, including nursing and convalescent care;

(2) Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of the patients on a continuing basis in accordance with accepted standards;

(3) Is authorized under State law to provide medical care; and

(4) Is staffed by professional personnel who have clear and definite responsibility to the institution in the provision of professional medical and nursing services including adequate and continual medical care and supervision by a physician; sufficient registered nurse or licensed practical nurse supervision and services and nurse aid services to meet nursing care needs; and appropriate guidance by a physician on the professional aspects of operating the facility."

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25. Section 17-1721.1-2, Hawaii Administrative Rules, is amended by deleting the definitions "Effective date of coverage", "Personal reserve standard" and "Primary care services".

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[""Effective date of coverage" means the date on which eligibility is determined by the department and may precede the date upon which the health plan receives notification of enrollment."]

***

[""Personal reserve standard" means the maximum amount of countable assets that may be held by an individual or family while establishing or maintaining eligibility for medical assistance."]

[""Primary care services" means the provision of integrated, accessible health services by clinicians and providers of health care services who are accountable for addressing a broad spectrum of an individual's health care needs (including physical, mental and emotional)."]

***

[Eff 01/31/09; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25; 440.255; P.L. 109-171; P.L. 111-148; SLH 2011 Act 220)

26. Section 17-1721.1-16, Hawaii Administrative Rules, is amended to read as follows:

"§17-1721.1-16 Individuals eligible for QExA. The following individuals shall be eligible for QExA:

(1) An aged, blind or disabled individual who meets the provisions of chapter 17-1721;
(2) A blind or disabled individual who meets the provisions of subchapter 2 [and] of chapter 17-1722;
(3) An aged, blind or disabled individual who meets the provisions of subchapter 3 of chapter 17-1722

[(3)](4) An aged individual who meets the provisions of subchapter 6 of chapter 17-1722;

(5) An aged, blind or disabled individual who meets the provisions of subchapter 8 of chapter 17-1722

[(4)](6) A blind or disabled child who meets the provisions of subchapter 10 of chapter 17-1722;

[(5)](7) An aged, blind or disabled individual who meets the provisions of subchapter 13 of chapter 17-1722;

[(6)](8) A blind or disabled immigrant child who meets the provisions of chapter 17-1722.1;

[(7)](9) A blind or disabled pregnant immigrant woman who meets the provisions of chapter [17-1721.2;] 17-1722.2;

[(8)](10) An aged, blind or disabled individual who meets the provisions of subchapter 3 of chapter 17-1723;

[(9)](11) A blind or disabled child or pregnant woman who meets the provisions of chapter 17-1732;

[(10)](12) [Individuals] An individual [found eligible under] who meets the provisions of chapter 17-1733; and

[(11) Individuals found eligible under the provisions of chapter 17-1734.]

(13) An aged, blind or disabled individual who meets the provisions of subchapter 3 of chapter 17-661."[Eff 01/31/09; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

27. Section 17-1721.1-17, Hawaii Administrative Rules, is amended to read as follows:

"§17-1721.1-17 Enrollment. (a) An individual eligible to participate in QExA shall be enrolled in a health plan.

(b) The department may enroll an eligible individual in a health plan for purposes of providing the individual with covered services [during the period between] effective the date the individual is determined eligible for QExA as described in section 17-1721.1-19(a). [and the date that the individual

selects or is assigned to a health plan pursuant to subsections (c) and (d).]

(c) After being [found] determined eligible for coverage under QExA, an individual shall be:

(1) Assigned to a health plan;

(2) Sent an enrollment letter identifying the assigned plan and the option to remain in the assigned plan or to select a different health plan; and

(3) [allowed] Allowed fifteen days [after] from the date of the enrollment letter to select from among the participating health plans available in the service area in which the individual resides[.] that are open to receiving new members.

(d) If an individual does not select a different health plan within fifteen days [after] from the date of the enrollment letter, enrollment shall continue in [a] the health plan [shall be] assigned by the department[.] and the enrollee shall be informed of the ninety-day grace period to change health plans.

(e) If an individual selects a different health plan within fifteen days, on the first day of the following month [A] a confirmation notice of their plan of choice [will] with a ninety-day grace period to change plans shall be mailed to the [individual once the individual is enrolled in a health plan] enrollee.

(f) [After selecting or being assigned to a health plan,] If a selection is made to reenroll into a previously enrolled health plan, [an] the enrollee shall [have a ninety-day grace period] not be allowed to change health plans until the next annual plan change period except as provided under subsection (g).

(g) Except for changes made by an enrollee during the ninety-day grace period, an enrollee shall only be allowed to change enrollment from one health plan to another that is open to receiving new members during the annual plan change period. The exceptions to this provision include:

(1) [Change in residence by an] Relocation of the enrollee [from one] to a service area where the health plan does not provide service; [to another:

(A) In this event the individual or family shall be allowed fifteen days after the

date of the enrollment letter to select a health plan servicing the new service area in which the individual resides.

(B) If a selection is not made within fifteen days after the date of the enrollment letter, the individual shall remain enrolled in their current health plan, provided that health plan services that area.]

(2) Member's PCP or long-term care residential facility is not in the health plan's provider network and is in the provider network of a different health plan provided the health plan is not at its maximum enrollment;

(3) Member is eligible to receive HCBS or personal assistance services level I and is enrolled in a health plan with a waiting list for HCBS or personal assistance services level I and the other health plan does not have a waiting list for the necessary service(s);

(4) The individual has missed the annual plan change period due to temporary loss of Medicaid eligibility and been reenrolled in their previous health plan;

(5) The enrollee chooses a health plan during the annual plan change period and that health plan is capped;

[(2)](6) Decisions from administrative hearings;

[(3)](7) Provisions in federal or state statutes or administrative rules;

[(4)](8) Legal decisions;

[(5)](9) Change in foster placement [or subsidized adoption] if it is in the best interest of the child;

[(6)](10) The health plan's refusal, because of moral or religious objections, to cover the service the enrollee seeks as allowed for in the department's contract with the health plan;

[(7)](11) The enrollee's need for related services (i.e. a cesarean section and a tubal ligation) to be performed at the same time and not all related services are available within the network and the enrollee's PCP or

another provider determines that receiving the services separately would subject the enrollee to unnecessary risk;

[(8)](12) Termination of the enrollee's health plan's contract as specified in section 17-1721.1-70 or the start of a new contract;

[(9)](13) Mutual agreement by the health plans involved, the enrollee, and the department;

[(10)](14) Violations by a health plan as specified in [sections] section 17-1721.1-69[and 17-1721.1-70];

[(11)](15) Lack of direct access to women's healthcare specialists for breast cancer screening, pap smears and pelvic exams;

[(12)](16) Other reasons, including but not limited to, poor quality of care, lack of access to covered services, or lack of access to providers experienced in dealing with the enrollee's healthcare needs, lack of direct access to certified nurse midwives, pediatric nurse practitioners, family nurse practitioners, if available in the geographic area in which the enrollee resides; or

[(13)](17)Other special circumstances as determined by the department."

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[Eff 01/31/09; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25; 431.51)

28. Section §17-1721.1-18 Hawaii Administrative Rules, is amended by amending subsection (a) to read as follows:

"§17-1721.1-18 Annual plan change period. (a) Except as limited by section 17-1721.1-6, an enrollee shall be allowed to change enrollment from one health plan to another health plan within the service area in which the enrollee resides that is open to receiving new members during the annual plan change period."

***

[Eff 01/31/09; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25; 431.51)

29. Section §17-1721.1-19 Hawaii Administrative Rules, is amended to read as follows:

"§17-1721.1-19 Effective date of enrollment. (a) For individuals newly approved for coverage and eligible prospectively, the effective date of enrollment shall be one of the following:

(1) The date [of] the application is received by the department;

(2) Any date specified by the individual on which appropriate Medicaid eligible services were incurred and is no earlier than the first day of the [three months] third month prior to the month [of] the application[; or] is received by the department for individuals applying for the coverage of long-term care services or the immediate five calendar days prior to the date the application is received by the department for all other individuals; or

(3) The date when all eligibility requirements are met by the applicant.

(b) The effective date of retroactive enrollment shall not be earlier than the start date of the health plan contract period in which an eligibility determination is made.

[(b)](c) The effective date of enrollment resulting from a change from one health plan to another during the annual plan change period shall generally be the first day of the second month after the annual plan change period ends.

[(c)](d) The effective date of enrollment resulting from a change from one health plan to another, other than during the annual plan change period, shall be one of the following:

(1) The first day of the month following the date on which the department authorizes the enrollment change.

(2) If an enrollee changes residence from one service area to another, the date the enrollment process has been completed to enroll an individual in a health plan in the new service area.

[(d)](e) The effective date of enrollment resulting from a change from QUEST, QUEST-Net, or

QUEST-ACE to a QExA health plan is the QExA eligibility start date. An exception to this provision is for an individual who attains the age of sixty-five. The effective date of enrollment in a QExA plan is the first day of the month the individual becomes age sixty-five."

[(e)](f) The effective date of enrollment for a newborn of a QExA recipient is as follows:

(1) A newborn who is not blind or disabled shall receive coverage [on a fee-for-service basis] through enrollment into a QUEST plan effective the date of birth[to the date the enrollment process has been completed to enroll the newborn in a QUEST plan], or

(2) [If the] A newborn who is blind or disabled[, the newborn] shall receive coverage under the mother's QExA health plan effective the date of birth until the department notifies the health plan that the newborn is enrolled in a different health plan." [Eff 01/31/09; am 06/11/09; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25; 431.51)

30. Section 17-1721.1-20, Hawaii Administrative Rules, is amended to read as follows:

"§17-1721.1-20 Limitation on health plan enrollment. (a) The department shall review the enrollments of the health plans [On] on the fifteenth day of each month or on the [first] next business day [following] if the fifteenth [in the event the] day falls on a weekend or State holiday[,]. If [the] a health plan has an enrollment that is equal to or exceeding its maximum enrollment allowed for the service area, the department [will] may stop enrollment for that health plan [effective the following] on the next business day. [This] If the department utilizes this provision, it will remain in effect until [the fifteenth of the following month when] the department [will again review] reviews the

enrollment of the health plans[.] on the fifteenth day of the following month. If the enrollment is:

(1) [below] Below the maximum enrollment allowed for the [island] service area, the restriction from enrolling an individual into a health plan will be lifted for the following month.

(2) [If the enrollment is equal] Equal to or exceeds [its] its' maximum enrollment allowed for the [island] service area, the restriction from enrolling an individual into a health plan will remain in effect.

(b) When a health plan is [restriction] restricted from enrolling an individual, [into a health plan is imposed on a health plan,] the health plan shall not be available as a recipient's selection [or] nor will the department assign an individual into that health plan until the restriction is lifted. The exceptions to this provision are:

(1) Newborns who are eligible for the QExA program and born to a QExA mother who is currently enrolled in a QExA health plan that is at its maximum enrollment, shall be enrolled in the mother's health plan;

(2) Enrollees enrolled in a health plan with a waiting list for HCBS or personal assistance services-level I may enroll in a health plan that has maximum enrollment; and

(3) Enrollees who have lost eligibility for a period of sixty days or less shall be reenrolled into the same health plan, even if that health plan is identified as having maximum enrollment.

(4) If the individual is enrolled in a health plan that has statewide service, the individual can continue to be enrolled in that health plan."

[Eff 01/31/09; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25; 431.51)

31. Section 17-1721.1-37, Hawaii Administrative Rules, is amended to read as follows:

"§17-1721.1-37 Disenrollment of enrollees from health plans. An enrollee may be disenrolled for

reasons that include, but are not limited to, the following:

(1) In compliance with administrative appeal decisions or court orders;
(2) A mutual agreement between the enrollee, the participating health plan involved, and the department;
(3) A voluntary withdrawal from participation in QExA by the enrollee;
(4) The enrollee is a medically needy individual who is two full months in arrears in the payment of the designated enrollment fee, unless the failure to pay occurs because:
    (A) The enrollee is not in control of their personal finances, and the arrearage is caused by the party responsible for the enrollee's finances, and action is being taken to remediate the situation, including but not limited to:
        (i) Appointment of a new responsible party for the enrollee's finances;
        (ii) Recovery of the enrollee's funds from the responsible party which will be applied to the enrollee's enrollment fee obligation;
    (B) The enrollee is in control of their finances, and the arrearage is due to the unavailability of the enrollee's funds due to documented theft or financial exploitation, and action is being taken to:
        (i) Ensure that theft or exploitation does not continue;
        (ii) Recover the enrollee's funds to pay the enrollee's enrollment fee obligation;
(5) The enrollee no longer meets QExA eligibility requirements;
(6) Death of the enrollee;
(7) Incarceration of the enrollee;
(8) The enrollee enters the Hawaii State hospital;

[(9) The enrollee becomes a Program of All-Inclusive Care for the Elderly (PACE) participant;

(10)](9) The enrollee enters the State of Hawaii organ and tissue transplant (SHOTT) program;

[(11)](10) The enrollee is in foster care or a subsidized adoption agreement and has been moved out-of-state by the department;

[(12)](11) The enrollee provides false information with the intent of enrolling in the QExA program under false pretenses;

[(13)](12) The enrollee chooses another health plan during the annual plan change period and that health plan is not capped;

[(14)](13) The enrollee is enrolled in a health plan with a waiting list for HCBS or personal assistance level I and the other health plan does not have a waiting list for the necessary service(s);

[(15)](14) The enrollee's long-term care residential facility is not in the health plan's provider network and is in the provider network of a different health plan, provided the health plan is not at its maximum enrollment; or

[(16)](15) The enrollee's PCP is not in the health plan's provider network and is in the provider network of a different health plan, provided the health plan is not at its maximum enrollment." [Eff 01/31/09; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

32. Section 17-1721.1-51, Hawaii Administrative Rules, is amended to read as follows:

"§17-1721.1-51 [Standard] QExA benefits package. (a) Each of the participating health plans shall be required to provide [a standard benefits package that minimally includes services identified in sections 17-1721.1-52, 17-1721.1-53, 17-1721.1-54, and 17-1721.1-

55.] medical services as defined in the contract between a participating health plan and the department.

(b) The benefits minimally required to be provided by each of the participating health plans shall be known as the QExA benefits package.

(c) Participating health plans shall be required to provide a QExA benefits package that minimally includes services identified in sections 17-1721.1-52, 17-1721.1-53, 17-1721.1-54 and 17-1721.1-55.

[(c)](d) The health plan shall coordinate services listed in section 17-1735-3(b) as appropriate.

[(b)](e) A participating health plan may, at the health plan's option, or as otherwise required by the contract between the health plan and the department or a waiver to the state plan, provide benefits which exceed the requirements of the [standard] QExA benefits package." [Eff 01/31/09; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

33. Section 17-1721.1-52, Hawaii Administrative Rules, is amended by amending subsection (b) and (c) to read as follows:

"§17-1721.1-52 Primary and acute care services to be provided by participating health plans. ***

(b) Participating health plans shall provide medically necessary preventive, psychiatric, diagnostic, and treatment services which minimally include, but are not limited to, the following:

(1) Inpatient hospital services for medical, surgical, rehabilitative, maternity, and newborn care, including room and board, nursing care, medical supplies, equipment, drugs, diagnostic services, physical and occupational therapy, speech and language pathology, and other medically necessary services;
(2) Outpatient hospital services, including emergency room services, post stabilization services, ambulatory surgery, urgent care

services, medical supplies and equipment, drugs, diagnostic services, therapeutic services such as chemotherapy and radiation therapy, and other medically necessary services;

(3) Preventive services, including initial and interval histories, physical examinations and developmental assessments, immunizations, diagnostic and screening laboratory and radiology services. Other [preventative] preventive services [includes] include screening (blood pressure measurement, weight-height measurement, total cholesterol measurement, tuberculosis, and screening for breast, cervical, colorectal, and prostate cancer), rubella serology or vaccine history, health education and counseling, and chemoprophylaxis;

(4) Preventive services for children, including newborn screening, hospital stays for normal, term, healthy newborns for up to forty-eight hours after normal vaginal delivery or up to ninety-six hours after cesarean section delivery, other age appropriate laboratory screening tests, screening to assess health status, tuberculin skin testing, immunizations, age appropriate dental referral and oral fluoride, and age appropriate health education;

(5) Prescribed drugs, blood, and blood products in accordance with the health plan's own formulary or prior authorization by the health plan[.];

(6) Radiology, laboratory, and other diagnostic services including imaging, screening mammograms, screening and diagnostic laboratory tests, therapeutic radiology, and other medically necessary diagnostic services;

(7) Physician services, including services of psychiatrists provided at locations including, but not limited to, a physician's office, clinic, private home, licensed

hospital, licensed nursing facility, or a licensed or certified residential setting;

(8) Maternity services such as prenatal visits and laboratory screening tests, health education and screening, diagnosis of premature labor, diagnostic amniocentesis, diagnostic ultrasound, fetal stress, and non-stress testing, treatment of missed, threatened, incomplete and elective abortions, hospital stays for delivery of infants, postpartum care, and prenatal vitamins including folic acid;

(9) Medical services related to dental needs that are provided in an inpatient hospital or ambulatory surgery center, including but not limited to referrals, follow-up, coordination and provision of appropriate medical services[.]<u>;</u>

(10) Other practitioner services including podiatrists, optometrists, psychologists, certified nurse midwives, licensed advanced practice registered nurse services (including family, pediatric, geriatric, and psychiatric health specialists), and other health care professionals licensed or certified by the State;

(11) Personal assistance services - level I shall include one or more of the following activities:

(A) Routine housecleaning such as sweeping, mopping, dusting, making beds, cleaning the toilet and shower or bathtub, taking out rubbish;

(B) Care of clothing and linen by washing, drying, ironing, mending;

(C) Marketing and shopping for household supplies and personal essentials;

(D) Light yard work such as mowing the lawn, raking the lawn, trimming hedges, bundling rubbish for refuse collection;

(E) Simple home repairs such as mending screens, replacing light bulbs,

replacing light fixtures, fixing leaky faucets, clearing stopped-up drains;

(F) Preparing meals;

(G) Running errands such as paying bills, picking up medication, escorting the recipient to medical care services, nutritional or recreational programs; or

(H) Assistance with bathing, dressing, grooming.

Maximum enrollment and number of weekly hours for personal assistance level [-] I services may be limited by the department[.];

(12) Rehabilitation services include physical therapy, occupational therapy, speech and language pathology, and audiology services, and other medically necessary therapeutic services;

(13) Cognitive [Rehabilitation] rehabilitation services are provided to cognitively impaired persons that assess and treat communication skills, cognitive and behavioral ability, and cognitive skills related to performing activities of daily living (ADL);

(14) Durable medical equipment, prosthetic devices, orthotics, and medical supplies including, but not limited to, oxygen tanks, oxygen concentrators, eyeglasses, ventilators, wheelchairs, crutches, canes, braces, hearing aids, pacemakers, and other medically necessary appliances, supplies, and artificial aids;

(15) Home health services are part-time or intermittent care for enrollees who do not require hospital care. This service is provided under the direction of a physician in order to prevent re-hospitalization or institutionalization. The home health service provider must meet Medicare requirements. Medicaid services provided to

enrollees receiving Medicare home health services that are duplicative of Medicare home health benefits (i.e., physical therapy and home health aides) will not be covered. Home health services include skilled nursing, home health aides, therapeutic services (physical and occupational therapy, audiology and speech-language pathology), medical supplies and equipment, and other medically necessary home health services;

(16) Hospice services [is a program that provides care] provided to terminally ill patients who have six months or less to live. A hospice provider must meet Medicare requirements. Medicaid will not cover hospice services that an enrollee is receiving from Medicare. Only when the service need is not related to the hospice diagnosis can the service be covered by Medicaid[.]except when the individual is under age twenty-one years;

(17) Organ and tissue transplant services, including cornea[, kidney] and, if a Medicare beneficiary, kidney transplant [allogenic and bone marrow];

(18) Transportation services [include] including both emergency and non-emergency ground and air services. Transportation shall be provided to and from medically necessary medical appointments for enrollees who have no means of transportation, who reside in areas not served by public transportation, or cannot access public transportation due to their disability. Transportation shall be provided to enrollees who are referred to a provider that is located in a different service area. Whatever modes of transportation that are available and can be safely utilized by the enrollee can be used. In cases where the enrollee requires assistance, an attendant may accompany the enrollee to and from medically necessary

visits to providers. The health plan is responsible for the arrangement and payment of the travel costs for the enrollee and the attendant and the lodging and meals associated with off-island or out-of-state travel;

(19) Sterilizations for both men and women only if all of the following requirements are met for the enrollee:
   (A) At least twenty-one years of age at the time consent is obtained;
   (B) Mentally competent;
   (C) Voluntarily gives informed consent by completing the informed consent for sterilization form DHS 1146;
   (D) The provider completes form DHS 1146;
   (E) At least thirty days, but not more than one-hundred eighty days, have passed between the date of informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery; and
   (F) An interpreter is provided when language barriers exist[.];

(20) Additional requirements for sterilizations for women at the time of premature delivery or emergency abdominal surgery. At least seventy-two hours must have passed since informed consent for sterilization was signed. In the case of premature delivery, the informed consent must have been given at least thirty days before the expected date of delivery (the expected date of delivery must be provided on the consent form). Arrangements are to be made to effectively communicate the required information to an enrollee who is visually impaired, hearing impaired or otherwise disabled. The enrollee shall not be institutionalized in a correctional facility, mental hospital or other rehabilitative facility;

(21) Hysterectomies are a covered service when:

(A) The enrollee voluntarily gives informed consent by completing the hysterectomy acknowledgement form DSSH 1145;

(B) Has been informed orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing (this is not applicable if the individual was sterile prior to the hysterectomy or in the case of an emergency hysterectomy); and

(C) The enrollee has signed and dated a "patient's acknowledgement of prior receipt of hysterectomy information form" prior to the hysterectomy.

Regardless of whether the requirements listed above are met, a hysterectomy shall not be covered under the following circumstances:

(A) It is performed solely for the purpose of rendering [a] an enrollee permanently incapable of reproducing;

(B) There is more than one purpose for performing the hysterectomy but the primary purpose is to render the enrollee permanently incapable of reproducing; or

(C) It is performed for the purpose of cancer prophylaxis;

(22) Urgent care services [is] including the diagnosis and treatment of medical conditions which are serious or acute but pose no immediate threat to life and health but which require medical attention within twenty-four hours[.];

(23) Vision services including vision examinations[,]; ophthalmic examination with refraction[,]; prescription lenses[,] and contact lenses, which may be subject to limitations; cataract removal; and prosthetic eyes;

(24) Services federally mandated by the Early and

Periodic [Diagnosis,] Screening, Diagnosis and Treatment Program [(EPDST)] (EPSDT);

(25) Behavioral health services including preventive, diagnostic, therapeutic, and rehabilitative services, and subject to the limitations set forth in section 17-1721.1-53, including but not limited to:
   (A) Twenty-four hour care for acute psychiatric illnesses;
   (B) Ambulatory services, with crisis services available twenty-four hours a day, seven days a week;
   (C) Acute day hospital and partial hospitalization;
   (D) Health plans are not required to provide behavioral health services to enrollees whose services are not medically necessary or who have been criminally committed for evaluation or treatment in an inpatient setting under HRS chapter 706; and
   (E) Behavioral health services for individuals with serious and persistent mental illness or with severe emotional behavioral disorders may be provided pursuant to section 17-1721.1-53[.];

(26) Substance abuse services including preventive, diagnostic, therapeutic, and rehabilitative services, and including methadone[-] or levo-alpha-acetyl-methadol (LAAM) services for acute opiate detoxification and maintenance. The health plan may utilize community-based substance abuse treatment programs that are accredited and monitored by the alcohol and drug abuse division (ADAD); and

(27) Family planning service including services to enrollees wishing to prevent pregnancies, plan the number of pregnancies, plan the spacing between pregnancies, or obtain confirmation of pregnancy. These services shall include, at a minimum, education and

counseling necessary to make informed choices and understand contraceptive methods; emergency contraception; follow-up, brief and comprehensive visits; pregnancy testing; contraceptive supplies and follow-up care; diagnosis and treatment of sexually transmitted diseases; and infertility assessment.

(c) Emergency and post stabilization services. The health plan shall provide emergency services twenty-four hours a day, seven days a week to treat an emergency medical condition.

(1) Emergency services shall be covered when furnished by a qualified provider, even if the provider is not in the health plan's network.

(2) Emergency services shall not be subject to prior authorization.

(3) The emergency room physician or other provider that is qualified to furnish such services actually treating the enrollee is responsible for determining when an enrollee is sufficiently stabilized for transfer or discharge, which decision is binding upon the health plan. If agreed to by the hospital, the health plan may send one of its own physicians with appropriate emergency room privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the enrollee, provided that such arrangement does not delay the provision of medical services.

(4) The health plan shall cover emergency services when the enrollee's PCP or other health plan representative instructs the enrollee to seek emergency services, without regard to whether the condition meets the prudent layperson standard.

(5) Inpatient and outpatient post-stabilization services related to an emergency medical condition for purposes of maintaining the stabilized condition or, as prescribed in

42 CFR §438.114, to improve or resolve the enrollee's condition, shall be provided twenty-four hours a day, seven days a week.

(6) Post-stabilization services are not subject to prior authorization or pre-certification by an in-network provider or health plan representatives, regardless of whether the services are provided within or outside the health plan's network of providers, if:

(A) The health plan does not respond to the provider's request for pre-certification or prior authorization within one hour;

(B) The health plan cannot be contacted;

(C) The health plan's representative and the enrollee's attending physician cannot reach an agreement concerning the enrollee's care and a health plan physician is not available for consultation[.];

(D) The health plan must give the attending physician the opportunity to consult with an in-network physician and the attending physician may continue with care of the enrollee until a health plan physician is reached or the health plan's responsibility for post-stabilization services that it has not approved ends because:

(i) An in-network provider with privileges at the treating hospital assumes responsibility for the enrollee's care;

(ii) An in-network provider assumes responsibility for the enrollee's care through transfer of the enrollee to another hospital;

(iii) The health plan's representative and the attending physician reach an agreement concerning the enrollee's care; or

(iv) The enrollee is discharged."

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[Eff 01/31/09; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

34. Section 17-1721.1-54, Hawaii Administrative Rules, is amended by amending subsection (d) to read as follows:

"§17-1721.1-54 Home and community based services (HCBS). ***

(d) The following are HCBS covered services as described in the QExA program:

(1) Adult day care services provided by a licensed facility maintained and operated by an individual, organization, or agency for the purpose of providing regular supportive care to four or more disabled adult participants, with or without charging a fee. Adult day care services include therapeutic, social, educational, recreational, and other activities. Adult day care staff members may not perform healthcare related services such as medication administration, tube feedings, and other activities which require healthcare related training;

(2) Adult day health services provided by an organized program of therapeutic, social and health activities and services provided to enrollees with functional impairments, for the purpose of restoring or maintaining the individual's optimal capacity for self-care. Adult day health facilities are licensed in accordance with chapter 11-96 and [section 11-94-5] subchapter 2 of chapter 11-94.1;

(3) Assisted living services are services that include personal care and supportive care services (such as homemaker services, chore[,] services, attendant services, meal preparation) that are furnished to enrollees who reside in an assisted living facility. Payment for room and board is prohibited;

(4) [Pediatric attendant] Attendant care services [is the] means hands-on care, both supportive and health-related in nature, provided to medically fragile children. The service includes enrollee supervision specific to the needs of a medically stable, physically handicapped child. Attendant care may include skilled nursing care to the extent permitted by law. Housekeeping activities that are incidental to the performance of care may also be furnished as part of this activity. Supportive services, a component of attendant care, are those services that substitute for the absence, loss, [dimunition] diminution, or impairment of a physical or cognitive function;

(5) Community care management agency (CCMA) services are provided by a person, agency, or organization that is licensed by the department to locate, coordinate, and monitor comprehensive services to meet the needs of enrollees whom the case management agency serves in community care foster family homes or enrollees in expanded adult residential care homes, or assisted living facilities. CCMA's provides activities, to include but not limited to, continuous and ongoing nurse delegation to the caregiver in accordance with chapter 16-89 subchapter 15, initial and ongoing assessments to make recommendations to for, at a minimum, indicated services, supplies, and equipment needs of enrollees, ongoing face-to-face monitoring and implementation of the enrollee's care plan, and interaction with the caregiver on adverse effects and changes in condition of enrollees. CCMAs shall:

(A) [communicate] Communicate with an enrollee's physician regarding the enrollee's needs including changes in medication and treatment orders;

(B) Work with an [enrollees] enrollee’s family regarding service needs of an enrollee;
(C) Serve as an advocate for the enrollee;
(D) Train caregivers on specific care requirements to ensure care is delivered correctly; and
(E) Be accessible to the enrollee’s caregiver twenty-four hours a day, seven days a week;

(6) Community care foster family [homes] home (CCFFH) services are services provided in a home that is certified by the department to provide, for a fee, twenty-four[-] hour living accommodations, including personal care, [homemaker services,] supportive services[,](such as homemaker services, chore[,] services and attendant care and companion services) and medication oversight (to the extent permitted under State law). Services shall be provided in a certified private home by a principal care provider who lives in the home for not more than three adults at any one time, at least two of whom shall be Medicaid recipients, and all of whom are at nursing facility level of care, are unrelated to the foster family, and are being monitored in the home by a licensed community care management agency. It does not include expanded adult residential care homes and assisted living facilities, which shall continue to be licensed by the department of health;

(7) Counseling and training services involve counseling for the enrollee, family or caregiver, and professional and paraprofessional caregivers to provide the necessary support to build and enhance coping skills, as well as training that may include, but not limited to, enrollee care training for enrollees, family and caregivers regarding the nature of the

disease and the disease process; methods of transmission and infection control measures; biological, psychological care and special treatment needs-regimens; employer training for consumer directed services; instruction about the treatment regimens; use of equipment specified in the service plan; employer skills updates as necessary to safely maintain the individual at home; crisis intervention; supportive counseling; family therapy; suicide risk assessments and intervention; death and dying counseling; anticipatory grief counseling; substance abuse counseling; and nutritional assessment and counseling;

(8) Environmental accessibility adaptations are changes to the enrollee’s living environment, but not including community care foster family homes and expanded adult residential care homes (E-ARCH), to promote safety or facilitate the enrollee's self-reliance by enabling the enrollee to perform basic activities of daily living. Modifications may include installation of ramps and handrails, widening of doorways, removal of other architectural barriers, bathroom modifications, electrical, plumbing or air conditioners and modifications to the telephone system which enable the individual to function with greater independence in the home, and without which the enrollee would require institutionalization. Window air conditioners may be installed when it is necessary for the health and safety of the enrollee. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefit to the enrollee, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from this benefit. All services

shall be provided in accordance with applicable State or local building codes;

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

(10) Home delivered meals are nutritionally sound meals delivered to a location where an individual resides (excluding residential or institutional settings). The meals will not replace or substitute for a full day's nutritional regimen (i.e., no more than two meals per day). Home delivered meals are provided to individuals who cannot prepare nutritionally sound meals without assistance and are determined, through an assessment, to require the service in order to remain independent in the community and to prevent institutionalization;

(11) Home maintenance is a service necessary to maintain a safe, clean and sanitary environment. Home maintenance services are those services not included as a part of personal assistance and include heavy duty cleaning, which is utilized only to bring a home up to acceptable standards of cleanliness at the inception of service to an enrollee, minor repairs to essential appliances limited to stoves, refrigerators, and water heaters, and fumigation or extermination services. Home maintenance is provided to individuals who cannot perform cleaning and minor repairs without assistance and are determined, through an

assessment, to require the service in order to prevent institutionalization;

(12) Medically fragile day care is a non-residential service for children who are medically or technology dependent, or both. The service includes activities focused on meeting the psychological as well as the physical, functional, nutritional and social needs of children. Services are furnished four or more hours per day on a regular scheduled basis for one or more days per week in an outpatient setting encompassing both health and social services needed to ensure the optimal function of the individual;

(13) Moving assistance is provided in rare instances when it is determined through an assessment that an individual needs to relocate to a new home. The following are the circumstances under which moving assistance can be provided to an enrollee: unsafe home due to deterioration; the individual is wheel-chair bound living in a building with no elevator; multi-story building with no elevator, where the enrollee lives above the first floor; enrollee is evicted from their current living environment; or the enrollee is no longer able to afford the home due to a rent increase. Moving expenses include packing and moving of belongings. Whenever possible, family, landlord, community and third party resources who can provide this service without charge will be utilized;

(14) Non-medical transportation is the necessary transportation provided to and from facilities, resources, and appointments in order for the enrollee to receive the services included in the plan of care;

(15) Personal assistance service - level II is the assistance with activities of daily living such as ambulation, mobility,

transfer and lifting, positioning and turning, bowel and bladder care, toileting, bathing, dressing, grooming, feeding, exercise and range of motion, and assisting with medications which are normally self-administered; and instrumental activities of daily living which are directly related to the wellbeing of the enrollee, such as meal preparation, bed, kitchen and bathroom cleanliness, essential errands, and maintenance of health records;

(16) Personal emergency response system is an electronic system placed in homes of high risk enrollees who live alone or are alone significant parts of the day, have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision, to enable them to secure immediate help in the event of a physical, emotional, or environmental emergency;

(17) Private duty nursing is the provision of skilled nursing services including, but not limited to:

(A) Observation and assessment of the enrollee’s changing condition;
(B) Enrollee education;
(C) Skilled rehabilitation services;
(D) Intravenous, intramuscular or subcutaneous injections and intravenous feedings;
(E) Tube feedings;
(F) Nasopharyngeal and tracheostomy aspiration;
(G) Insertion, sterile irrigation and replacement of catheters;
(H) Application of dressings involving prescriptive medicines and aseptic techniques;
(I) Treatment of extensive decubitus ulcers or other widespread skin disorders;

(J) Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by a nurse to adequately evaluate the enrollee's progress;

(K) Initial phases of a regimen involving administration of oxygen therapy nebulizer; and

(L) Rehabilitation nursing procedures including the related teaching and adaptive aspects of nursing that are part of active treatment;

(18) Respite care is temporary institutional, community or home-based services needed to allow persons, who ordinarily care for the enrollee, relief from these duties; and

(19) Specialized medical equipment and supplies entails the purchase, rental, lease, warranty costs, installation, repairs and removal of devices, controls, or appliances, specified in a plan of care, that enable individuals to increase or maintain their abilities to perform activities of daily living, or to perceive, control, participate in, or communicate with the environment in which they live." [Eff 01/31/09; am] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§430.25, 435.232, 440.180)

35. Section 17-1721.1-56, Hawaii Administrative Rules, is amended to read as follows:

"§17-1721.1-56 Dental Services. (a) [Dental services are not covered through a health plan, but are provided to enrollees by the department on a fee-for-service basis.] All required preventive dental services and all medically necessary dental services, as described in section 17-1737-75(b), shall be provided to an individual under age twenty-one years.

(b) An individual age twenty-one years and older, who is eligible for QExA shall have coverage provided in accordance with section 17-1737-75(d).

(c) The dental services described in subsections (a) and (b) shall be provided on a fee-for-service basis.

(d) The health plans shall coordinate with the department or its designee to refer enrollees to the department's dental third party administrator.
[Eff 01/31/09; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

36. Section 17-1721.1-70, Hawaii Administrative Rules, is amended to read as follows:

"§17-1721.1-70 Termination of contract with participating health plans. (a) The department shall have the authority to terminate the health plan's contract for any or all of the following reasons:

(1) Default by the health plan;
(2) Failure by the health plan to abide by the contract conditions or to meet federal or state statutes;
(3) Convenience;
(4) Expiration of QExA;
(5) Insolvency of or declaration of bankruptcy by the health plan; or
(6) Unavailability of funds.

(b) When termination of contract is due to reasons identified under subsection (a) paragraphs (1) [and] or (2) the department shall provide a hearing for the affected health plan prior to termination of contract.

(c) After the department notifies the health plan of its intent to terminate the contract due to reasons identified under subsection (a) paragraphs (1) [and] or (2), the department may do the following:

(1) Provide the affected enrollees written notice of the department's intent to terminate the contract; and

(2) Allow the affected enrollees to change health plans immediately without cause."
[Eff 01/31/09; am]
(Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25; 438.708)

37. Section 17-1727-2, Hawaii Administrative Rules, is amended by amending the definitions of "Benefit period", "Enrollee", "Family", "Managed care", "Non-returning plan", "Primary care provider", and "[Standard] QUEST benefits package" to read:

""Benefit period" or "benefit year" means the period from the first day of the month following the close of the annual plan change period and extending for a period designated by the department."

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""Enrollee" means an individual who has selected or is assigned by the Department to be a member of a participating health plan."

""Family" means an individual or a group of individuals living in the same household, generally consisting of parents and their natural, adoptive, or hanai children under age nineteen years,[grandparents and their grandchildren under nineteen,] an adult sibling and his or her hanai children under age nineteen years, grandparents and their grandchildren under age nineteen years, an adult sibling and his or her siblings under age nineteen years, a married couple and siblings under age nineteen years of either spouse, an uncle or an aunt and his or her nephews and nieces under age nineteen years, a married couple and their nephews and nieces under age nineteen years, a single adult and his or her first cousins under age nineteen years, married couples and first cousins under age nineteen years of one of the spouses, any combination of the preceding relationships prefixed with grand, great-grand, great, great-great, half, and step."

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""Managed care" means a [method of health care delivery that integrates the financing, administration, and delivery of health services, or a coordinated delivery system made up of pre-established networks of] comprehensive approach to the provision of health care [providers providing a defined package of benefits under pre-established reimbursement arrangements.] that combines clinical services and administrative procedures within an integrated, coordinated system to provide timely access to primary care and other necessary services in a cost effective manner."

""Non-returning plan" means a participating health [coverage carrier] plan that has a current, but no new contract with the department."

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""Primary care provider" or "PCP" means a [physician or a nurse practitioner] provider who is licensed [to practice in the State] in Hawaii and is [contracted by a participating health plan to assess an enrollee's health care needs and provide services to meet those needs either directly or through the plan's provider network. A primary care provider who is a nurse practitioner shall be a family nurse practitioner, pediatric nurse practitioner, or, if the enrollee is a pregnant women, a nurse midwife.] 1) a physician, either an M.D. (doctor of medicine) or a D.O. (doctor of osteopathy), and must generally be a family practitioner, general practitioner, general internist, pediatrician, obstetrician-gynecologist (for women, especially pregnant women), or geriatrician; or 2) an advanced practice registered nurse with prescriptive authority. PCPs have the responsibility for supervising, coordinating and providing initial and primary care to the enrollee and for initiating referrals and maintaining the continuity of the enrollee care."

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""[Standard] QUEST benefits [package] package" means the minimum benefits and services [which] that must be provided by each participating health plan which is contracted under QUEST."

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38. Section 17-1727-2, Hawaii Administrative Rules, is amended by adding new definitions to read as follows:

""Adult" means a person who is age nineteen years or older."
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""Blind" means, in relation to an individual applying for or receiving medical assistance from the department, meeting the Social Security Administration certification requirements for blindness."
""Capitated payment" means a fixed monthly payment paid per person by the department to a participating health plan for which the health plan provides a defined set of benefits."
***
""Child" means a person under age nineteen years."
""Disabled" means, in relation to an individual applying for or receiving medical assistance from the department, meeting the Social Security Administration certification requirements for disability."
***
""Health plan contract period" means the period of time under which a health plan is continuously operating under a contract including amendments without a new procurement.""
***
""Open enrollment" previous known as "annual plan change" means a period when an eligible individual is allowed to change from one to another participating health plan."
***

39. Section 17-1727-2, Hawaii Administrative Rules, is amended by deleting the definitions "Capitated rate", "Catastrophic coverage", "Date of approval", "Effective date of coverage", "Emergency medical condition", "Emergency services", "Hawaii QUEST or QUEST", "Premium-share", "Prudent layperson",

"Prudent layperson standard", "QUEST-related program", "Spend-down" and "Unadjusted contracted rate":

***

[""Capitated rate" means the fixed monthly payment per person paid by the State to a medical, behavioral or catastrophic coverage plan."]

[""Catastrophic coverage" means the coverage purchased to protect the State when eligible medical costs incurred by recipients exceed a specified dollar threshold which is determined by contractual agreement between the department and the medical plan."]

[""Date of approval" means the date on which the department completes the administrative process to certify that an individual or a family is eligible for QUEST."]

[""Effective date of coverage" means the date on which eligibility is determined by the department and may precede the date upon which the health plan receives notification of enrollment."]

[""Emergency medical condition" means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possess an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(1) Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(2) Serious impairment to body functions; or

(3) Serious dysfunction of any bodily organ or part."]

[""Emergency services" means covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition that is found to exist using a prudent layperson standard."]

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[""Hawaii QUEST or QUEST" means the demonstration project developed by the department which will deliver medical and behavioral health services through health plans employing managed care concepts to certain individuals formerly covered by public assistance programs including the Aid to Families with Dependent

Children (AFDC) related medical programs, General Assistance (GA), and the State Health Insurance Program (SHIP)."]

[""Premium-share" means the unadjusted contracted rate, plus that of catastrophic coverage, that certain individuals, based on their income, are required to remit to the department to be eligible to be enrolled in a participating health plan."]

[""Prudent layperson" means one who possesses an average knowledge of health and medicine."]

[""Prudent layperson standard" refers to the determination of a emergency medical condition based on the judgment of a prudent layperson."]

[""QUEST-related program" means a medical assistance program that is related to Hawaii QUEST, to include, QUEST-Net, QUEST-Spenddown, and AFDC Transitional Medical Coverage."]

[""Spend-down" means the monthly process by which an individual's or family's income in excess of the medically needy standard is applied toward incurred medical expenses until the net income no longer exceeds the medically needy standard resulting in eligibility for medical assistance."]

[""Unadjusted contracted rate" means the monthly payment paid by the State to a participating health plan for each member assuming the application of risk adjustments across the entire population."]
[Eff 08/01/94; am 07/20/95; am 01/29/96; am 03/30/96; am 07/06/99; am 06/19/00; am 10/26/01; am 12/03/01; am 02/16/02; am 08/19/11; am] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §346-14)

40. Section 17-1727-4, Hawaii Administrative Rules, is amended to read as follows:

"§17-1727-4 Choice of participating health plans. (a) An eligible individual shall be allowed to choose from among the participating [medical] health plans which service the geographic area in which the individual resides. This provision shall not apply to an individual identified in subsection [(b)] c.

(b) If a health plan has reached its maximum enrollment, the eligible individual shall select

another health plan that is available. If only one other health plan is available to new members, subsection (c) shall apply.

[(b)] (c) In the absence of a choice of health [plan] plans in a service area, an eligible individual who resides in that particular service area shall be enrolled in the participating [medical] health plan that is accepting new members." [Eff 08/01/94; am 02/16/02; am 05/10/03; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 430.51)

41. Section 17-1727-5, Hawaii Administrative Rules, is repealed:

["§17-1727-5 Assigned enrollment in participating health plans. (a) An eligible individual shall be allowed ten days to select an available medical plan in which to enroll. This provision shall not apply to an individual identified in subsection (c).

(b) If timely selection among available health care plans is not made, the department shall assign the enrollment of the individual to a health plan.

(c) In the absence of a choice of plan in a service area an eligible individual who resides in that particular service area shall be enrolled in the participating medical plan."] [Eff 08/01/94; am 02/16/02; am 05/10/03; R] (Auth: HRS §346-14) (Imp: HRS §346-15; 42 C.F.R. §§430.25, 430.51)

42. Section 17-1727-11, Hawaii Administrative Rules, is amended to read as follows:

"§17-1727-11 Purpose. This subchapter describes the eligibility requirements for participation in the QUEST [and receipt of health care services through participating health plans.] program." [Eff 08/01/94;

am 01/29/96; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

43. Section 17-1727-12, Hawaii Administrative Rules, is amended to read as follows:

"§17-1727-12 Non-financial eligibility requirements. (a) Applicants and recipients shall meet the basic eligibility requirements, which include but are not limited to, U.S. citizenship or legal resident alien status, state residency, not residing in a public institution, and provision of social security number, as described in chapter 17-1714.

[(b) A pregnant woman shall be medically verified as pregnant by a medical professional authorized under State law to make such a determination, to include midwives, with an estimated date of delivery.

(c)](b) A [pregnant] woman who self-attests that she is pregnant is not required to assist the State in establishing paternity for purposes of her eligibility. [Eff 08/01/94; am 05/10/03; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

44. Section 17-1727-13, Hawaii Administrative Rules, is amended to read as follows:

"§17-1727-13 Categorical requirements. Persons who are ineligible to participate in QUEST include the following groups of individuals.

(1) Persons who are age sixty-five or older.
(2) Persons who are blind or disabled according to the criteria employed by the Social Security Administration.
(3) Persons who are age nineteen years and older and not identified under subparagraph (A) [but under age sixty-five, employed, and receive or are eligible to receive employer sponsored health care coverage through their employer.].

[(A) This provision applies to affected employed persons and not to their dependent family members.

(B)](A) This provision [does] shall not apply to [individuals]:

(i) Individuals and families covered under the provisions of section 1931 of the Social Security Act as described in chapter 17-1726[, GA recipients of financial assistance as described in section 17-1727-15, recipients of];

(ii) Individuals and families covered under the provisions of transitional medical assistance as described in chapter 17-1726[, and pregnant];

(iii) Pregnant women[.];

(iv) Children under age twenty-one years of age who receive child welfare services, to include children in foster care or who aged out of foster care and children covered by adoption assistance agreements; and

(v) Individuals age nineteen years and older and not identified under clauses (i) through (iv), who were eligible for and receiving QUEST coverage on the last day of the month this section is adopted, may continue participating in QUEST or may be moved to QUEST-Net if eligible as determined by the department. Except that individuals who are employed, and receive or are eligible to receive employer sponsored health care coverage through their employer or individuals who are enrolled in or eligible for any medical plan, to include medical coverage as an active military enlistee, a retired military personnel, or a

dependent of an active or retired military enlistee shall not be eligible to participate in QUEST. Individuals who met the provisions of this clause and then lose eligibility under QUEST after the last day of the month this section is adopted with a break in eligibility shall not be eligible to participate in QUEST.

[(C)](B) This provision shall apply regardless of a person's previous eligibility for coverage under QUEST, prior to the implementation of this provision.

(4) [An individuals] Individuals under age nineteen[,] years, whose financial eligibility is established under section 17-1727-14(f), and is covered by a medical plan in the month in which eligibility for medical assistance is determined. For the purposes of this paragraph, "uninsured" means not covered by a [medical] health plan." [Eff 08/1/94; am 07/20/95; am 01/29/96; am 06/19/00; am 10/26/01; am 12/03/01; am 09/10/09; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25; Pub. L. No. 105-33)

45. Section 17-1727-14, Hawaii Administrative Rules, is amended to read as follows:

"§17-1727-14 Financial eligibility requirements. (a) Assets shall be evaluated in the determination of financial eligibility for participation in QUEST in the following manner:

(1) Assets shall be evaluated for an individual or family, with the exception of a pregnant woman [and] , a child under the age of nineteen[;], or both;

(2) An individual or family subject to the asset

determination, whose total countable assets as determined in chapter 17-1725 exceed the personal reserve standard of the QUEST program, shall be ineligible for QUEST; and

(3) The following personal reserve standard shall apply:

(A) For an individual or a couple applying for or receiving assistance the standard shall be equal to the standard employed by the SSI program.

(B) For each additional family member, $250 shall be added to the SSI personal reserve standard for a couple. The resultant amount is the standard for the family.

(b) An individual or family whose monthly countable family income does not exceed the following income limits shall be financially eligible for participation in QUEST:

(1) The income limit for a pregnant woman is one hundred eighty-five per cent of the federal poverty level for a family size which includes the number of unborn children expected;

(2) The income limit for an infant under one year of age is one hundred eighty-five per cent of the federal poverty level for a family of applicable size;

(3) The income limit for a child age one but under age six is one hundred thirty-three per cent of the federal poverty level for a family of applicable size; and

(4) The income limit for all other individuals is one hundred per cent of the federal poverty level for a family of applicable size.

(c) A woman whose eligibility is established, under the provisions of subsection (b)(1), shall retain her eligibility throughout her pregnancy and for a sixty-day period following childbirth until the end of the month in which the sixty-day period ends. The woman's eligibility shall be redetermined for the

first month following the month in which the sixty-day period ends.

(d) [For a] A newborn [who is added to] of a mother who is a QUEST recipient [household, under the provisions of section 17-1711-16(a),], shall remain eligible for a period of one year following the birth of the newborn. The newborn's continued eligibility shall be determined for the first month following the month in which the child attains one year of age.

(e) Eligibility shall be redetermined for the first month following the month in which a child will attain the maximum age, for a child whose eligibility is established under the provisions of subsection (b)(2) [and (3).], (3), and (4).

(f) An uninsured individual under age nineteen, whose monthly countable family income exceeds the appropriate income limit under the provisions of subsection (b), but does not exceed [two] three hundred per cent of the federal poverty level for a family of applicable size shall be financially eligible for participation in QUEST.

[(g) For an applicant or recipient, eligibility for medical assistance in QUEST-Spenddown shall be determined when one of the following conditions is met:

(1) The applicant or recipient has monthly countable income that exceeds the appropriate income limit under the provisions of subsections (b) or (f); or

(2) The applicant or recipient meets the provision of section 17-1727-13(4).

(h) For a recipient, eligibility for medical assistance in QUEST-Net or QUEST-Spenddown shall be determined when monthly countable income exceeds the appropriate income limit.]

(g) When an individual is determined ineligible for QUEST, eligibility for other available medical assistance programs shall be determined.

[(i)](h) The countable family income shall be determined in the following manner:

(1) For a pregnant woman [and], a child under nineteen years old [who is born after September 30, 1983:], or both:
   (A) Subtract a standard deduction of ninety dollars from the monthly gross earned income of each employed individual; and
   (B) Add the monthly net earned income for each employed individual as well as any monthly unearned income to determine the countable family income.
(2) For all other family members, add the monthly gross earned income of each employed person and any monthly unearned income.

[(j)](i) The provisions of [chapter] chapters 17-1724 and 17-1725 shall be used to determine non-exempt income[.] and assets, respectively.

[(k)](j) When determining the financial eligibility of applicants for a specific calendar month, the applicants' total countable family income for that month shall be used, regardless of the date of application.

[(l)](k) A prospective budgeting method employing the department's best estimate of family size, income, and any other relevant factor shall be used in determining continued eligibility for participation in QUEST.

[(m) When determining the premium-share for applicants or recipients of QUEST-related programs, the total countable family income for a month shall be rounded down to the next lower whole dollar and compared to the federal poverty level.]"
[Eff 08/01/94; am 01/29/96; am 03/30/96; am 12/27/97; am 07/06/99; am 06/19/00; am 10/26/01; am 05/10/03; am 04/30/10; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25; Pub. L. No. 105-33, §4901(a))

46. Section 17-1727-14.1, Hawaii Administrative Rules, is amended by amending subsection (c) to read as follows:

§17-1727-14.1 <u>Special provisions for individuals who are claimed as federal or state tax dependents.</u>

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(c) In situations in which the individual claimed as a tax dependent does not reside in the household of a parent or legal guardian who is claiming the tax dependent, the tax dependent's total countable income shall be determined in the following manner:

(1) Determine the tax dependent's gross monthly income according to the provisions of chapter 17-1724.

(2) Determine the amount of support attributable to the tax dependent from the parent or legal guardian who is claiming the tax dependent as follows:

   (A) Determine the gross monthly income of the parent or legal guardian who is claiming the tax dependent according to the provisions of chapter 17-1724.

   (B) Subtract the amount equal to three hundred per cent of the federal poverty level for a family size equal to the number of individuals in the family of the parent or legal guardian who is claiming the tax dependent, excluding the tax dependent for whom eligibility is being determined.

   (C) The remaining income is used as the support attributable to the tax dependent.

(3) Add the tax dependent's gross income and the support attributable to the tax dependent to arrive at the tax dependent's total countable income.

(4) The tax dependent's total countable income shall be used to determine eligibility for a [QUEST-related] <u>QUEST Expanded</u> program[, and any assessment of and any assessment of premium-share for QUEST-Net.]<u>.</u>

[Eff 07/20/95; am 01/29/96; am 12/27/97; am 06/19/00, am] (Auth: HRS

§346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

47. Section 17-1727-15, Hawaii Administrative Rules, is repealed:

["§17-1727-15 Eligibility for GA financial assistance recipients. (a) Individuals who are recipients of financial assistance under the GA program shall be eligible for participation in QUEST if all categorical requirements specified in this subchapter are met.

(b) A GA financial assistance recipient who is age sixty-five or older or who is blind or disabled according to criteria employed by the Social Security Administration shall be ineligible to participate in QUEST. Such an individual may receive medical assistance through the department's fee-for-service program."] [Eff 08/01/94; am 01/29/96; am 02/10/97; am 12/03/01; R] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25; 42 U.S.C. §1396u-1)

48. Section 17-1727-16, Hawaii Administrative Rules, is repealed:

["§17-1727-16 Special provisions for individuals with family incomes in excess of three hundred per cent of the federal poverty level on July 31, 1994 and who are eligible for medical assistance on a spend-down basis. (a) Individuals, whose family incomes exceed three hundred per cent of the federal poverty level, who are otherwise eligible for coverage under QUEST, and who are eligible for medical assistance on a spend-down basis on July 31, 1994, may be allowed to participate in QUEST.

(b) The individuals described in subsection (a) shall be eligible for coverage under QUEST if they assume financial responsibility for the lessor of one hundred percent of the capitated rate for the plan in

which they are enrolled or the dollar amount that the individuals were required to spend-down for the month of July 1994."] [Eff 08/01/94; am 01/29/96; R] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

49. Section 17-1727-17, Hawaii Administrative Rules, is amended by amending subsection (e) to read as follows:

"§17-1727-17 Eligibility for individuals eligible under Title IV-E.***

(e) Individuals eligible for coverage under Title IV-E who are blind or disabled shall be [provided medical coverage on a fee-for-service basis.] enrolled in a QExA health plan and provided coverage under the provisions of chapter 17-1721.1."

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[Eff 11/25/96; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

50. Section 17-1727-22, Hawaii Administrative Rules, is amended to read as follows:

"§17-1727-22 Initial enrollment. (a) After being [found] determined eligible for coverage under QUEST, [an individual shall be allowed ten days to select from among the participating health plans available in the area in which the individual resides. This provision shall not apply to an individual identified in subsection (e).] an individual shall be enrolled in a health plan for purposes of providing the individual with covered services effective the applicable date as described in section 17-1727-24(a).

(b) After the individual is enrolled in a participating health plan, the individual shall be:

(1) Sent an enrollment letter identifying the assigned plan and the option to remain in the assigned plan or to select a different health plan;
(2) Allowed ten days from the date of the enrollment letter to select from among the

participating health plans available in the service area in which the individual resides that are accepting new members. This provision shall not apply to an individual identified in subsection (g).

[(b)](c) If an individual does not select a [medical] different health plan within ten days [of being determined eligible,] from the date of the enrollment letter, [in a health plan] enrollment shall [be] continue in the health plan assigned by the department.

(d) If an individual chooses to enroll in a different health plan within ten days, a confirmation notice will be mailed to the enrollee on the first day of the following month when enrollment in the new health plan becomes effective.

[(c)](e) An enrollee shall only be allowed to change enrollment from one [medical] health plan to another that is open to receiving new members during the annual open enrollment period. The exceptions to this provision include:

(1) Decisions from administrative hearings;

(2) Legal decisions;

(3) Termination of the enrollee's health [plan] plan's contract or the start of a new contract;

(4) Mutual agreement [of] by the health plans involved, the enrollee, and the department; [or]

(5) Violations by a health plan as specified in sections 17-1727-61 and 17-1727-62[,];

[(6) Change in residence by an enrollee from one service area to another;

(A) In this event, individual or family shall be allowed ten days to select a health plan servicing the new service area in which the individual resides.

(B) If a selection is not made within ten days of request, enrollment in a health plan shall be assigned by the department.]

(6) Relocation of the enrollee to a service area where the health plan does not provide service;

(7) Change in foster placement if necessary for the best interest of the child; [and]

(8) The individual missed the open enrollment period due to temporary loss of Medicaid eligibility and shall be re-enrolled in their previous assigned health plan within sixty (60) days of losing eligibility;

(9) The enrollee chooses a health plan during the annual plan change period and that health plan is capped;

(10) Provisions in federal or state statutes or administrative rules;

(11) Member's PCP is not in the health plan's provider network and is in the provider network of a different health plan;

(12) The health plan's refusal, because of moral or religious objections, to cover the service the enrollee seeks as allowed for in the contract with the health plan;

(13) The enrollee's need for related services (i.e., a cesarean section and a tubal ligation) to be performed at the same time and not all related services are available within the network and the enrollee's primary care physician or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk;

(14) Lack of direct access to women's health care specialists for breast cancer screening, pap smears and pelvic exams;

(15) Other reasons, including but not limited to, poor quality of care, lack of access to covered services, or lack of access to providers experienced in dealing with the enrollee's health care needs, lack of direct access to certified nurse midwives, pediatric nurse practitioners, family nurse practitioners, if available in the

geographic area in which the enrollee resides; or

[(8)](16)Other special circumstances as determined by the department.

[(d)](f) An individual who is disenrolled from a QUEST health plan shall be allowed to select a plan of their choice that is open to receiving new members:

(1) If disenrollment extends for more than sixty calendar days in a benefit period;

(2) If disenrollment occurred in a period involving the annual open enrollment period; or

(3) If disenrollment includes the first day of a new benefit period.

[(e)](g) In the absence of a choice of health [plan] plans in a [rural] service area, an eligible individual who resides in that particular service area shall be enrolled in the participating [medical] health plan." [Eff 08/01/94; am 01/29/96; am 06/19/00; am 10/26/01; am 02/16/02; am 05/10/03; am 09/17/07; am 08/19/11; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25; 431.51; 438.56)

51. Section 17-1727-23, Hawaii Administrative Rules, is amended by amending subsections (a), (b), (c), and (d) to read as follows:

"§17-1727-23 Open enrollment period. (a) An eligible individual shall be allowed to change the individual's enrollment from one [medical] health plan to another participating health plan within the service area in which the individual or family resides that is open to new members during the annual open enrollment period. This provision shall not apply to an individual identified in subsection (f).

(b) The open enrollment period shall [generally occur in May of each calendar year.] occur each calendar year at a time to be determined by the department.

(c) A recipient who is enrolled in a non-returning health plan shall be allowed to select from the available health plans.

(d) If the recipient is required to select a health plan, but does not select a health plan during the open enrollment period, enrollment in a health plan shall be assigned by the department. "

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[Eff 08/01/94; am 06/19/00; am 02/16/02; am 05/10/03; am 08/19/11; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25; 431.51)

52. Section 17-1727-23, Hawaii Administrative Rules, is amended by amending subsection (f) to read as follows:

"§17-1727-23 Open enrollment period. ***

(f) In the absence of a choice of health plan in a [rural] service area, an enrollee who resides in that particular service area shall be enrolled in that participating health plan and shall not participate in the annual open enrollment period." [Eff 08/01/94; am 06/19/00; am 02/16/02; am 05/10/03; am 08/19/11; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25; 431.51)

53. Section 17-1727-24, Hawaii Administrative Rules, is amended by amending subsections (a), (b), and (c) to read as follows:

"§17-1727-24 Effective date of enrollment. (a) For applicants newly approved for coverage and eligible prospectively, the effective date of enrollment shall be one of the following:

(1) The date [the enrollment process has been completed to enroll an individual or family in a QUEST health plan.] the applicant met the QUEST eligibility requirements and is determined eligible for QUEST:

(A) The date the application is received by the department; or
(B) If specified by the applicant, any date on which appropriate medical expenses, in accordance with chapter 17-1737, were incurred and which is within the immediate five calendar days prior to the date the application is received by the department.

(2) If the applicant is found to be ineligible for the month of application, the date of the subsequent month in which all eligibility requirements are met by the applicant.

(3) The effective date of retroactive enrollment shall not be earlier than the start date of the health plan contract period in which an eligibility determination is made.

(b) The effective date of enrollment resulting from a change from one health plan to another during the annual open enrollment period shall be the first day of [July of that calendar year.] the month as determined by the department and shall generally extend for the benefit period.

(c) The effective date of enrollment resulting from a change from one health plan to another, other than during the open enrollment period, shall be one of the following:

(1) The first day of the month following the date on which the department authorizes the enrollment change.

(2) If an individual changes residence from one service area to another, the date the enrollment process has been completed [to enroll and individual in a QUEST health plan.]."

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[Eff 8/01/94; am 07/20/95; am 01/29/96; am 10/26/01; am 05/10/03; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25; 431.51)

54. Section 17-1727-25, Hawaii Administrative Rules, is repealed:

["§17-1727-25 Coverage of QUEST eligibles prior to the date of enrollment. (a) An applicant who is initially determined eligible under QUEST shall be eligible for coverage of health care costs by the department on a fee for service basis as of the date of coverage through the date of enrollment.

(b) The date of coverage shall be one of the following:

(1) The date of application;
(2) If specified by the applicant, the date on which appropriate medical expenses were incurred and which is within the immediate five calendar days prior to the date the application is received by the department; or
(3) If ineligible in the month of application, the date on which all eligibility requirements are met by the applicant in a subsequent month.

(c) The provisions of the fee for service program as described in chapter 17-1735, 17-1736, and 17-1737 shall apply from the date of eligibility to the date of enrollment for those who are initially determined eligible for QUEST.]" [Eff 07/20/95; am 12/03/01; am 01/31/09; am 06/11/09; am 08/19/11; R] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

55. Section 17-1727-26, Hawaii Administrative Rules, is repealed:

["§17-1727-26 Limitations of statewide enrollment in participating health plans. (a) The maximum statewide enrollment in the QUEST medical plans shall be 125,000 enrollees.

(b) The department shall not accept applications for QUEST coverage when the statewide enrollment as of

the last day of the previous calendar year exceeds the maximum allowed by this section.

(c) The department shall accept applications for QUEST coverage during an open application period to be announced by the department as described in sections 17-1711-2 and 17-1711-3.

(d) The following individuals are exempt from this provision and shall be enrolled in a participating health plan if determined eligible for QUEST:

(1) GA financial assistance recipients;
(2) Individuals whose countable family income does not exceed the financial assistance payment standard;
(3) Pregnant women whose countable family income does not exceed one hundred eighty-five per cent of the federal poverty level for a family size which includes the number of unborn children expected;
(4) Children under the age of nineteen, whose countable family income does not exceed two hundred per cent of the federal poverty level;
(5) Individuals whose coverage in an employer sponsored health plan is terminated due to loss of employment which occurred within forty-five calendar days of the date of application for medical assistance;
(6) Individuals whose health coverage in a group health plan is extended as a result of loss of employment and such coverage ends within forty-five calendar days of the date of application for medical assistance; and
(7) Children under age twenty-one years of age who receive child welfare services, to include children in foster care and children covered by adoption assistance agreements.
(8) Individuals and families covered under the provisions of section 1931 of the Social Security Act as described in chapter 17-1726."] [Eff 01/29/96; am 03/30/96; am 11/25/96; am 12/27/97; am 06/19/00;

am 12/03/01; R] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 431.51; 42 U.S.C. §1396u-1)

56. Section 17-1727-30, Hawaii Administrative Rules, is amended to read as follows:

"§17-1727-30 Disenrollment of enrollees from QUEST health plans. (a) The department shall have sole authority to disenroll a QUEST enrollee.

(b) An individual who does not meet the QUEST eligibility requirements shall be disenrolled from the QUEST health plan in which the individual is enrolled.

(c) An individual or family may be disenrolled for reasons, which include, but are not limited to, the following:

(1) [Failure to pay the individual's or family's total designated premium-share for QUEST or QUEST-Net coverage;] In compliance with an administrative appeal decision or a court order;
(2) A mutual agreement among an individual or family, the participating health plans involved, and the department; [or]
(3) A voluntary withdrawal from participation in QUEST by an individual or family.
(4) The individual or family failed to meet a QUEST eligibility requirement.
(5) Death of the enrollee;
(6) Incarceration of the enrollee;
(7) The enrollee enters the Hawaii State hospital;
(8) The enrollee enters the State of Hawaii organ and tissue transplantation (SHOTT) program;
(9) The enrollee is in foster care or a subsidized adoption agreement and has been moved out-of-state by the department; or
(10) The enrollee provides false information with the intent of enrolling in the QUEST program under false pretenses." Eff 08/01/94; am 01/29/96; am 11/25/96; am 12/27/97;

am 05/10/03; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

57. Section 17-1727-35, Hawaii Administrative Rules, is amended to read as follows:

"§17-1727-35 Capitated payments. (a) Each participating health plan shall be paid on a capitated basis, as negotiated with the [Department] department, for individuals enrolled in that health plan.

(b) The [Department] department shall provide the capitated payment, as stipulated in the contract between the [Department] department and each participating health plan, in return for the health plan's provision of all [negotiated services] contracted coverage for the health plan's enrollees." [Eff 08/01/94; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

58. Section 17-1727-40, Hawaii Administrative Rules, is repealed:

["§17-1727-40 Premium-share. (a) An enrollee may be assessed responsibility for payment of the monthly unadjusted contracted rate which is paid by the department for the enrollee's coverage. The unadjusted contracted rate, including that of catastrophic coverage, for which an enrollee may be responsible is known as the premium-share.

(b) An enrollee who is assessed a premium-share shall pay that amount to the department by the tenth day of the benefit month.

(c) The department shall initiate disenrollment procedures for an enrollee whose premium-share payments are two months in arrears.

(d) An individual eligible for medical assistance only coverage in QUEST, with the exception of individuals identified in subsection (e) of this section, shall be required to satisfy all outstanding

premium-share debts, to the department's satisfaction, prior to being allowed to participate in QUEST.

(e) The following individuals, who are exempt from the maximum enrollment provisions, shall be exempt from the provision to satisfy premium-share debts prior to being allowed to participate in QUEST:

(1) GA financial assistance recipients;

(2) Individuals whose countable family income does not exceed the financial assistance payment standard;

(3) Pregnant women whose countable family income does not exceed one hundred eighty-five per cent of the federal poverty level for a family size which includes the number of unborn children expected;

(4) Children under the age of nineteen, whose countable family income does not exceed two hundred per cent of the federal poverty level;

(5) Individuals whose coverage in an employer sponsored health plan is terminated due to loss of employment which occurred within forty-five calendar days of the date of application for medical assistance;

(6) Children under age twenty-one years of age who are eligible for foster care maintenance payments or adoption subsidy payments.

(7) Individuals and families covered under the provisions of section 1931 of the Social Security Act as described in chapter 17-1726.]" [Eff 08/01/94; am 01/29/96; am 03/30/96; am 02/10/97; am 12/27/97; am 06/19/00; am 10/26/01; am 12/03/01; R] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25; 42 U.S.C. §1396u-1)

59. Section 17-1727-48, Hawaii Administrative Rules, is amended to read as follows:

"§17-1727-48 [Standard] QUEST benefits [package] packages. (a) Each of the participating health plans shall be required to provide [certain benefits] medical services as defined in the contract between the health plans and the [Department.] department.

[(1) Participating medical plans shall provide all required basic medical services, as defined in the contract with the Department.

(2) Participating behavioral health managed care plans who contract with the Department to treat individuals who are diagnosed by an independent clinical evaluator as suffering from severe disabling mental illness, shall provide the services defined in the contract with the Department.]

(b) The benefits minimally required [of] to be provided by each of the participating health plans shall be known as the [standard] QUEST benefits [package] packages.

(1) An individual age twenty-one years and older enrolled in a participating health plan shall be provided the QUEST-Adult benefits package described in 17-1727-48.1.

(2) An individual under age twenty-one years enrolled in a participating health plan shall be provided the QUEST-Keiki benefits package described in 17-1727-48.2.

(c) The QUEST benefits packages as defined in this section are based on a twelve-month benefit period. Benefits shall be pro-rated for any benefit period other than a twelve-month period. If a recipient changes health plans during a benefit period, the remaining unused benefits will be covered by the new health plan for the duration of the benefit period while enrolled in the new health plan.

[(c)](d) A participating health plan may, at the health plan's option, or as otherwise required by the contract between the health plan and the department or the state plan, provide benefits which exceed the requirements of the [standard] QUEST benefits [package] packages." [Eff 08/01/94; am 02/16/02;

am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

60. Chapter 17-1727, Hawaii Administrative Rules, is amended by adding a new section to read as follows:

"§17-1727-48.1 QUEST-Adult benefits package. (a) Participating health plans shall be required to provide a maximum coverage of thirty (30) medical inpatient days within a benefit period for medically necessary inpatient hospital care related to medical care, surgery, post-stabilization, and acute rehabilitation and a maximum coverage of thirty (30) behavioral health inpatient days within a benefit period for psychiatric care and inpatient substance abuse treatment, all of which include the following:

(1) Semi-private room and board and general nursing care for inpatient stays related to medical care, surgery, psychiatric care, and substance abuse treatment;

(2) Intensive care room and board and general nursing care for medical care and surgery;

(3) Use of an operating room and related facilities, inpatient anesthesia, radiology, laboratory and other diagnostic services agreed upon by the plan medical director for medical care and surgery;

(4) Drugs, dressings, blood derivatives and their administration, general medical supplies, and diagnostic and therapeutic procedures as prescribed by the attending physician;

(5) Other ancillary services associated with hospital care except private duty nursing; and

(b) Within a benefit period, a participating health plan shall be required to provide the following medical necessary outpatient services for each individual:

(1) Bona fide emergency services. Coverage shall be provided for bona fide emergency services including ground and air (fixed wing and rotor) ambulance for emergency transportation,

emergency room services, and physician services in conjunction with the emergency room visits. Bona fide emergency room visits shall be restricted to those requiring services for medical conditions manifesting themselves in acute symptoms of such severity that the absence of medical attention could reasonably be expected to result in placing the individual's health in serious jeopardy, or serious impairment of bodily functions, or serious dysfunction of any body organ part.

(2) Coverage of medically necessary outpatient hospital procedures or ambulatory surgical center procedures may be subject to prior authorization and are included in the covered medical visits per benefit period.

(3) Diagnostic testing, including laboratory and x-ray, directly related to a covered outpatient visit.

(4) Pregnancy-related services.

(5) Maternity care shall be provided.

(6) Coverage shall be provided for physician, and other practitioner services.

(7) Coverage shall be provided for preventive services.

(8) Coverage shall be provided for behavioral health services including preventive, diagnostic, therapeutic, and rehabilitative services for mental health problems, drug abuse, and substance abuse.

(9) Smoking cessation services shall be provided.

(10) Coverage shall be provided for family planning services to include family planning services rendered by physician or nurse midwife and family planning drugs, supplies and devices approved by the federal Food and Drug Administration.

(11) Coverage shall be provided for home health services which shall not include rehabilitative services.

(12) Urgent care shall be provided.

(13) Coverage shall be provided for vision services excluding optometrists' services and visual appliances to include but not limited to prescription lenses, contact lenses or prosthetic eyes.

(14) Coverage of immunization including influenza, pneumococcal, and diphtheria and tentanus.

(15) Coverage shall be provided for over-the-counter and prescription drugs limited by a strict formulary and defined in the contract negotiated between the plans and the department.

(16) Coverage shall be provided for diabetic supplies to include syringes, test strips, and lancets.

(17) Non-emergency transportation shall be provided.

(18) A participating health plan shall provide long-term care and hospice services for sixty (60) days during the transitional period." [Eff] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

61. Chapter 17-1727, Hawaii Administrative Rules, is amended by adding a new section to read as follows:

"§17-1727-48.2 QUEST-Keiki benefits package. (a) For an individual under age twenty-one years, each participating health plan shall provide the QUEST benefits package as described in 17-1727-48.1.

(b) For an individual under age twenty-one years who requires benefits for which either, coverage has been exhausted or not described under section 17-1727-48.1, each participating health plan shall provide medically necessary services to be in compliance with Early and Periodic Screening, Diagnosis, and Treatment requirements. Benefits shall include but not be limited to coverage of:

(1) Durable medical equipment and medical supplies.

(2) Rehabilitation services such as physical and occupational therapy, audiology and speech-language pathology.
(3) Vision and hearing services to include visual aids prescribed by ophthalmologists and optometrists to include eyeglasses. New lenses are limited to once in a twelve (12) month period. Replacement glasses or new glasses with significant changes in prescription are covered within the benefit period. Contact lenses are not covered for cosmetic reasons. Hearing devices are covered for both analog and digital models.
(4) Medically necessary inpatient days.

[Eff] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25; 42 C.F.R. §430.25)

62. Chapter 17-1727, Hawaii Administrative Rules, is amended by adding a new section to read as follows:

"§17-1727-48.5 Exclusions and limitations. Medical assistance payments shall not be made for certain services, procedures, medications, supplies, equipment, or other items that are:

(1) Specifically excluded from coverage by State or federal requirements;
(2) Provided by providers not licensed or certified in the State of Hawaii to perform the service;
(3) Available without charge to the general public through a separate State or federally administered federally-funded program;
(4) Covered by a third party medical or liability insurance, including Medicare;
(5) Required to receive prior authorization but did not receive it;
(6) Experimental in nature and/or have not been approved by the United States Food and Drug Administration;
(7) Elective and do not improve outcomes such as decreasing risk of morbidity or mortality;
(8) Without sufficient evidence of effectiveness or net benefit as determined by the

department and/or not covered under the currently approved Medicaid State Plan and/or Medicaid waivers;

(9) Comparatively effective to a tolerated lower cost alternative; or

(10) Otherwise determined by the department to be non-covered, excluded, or limited.

[Eff] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §456.3)

63. Section 17-1727-49, Hawaii Administrative Rules, is repealed:

["§17-1727-49 Basic medical services to be provided by participating plans. (a) Participating medical plans shall provide all medical services that are required by medicaid.

(b) There shall be a one-month waiting period for all non-urgent and non-emergent medically necessary services as determined by the department or the participating health plan. This provision does not apply to an enrollee below the age of twenty-one.

(c) Participating medical plans shall provide preventive, diagnostic, and medically necessary services which include, but are not limited to, the following:

(1) Inpatient hospital services for medical, surgical, rehabilitative, maternity, and newborn care, including room and board, nursing care, medical supplies, equipment, drugs, diagnostic services, physical and occupational therapy, speech and language therapy, and other medically necessary services;

(2) Outpatient hospital services, including emergency room services, ambulatory surgery, urgent care services, medical supplies and equipment, drugs, diagnostic services, therapeutic services such as chemotherapy and radiation therapy, and other medically necessary services;

(3) Preventive services, including initial and interval histories, physical examinations and developmental assessments, immunizations, family planning services, diagnostic and screening laboratory and radiology services including screening for tuberculosis;
(4) Prescribed drugs, blood, and blood products;
(5) Radiology, laboratory, and other diagnostic services including imaging, screening mammograms, screening and diagnostic laboratory tests, therapeutic radiology, and other medically necessary diagnostic services;
(6) Physician services, including services of psychiatrists;
(7) Maternity services such as prenatal care and laboratory screening tests, treatment of missed, threatened, incomplete and elective abortions, delivery of infants, and postpartum care;
(8) Other practitioner services including podiatrists, optometrists, psychologists, nurse midwives, pediatric nurse practitioners, family nurse practitioners, and other practitioner services needed to provide medical care;
(9) Therapeutic services including physical therapy, occupational therapy, speech therapy, and audiology services, and other medically necessary therapeutic services;
(10) Durable medical equipment, prosthetic devices, orthotics, and medical supplies including, but not limited to, oxygen tanks, oxygen concentrators, eyeglasses, ventilators, wheelchairs, crutches, canes, braces, hearing aids, pacemakers, and other medically necessary appliances, supplies, and artificial aids;
(11) Home health services including skilled nursing, home health aides, therapeutic services, medical supplies and equipment, and other medically necessary home health

services;
(12) Hospice services;
(13) Organ and tissue transplant services, including cornea, kidney, allogenic and bone marrow;
(14) Transportation services;
(15) Sterilizations;
(16) Hysterectomies;
(17) Services federally mandated by the Early and Periodic Diagnosis, Screening, and Treatment program; and
(18) Behavioral health services including preventive, diagnostic, therapeutic, and rehabilitative services for mental health problems, drug abuse, and substance abuse, with limitations as specified in section 17-1727-49.1; and
(19) Out-of-state services."] [Eff 08/01/94; am 01/29/96; am 03/30/96; am 11/25/96; am 02/10/97; am 12/27/97; am 06/19/00; R] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

64. Section 17-1727-49.1, Hawaii Administrative Rules, is repealed:

["§17-1727-49.1 Limitations to behavioral health benefits. (a) Behavioral health benefits provided through participating medical plans are limited as follows:

(1) Twenty-four hours of outpatient visits and thirty days of hospitalization per benefit year. Outpatient hours or inpatient days not used in a benefit year shall not be added to the benefits of the following year;
(2) The diagnosis and treatment of substance abuse shall be included in the inpatient and outpatient benefits for psychiatric treatment. Each day of inpatient hospital services may be exchanged for two days of non-hospital residential services, two days

of partial hospitalization services, or two days of day treatment or two days intensive outpatient services. Detoxification, whether provided in a hospital or in a non-hospital facility, shall be considered as a part of the inpatient benefit limit.

(b) A participating plan may, at the plan's option, exceed the limits on behavioral health services.

(c) For an enrollee below the age of twenty-one, the plan may exceed the limits for medically necessary services to be in compliance with EPSDT requirements."] [Eff 03/30/96; am 12/27/97; am 06/19/00; R] (Auth: HRS §346-14) (Imp: 42 C.F.R. §430.25)

65. Section 17-1727-50, Hawaii Administrative Rules, is amended to read as follows.

"§17-1727-50 Dental services. (a) All required preventative dental services and all medically necessary dental services, as described in section 17-1737-75(b), shall be provided to an individual under age twenty-one years. [Services shall include, but are not limited to, the following:

(1) Diagnostic and preventative services provided once every six months;
(2) Non-emergency care including endodontic therapy, periodontic therapy, restoration, and prosthodontic services;
(3) Emergency treatment which includes services to relieve dental pain, eliminate infection, and treatment of acute injuries to the teeth and supporting structures of the oro-facial complex; and
(4) EPSDT services shall be provided routinely beginning at twelve months of age; however, EPSDT services are allowable as early as six months of age at the discretion of the participating dentist.]

[(b) All dental services required under the federally mandated Early and Periodic Screening, Diagnosis, and Treatment program for an individual under the age of twenty-one shall be provided by a participating dentist.

(c)] (b) An individual age twenty-one years and older who is eligible for QUEST shall have coverage provided in accordance [to section] with section [17-1737-75.1.] 17-1737-75(d).

[(1) Relief of dental pain;
(2) Elimination of infection; and
(3) Treatment of acute injuries to the teeth or supporting structures of the oro-facial complex.

(d)] (c) The dental services described in subsections (a) through [(c)] (b) shall be provided on a fee for service basis." [Eff 08/01/94; am 01/29/96; am 03/30/96; am 11/25/96; am 06/19/00; am 02/16/02; am 09/10/09; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

66. Section 17-1727-51, Hawaii Administrative Rules, is repealed:

["§17-1727-51 Behavioral health services for individuals with serious and persistent mental illness. (a) Individuals who are certified by an independent clinical evaluator as suffering from serious and persistent mental illness shall be eligible for enrollment in a behavioral health managed care plan contracted by the Department to treat these individuals.

(b) Upon an individual's enrollment in a behavioral health managed care plan, the basic medical plan in which the individual is enrolled shall no longer be responsible to provide behavioral health services for that individual."] [Eff 08/01/94; R] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

67. Section 17-1727-62, Hawaii Administrative Rules, is amended as follow:

"§17-1727-62 Termination of contract with participating health plan. (a) The department shall have the authority to terminate the health plan's contract for any or all of the following reasons:

(1) Default by the health plan;
(2) Convenience;
(3) Expiration of Hawaii QUEST;
(4) Insolvency of or declaration of bankruptcy by the health plan;
(5) Unavailability of funds; [or]
(6) Failure by the health plan to abide by the contract conditions [or to meet]; or
(7) Meet federal or State statutes, or both.

(b) When termination of contract is due to reasons identified under subsection (a) paragraphs (1) [and], (6)[,] or (7), the department shall provide a hearing for the affected health plan prior to termination of contract.

(c) After the department notifies the health plan of its intent to terminate the contract due to reasons identified under subsection (a) paragraphs (1) [and], (6), or (7), the department may do the following:

(1) Provide the affected enrollees written notice of the department's intent to terminate the contract; and
(2) Allow the affected enrollees to change health plans immediately without cause." [Eff 09/17/07; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25; 438.708)

68. Section 17-1728-1, Hawaii Administrative Rules, is amended as follows:

"§17-1728-1 Purpose. This chapter describes the QUEST-Net [Program] program which provides [medical] health benefits to certain medical assistance

recipients who become ineligible for [a QUEST-related] another QUEST Expanded program or [the fee for service coverage for aged, blind, and disabled individuals.] the fee-for-service delivery system." [Eff 03/30/96; am 06/19/00; am 05/10/03; am] (Auth: HRS §346-14) (Imp: HRS §346-14)

69. Section 17-1728-2, Hawaii Administrative Rules, is amended by amending the definitions of "Non-returning plan", and "Personal reserve standard" to read:

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""Non-returning plan" means a participating health [coverage carrier] plan that has a current, but no new contract with the department."

"Personal reserve standard" means the maximum amount of countable assets that may be held by an individual [, a] or family [, or a household] while establishing or maintaining eligibility for medical assistance."

***

[Eff 03/30/96; am 06/19/00; am 10/26/01; am 02/16/02; am 09/17/07; am 08/19/11; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

70. Section 17-1728-2, Hawaii Administrative Rules, is amended by adding new definitions to read as follows:

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""Aged" means an individual age sixty-five years or older."***

""Effective date of enrollment" means the date as of which a participating health plan is required to provide benefits to an enrollee."

""Enrollee" means an individual who has selected, or is assigned by the department to be a member of a participating health plan."

""Family" means an individual or a group of individuals living in the same household, generally consisting of parents and their natural, adoptive, or

hanai children under age nineteen years, grandparents and their grandchildren under age nineteen years, an adult sibling and his or her hanai children under age nineteen years, an adult sibling and his or her siblings under age nineteen years, a married couple and siblings under age nineteen years of either spouse, an uncle or an aunt and his or her nephews and nieces under age nineteen years, a married couple and their nephews and nieces under age nineteen years, a single adult and his or her first cousins under age nineteen years, married couples and first cousins under age nineteen years of one of the spouses, any combination of the preceding relationships prefixed with grand, great-grand, great, great-great, half, and step."

***

""Managed care" means a comprehensive approach to the provision of health care that that combines clinical services and administrative procedures within an integrated, coordinated system to provide timely access to primary care and other necessary services in a cost effective manner."

***

""Participating health plan" means a health plan contracted by the State to provide medical or behavioral health care services, through a managed care system, to individuals who are found eligible to participate in QUEST-Net and have been enrolled in that health plan."

***

""Primary care provider" means a provider who is licensed in Hawaii and is 1) a physician, either an M.D. (doctor of medicine) or a D.O. (doctor of osteopathy), and must generally be a family practitioner, general practitioner, general internist, pediatrician or obstetrician-gynecologist (for women, especially pregnant women) or geriatrician, or 2) an advanced practice registered nurse with prescriptive authority. PCPs have the responsibility for supervising, coordinating and providing initial and primary care to the enrollee and for initiating referrals and maintaining the continuity of the enrollee care."

***

""QUEST benefits packages" means the minimum benefits and services which must be provided by each participating health plan which is contracted under QUEST."

***

""Service area" means the geographical area defined by zip codes, census tracts, or other geographic subdivisions that is served by a participating health plan as defined in the plan's contract with the Department."

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71. Section 17-1728-2, Hawaii Administrative Rules, is amended by deleting the definitions, "Child", "Hawaii QUEST", "Health coverage carrier", "Premium-share", "QUEST-related program", and "Spenddown requirement".

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[""Child" means a person under age nineteen."]

***

[""Hawaii QUEST" means the demonstration project developed by the department which will deliver medical and behavioral health services through health plans employing managed care concepts, to certain individuals formerly covered by public assistance programs including the Aid to Families with Dependent Children (AFDC), related medical assistance programs, General Assistance (GA), and the State Health Insurance Program (SHIP)."]

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[""Health coverage carrier" means an insurance company or other organization which provides different health care benefit packages to one or more groups of enrollees."]

***

[""Premium-share" means that part of the unadjusted contracted rate that certain individuals, based on their income, are required to remit to the department to be eligible to be enrolled in a health plan participating in QUEST-Net."]

***

[““QUEST-related program” means a medical assistance program that is related to Hawaii QUEST, to include, QUEST-Net, QUEST-Spenddown, and AFDC Transitional Medical Coverage.”]

***

[““Spenddown requirement” means the dollar amount of monthly medical expenses which an affected person must incur, prior to receipt of medical assistance coverage from the department.”]

***

[Eff 03/30/96; am 06/19/00; am 10/26/01; am 02/16/02; am 09/17/07; am 08/19/11; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

72. Section 17-1728-7, Hawaii Administrative Rules, is amended by amending the title to read:

“§17-1728-7 [Basic] Non-financial eligibility requirements.”

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[Eff 03/30/96; am 05/10/03; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

73. Section 17-1728-8, Hawaii Administrative Rules, is amended to read as follows:

“§17-1728-8 Categorical eligibility requirements. (a) When requesting coverage under QUEST-Net, a person shall be age nineteen years or older and be a recipient of medical assistance either through another QUEST Expanded program or the fee for service program. [This provision shall not apply to persons under age nineteen years.]

(b) A person who is not eligible to participate in QUEST-Net includes a person who:

(1) Does not meet the requirements of subsection (a);

(2) Is not receiving medical assistance from the department either through another QUEST Expanded program or the fee for service

program, when requesting conversion to medical assistance through QUEST-Net [with the exception of persons under age nineteen years;];

(3) Does not meet the financial eligibility requirements of QUEST-Net;

(4) Is eligible for Medicare coverage;

(5) Is employed and is eligible for coverage by an employer sponsored medical plan, with the exception of a financial assistance recipient[, a person under age nineteen,] and a person who is participating in the department's grant diversion or supporting employment empowerment programs; and

(6) Is enrolled in, or eligible for any medical plan, to include medical coverage as an active military enlistee, a retired military personnel, or a dependent of an active or retired military enlistee[;].

[(7) Is eligible for or enrolled in any medical plan at no cost to the person; or

(8) Is covered by a medical plan.]"

[Eff 03/30/96; am 06/19/00; am 12/03/01; am 05/10/03; am 09/17/07; am 09/10/09; am 08/19/11; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

74. Section 17-1728-9, Hawaii Administrative Rules, is amended to read as follows:

"§17-1728-9 Financial eligibility requirements. (a) A person [age nineteen years or older] whose countable family assets exceed the personal reserve standard for a family of applicable size shall be ineligible for QUEST-Net.

(1) For a one-member family, the personal reserve standard shall be $5,000.

(2) For a two-member family, the personal reserve standard shall be $7,000.

(3) For family of more than two members, the personal reserve standard shall be $7,000 plus $500 for each additional family member.

[(b) A person under age nineteen years whose countable family income does not exceed two hundred per cent of the federal poverty level for a family of applicable size shall be ineligible to participate in QUEST-Net.

(c) A person under age nineteen years whose countable family income exceeds two hundred per cent of the federal poverty level for a family of applicable size, shall also meet the provision in subsection (d).

(d) A person under age nineteen years whose countable family income exceeds three hundred per cent of the federal poverty level for a family of applicable size shall be ineligible to participate in QUEST-Net.

(e)](b) A person [age nineteen years and older] whose countable family income exceeds [two] one hundred thirty-three per cent of the federal poverty level for a family of applicable size shall be ineligible to participate in QUEST-Net.

[(f)](c) A person's countable family income shall be determined by [in the following manner:

(1) For a pregnant woman and a child under nineteen years old:
   (A) Subtract a standard deduction of ninety dollars from the monthly gross earned income of each employed person; and
   (B) Add the monthly net earned income for each employed person as well as any monthly unearned income to determine the countable family income.
(2) For all other family members, add] adding the monthly gross earned income of each employed person and any monthly unearned income." [Eff 03/30/96; am 07/06/99; am 10/26/01; am 09/17/07; am 09/10/09; am 08/19/11; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

75. Section 17-1728-9.1, Hawaii Administrative Rules, is repealed:

["§17-1728-9.1 Special provisions. (a) An individual age nineteen years or older whose countable family income exceeds two hundred per cent and does not exceed three hundred per cent of the federal poverty level for a family of applicable size and who is eligible for and receiving QUEST-Net coverage on the last day of the month this section is adopted, may continue participating in QUEST-Net.

(b) This section shall not apply to an individual who met the provisions of subsection (a) and loses eligibility under QUEST-Net after the last day of the month this section is adopted and there is a break in eligibility."] [Eff 08/19/11; R] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

76. Chapter 17-1728, Hawaii Administrative Rules, is amended by adding a new section to read as follows:

"§17-1728-9.2 Eligibility for general assistance (GA) recipients. (a) An individual who is a recipient of another QUEST Expanded program and is later determined eligible for financial assistance under the department's GA program, shall be eligible for participation in QUEST-Net if all categorical requirements specified in this subchapter are met.

(b) A GA financial assistance recipient who is age sixty-five years or older, or who is blind or disabled according to criteria employed by the Social Security Administration shall first be determined ineligible for the department's QUEST Expanded Access program before participation in QUEST-Net is allowed." [Eff] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25; 42 U.S.C. §1396u-1)

77. Section 17-1728-14, Hawaii Administrative Rules, is amended to read as follows:

"§17-1728-14 Purpose. This subchapter describes the adults who are eligible to participate in QUEST-Net, the benefits to be provided, and the enrollment provisions[, and the financial responsibility of enrollees for coverage of health care costs.]."
[Eff 03/30/96; am] (Auth: HRS §346-14)
(Imp: HRS §346-14; 42 C.F.R. §430.25)

78. Section 17-1728-15, Hawaii Administrative Rules, is amended to read as follows:

"§17-1728-15 Adults in QUEST-Net. (a) An adult who is eligible for QUEST-Net includes an adult who:

(1) Was either a former [QUEST-related program or aged, blind, or disabled] QUEST Expanded or fee-for-service recipient and became ineligible because the adult does not meet the financial eligibility requirements of the [QUEST-related program or aged, blind, or disabled] QUEST Expanded or fee-for-service programs;

(2) Voluntarily requested termination [of] from a [QUEST-related program or fee for service coverage;] QUEST Expanded or fee-for-service program; or

(3) Was receiving coverage under [a QUEST-related] the QUEST program but became ineligible as the adult was determined to be over age sixty-five, blind, or disabled and therefore, categorically ineligible for the [QUEST-related] QUEST program.

(b) An adult eligible for QUEST-Net shall be enrolled in a participating [medical] health plan [for provision of covered medical services.] for purposes of providing the adult with covered services."
[Eff 03/30/96; am 12/27/97; am 06/19/00; am 05/10/03; am] (Auth: HRS

§346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

79. Section 17-1728-16, Hawaii Administrative Rules, is amended to read as follows:

"§17-1728-16, [Standard benefits package.] QUEST-Net benefits. (a) A participating health plan shall be required to provide certain benefits as defined in the contract between the health plan and the department.

(b) The benefits minimally required to be provided by [of] each of the participating health [plan] plans [shall be known as the standard benefits package] are named the QUEST-Adult and QUEST-Keiki benefits packages as defined in section 17-1727-48.1 and 17-1727-48.2 respectively.

(c) The [standard] QUEST-Net benefits [package] as defined in this section [is] are based on a twelve-month benefit period. Benefits shall be pro-rated for any benefit period other than a twelve-month period. If a recipient changes health plans during a benefit period, the remaining unused benefits will be covered by the new health plan for the duration of the benefit period while enrolled in the new health plan.

(d) A participating health plan may, at the health plan's option, or as otherwise required by the contract between the health plan and the department or the state plan, provide benefits which exceed the requirements of the [standard] QUEST-Net benefits [package]." [Eff 03/30/96; am 08/19/11; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

80. Chapter 17-1728, Hawaii Administrative Rules, is amended by adding a new section to read as follows:

"§17-1728-16.1 Exclusions and limitations. Medical assistance payments shall not be made for

certain services, procedures, medications, supplies, equipment, or other items that are:

(1) Specifically excluded from coverage by State or federal requirements;
(2) Provided by providers not licensed or certified in the State of Hawaii to perform the service;
(3) Available without charge to the general public through a separate State or federally administered federally-funded program;
(4) Covered by a third party medical or liability insurance, including Medicare;
(5) Required to receive prior authorization but did not receive it;
(6) Experimental in nature and/or have not been approved by the United States Food and Drug Administration;
(7) Elective and do not improve outcomes such as decreasing risk of morbidity or mortality;
(8) Without sufficient evidence of effectiveness or net benefit as determined by the department and/or not covered under the currently approved Medicaid State Plan and/or Medicaid waivers;
(9) Comparatively effective to a tolerated lower cost alternative; or
(10) Otherwise determined by the department to be non-covered, excluded, or limited.

[Eff] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §456.3)

81. Section 17-1728-17, Hawaii Administrative Rules, is repealed:

["§17-1728-17 Hospital services to be covered by the plan. (a) A standard benefits package shall provide each enrollee a maximum coverage of ten days of medically necessary inpatient hospital care related to medical care, surgery, psychiatric care, and substance abuse treatment. The following hospital services shall be made available to each enrollee:

(1) Semi-private room and board and general nursing care for inpatient stays related to

medical care, surgery, psychiatric care, and substance abuse treatment;
(2) Intensive care room and board and general nursing care for medical care and surgery;
(3) Use of an operating room and related facilities, inpatient anesthesia, radiology, laboratory and other diagnostic services agreed upon by the plan medical director for medical care and surgery;
(4) Drugs, dressings, blood derivatives and their administration, general medical supplies, and diagnostic and therapeutic procedures as prescribed by the attending physician;
(5) Other ancillary services associated with hospital care except private duty nursing; and
(6) Ten inpatient physicians visits.

(b) Coverage of inpatient hospital care related to maternity, newborn nursery, neonatal intensive care, and inpatient services in a freestanding rehabilitation hospital shall not be required."] [Eff 03/30/96; am 08/19/11; R] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

82. Section 17-1728-18, Hawaii Administrative Rules, is repealed:

["§17-1728-18 Outpatient services to be covered by the plan. (a) A standard benefits package shall provide each enrollee the following outpatient services:

(1) A maximum of twelve outpatient visits including adult health assessments, family planning services, diagnosis, treatment, consultations, and second opinions. The maximum of twelve outpatient visits shall not pertain to:
    (A) Bonafide emergency room visits.
    (B) An enrollee's first six mental health visits. After the first six mental

health visits, an enrollee may choose to apply a maximum of six additional mental health visits toward the maximum of twelve outpatient visits.

(C) Diagnostic testing, including laboratory and x-ray, directly related to a covered outpatient visit.

(2) Maternity care coverage shall be limited to one routine visit to confirm pregnancy and any visits for the diagnosis and treatment of conditions related to medically indicated or elective termination of pregnancy such as ectopic pregnancy, hydatiform mole, and missed, incomplete, threatened, or elective abortions. These visits shall count toward the twelve maximum outpatient visits, ten maximum inpatient days, or three maximum ambulatory surgeries.

(3) Coverage of medically necessary ambulatory surgical care shall be limited to three procedures.

(b) For an enrollee age twenty-one or older coverage shall be provided for the following health assessments which shall be counted toward the maximum of twelve outpatient visits.

(1) An enrollee age twenty-one to thirty-five years old, inclusive, shall be allowed one examination within a period designated by the Department.

(2) An enrollee thirty-six to fifty-five years old, inclusive, shall be allowed one examination within a period designated by the Department.

(3) An enrollee over fifty-five years old shall be allowed one examination within a period designated by the Department.

(4) An annual pap smear for a women of child bearing age shall be included in the health assessment for an enrollee age twenty-one or older.

(c) Coverage of immunizations for diphtheria and tentanus shall be provided.

(d) Coverage shall be provided for bona fide emergency room visits including ground ambulance, emergency room services, and physician services in conjunction with the emergency room visits. Bona fide emergency room visits shall be restricted to those requiring services for medical conditions manifesting themselves in acute symptoms of such severity that the absence of medical attention could reasonably be expected to result in placing the enrollee's health in serious jeopardy, or serious impairment of bodily functions, or serious dysfunction of any body organ or part.

(e) Each enrollee shall be provided a maximum coverage of six mental health visits, limited to one treatment per day.

(1) After exhausting the coverage of six mental health visits, an enrollee may use coverage of up to six of the enrollee's twelve outpatient visits, as available, for additional mental health visits.

(2) Services for substance abuse conditions shall be covered as mental health visits. The following restrictions on substance abuse treatment apply.

(A) Outpatient substance abuse services shall be considered toward the maximum coverage of six mental health visits and six annual outpatient visits if used for additional mental health visits.

(B) Inpatient substance abuse services shall be considered toward an enrollee's maximum coverage of ten hospital days.

(C) All substance abuse services shall be provided under an individualized treatment plan approved by the plan.

(f) Coverage shall be provided for over-the-counter and prescription drugs limited by a strict formulary and defined in the contract negotiated between the plans and the department.

(g) Coverage shall be provided for family planning services to include family planning services rendered by physician or nurse midwife and family planning drugs, supplies and devices approved by the federal Food and Drug Administration.

(h) A participating plan may at the plan's option provide coverage of any service not required by the contract with the department, not covered under this section, or excluded under section 17-1728-17.

(i) Except for capitated payments to the plans, the department shall not be responsible for coverage of any service for any adult in QUEST-Net."]
[Eff 03/30/96; am 11/25/96; am 06/19/00;
am 08/19/11; R] (Auth: HRS §346-14)
(Imp: HRS §346-14; 42 C.F.R. §430.25)

83. Section 17-1728-19, Hawaii Administrative Rules, is repealed:

["§17-1728-19 Medical services not available to adults in QUEST-Net. The following services shall not be required to be covered by participating plans or the department for an individual age twenty-one or older in QUEST-Net:

(1) Custodial or domiciliary care;
(2) Services received in skilled nursing facilities, intermediate care facilities, and intermediate care facilities for the mentally retarded;
(3) Personal care items such as shampoos, toothpaste, mouthwashes, denture cleansers, shoes including orthopedic footwear, slippers, clothing, laundry services, baby oils and powders, sanitary napkins, soaps, lip balms, and bandages;
(4) Non-medical items such as books, telephones, electronic transmitting and paging devices, radios, linens, clothing, televisions sets, computers, air conditioners, air purifiers, fans, household items and furnishings;

(5) Emergency facility services for non-emergencies;
(6) Out-of-state emergency and non-emergency services;
(7) Experimental and investigational services, procedures, drugs, devices, and treatments;
(8) Organ and tissue transplantation and transplantation services for either a recipient or a donor;
(9) Blood, blood products, and blood storage on an outpatient basis;
(10) Gender reassignment and related medical, surgical, and psychiatric services, drugs, and hormones;
(11) In vitro fertilization, reversal of sterilization, artificial insemination, sperm banking procedures, and drugs to test fertility;
(12) Eyeglasses, contact lenses, low vision aids, orthoptic training, and refractions;
(13) Hearing aids and related supplies and services, including fitting for, purchase of, rental of, and insuring of hearing aids;
(14) Durable medical equipment, prosthetic devices, orthotics, medical supplies, and related services including purchases, rental, repairs, and related services, except as supplied as part of an inpatient hospital stay;
(15) Biofeedback, acupuncture, naturopathic services, faith healing, Christian Science services, hypnosis, massage treatment;
(16) Obesity treatment, weight loss programs, food, food supplements, health foods, and prepared formulas;
(17) All services, procedures, equipment, supplies not specifically listed which are not medically necessary;
(18) Cosmetic surgery or treatment, cosmetic rhinoplasties, reconstructive or plastic surgery to improve appearance and not bodily function, piercing of ears and other body

areas, electrolysis, hair transplantation, reduction and augmentation mammoplasties, paniculectomies and other body sculpturing procedures, excision or destruction of benign skin or subcutaneous lesions without medical justification;

(19) Transportation including air (fixed wing or helicopter) ambulances;

(20) Hospice services;

(21) All home health agency services;

(22) Personal care, chore services, adult day health, private duty nursing, social worker services, case management services, targeted case management services, and community care long term care branch services;

(23) Tuberculosis services when provided without cost to the general public;

(24) Hansen's disease treatment or follow-up;

(25) Treatment of persons confined to a public institution;

(26) Penile and testicular prostheses and related services;

(27) Chiropractic services;

(28) Psychiatric care and treatment for sex and marriage problems; weight control, employment counseling, primal therapy, long term character analysis, marathon group therapy, and consortium;

(29) Routine foot care and treatment of flat feet;

(30) Swimming lessons, summer camp, gym membership, weight control classes;

(31) Outpatient renal dialysis, cardiac and coronary artery surgery involving cardio-pulmonary by-pass, cataract surgery with or without intraoccular lens implants, and refractive keratoplasty;

(32) Physical therapy, occupational therapy, speech therapy, respiratory services, and sleep studies rendered on an outpatient basis;

(33) Medical services provided without charge by any other federal, state, municipal, territorial, or other government agency including the Veterans Administration;

(34) Medical services for an injury or illness caused by another person or third party from whom the enrollee has or may have a right to recover damages;

(35) Medical services that are payable under the terms of any other group or non-group health plan overage;

(36) Medical services that do not follow standard medical practice or are not medically necessary;

(37) Stand-by services by a stand-by physician and telephone consultation;

(38) Services provided for illness or injury caused by an act of war, whether or not a state of war legally exists, or required during a period of active duty that exceeds thirty days in any branch of the military;

(39) Treatment of sexual dysfunction including medical and surgical procedures, supplies, drugs, and equipment;

(40) All services excluded by the Hawaii Medicaid Program;

(41) All services not provided by providers licensed or certified in the State of Hawaii to perform the service;

(42) Medical services that are payable under terms of worker compensation, automobile medical and no-fault, underinsured or uninsured motorist, or similar contract of insurance;

(43) Physical examination required for continuing employment, such as taxi driver's or truck driver's licensing, or as required by government or private businesses;

(44) Physical examinations, psychological evaluations, and immunizations as a requirement for licenses or for purposes of securing insurance policies or plans;

(45) Allergy testing and treatment;
(46) Treatment of any complication resulting from previous cosmetic, experimental, investigation service, or any other non-covered service;
(47) Rehabilitation services requiring intensive continuous care, inpatient or outpatient, including cardiac, alcohol or drug dependence rehabilitation;
(48) All acne treatment, surgery, drugs for adults; removal or treatment of asymptomatic benign skin lesions or growth; and
(49) Prenatal, postpartum, and delivery services including all laboratory testing in both inpatient and outpatient setting. An exception is one outpatient visit to confirm pregnancy, as identified as a covered service in this chapter."] [Eff 03/30/96; am 06/19/00; am 09/10/09; R] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

84. Section 17-1728-20, Hawaii Administrative Rules, is amended by amending subsection (a) to read as follows:

"§17-1728-20 Dental services for adults in QUEST-Net. (a) Dental services for an individual age twenty-one years and older in QUEST-Net shall be provided in accordance [to] with section [17-1737-75.1.] 17-1737-75(b).

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[Eff 03/30/96; am 06/19/00; am 02/16/02; am 09/10/09; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

85. Section 17-1728-21, Hawaii Administrative Rules, is amended by amending subsection (b) to read as follows:

"§17-1728-21 Reimbursement to participating [medical] health plans.

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(b) The department shall provide the capitated payment, as stipulated in the contract between the department and each participating health plan, in return for the health plan's provision of all contracted coverage for the health plan's enrollees." [Eff 03/30/96; am 02/16/02; am] (Auth: HRS §346-14) (Imp: HRS §346-16; 42 C.F.R. §430.25)

86. Section 17-1728-22, Hawaii Administrative Rules, is amended to read as follows:

"§17-1728-22 Enrollment of adults in QUEST-Net[medical] health plans. (a) An adult who was enrolled in a QUEST health plan prior to participating in QUEST-Net shall be enrolled in the QUEST-Net health plan administered by [the health coverage carrier] the participating health plan which administered the QUEST health plan in which the person was enrolled.

[(b) If an adult was enrolled in a QUEST plan administered by a health coverage carrier which does not participate in QUEST-Net, the adult shall select and be enrolled in a QUEST-Net plan serving the area of the adult's residence.

(c) An adult who participated in QUEST prior to QUEST-Net but was not enrolled in a QUEST plan shall select and be enrolled in a participating QUEST-Net plan serving the area of the adult's residence with the exception of an adult identified in subsection (f).]

[(d)](b) An adult who is disenrolled from a QUEST-Net health plan shall be allowed to select a health plan of their choice:

(1) If disenrollment extends for more than sixty calendar days in a benefit period;
(2) If disenrollment occurred in a period involving the annual open enrollment period; or

(3) If disenrollment includes the first day of a new benefit period.

[(e)](c) An adult who [participated in the fee for service QUEST-Spenddown program or coverage for aged, blind, and disabled individuals] was covered by fee-for-service prior to QUEST-Net, shall select and be enrolled in a participating QUEST-Net health plan serving the area of the person's residence with the exception of an adult identified in subsection [(f)](d).

[(f)](d) In the absence of a choice of health [plan] plans in a [rural] service area, an adult who resides in that particular service area shall be enrolled in the participating QUEST-Net health plan." [Eff 03/30/96; am 06/19/00; am 02/16/02; am 05/10/03; am 08/19/11; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

87. Section 17-1728-23, Hawaii Administrative rules, is amended to read as follows:

"§17-1728-23 Initial enrollment in QUEST-Net [medical] health plans. (a) An adult, who was not enrolled in a QUEST health plan prior to QUEST-Net participation, shall be [allowed ten days to select a QUEST-Net plan.] enrolled in a health plan for purposes of providing the individual with covered services effective the applicable date as described in section 17-1728-24 and the date the individual selects or is assigned to a health plan.

(b) After the individual is enrolled in a participating health plan, the individual shall be:

(1) Sent an enrollment letter identifying the assigned plan and the option to remain in the assigned plan or to select a different health plan;

(2) Allowed ten days from the date of the enrollment letter to select from among the participating health plans available in the service area in which the individual resides that are accepting new members. This

provision shall not apply to an individual identified in subsection (f).

(c) If an individual does not select a different health plan within ten days from the date of the enrollment letter, enrollment shall continue in the same health plan in which the adult was enrolled.

(d) If an individual chooses to enroll in a different health plan within ten days, a confirmation notice will be mailed to the enrollee on the first day of the following month when enrollment in the new health plan becomes effective.

[(b) An adult, who was enrolled in a QUEST plan administered by a health coverage carrier that does not administer a QUEST-Net plan shall be allowed ten days to select a QUEST-Net plan.

(c)](e) An adult who was enrolled in a QUEST health plan shall [be allowed ten days to provide a written request to participate in the QUEST-Net plan administered by the same health coverage carrier that administers the QUEST]be allowed to change enrollment from one health plan [in which the adult was enrolled.] to another that is open to new members during the annual open enrollment period.

[(d)](f) In the absence of a choice of health [plan] plans in a [rural] service area, an adult who resides in that particular service area shall be [allowed ten days to provide a written request to participate in the QUEST-Net] enrolled in the participating health plan.

[(e) An adult who fails to select a QUEST-Net plan or provide a written request to participate in QUEST-Net within ten days shall be deemed ineligible for QUEST-Net participation.]" [Eff 03/30/96; am 10/26/01; am 02/16/02; am 05/10/03; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

88. Section 17-1728-24, Hawaii Administrative Rules, is amended to read as follows:

"§17-1728-24 Effective date of enrollment. (a) For an adult who [participated in the fee for service QUEST-Spenddown program or coverage for aged, blind, and disabled individuals,] was covered by fee-for-service, the effective date of QUEST-Net enrollment shall be the first day of the month after the adult's [fee for service] fee-for-service coverage is terminated.

(b) For an adult enrolled in a QUEST health plan, the effective date of QUEST-Net enrollment shall be the first day of the month after the last day of coverage by the QUEST health plan.

[(c) For a QUEST recipient who was not enrolled in a QUEST plan, the effective date of QUEST-Net enrollment is the date the enrollment process has been completed to enroll the adult in a QUEST-Net plan.

(d)](c)If an adult changes residence from one service area to another, the effective date of QUEST-Net enrollment is the date the enrollment process has been completed to enroll the adult in a QUEST-Net health plan." [Eff 03/30/96; am 06/19/00; am 05/10/03; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

89. Section 17-1728-25, Hawaii Administrative Rules, is amended by amending subsections (a), (b), (c), and (d) to read as follow:

"§17-1728-25 Changes from one QUEST-Net health plan to another. (a) An enrollee shall only be allowed to change from one QUEST-Net health plan to another that is open to new members during the annual QUEST-Net open enrollment period. Exceptions to this provision include:

(1) Decisions from administrative hearings;
(2) Legal decisions;
(3) Termination of the enrollee's health [plan] plan's contract;
(4) Mutual agreement [of] by the [medical] health plan involved, the enrollee, and the department; [or]

(5) Violations by health plan as specified in sections 17-1727-61 and 17-1727-62[.];

[(6) Change of residence by an enrollee from one service area to another and:

(A) In this event, the individual or family shall be allowed ten days to select a health plan servicing the new service area in which the individual resides; and

(B) If a selection is not made within ten days of request, enrollment in a health plan shall be assigned by the department; or]

(6) Relocation of the enrollee to a service area where the health plan does not provide service;

(7) The enrollee's PCP is not in the health plan's provider network and is in the provider network of a different health plan;

(8) The enrollee missed the open enrollment period due to temporary loss of Medicaid eligibility and was re-enrolled in their previous assigned health plan;

(9) Provisions in federal or state statutes or administrative rules;

(10) The health plan's refusal, because of moral or religious objections, to cover the service the enrollee seeks as allowed for in the contract with the health plan;

(11) The enrollee's need for related services (i.e., a cesarean section and a tubal ligation) to be performed at the same time and not all related services are available within the network and the enrollee's primary care physician or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk;

(12) Lack of direct access to women's health care specialists for breast cancer screening, pap smears, and pelvic exams;

(13) Other reasons, including but not limited to, poor quality of care, lack of access to covered services, or lack of access to providers experienced in dealing with the enrollee's health care needs, lack of direct access to certified nurse midwives, pediatric nurse practitioners, family nurse practitioners, if available in the geographic area in which the enrollee resides; or

[(7)](14) Other special circumstances as determined by the department.

(b) The annual QUEST-Net open enrollment period shall generally occur [in May of each calendar year.] each calendar year at a time designated by the department.

(c) An enrollee who is enrolled in a non-returning health plan shall be allowed to select from the available health plans[.] during the open enrollment period.

(d) If the enrollee is required to select a health plan, but does not select a health plan during the open enrollment period, enrollment in a health plan shall be assigned by the department."

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[Eff 03/30/96; am 11/25/96; am 06/19/00; am 10/26/01; am 05/10/03; am 09/17/07; am 08/19/11; am
] (Auth: HRS §346-14) (Imp HRS §346-14; 42 C.F.R. §430.25; §438.56)

90. Section 17-1728-25, Hawaii Administrative Rules, is amended by amending subsection (f) to read as follow:

"§17-1728-25 Changes from one QUEST-Net health plan to another.

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(f) In the absence of a choice of health plan in a [rural] service area, an enrollee who resides in that particular service area shall be enrolled in the

participating health plan and shall not participate in the annual open enrollment period."

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[Eff 03/30/96; am 11/25/96; am 06/19/00; am 10/26/01; am 05/10/03; am 09/17/07; am 08/19/11; am] (Auth: HRS §346-14) (Imp HRS §346-14; 42 C.F.R. §430.25; §438.56)

91. Section 17-1728-26, Hawaii Administrative Rules, is repealed.

["§17-1728-26 Financial responsibility of adult enrollees. (a) An adult enrollee may be responsible for payment of the unadjusted contracted rate paid by the department to a participating plan for the enrollee's coverage. This payment required of the enrollee shall be known as the premium-share.

(b) An enrollee who is assessed a premium-share shall pay the amount to the department by the tenth day of the benefit month.

(c) An adult enrollee whose countable family income exceeds two hundred per cent of the federal poverty level for a family of applicable size shall be responsible for a premium-share equal to the total cost of the enrollee's coverage under QUEST-Net. The following groups of individuals are exempt from this provision:

(1) A financial assistance recipient;
(2) A grant diversion program participant for up to four months. Any month in which the participant received medical assistance coverage shall count as one of the four months; and
(3) A supporting employment empowerment program participant for up to six months. Any month in which the participant received medical assistance coverage shall count as one of the six months.

(d) An adult enrollee whose countable family income does not exceed two hundred per cent of the

federal poverty level for a family of applicable size shall not be responsible for a premium-share.

(e) A maximum of five enrollees in a family shall be assessed a premium-share for QUEST-Net coverage by the department in the following manner:

(1) Determine the number of persons in a family eligible for QUEST-Net coverage who are responsible for a premium-share; and

(2) Assess premium-shares to a maximum of five enrollees in descending order by date of birth."] [Eff 03/30/96; am 11/25/96; am 06/19/00; am 10/26/01; am 12/03/01; am 09/17/07; am 09/10/09; R] (Auth: HRS §346-14) (Imp HRS §346-14; 42 C.F.R. §430.25)

92. Section 17-1728-27, Hawaii Administrative Rules, is amended by amending subsections (b) and (c) to read as follows:

"§17-1728-27 Disenrollment from QUEST-Net health plans.

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(b) An individual who does not meet the QUEST-Net eligibility requirements shall be disenrolled from the QUEST-Net health plan in which the individual is enrolled.

(c) The department may disenroll an enrollee for reasons which include, but are not limited to, the following:

[(1) The individual's or family's designated premium-share payments for QUEST or QUEST-Net coverage are two months in arrears;]

[(2)](1) [To]Failure to comply with an administrative appeal decision or a court order;

[(3)](2) A mutual agreement between the individual, the [medical] health plan involved, and the department; or

[(4)](3) An individual's voluntary withdrawal from participation in QUEST-Net."

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[Eff 3/30/96; am 11/25/96; am 02/16/02; am 05/10/03; am 09/17/07; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25; §438.56)

93. Section 17-1728-29, Hawaii Administrative Rules, is amended by amending subsection (a) to read as follows:

"§17-1728-29 Requirements of QUEST-Net recipients requesting a change in coverage to QUEST or [the fee for service coverage for the aged, blind and disabled] QUEST Expanded Access. (a) A QUEST-Net recipient may verbally request a change in coverage to QUEST or [the fee for service coverage for the aged, blind and disabled as applicable.] QUEST Expanded Access.

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[Eff 11/25/96; am 02/10/97; am 06/19/00; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

94. Section 17-1728-29, Hawaii Administrative Rules, is amended by amending subsection (c) to read as follows:

"§17-1728-29 Requirements of QUEST-Net recipients requesting a change in coverage to QUEST or [the fee for service coverage for the aged, blind and disabled] QUEST Expanded Access. ***

(c) Upon the timely submittal of a written request, the date of a verbal request for coverage shall be the effective date of QUEST coverage. The effective date of [fee for service] QUEST Expanded Access coverage shall be the first day of the month in which the verbal request was received.

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[Eff 11/25/96; am 02/10/97; am 06/19/00; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

95. Chapter 17-1728, Hawaii Administrative Rules, is amended by adding new section to read as follows:

"§17-1728-31.1 Choice of participating health plans. (a) An eligible individual shall be allowed to choose from among the participating health plans which service the geographic area in which the individual resides. This provision shall not apply to an individual identified in subsection c.

(b) If a health plan has reached its maximum enrollment, the eligible individual shall select another health plan that is available. If only one other health plan is available to new members, subsection (c) shall apply.

(c) In the absence of a choice of health plans in a service area, an eligible individual who resides in that particular service area shall be enrolled in the participating health plan that is accepting new members." [Eff] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 430.51)

96. Chapter 17-1728, Hawaii Administrative Rules, is amended by adding a new section to read as follows:

"§17-1728-31.2 Assigned enrollment in participating health plans. (a) An eligible individual shall be allowed ten days to select an available health plan in which to enroll. This provision shall not apply to an individual identified in subsection (c).

(b) If timely selection among available health plans is not made, the department shall assign the enrollment of the individual to a health plan.

(c) In the absence of a choice of health plans in a service area, an eligible individual who resides in that particular service area shall be enrolled in the participating health plan." [Eff] (Auth: HRS §346-14) (Imp: HRS §346-15; 42 C.F.R. §§430.25, 430.51)

97. Chapter 17-1728, Hawaii Administrative Rules, is amended by adding a new section to read as follows:

"§17-1728-31.3 Choice of primary care provider. An eligible individual shall be allowed, under the procedures established by the health plan, to select a primary care provider from among those available within the health plan." [Eff] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 430.51)

98. Chapter 17-1728, Hawaii Administrative Rules, is amended by adding a new section to read as follows:

"§17-1728-31.4 Assignment of primary care provider. If timely selection by an enrollee from among the available primary care providers within the health plan is not made, the health plan shall assign the individual's care to a primary care provider of the health plan's choice." [Eff] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 430.51)

99. Subchapter 4 of Chapter 17-1728 is repealed.

100. Subchapter 5 of Chapter 17-1728 is repealed.

101. Section 17-1728.1-2, Hawaii Administrative Rules, is amending the definitions of "Adult", "Managed care", "Non-returning plan", "Participating health plan", "Personal reserve standard", and "Primary care provider" to read:

""Adult" means a person who is age nineteen and older [and is not a child under age twenty-one who is in foster care placement or is covered by a subsidized adoption agreement]."

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""Managed care" means a [method of health care delivery that integrates the financing, administration, and delivery of health services, or a coordinated delivery system made up of pre-established networks of] comprehensive approach to the provisions of

health care [providers providing a defined package of benefits under pre-established reimbursement arrangements.] that combines clinical services and administrative procedures within an integrated, coordinated system to provide timely access to primary care and other necessary services in a cost effective manner."

""Non-returning plan" means a [participating] health [plan] coverage carrier that [will not have its] has a current contract, [with the department renewed]but no new contract with the department."

""Participating health plan" means a health plan contracted by the State to provide medical services[,] or behavioral health services, through a managed care system, to individuals who are found eligible to participate in QUEST-ACE and have been enrolled in that health plan."

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""Personal reserve standard" means the maximum amount of countable assets that may be held by an individual[, a] or family[, or a household] while establishing or maintaining eligibility for medical assistance."

""Primary care provider" or "PCP" means a [physician or a nurse practitioner] provider who is licensed [to practice in the State and is contracted by a participating health plan to assess an enrollee's health care needs and provide services to meet those needs either directly or through the plan's provider network. A primary care provider who is a nurse practitioner shall be a family nurse practitioner, pediatric nurse practitioner, or, if the enrollee is a pregnant women, a nurse midwife.] in Hawaii and is 1) a physician, either an M.D. (doctor of medicine) or a D.O. (doctor of osteopathy), and must generally be a family practitioner, general practitioner, general internist, pediatrician, obstetrician-gynecologist (for women, especially pregnant women), or geriatrician, or 2) an advanced practice registered nurse with prescriptive authority. PCPs have the responsibility for supervising, coordinating and providing initial and primary care to the enrollee and for initiating referrals and maintaining the continuity of the enrollee care."

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102. Section 17-1728.1-2, Hawaii Administrative Rules, is amended by adding new definitions to read as follows:

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""Family" means an individual or a group of individuals living in the same household, generally consisting of parents and their natural, adoptive, or hanai children under nineteen, grandparents and their grandchildren under nineteen, an adult sibling and his or her hanai children under nineteen, an adult sibling and his or her siblings under nineteen, a married couple and siblings under nineteen of either spouse, an uncle or an aunt and his or her nephews and nieces under nineteen, a married couple and their nephews and nieces under nineteen, a single adult and his or her first cousins under nineteen, married couples and first cousins under nineteen of one of the spouses, any combination of the preceding relationships prefixed with grand, great-grand, great, great-great, half, and step."

""Hanai" means a child who is taken permanently to be reared, educated, and loved by an individual(s) other than natural parents at the time of the child's birth or early childhood. The child is given outright; the natural parents renounce all claims to the child."

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103. Section 17-1728.1-2, Hawaii Administrative Rules, is amended by deleting the definitions, "Date of approval", "Effective date of coverage", "Emergency services", "Hawaii QUEST or QUEST", "Health coverage carrier", "Prudent layperson", "Prudent layperson standard", and "Unadjusted contracted rate" .

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[""Date of approval" means the date on which the department completes the administrative process to

certify that an individual or a family is eligible for QUEST.”]

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[““Effective date of coverage" means the date on which health care services shall be covered by QUEST-ACE either through fee-for-service reimbursement by the department or its fiscal agent, or through enrollment in a QUEST-ACE health plan.]

[“Emergency services" means covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition that is found to exist using a prudent layperson standard.”]

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[““Hawaii QUEST or QUEST" means the demonstration project developed by the department which will deliver medical, dental, and behavioral health services, through health plans employing managed care concepts, to certain individuals formerly covered by public assistance programs including the aid to families with dependent children (AFDC), related medical assistance programs, general assistance (GA), and the state health insurance program (SHIP).”]

[““Health coverage carrier" means an insurance company or other organization which provides different health care benefit packages to one or more groups of enrollees.”]

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[““Prudent layperson" means one who possesses an average knowledge of health and medicine.”]

[““Prudent layperson standard" refers to the determination of a emergency medical condition based on the judgment of a prudent layperson.”]

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[““Unadjusted contracted rate" means the monthly payment paid by the State to a participating health plan for each member of the participating health plan assuming the application of risk adjustments across the entire population.”]

[Eff 05/24/07; am 09/10/09; am 08/19/11; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

104. Chapter 17-1728.1-6, Hawaii Administrative Rules, is amended to read as follows:

"§17-1728.1-6 Choice of participating health plans. (a) An eligible individual shall be allowed to choose from among the participating health plans which service the geographic area in which the individual resides. This provision shall not apply to an individual identified in subsection [(b)] (c).

(b) If a health plan has reached its maximum enrollment, the eligible individual shall select another health plan that is available. If only one other health plan is available to new members, subsection (c) shall apply.

[(b)] (c) In the absence of a choice of health [plan] plans in a [rural] service area, an eligible individual who resides in that particular service area shall be enrolled in the participating health plan that is accepting new members. [Eff 05/24/07; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 431.51)

105. Chapter 17-1728.1, Hawaii Administrative Rules, is amended by adding a new section to read as follows:

"§17-1728.1-8 Choice of primary care provider. An eligible individual shall be allowed, under the procedures established by the health plan, to select a primary care provider from among those available within the plan. [Eff] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 430.51)"

106. Chapter 17-1728.1, Hawaii Administrative Rules, is amended by adding a new section to read as follows:

"§17-1728.1-9 Assignment of primary care provider. If timely selection by an enrollee from among the available primary care providers within the health plan is not made, the health plan shall assign the individual's care to a primary care provider of the health plan's choice. [Eff] (Auth:

HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 430.51)"

107. Section 17-1728.1-12, Hawaii Administrative Rules, is amended by amending the title to read:

"§17-1728.1-12 [Basic] Non-financial eligibility requirements."

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[Eff 05/24/07; am 09/10/09; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

108. Section 17-1728.1-13, Hawaii Administrative Rules, is amended to read as follows:

"§17-1728.1-13 Categorical eligibility requirements. An individual who is eligible to participate in QUEST-ACE shall be:

(1) Age nineteen years and older;
(2) Not enrolled in, or covered by, a health plan;
(3) Not entitled for coverage by an employer sponsored health plan, with the exception of a financial assistance recipient [and] or a person who is participating in the department's grant diversion or supporting employment empowerment programs; and
(4) Not entitled to, or enrolled in, Medicare[; or
(5) Would be eligible for QUEST but is unable to enroll in QUEST due to the limitations of the statewide enrollment, as provided in section 17-1727-26 and meets all the provisions listed above.]." [Eff 05/24/07; am 09/10/09; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

109. Section 17-1728.1-14, Hawaii Administrative Rules, is amended to read as follows:

"§17-1728.1-14 Financial eligibility requirements. (a) An individual [shall have] whose countable family assets [that do not] exceed the personal reserve standards established in section [17-1721-14 or section 17-1727-14 to be eligible for] 17-1728-9 for a family of applicable size, shall be ineligible to participate in QUEST-ACE.

(b) An individual [who is not aged, blind or disabled] whose countable family income exceeds [the financial assistance payment standard and is equal to or below two] one hundred thirty-three per cent of the federal poverty level for a family of applicable size shall be [eligible] ineligible to participate in QUEST-ACE[;].

(c) An individual who is [aged] age sixty-five years or older, or who is blind or disabled [and whose countable income is above one hundred per cent of the FPL and does not exceed two hundred per cent of the FPL for a family of applicable size shall be eligible to participate in QUEST-ACE;] according to criteria employed by the Social Security Administration, shall first be determined ineligible for the department's QUEST Expanded Access program before participation in QUEST-ACE is allowed.

[(d) An individual who is blind and whose countable income is above SSI standard but does not exceed two hundred per cent of the FPL for a family of applicable size shall be eligible to participate in QUEST-ACE.]" [Eff 05/24/07; am 09/10/09; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

110. Chapter 17-1728.1, Hawaii Administrative Rules, is amended by adding a new section to read as follows:

"§17-1728.1-14.1 Eligibility for general assistance (GA). (a) An individual whose application

for financial assistance is approved under the department's GA program and who was not enrolled in another QUEST Expanded program the month prior to eligibility for GA,, shall be eligible for participation in QUEST-ACE if all categorical requirements specified in this subchapter are met.

(b) A GA applicant who is age sixty-five years or older, or who is blind or disabled according to criteria employed by the Social Security Administration, shall first be determined ineligible for the department's QExA program before participation in QUEST-ACE is allowed. [Eff] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25; 42 U.S.C. §1396u-1)"

111. Section 17-1728.1-21, Hawaii Administrative Rules, is amended to read as follows:

"§17-1728.1-21 Purpose. This subchapter describes the coverage and benefits that will be provided to recipients of the QUEST-ACE program and the change of coverage provision. [This subchapter also describes the enrollment provisions of the QUEST-ACE program.]" [Eff 05/24/07; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

112. Section 17-1728.1-22, Hawaii Administrative Rules, is amended to read as follows:

"§17-1728.1-22 [Standard] QUEST-ACE benefits [package]. (a) A participating health plan shall be required to provide [the benefits defined in this chapter, which shall be known as the standard benefits package] certain benefits as defined in the contract between the health plan and the department.

(b) The benefits minimally required to be provided by each of the participating health plans are named the QUEST-Adult and QUEST-Keiki benefits packages as defined in section 17-1727-48.1 and 17-1727-48.2 respectively.

[(b)](c) The [standard] QUEST-ACE benefits [package] as defined in this section [is] are based on a twelve-month benefit period. Benefits shall be pro-rated for any benefit period other than a twelve-month period. If a recipient changes health plans during a benefit period, the remaining unused benefits will be covered by the new health plan for the duration of the benefit period while enrolled in the new health plan.

[(c)](d) A participating health plan may, at the health plan's option, or as otherwise required by the contract between the health plan and the department or the state plan, provide benefits which exceed the requirements of the [standard] QUEST-ACE benefits [package].

[(d) The benefits provided for an individual under age twenty-one as described in chapter 17-1727 shall be provided for an individual under age twenty-one in QUEST-ACE.]" [Eff 05/24/07; am 09/10/09; am 08/19/11; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

113. Chapter 17-1728.1, Hawaii Administrative Rules, is amended by adding a new section to read as follows:

"§17-1728.1-22.1 Exclusions and limitations. Medical assistance payments shall not be made for certain services, procedures, medications, supplies, equipment, or other items that are:

(1) Specifically excluded from coverage by State or federal requirements;
(2) Provided by providers not licensed or certified in the State of Hawaii to perform the service;
(3) Available without charge to the general public through a separate State or federally administered federally-funded program;
(4) Covered by a third party medical or liability insurance, including Medicare;
(5) Required to receive prior authorization but did not receive it;

(6) Experimental in nature and/or have not been approved by the United States Food and Drug Administration;
(7) Elective and do not improve outcomes such as decreasing risk of morbidity or mortality;
(8) Without sufficient evidence of effectiveness or net benefit as determined by the department and/or not covered under the currently approved Medicaid State Plan and/or Medicaid waivers;
(9) Comparatively effective to a tolerated lower cost alternative; or
(10) Otherwise determined by the department to be non-covered, excluded, or limited.
[Eff] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §456.3)

114. Section 17-1728.1-23, Hawaii Administrative Rules, is repealed:

["§17-1728.1-23 Hospital services to be covered by the participating health plan. (a) A standard benefits package shall provide each enrollee no more than ten days of medically necessary inpatient hospital care related to medical care, surgery, psychiatric care, and substance abuse treatment. The following hospital services shall be made available to each enrollee:

(1) Semi-private room and board and general nursing care for inpatient stays related to medical care, surgery, psychiatric care, and substance abuse treatment;
(2) Intensive care room and board and general nursing care for medical care and surgery;
(3) Use of an operating room and related facilities, inpatient anesthesia, radiology, laboratory and other diagnostic services agreed upon by the participating health plan medical director for medical care and surgery;
(4) Drugs, dressings, blood derivatives and their administration, general medical supplies, and diagnostic and therapeutic

procedures as prescribed by the attending physician;

(5) Other ancillary services associated with hospital care except private duty nursing; and

(6) Ten inpatient physician visits.

(b) The following services are not included in the standard benefits package: inpatient hospital care related to maternity, newborn nursery, neonatal intensive care, and inpatient services in a freestanding rehabilitation hospital."]
[Eff 05/24/07; am 08/19/11; am 08/19/11;
R] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)]

115. Section 17-1728.1-24, Hawaii Administrative Rules, is repealed:

["§17-1728.1-24 Outpatient services to be covered by the participating health plan. (a) A standard benefit package shall provide each enrollee the following outpatient services:

(1) A maximum of twelve outpatient visits including adult health assessments, family planning services, diagnosis, treatment, consultations, to include substance abuse treatment, and second opinions. The maximum of twelve outpatient visits shall not pertain to:
   (A) Bonafide emergency room visits.
   (B) An enrollee's first six mental health visits. After the first six mental health visits, an enrollee may choose to apply a maximum of six additional mental health visits toward the maximum of twelve outpatient visits.
   (C) Diagnostic testing, including laboratory and x-ray, directly related to a covered outpatient visit.

(2) Coverage of medically necessary ambulatory surgical care shall be limited to three procedures.

(3) Maternity care coverage shall be limited to one routine visit to confirm pregnancy and any visits for the diagnosis and treatment of conditions related to medically indicated or elective termination of pregnancy such as ectopic pregnancy, hydatiform mole, and missed, incomplete, threatened, or elective abortions. These visits shall count toward the twelve maximum outpatient visits, ten maximum inpatient days, or three maximum ambulatory surgeries.

(b) An enrollee shall be provided the following health assessments which shall be counted toward the maximum of twelve outpatient visits.

(1) An enrollee age twenty-one to thirty-five years old, inclusive, shall be allowed one examination within a period designated by the department.

(2) An enrollee thirty-six to fifty-five years old, inclusive, shall be allowed one examination within a period designated by the department.

(3) An enrollee over fifty-five years old shall be allowed one examination within a period designated by the department.

(4) An annual pap smear for a woman of child bearing age shall be included in the health assessment for an enrollee age twenty-one or older.

(c) Coverage of immunizations for diphtheria and tentanus shall be provided.

(d) Coverage shall be provided for bonafide emergency room visits including ground ambulance, emergency room services, and physician services in conjunction with the emergency room visits. Bonafide emergency room visits shall be restricted to those requiring services for medical conditions manifesting themselves in acute symptoms of such severity that the absence of medical attention could reasonably be expected to result in placing the enrollee's health in serious jeopardy, or serious impairment of bodily functions, or serious dysfunction of any body organ or part.

(e) Each enrollee shall be provided a maximum coverage of six mental health visits, limited to one treatment per day.

(1) After exhausting the coverage of six mental health visits, an enrollee may use coverage of up to six of the enrollee's twelve outpatient visits, as available, for additional mental health visits.

(2) Services for substance abuse conditions shall be covered as mental health visits. The following restrictions on substance abuse treatment apply.

(A) Outpatient substance abuse services shall be considered toward the maximum coverage of six mental health visits and six annual outpatient visits if used for additional mental health visits.

(B) Inpatient substance abuse services shall be considered toward an enrollee's maximum coverage of ten hospital days.

(C) All substance abuse services shall be provided under an individualized treatment plan approved by the participating health plan."] [Eff 05/24/07; am 08/19/11; am 08/19/11; R] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

116. Section 17-1728.1-25, Hawaii Administrative Rules, is repealed:

["§17-1728.1-25 Medical services not available in QUEST-ACE. The following services shall not be required to be covered by participating health plans or the department:

(1) Custodial or domiciliary care;

(2) Services received in skilled nursing facilities, intermediate care facilities,

and intermediate care facilities for the mentally retarded;

(3) Personal care items such as shampoos, toothpaste, mouthwashes, denture cleansers, shoes including orthopedic footwear, slippers, clothing, laundry services, baby oils and powders, sanitary napkins, soaps, lip balms, and bandages;

(4) Non-medical items such as books, telephones, electronic transmitting and paging devices, radios, linens, clothing, televisions sets, computers, air conditioners, air purifiers, fans, household items and furnishings;

(5) Emergency facility services for non-emergencies;

(6) Out-of-state emergency and non-emergency services;

(7) Experimental and investigational services, procedures, drugs, devices, and treatments;

(8) Organ and tissue transplantation and transplantation services for either a recipient or a donor;

(9) Blood, blood products, and blood storage on an outpatient basis;

(10) Gender reassignment and related medical, surgical, and psychiatric services, drugs, and hormones;

(11) In vitro fertilization, reversal of sterilization, artificial insemination, sperm banking procedures, and drugs to test fertility;

(12) Eyeglasses, contact lenses, low vision aids, orthoptic training, and refractions;

(13) Hearing aids and related supplies and services, including fitting for, purchase of, rental of, and insuring of hearing aids;

(14) Durable medical equipment, prosthetic devices, orthotics, medical supplies, and related services including purchases, rental, repairs, and related services,

except as supplied as part of an inpatient hospital stay;

(15) Biofeedback, acupuncture, naturopathic services, faith healing, Christian Science services, hypnosis, massage treatment;

(16) Obesity treatment, weight loss programs, food, food supplements, health foods, and prepared formulas;

(17) All services, procedures, equipment, supplies not specifically listed which are not medically necessary;

(18) Cosmetic surgery or treatment, cosmetic rhinoplasties, reconstructive or plastic surgery to improve appearance and not bodily function, piercing of ears and other body areas, electrolysis, hair transplantation, reduction and augmentation mammoplasties, paniculectomies and other body sculpturing procedures, excision or destruction of benign skin or subcutaneous lesions without medical justification;

(19) Transportation including air (fixed wing or helicopter) ambulances;

(20) Hospice services;

(21) All home health agency services;

(22) Personal care, chore services, adult day health, private duty nursing, social worker services, case management services, targeted case management services, and community care long term care branch services;

(23) Tuberculosis services when provided without cost to the general public;

(24) Hansen's disease treatment or follow-up;

(25) Treatment of persons confined to a public institution;

(26) Penile and testicular prostheses and related services;

(27) Chiropractic services;

(28) Psychiatric care and treatment for sex and marriage problems; weight control, employment counseling, primal therapy, long

term character analysis, marathon group therapy, and consortium;

(29) Routine foot care and treatment of flat feet;

(30) Swimming lessons, summer camp, gym membership, weight control classes;

(31) Outpatient renal dialysis, cardiac and coronary artery surgery involving cardio-pulmonary by-pass, cataract surgery with or without intraoccular lens implants, and refractive keratoplasty;

(32) Physical therapy, occupational therapy, speech therapy, respiratory services, and sleep studies rendered on an outpatient basis;

(33) Medical services provided without charge by any other federal, state, municipal, territorial, or other government agency including the Veterans Administration;

(34) Medical services for an injury or illness caused by another person or third party from whom the enrollee has or may have a right to recover damages;

(35) Medical services that are payable under the terms of any other group or non-group health plan overage;

(36) Medical services that do not follow standard medical practice or are not medically necessary;

(37) Stand-by services by a stand-by physician and telephone consultation;

(38) Services provided for illness or injury caused by an act of war, whether or not a state of war legally exists, or required during a period of active duty that exceeds thirty days in any branch of the military;

(39) Treatment of sexual dysfunction including medical and surgical procedures, supplies, drugs, and equipment;

(40) All services excluded by the Hawaii Medicaid Program;

(41) All services not provided by providers licensed or certified in the State of Hawaii to perform the service;
(42) Medical services that are payable under terms of worker compensation, automobile medical and no-fault, underinsured or uninsured motorist, or similar contract of insurance;
(43) Physical examination required for continuing employment, such as taxi driver's or truck driver's licensing, or as required by government or private businesses;
(44) Physical examinations, psychological evaluations, and immunizations as a requirement for licenses or for purposes of securing insurance policies or plans;
(45) Allergy testing and treatment;
(46) Treatment of any complication resulting from previous cosmetic, experimental, investigation service, or any other non-covered service;
(47) Rehabilitation services requiring intensive continuous care, inpatient or outpatient, including cardiac, alcohol or drug dependence rehabilitation;
(48) All acne treatment, surgery, drugs for adults; removal or treatment of asymptomatic benign skin lesions or growth; and
(49) Prenatal, postpartum, and delivery services including all laboratory testing in both inpatient and outpatient setting. An exception is one outpatient visit to confirm pregnancy, as identified as a covered service in this chapter."][Eff 05/24/07, am 09/10/09; R] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

117. Section 17-1728.1-26, Hawaii Administrative Rules, is amending subsection (a) to read as follows:

"§17-1728.1-26 Dental services in QUEST-ACE.
(a) Dental services for an individual age twenty-one years and older are provided in accordance [to] with section [17-1737-75.1] 17-1737-75(b)."

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[Eff 05/24/07; am 09/10/09; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

118. Section 17-1728.1-32, Hawaii Administrative Rules, is amended to read as follows:

"§17-1728.1-32 [Reimbursement to participating health plans]Capitated payments. (a) Each participating health plan shall be paid on a capitated [payment] basis, [under the contract] as negotiated with the department, for individuals enrolled in the plan.

(b) The department shall provide the capitated payment, as stipulated in the contract between the department and each participating health plan, in return for the health plan's provision of all negotiated services for the health plan's enrollees."
[Eff 05/24/07; am] (Auth: HRS §346-14) (Imp: HRS §346-16; 42 C.F.R. §430.25)

119. Section 17-1728.1-35, Hawaii Administrative Rules, is amended to read as follows:

"§17-1728.1-35 Enrollment in QUEST-ACE [medical] health plans. (a) After being [found] determined eligible for coverage under QUEST-ACE, [an individual shall be allowed 10 days to select from among the participating health plans available in the service area in which the individual resides. This provision shall not apply to an individual identified in subsection (d).] an individual shall be enrolled in a health plan for purposes of providing the individual with covered services effective the applicable date as described in 17-1728.1-36(a) and the date the individual selects or is assigned to a health plan.

(b) After the individual is enrolled in a participating health plan, the individual shall be:

(1) Sent an enrollment letter identifying the assigned plan and the option to remain in the assigned plan or to select a different health plan;

(2) Allowed ten days from the date of the enrollment letter to select from among the participating health plans available in the service area in which the individual resides that are accepting new members. This provision shall not apply to an individual identified in subsection (g).

[(b)] (c) If an individual does not select a different participating health plan within ten days [of being determined eligible, the department shall assign and enroll the individual in a participating health plan.] from the date of the enrollment letter, enrollment shall continue in the health plan assigned by the department.

(d) If an individual chooses to enroll in a different health plan within ten days, a confirmation notice will be mailed to the enrollee on the first day of the following month when enrollment in the new health plan becomes effective.

(e) An enrollee shall only be allowed to change enrollment from one health plan to another that is open to receiving new members during the annual open enrollment period.

[(c)](f) An individual who is disenrolled from a participating health plan shall be allowed to select a health plan of their choice:

(1) If disenrollment extends for more than sixty calendar days in a benefit period;

(2) If disenrollment occurred in a period involving the annual open enrollment period; or

(3) If disenrollment includes the first day of a new benefit period.

[(d)](g) In the absence of a choice of health [plan] plans in a [rural] service area, an eligible individual who resides in that particular service area shall be enrolled in the participating health plan."
[Eff 05/24/07; am 08/19/11; am] (Auth:

HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 431.51)

120. Section 17-1728.1-36, Hawaii Administrative Rules, is amended to read as follows:

"§17-1728.1-36 Effective date of enrollment. (a) For applicants newly approved for coverage, the effective date of enrollment shall be one of the following:

(1) [The date the enrollment process has been completed to enroll an individual in a participating health plan.]The date the application is received by the department;

(2) Any date specified by the individual on which appropriate Medicaid eligible services were incurred and is no earlier than the immediate five days prior to the date the application is received by the department; or

(3) The date when all eligibility requirements are met by the applicant.

[(2)](4)If the applicant is found to be ineligible for the month of application, the first day of the subsequent month in which all eligibility requirements are met by the applicant.

(b) The effective date of enrollment resulting from an open enrollment period shall be implemented effective the first day of the month as determined by the [Department] department and shall generally extend [through the following year] for the benefit period.

(c) The effective date of enrollment resulting from a change from one health plan to another, other than during the open enrollment, shall be one of the following:

(1) The first day of the month following the date on which the department authorizes the enrollment change.

(2) If an individual changes residence from one service area to another, the date the enrollment process has been completed to enroll the individual in a participating

health plan."[Eff 05/24/07;
am] (Auth: HRS §346-14)
(Imp: HRS §346-14; 42 C.F.R. §§430.25[;],
431.51)

121. Section 17-1728.1-37, Hawaii Administrative Rules, is amended to read as follows:

"§17-1728.1-37 [Coverage of QUEST-ACE eligibles prior to the date of enrollment.] Method of coverage.
(a) An applicant who is initially determined eligible [under QUEST-ACE] shall be [eligible for coverage of health care costs within the scope of QUEST-ACE coverage by the department on a fee-for-service basis as of the date of coverage through the date of enrollment] covered by QUEST-ACE through enrollment in a QUEST-ACE health plan.

[(b) The date of coverage shall be one of the following:

(1) The date of application;
(2) If the applicant is found to be ineligible for the month of application, the first day of the subsequent month on which all eligibility requirements are met by the applicant; or
(3) If specified by the applicant, any date on which appropriate medical expenses, in accordance with this chapter, were incurred and which is within the immediate five calendar days prior to the date of application.

(c) The provisions of the fee for service program as described in chapter 17-1735, 17-1736, and 17-1737, are limited to the services in this chapter, and shall apply from the date of eligibility to the date of enrollment for those who are initially determined eligible for QUEST-ACE."] [Eff 05/24/07; am 09/10/09; am 08/19/11; am]
(Auth: HRS §346-14)(Imp: HRS §346-14; 42 C.F.R. §430.25)

122. Section 17-1728.1-38, Hawaii Administrative Rules, is amended to read as follows:

"§17-1728.1-38 Limitations to statewide enrollment in participating health plans. (a) The maximum statewide enrollment limit in the QUEST-ACE participating health plans shall be determined by the department and be no less than twelve thousand enrollees.

(b) The department shall not accept applications for QUEST-ACE coverage when the statewide enrollment [as of the last day of the previous calendar year exceeds] reaches the maximum allowed by this section.

(c) The department shall accept applications for QUEST-ACE coverage during an open application period to be announced by the department.

(1) Applications received during this open application period shall be processed within each Med-QUEST [Division] division eligibility office in the chronological order of their receipt by the Med-QUEST [Division] division.

(2) Individuals who are found eligible during this open application period shall be enrolled in participating health plans until the maximum enrollment allowed in subsection (a) is reached.

(3) All pending applications received during the open application period shall be discontinued when the maximum enrollment is reached.

(4) The open application period is the only period during which applications shall be accepted from individuals subject to the maximum statewide enrollment provision described in subsection (a). This period shall be established when the statewide enrollment on the last day of the previous calendar year is below ten thousand enrollees. The open application period shall occur [in May of the following calendar year] during the following year as

determined by the department. An open application period shall not occur more than once per calendar year." [Eff 05/24/07; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 431.51)

123. Section 17-1728.1-39, Hawaii Administrative Rules, is amended to read as follows:

"§17-1728.1-39 Changes from one QUEST-ACE plan to another. (a) The annual QUEST-ACE open enrollment period [shall generally] will occur [in May of each calendar year] as determined by the department.

(1) An enrollee who is enrolled in a non-returning health plan shall be allowed to select from the available participating health plans.

(2) If the enrollee is required to select a health plan, but does not select a health plan during the open enrollment period, enrollment in a health plan shall be assigned by the department.

(3) Changes in enrollment resulting from an open enrollment period shall be implemented effective the first day of the month as determined by the [Department] department and shall generally extend [to the following year] for the benefit period.

(4) In the absence of a choice of health [plan] plans in a [rural] service area, an enrollee who resides in that particular service area shall be enrolled in the particular health plan and shall not participate in the annual open enrollment period.

(b) An enrollee shall only be allowed to change from one QUEST-ACE health plan to another that is open to receiving new members during the annual QUEST-ACE open enrollment period.

(c) Exceptions to subsection (b) include the following:

(1) Decisions from administrative hearings;
(2) Legal decisions;
(3) Termination of the [participating] enrollee's health [plan] plan's contract;
(4) Mutual agreement by the participating health plans involved, the enrollee, and the department;
(5) Violations by a participating health plan as specified in sections 17-1727-61 and 17-1727-62[.];
[(6) Change of residence by an enrollee from one service area to another and:
(A) The individual shall be allowed ten days to select a health plan servicing the new service area in which the individual resides; and
(B) If a selection is not made within ten days of request, enrollment in a health plan shall be assigned by the department; or]
(6) Relocation of the member to a service area where the health plan does not provide service;
(7) Member's PCP is not in the health plan's provider network and is in the provider network of a different health plan.
(8) Provisions in federal and/or state statutes or administrative rules;
(9) The health plan's refusal, because of moral or religious objections, to cover the service the enrollee seeks as allowed for in the contract with the health plan;
(10) The enrollee's need for related services (i.e., a cesarean section and a tubal ligation) to be performed at the same time and not all related services are available within the network and the enrollee's PCP or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk;
(11) Lack of direct access to women's health care

specialists for breast cancer screening, pap smears, and pelvic exams;

(12) Other reasons, including but not limited to, poor quality of care, lack of access to covered services, or lack of access to providers experienced in dealing with the enrollee's health care needs, lack of direct access to certified nurse midwives, pediatric nurse practitioners, family nurse practitioners, if available in the geographic area in which the enrollee resides; or

[(7)](13) Other special circumstances as determined by the department."
[Eff 05/24/07; am] (Auth: HRS §346-14) (Imp HRS §346-14; 42 C.F.R. §430.25)

124. Section 17-1732-2, Hawaii Administrative Rules, is amended by deleting the definition of "Spenddown amount".

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[""Spenddown amount" means the amount of the individual's income in excess of the medically needy standard that is identified by the department as available to meet a portion of the individual's health care cost."]

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[Eff 07/06/99; am 04/30/10; am] (Auth: HRS §346-14) (Imp: HRS §346-14)

125. Section 17-1732-6, Hawaii Administrative Rules, is amended by amending subsection (c) to read as follows:

"§17-1732-6 Financial requirements. ***
(c) An uninsured individual under age nineteen, whose countable family income exceeds the appropriate income limit under the provisions of subsection (b) and the optional and mandatory categorically needy coverage groups in chapter 17-1721, but does not exceed [two]

three hundred per cent of the federal poverty level for a family of applicable size shall be financially eligible for medical assistance." [Eff 07/06/99; am 06/19/00; am 10/26/01; am] (Auth: HRS §346-14) (Imp: 42 U.S.C. §1396a; Pub. L. No. 105-33, §4901(a)

126. Section 17-1732-7, Hawaii Administrative Rules, is amended by amending subsection (b) to read as follows:

"§17-1732-7 Treatment of income. ***

(b) The countable family income shall be determined in the following manner:

(1) For a pregnant woman [and] or a child under nineteen years old, [who is born after September 30, 1983:] or both:
  - (A) Subtract a standard deduction of ninety dollars from the monthly gross earned income of each employed individual; and
  - (B) Add the monthly net earned income for each employed individual as well as any monthly unearned income.

(2) For all other family members, add the monthly gross earned income of each employed person and any monthly unearned income." [Eff 07/06/99; am 06/19/00; am] (Auth: HRS §346.14; 42 C.F.R. §435.601) (Imp: 42 C.F.R. §435.601)

127. Section 17-1732-10, Hawaii Administrative Rules, is amended by amending subsection (b) to read as follows:

"§17-1732-10 Continued eligibility for a pregnant woman.

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(b) Eligibility shall continue for a sixty day period following childbirth until the end of the month in which the sixty-day post-partum period ends. The woman's eligibility shall be redetermined for the

first month following the month in which the sixty-day period ends." [Eff 07/06/99; am]
(Auth: HRS §346-14; 42 C.F.R. §435.170) (Imp: 42 U.S.C. §1396a)

128. Section 17-1732-16, Hawaii Administrative Rules, is amended to read as follows:

"§17-1732-16 Effective date of coverage. Medical payment for covered services shall be authorized for eligible persons effective:

(1) The date [of] the application is received by the department;
(2) [If] Any date specified by the applicant[,] on which appropriate Medicaid eligible services were incurred and is [retroactive coverage may begin] no earlier than the first day of the [three months] third month prior to the month the application is received by the department[;] for individuals applying for the coverage of long-term care services, or the immediate five calendar days prior to the date the application is received by the department for all other individuals; or
(3) If ineligible for the month of application, the first day of the subsequent month [on] in which all eligibility requirements are met by the applicant." [Eff 07/06/99; am 01/31/09; am 06/11/09; am]
(Auth: HRS §346-14; 42 C.F.R. 430.25; §431.10) (Imp: 42 C.F.R. §435.914)

129. Section 17-1735-2, Hawaii Administrative Rules is amended by adding a new definition to read as follows:

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""Health plan contract period" means the period of time under which a health plan is continuously

operating under a contract including amendments without a new procurement."
[Eff 08/01/94; am] (Auth: HRS §346-14) (Imp: HRS §346-14)

130. Section 17-1735-3, Hawaii Administrative Rules, is amended to read as follows:

"§17-1735-3 Individuals covered under fee-for-service medical assistance. (a) Individuals eligible for the fee-for-service component under the medical assistance program include, but are not limited to:

(1) [Qualified Medicare Beneficiaries;
(2)] Children under age twenty-one who are residents of the State, receive child welfare services or subsidized adoption from the department or court, and are placed in another state;
[(3)](2) Emergency services for illegal, ineligible, qualified and non-qualified aliens[;]ineligible for Medicaid;
[(4) Individuals who are eligible for medical assistance for a period that is less than thirty days;
(5) Medically needy individuals who are expected to incur expenses sufficient to satisfy their spenddown obligation for less than a three-month period; and
(6)](3) Individuals who enter the State of Hawaii organ and tissue transplant (SHOTT) program[.]; and
(4) Incarcerated individuals who are admitted as an inpatient in a medical institution.

(b) Individuals who are enrolled in health plans participating under QUEST, QUEST-Net, QUEST-ACE, and QExA are excluded from the fee-for-service program, except [that] for the following services that may be provided on a fee-for-service basis subject to approval by the department:

(1) Services provided through the Medicaid waiver program for persons with developmental disabilities or [mental retardation] intellectual disabilities

(DD/ID) including HCBS, [DD-MR] and DD-ID case management[, and ICF-MR] services;
(2) [HCBS services provided through the Money Follows the Person (MFP) grant;
(3) ICF-MR] ICF-ID institutional services;
[(4)](3) School-based health related services [from the department of education];
[(5)](4) Early intervention program services [through the department of health]; [and]
[(6)](5) Serious and persistent mental illness and severe emotional behavioral disorder related services [through the department of health.]; and
(6) Dental services as described in 17-1737-75.

(c) Individuals who receive a determination of eligibility on or after the start date of a new health plan contract period that is retroactive to a date prior to the start of the new health plan contract period shall have services incurred during the period from the effective date of coverage up to the start date of the new health plan contract period covered on a fee-for-service basis.

(d) Individuals who receive a determination of eligibility for services incurred during a limited retroactive period and are not currently eligible shall have those services covered on a fee-for-service basis.

(e) As determined by the department on a case-by-base basis, an individual may be enrolled in a managed care program who otherwise would have had services covered on a fee-for-service basis."

[Eff 08/01/94; am 07/20/95; am 07/06/99, am 02/16/02; am 05/10/03; am 01/31/09; am] (Auth: HRS §346-14) (Imp: HRS §§88-4, 346-14; 42 C.F.R. §§435.1009; 440.150; 45 C.F.R §§211, 212; 42 U.S.C.§1396d(a)(28)(A))

131. Section 17-1735-5, Hawaii Administrative Rules, is amended to read as follows:

"§17-1735-5 Effective date of authorization. (a) [Medical payment for covered services shall be authorized for eligible persons under the

fee-for-service program beginning the first day of the month the application is received by the department].
The effective date for payments to be made for covered services under the fee-for-service program for individuals described in section 17-1735-3 shall be:

(1) The date the application is received by the department;

(2) Any date specified by the individual on which appropriate Medicaid eligible services were incurred and is no earlier than the first day of the third month prior to the month the application is received by the department for individuals applying for the coverage of long-term care services, or the immediate five calendar days prior to the date the application is received by the department for all other individuals; or

(3) The date when all eligibility requirements are met by the applicant.

(b) Payments shall be authorized retroactively for medical care and services received, no earlier than the first day of the [three months] third months prior to the month the application is received by the department [when:] for individuals applying for the coverage of long-term care services, *or* no earlier than the immediate five calendar days prior to the date the application is received by the department for all other individuals, when:

(1) The applicant's eligibility for medical assistance during the retroactive period is established:

(A) For the purpose of retroactive coverage, applicant includes a deceased individual on whose behalf a request for assistance is made by a relative, friend, or the department's representative after the individual's death; and

(B) The application form for a deceased individual shall be signed by the relative, friend, or the department's representative;

(2) Part or all of the applicant's medical bills remain unpaid;

(3) The expenses incurred by the applicant were for medical care and services within the scope of services covered under the department's medical assistance program and the department's medical consultant has approved the care received as medically necessary; and

(4) The care and services have been provided by an eligible participating provider."
[Eff 08/01/94; am 01/31/09; am 06/11/09; am] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §§435.914, 440.10, 440.20, 440.30, 440.40, 440.50, 440.60, 440.70, 440.80, 440.90, 440.100, 440.110, 440.120, 440.130, 440.140, 440.150, 440.155, 440.160, 440.165, 440.166, 440.167, 440-169, 440.170, 440.180, 440.181, 440-185)

132. Section 17-1737-2, Hawaii Administrative Rules, is amended by amending the definition of "Emergency medical condition" to read:

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""Emergency medical condition" means [a] the sudden onset of a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that a prudent layperson, who [possess] possesses an average knowledge of health and medicine, could reasonably expect the absence of emergency services or immediate medical attention to result in:

(1) Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(2) Serious impairment to body functions; or

(3) Serious dysfunction of any bodily organ or part;[.]

(4) Serious harm to self or others due to an alcohol or drug abuse emergency;

(5) Injury to self or bodily harm to others; or

(6) With respect to a pregnant woman who is having contractions:

(A) That there is adequate time to effect a safe transfer to another hospital before delivery; or

(B) That transfer may pose a threat to the health or safety of the woman or her unborn child."

***

133. Section 17-1737-2, Hawaii Administrative Rules, is amended by deleting the definitions of "Institutionalized individual", "Law enforcement agency", and "Med-QUEST":

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[""Institutionalized individual" means an individual who is involuntarily confined or detained, under a civil or criminal statute, in a correctional or rehabilitative facility, including a mental hospital or other facility for the care and treatment of mental illness; or confined, under a voluntary commitment, in a mental hospital or other facility for the care and treatment of mental illness."]

[""Law enforcement agency" means an agency charged under applicable law with enforcement of the general penal statutes of the United States or of any state or local jurisdiction."]

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[""Med-QUEST" means the division within the state department of human services which administers the medical assistance program."]

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[Eff 08/01/94; am 01/29/96; am 07/06/99; am 03/11/04; am 02/07/05;am 05/05/05; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 U.S.C. §1396r(8)(d)(4) and (5))

134. Section 17-1737-11, Hawaii Administrative Rules, is amended by amending the definition of "Psychiatric providers" to read as follows:

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""Psychiatric providers" means those individuals and facilities authorized to provide psychiatric services under the [medicaid] Medicaid program."

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135. Section 17-1737-11, Hawaii Administrative Rules, is amended by deleting the definitions of "Conjoint therapy", "Crisis intervention", "Emergency psychiatric care," "Group psychotherapy," "Psychiatric evaluation" and "Qualified clinical practitioner":

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[""Conjoint therapy" means treatment involving two family members only and shall be considered a form of individual therapy."]

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[""Crisis intervention" means a process providing time limited services to reduce a stressful situation or help a patient deal with stress more effectively."]

***

[""Emergency psychiatric care" means immediate relief or help to a person who has decompensated in the face of internal or external stress and who is unable to cope with the situation."]

***

[""Group psychotherapy" means a method of psychotherapeutic treatment involving interaction between patients and therapist for purposes which otherwise may not be feasible in individual psychotherapy or other modalities of treatment. Groups shall consist of four to ten patients."]

***

[""Psychiatric evaluation" means a diagnostic interview of a patient that includes history, mental status, and a report of the findings of the interview."]

***

[""Qualified clinical practitioner" means an authorized provider who maintains a private office and who cares for patients on a scheduled basis."]

***

[Eff 08/01/94; am 09/14/98; am]
(Auth: HRS §346-14) (Imp: 42 C.F.R. §§405.1011, 405.1020, 440.2, 440.50)

136. Section 17-1737-27, Hawaii Administrative Rules, is amended by amending the definitions of "Facility" and "ICF-MR" to read as follows:

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""Facility" means an institution such as a nursing facility or an intermediate care facility for the [mentally retarded] intellectually disabled or persons with related conditions [(ICF-MR)] ICF-ID, that furnishes health care services to inpatients."

***

[""ICF-MR"] "ICF-ID" means an intermediate care facility for the [mentally retarded] intellectually disabled or persons with related conditions."

***

137. Section 17-1737-27, Hawaii Administrative Rules, is amended by deleting the definitions of "Habilitation" and "IDPE":

***

[""Habilitation" means training or education provided to the recipient to enable the recipient to function better in society."]

[""IDPE" means an interdisciplinary professional evaluation conducted by an interdisciplinary professional evaluation team which, at the minimum, consists of complete medical, social, and psychological evaluations and diagnosis."]

***

[Eff 08/01/94; am 05/24/07; am] (Auth: HRS §346-14; 42 C.F.R. §§430.10, 431.10, 435.1009; Pub. L. No. 100-203) (Imp: 42 C.F.R. §§440.40, 440.150, 435.1009, 483.35, 483.301; 42 U.S.C. §§1396)

138. Section 17-1737-90, Hawaii Administrative Rules, is amended by deleting the definition of "Autologous bone marrow":

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[""Autologous bone marrow" is bone marrow obtained from the patient and stored for subsequent infusion."]

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[Eff 08/01/94; am 11/25/96; am] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §440.230; 42 U.S.C. §1396(b)(i))

139. Section 17-1737-103, Hawaii Administrative Rules, is amended to read as follows.

"17-1737-103 Eligibility for hospice care. (a) Hospice care shall be provided to eligible applicants and recipients of medical assistance who voluntarily elect hospice care. [in lieu of medicaid services which relate to the individual's terminal illness or a related condition, or which are duplicative of hospice services.] Medicaid will only cover services that are unrelated to the hospice diagnosis except for individuals under twenty-one years of age.

(b) Eligible applicants and recipients under twenty-one years of age shall be provided hospice service and curative treatment services related to the individual's terminal illness or associated condition.

[(b)](c) All of the following conditions shall be met:

(1) A written certification of terminal illness is obtained by the hospice, signed by the hospice physician and the individual's attending physician;
(2) The recipient or a representative voluntarily elects to participate in the [medicaid] Medicaid hospice program and signs the appropriate [medicaid] Medicaid form requesting this service; and
(3) Approval is obtained from the department on a designated form." [Eff 08/01/94; am] (Auth: HRS §346-14) (Imp: 42 U.S.C. §1396(a) and (d))

140. Section 17-1737-105, Hawaii Administrative Rules, is amended by amending subsection (a) to read as follows:

"§17-1737-105 Waiver of other [medicaid] Medicaid benefits. (a) An individual who elects hospice services shall waive all rights to [medicaid] Medicaid payments for services related to the treatment of the terminal condition for which hospice care was elected. [or a related condition or that are

equivalent to hospice care.] This provision shall not apply to individuals under twenty-one years of age."
***
[Eff 08/01/94; am] (Auth: HRS §346-14) (Imp: 42 U.S.C. §1396(a) and (d))

141. Section 17-1737-105, Hawaii Administrative Rules, is amended by amending subsection (c) to read as follows:

"§17-1737-105 Waiver of other [medicaid] Medicaid benefits. ***

(c) Medicaid payments may be made for other [medicaid] Medicaid covered services unrelated to the terminal condition for which hospice care was elected."
[Eff 08/01/94; am] (Auth: HRS §346-14) (Imp: 42 U.S.C. §1396(a) and (d))

142. Section 17-1737-116, Hawaii Administrative Rules, is amended by deleting the definition of "Acute care hospital services".

[""Acute care hospital services" means services ordinarily furnished in a licensed and certified hospital for the care and treatment of inpatients and does not include skilled nursing facility and intermediate care facility services."]
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[Eff 11/25/96; am 06/19/00; am] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §346-14)

143. Material, except source notes, to be repealed is bracketed. New Material is underscored.

144. Additions to update source notes to reflect these amendments are not underscored.

145. The amendments to chapters 17-1700, 17-1721, 17-1721.1, 17-1727, 17-1728, 17-1728.1, 17-1732, 17-1735 and 17-1737, Hawaii Administrative Rules, shall take effect ten days after filing with the Office of the Lieutenant Governor.