DEPARTMENT OF HUMAN SERVICES

Amendments to Chapters 17-1722.3, 17-1725, 17-1727 and 17-1739.1

Hawaii Administrative Rules

1. Section 17-1722.3-2, Hawaii Administrative Rules, is amended by amending the definition of "Benefit year" to read as follows:

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""Benefit year" means [the period from the first day of July of one calendar year through the thirtieth day of June of the following calendar year.] a continuous twelve month period generally following an open enrollment period.

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2. Section 17-1722.3-2, Hawaii Administrative Rules, is amended by deleting the definitions of "Annual plan change period", "Fee-for-service" and "QExA" to read as follows:

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[""Annual plan change period" means the period as determined by the department under section 17-1722.3-14 when enrollees may disenroll from the enrollee's current participating health plan and enroll in another participating health plan."]

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[""Fee-for-service" means the department's system of reimbursing health care providers for each eligible service provided."]

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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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3. Section 17-1722.3-2, Hawaii Administrative Rules, is amended by adding the definitions of "open application period" and "open enrollment period" to read as follows:

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""Open application period" means the only period during which applications shall be accepted from individuals subject to a specified duration and the statewide enrollment limit.

"Open enrollment period" previously known as "annual plan change period" means a period when an eligible individual is allowed to change from one to another participating health plan."

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[Eff 04/01/10; am] (Auth: HRS §346-14) (Imp: HRS §346-14)

4. Section 17-1722.3-10, Hawaii Administrative Rules, is amended to read as follows:

"§17-1722.3-10 Limitations to statewide enrollment in participating health plans. (a) The department shall accept applications [An] during an announced open application period [shall be announced] using one of the following methods as determined by the department:

(1) For a specified duration; or

(2) Up to a statewide enrollment limit. [after enrollment has dropped below 6,500 on last day of the previous calendar year that occurs after the implementation date.

(b) The maximum statewide enrollment in the participating health plans shall be 7,000.

(c)] (b) During the open application period, applicants shall submit their application to the med-QUEST division and the following shall apply:

(1) Applications shall be processed in the chronological order of their receipt by the med-QUEST division;

(2) Applications shall be processed in the following manner depending on the method used in subsection (a):

(A) If for a specified duration, all applications received after the specified duration shall be denied; and

(B) If up to a statewide enrollment limit, [All] all pending applications received during the open application period shall be denied when the number of individuals that have been determined eligible, when enrolled in a participating health plan, would meet the [maximum statewide enrollment allowed in subsection (b)] statewide enrollment limit; and

(3) Applications pending more than 45 days before a denial notification is issued shall not be subject to the provisions of subsection 17-1711-13(i).

[(d) An open application period shall not occur more than once per calendar year."] [Eff 04/01/10; am] (Auth: HRS §346-14) (Imp: HRS §346-14)

5. Section 17-1722.3-13, Hawaii Administrative Rules, is amended to read as follows:

"§17-1722.3-13 Enrollment in and choice of a participating health plan. (a) The department has the sole authority to enroll and disenroll an individual in a participating health plan.

(b) An eligible individual shall [within, ten days, select from among the participating] be enrolled in a health [plans] plan [available in the service area in which the] for purposes of providing the individual [resides if there is more than one participating health plan.] with covered services effective the date of eligibility as described in 17-1722.3-11.

(c) [If an] After the individual is in [subsection (b) does not select] a participating health plan, [within ten days of being determined eligible, the department shall assign and enroll] the individual [in a participating health plan.] 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 (h).

(d) 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 health plan assigned by the department.

(e) 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.

(f) An enrollee shall only be allowed to change enrollment from one health plan to another that is open to receiving new members during the 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's contract or the start of a new contract;

(4) Mutual agreement by the health plans involved, the enrollee, and the department;

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

(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;

(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 open enrollment period and that health plan's enrollment 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

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

(g) An individual who is disenrolled from a 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 open enrollment period; or

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

[(d)](h) In the absence of a choice of participating health plans in a service area, an eligible individual who resides in that particular service area shall be enrolled in the participating health plan.

[(e)](i) An individual who is disenrolled from a participating health plan or a health plan contracted to provide federal or state medical assistance shall be allowed to select a plan of their choice:

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

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

(3) If disenrollment includes the first day of a new benefit year." [Eff 04/01/10; am] (Auth: HRS §346-14) (Imp: HRS §346-14)

6. Section 17-1722.3-14, Hawaii Administrative Rules, is repealed:

["§17-1722.3-14 Changes from one participating health plan to another. (a) An enrollee shall only be allowed to change from one participating health plan to another during the annual plan change period, which shall occur once each calendar year.

(1) An enrollee who is enrolled in a non-returning plan shall be allowed to select

from the available participating health plans;

(2) If the enrollee is required to select a participating health plan, but does not select a participating health plan during the annual plan change period, enrollment in a participating health plan shall be assigned by the department;

(3) Changes in enrollment from one participating health plan to another during the annual plan change period shall be effective the first day of the month as determined by the department and shall generally extend to the following year;

(4) In the absence of a choice of participating health plans in a service area, an enrollee who resides in that particular service area shall not participate in the annual plan change period.

(b) Exceptions to subsection (a) include the following:

(1) Compliance with an administrative or judicial decision;

(2) Termination of the participating health plan contract;

(3) Mutual agreement by the participating health plans involved, the enrollee, and the department;

(4) As provided in sections 17-1727-61 and 17-1727-62;

(5) Change of residence by an enrollee from one service area to another with a choice of more than one participating health plan:

(A) The individual shall be allowed ten days to select a participating 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 participating health plan shall be assigned by the department.

(6) Change of residence by an enrollee from one service area to another with only one participating health plan shall result in enrollment into that participating health plan; or

(7) Other special circumstances as determined by the department."] [Eff 04/01/10; R] (Auth: HRS §346-14) (Imp: HRS §346-14)

7. Section 17-1722.3-16, Hawaii Administrative Rules, is amended to read as follows:

"§17-1722.3-16 Effective date of enrollment. (a) The effective date of enrollment into a participating health plan shall be the effective date [the enrollment process has been completed to enroll an individual in a participating health plan.] of eligibility as described in 17-1722.3-11.

(b) The effective date of enrollment resulting from a change from one participating health plan to another during the [annual plan change] open enrollment period, shall be the first day of the month as determined by the 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 participating health plan to another, other than during the [annual plan change] 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; or

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

[Eff 04/01/10; am] (Auth: HRS §346-14) (Imp: HRS §346-14)

8. Section 17-1722.3-17, Hawaii Administrative Rules, is repealed:

[“§17-1722.3-17 Coverage of Basic Health Hawaii eligibles prior to the date of enrollment. (a) An applicant who is initially determined eligible for Basic Health Hawaii shall be eligible for Basic Health Hawaii benefits provided by the department on a fee-for-service basis as of the date of eligibility through the date of enrollment.

(b) Health care services received on a fee-for-service basis are limited to the benefits identified in this chapter. Benefits received during this period shall be applied to the maximum benefits allowable in a benefit year.”] [Eff 04/01/10; R] (Auth: HRS §346-14) (Imp: HRS §346-14)

9. Section 17-1722.3-18, Hawaii Administrative Rules, is amended by adding subsection (j) to read as follows:

“§17-1722.3-18 Basic Health Hawaii benefits.

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“(j) The Basic Health Hawaii benefits defined in this section are based on a twelve-month period. Benefits shall be pro-rated for any period other than a twelve month period.”

[Eff 04/01/10; am] (Auth: HRS §346-14) (Imp: HRS §346-14)

10. Section 17-1725-10, Hawaii Administrative Rules, is amended to read as follows:

“§17-1725-10 Assets to be exempted. The following assets shall be exempted from consideration in the individual or family personal reserve:

(1) Basic maintenance items of limited value essential to day-to-day living including but not limited to clothing, furniture, stove, refrigerator, computer, or washing machine;
(2) One wedding ring and one engagement ring;
(3) All motor vehicles, with the exception of watercrafts or air transportation vehicles, including but not limited to, cars, trucks, vans, or motorcycles;
(4) Any equity in the home which is the usual residence of the individual, family, or household, as described in subchapter 5 except the home of a individual receiving long-term care services that is placed in a trust;
(5) All funds contained in a trust established after August 10, 1993 for a disabled (as defined in section 17-1721-6) individual under sixty-five years old established under 42 U.S.C. [§1396(p)] §1396p that meet the following conditions:
    (A) The trust was established with the assets of the disabled individual solely for the benefit of the disabled individual by a parent, grandparent, legal guardian, or court; and
    (B) The State will receive all amounts remaining in the trust upon the death of the disabled individual up to an amount equal to the total medical assistance received by the individual;
(6) All funds contained in a trust established after August 10, 1993 for a disabled (as defined in section 17-1721-6) individual under sixty-five years old that are established and managed by a non-profit organization established under 42 U.S.C. [§1396(p)] §1396p that meets the following conditions:
    (A) A separate account is maintained for each beneficiary of the trust, but for purposes of investment and management of funds, the trust may pool these accounts;
    (B) The accounts in the trust were established with the assets of the disabled individual solely for the

benefit of the individual by a parent, grandparent, legal guardian, or court; and

(C) The State will receive all amounts remaining in the disabled individual's account in the trust upon the death of the disabled individual up to an amount equal to the total medical assistance received by the individual;

(7) The value of the food stamp payments under the Food Stamp Act of l977 (7 U.S.C. §§2011-2027);

(8) The value of the U. S. Department of Agriculture donated foods (surplus commodities);

(9) Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (42 U.S.C. §§460l-4655);

(10) Payments distributed per capita to or held in trust for a member of any Indian tribe under 25 U.S.C. §§459-459e, 1179, 126l-1265, 1305, 1401-1407, and 1626 and Pub. L. No. 94-540. Effective October 17, 1975, pursuant to Pub. L. No. 94-114, §6 (89 Stat. 577, 25 U.S.C. §459e) receipts distributed to members of certain Indian tribes which are referred to in Pub. L. No. 94-114, §5 (89 Stat. 577, 25 U.S.C. 459d);

(11) Certain Indian judgment funds, as provided under Pub. L. No. 83-134, §7 and amended by Pub. L. No. 458, §4 (25 U.S.C. §1407), including those funds:

(A) Held in trust by the Secretary of the Interior (including interest and investment income accrued while such funds are so held in trust); or

(B) Distributed per capita to a household or member of an Indian tribe in accordance with a plan prepared by the Secretary of the Interior and not disapproved by a joint resolution of the Congress; and

(C) Initial purchases made with such funds. This exclusion does not apply to the proceeds from the sale of initial purchases, or to funds or initial

purchases which are inherited or transferred;

(12) As provided by Pub. L. No. 98-64, §2 (25 U.S.C. §1179), all funds:
  (A) Held in trust (including interest and investment income accrued while the funds were held in trust) by the Secretary of the Interior for an Indian tribe; [or]
  (B) Distributed per capita to a household or member of an Indian tribe; or
  (C) Initial purchases made with such funds.

  This exclusion does not apply to proceeds from the sale of initial purchases, subsequent purchases made with funds derived from the sale or conversion of initial purchases, or to funds or initial purchases which are inherited or transferred.

(13) Tax exempt portions of payments made pursuant to the Alaska Native Claims Settlement Act (43 U.S.C. §1620);

(14) As provided by Pub. L. No. 100-241, §15 (43 U.S.C. §1626), any of the following distributions made to a household, an individual Native, or a descendent of a Native by a Native Corporation established in accordance with the Alaska Native Claims Settlement Act (Pub. L. No. 92-203 as amended):
  (A) Cash distributions (including cash dividends on stock from a Native Corporation) received by an individual to the extent that such cash does not, in the aggregate, exceed $2,000 in a year. Cash which, in the aggregate, is in excess of $2,000 in a year is not subject to the above exclusion;
  (B) Stock, including stock issued or distributed by a Native Corporation as a dividend or distribution of stock;
  (C) A partnership interest;
  (D) Land or an interest in land, including land or an interest in land received by a Native Corporation as a dividend or distribution of stock; and
  (E) An interest in a settlement trust;

(15) Payments made to volunteers under the Domestic Volunteer Service Act of 1973 (Volunteers In Service to America (VISTA), student volunteers enrolled in institutions of higher education who participate in the University Year for Action (UYA) program, foster grandparents, senior health aides, senior companions) (42 U.S.C. §§4951-5085) and under the Small Business Act (Service Corps of Retired Executives (SCORE), and Active Corps of Executives (ACE)) (15 U.S.C. §637);

(16) Value of free school lunches, provided under the Child Nutrition Act of 1966 and the National School Lunch program (42 U.S.C. §§1771-1789);

(17) Any meals provided to senior citizens, such as congregate meals, or home delivered meals funded by the Older Americans Act of 1965 (42 U.S.C. §§3001-3057);

(18) Pursuant to Pub. L. No. 94-114, §6 (89 Stat. 577, 25 U.S.C. §459e) receipts distributed to members of certain Indian tribes which are referred to in Pub. L. No. 94-114, §5 (89 Stat. 577, 25 U.S.C. §459d);

(19) Refunds of utility and rental deposits paid by the department;

(20) Bonafide loans from any source including but not limited to educational loans, shall be exempt from consideration in the individual's or family's personal reserve. A bonafide loan is a debt that the borrower has an obligation to repay;

(21) Cash payments to the assistance unit responsible for household bills by a non-unit household member for his or her share of common household expenses;

(22) Restitution payments provided under the Civil Liberties Act of 1988, Title I of Pub. L. No. 100-383, and the Aleutian and Pribilof Islands Restitution Act, Title II of Pub. L. No. 100-383;

(23) Payments made from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.) effective to January 1, 1989;

(24) Effective August 1, 1994, payments to victims of Nazi persecution under Pub. L. No. 103-286;
(25) One burial space (including plots, vaults, and niches) per family member if intended for a member of the immediate family of the applicant or recipient;
(26) The value of bonafide funeral or burial plans or agreements;
(27) Payments received by aged, blind or disabled individuals under paragraphs 500 to 506 of the Austrian General Social Insurance Act to compensate individuals who suffered losses during the period March 1933 and May 1945 due to political, religious, or ethnic reasons;
(28) Payments received under the Radiation Exposure Compensation Act (Pub. L. No. 101-426) to compensate individuals for injuries or death resulting from the exposure to radiation from nuclear testing or uranium mining;
(29) Assistance payments received as a result of a declared federal major disaster or emergency from the Federal Emergency Management Agency (FEMA) and other comparable disaster assistance provided by any state or local government agency or disaster assistance organizations;
(30) Any grant made to an undergraduate or graduate student and made or insured under programs administered by the United States Secretary of Education, Title IV of the Higher Education Act, the Carl D. Perkins Vocational and Applied Technology Education Act (20 U.S.C. §2301), or the Bureau of Indian Affairs student assistance programs;
(31) Pursuant to Title IV, section 4735 of the Balanced Budget Act of 1997 (Pub. L. No. 105-33), payments received as a result of the settlement in the case of Susan Walker v. Bayer Corporation, et al, to compensate individuals who contracted the H.I.V. from contaminated blood products;
(32) Unspent portions of any retroactive RSDI or SSI benefits retained in the form of cash or deposited into a bank account is exempt for

a period of six calendar months following the month of receipt;

(33) Unspent portions of any VA payments received by or on behalf of certain Vietnam veteran's natural children for any disability resulting from spina bifida under Pub. L. 104-204 is exempt except for any interest that is earned on the unspent portion;

(34) Pursuant to Title IV, section 4735 of the Balance Budget Act of 1997 (Pub. L. No. 105-369), payments received from the Ricky Ray Hemophilia Relief Fund Act of 1998 (the Ricky Ray Act) to compensate individuals who contracted the H.I.V. from contaminated blood products; and

(35) Funds used to purchase an annuity that is irrevocable and not assignable.

(A) An annuity is irrevocable when the annuitant cannot void the contract and obtain the cash value of the annuity less early withdrawals and surrender fees.

(B) An annuity is not assignable when the annuitant cannot sell the annuity on the open market." [Eff 08/01/94; am 11/13/95; am 01/29/96; am 03/30/96; am 11/25/96; am 05/02/98; am 06/19/00; am 05/10/03; am 10/19/09; am] (Auth: HRS §346-53) (Imp: HRS §346-29; 20 C.F.R. 16.1201, 42 C.F.R. §431.10; 45 C.F.R. §233.20)

11. Section 17-1725-17, Hawaii Administrative Rules, is amended by amending subsection (d) and (e) to read as follows:

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"(d) In the case of a revocable trust the following apply:

(1) The corpus of the trust is considered an available asset;

(2) Payments from the trust to or for the benefit of the individual shall be considered income of the individual; and

(3) Any other payments from the trust shall be considered assets disposed and subject to penalty under circumstances described in

[section 17-1721-45] chapter 17-1721, subchapter 8.

(e) In the case of irrevocable trusts the following apply:

(1) If payments could be made to or for the benefit of the individual the portion of the corpus from which the payment could be made is considered an available asset;

(2) If payments could be made to or for the benefit of the individual the income on the corpus from which the payment could be made is considered an available asset;

(3) The payments in paragraphs (1) and (2) from the corpus or from the income on the corpus is considered income to the individual; and

(4) The portion of the corpus from which no payments could be made to or on behalf of the individual is considered assets disposed and subject to penalty under circumstances described in [section 17-1721-45] chapter 17-1721, subchapter 8."

[Eff 08/01/94; am 11/13/96; am] (Auth: HRS §346-53; 42 U.S.C. §1396p; C.F.R. §431.10) (Imp: HRS §346-53; 42 U.S.C. §1396p)

12. Section 17-1727-48.1, Hawaii Administrative Rules, is amended 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)] for 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)] for behavioral health inpatient days within a benefit period for psychiatric care and inpatient substance abuse treatment, all of which include, but are not limited to, 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; and
(5) Other ancillary services associated with hospital care except private duty nursing.

(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] <u>Outpatient</u> 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] to include but not limited to 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.

(19) Rehabilitation services including physical and occupational therapy, audiology and speech language pathology shall be provided.

(20) Coverage shall be provided for durable medical equipment, prosthetic devices, orthotics and medical supplies." [Eff 06/25/12; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

13. Section 17-1727-48.2, Hawaii Administrative Rules, is amended 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 06/25/12; am] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25; 42 C.F.R. §430.25)

14. Section 17-1739.1-2, Hawaii Administrative Rules, is amended by amending the definitions of "Drug formulary," "Enhanced prior authorization list," "Estimated acquisition cost" and "Preferred drug list" to read as follows:

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""Drug formulary" means [a listing of prescribed] prescription [drug] drugs [items] pursuant to 42 U.S.C. 1936r(8)(d)(4), for which payment may be made by the Hawaii Medicaid program."

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""Enhanced prior authorization list" means [a list of all other drugs in the therapeutic classes as those addressed by the preferred drug list but] non-preferred prescription drugs which require prior authorization."

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""Preferred drug list" means [a list of medications] prescription drugs, within specified therapeutic classes, or that are comparatively effective, that are designated as preferred for use as determined by a committee of physicians and pharmacists and approved by the department."

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15. Section 17-1739.1-2, Hawaii Administrative Rules, is amended by adding the definitions of "Estimated acquisition cost" and "Wholesale average cost" to read as follows:

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""Estimated acquisition cost" means the wholesale average cost.

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"Wholesale average cost" means the wholesale acquisition cost (WAC) which is defined as the list price paid by a wholesaler, distributor and other

direct accounts for drugs purchased from the wholesaler's supplier. Generally, it is the price put by the manufacturer of drug before any rebates, discounts, allowances or other price concessions are offered by the supplier of the product."

16. Section 17-1739.1-2, Hawaii Administrative Rules, is amended by deleting the definition of "Estimated acquisition cost for a drug product"

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[""Estimated acquisition cost for a drug product" means one of the following which shall be designated by the department:

(1) The average wholesale price minus 10.5 per cent; or

(2) The manufacturer's direct price. Average wholesale price shall be derived from the most commonly used package size listed in the Blue Book or the department's best estimate of the price generally and currently paid by providers for a drug labeler in the package size most frequently purchased by providers."]

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[Eff 10/26/01; am 05/10/03; am 03/11/04; am] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §§346-14, 346-59; 42 C.F.R. §431.10; 42 U.S.C. §1396r(8)(d)(4) and (5))

17. Section 17-1739.1-11, Hawaii Administrative Rules, is amended to read as follows:

"§17-1739.1-11 Payment for drugs and related supplies. (a) The state medical assistance program shall determine [allowances] reimbursement for [prescribed] the ingredient cost of prescription drugs using the following criteria:

(1) Single source drugs shall not exceed the lower of:

(A) The [billed charge] provider's invoice price;

(B) The provider's usual and customary charge to the general public; or

(C) The estimated acquisition cost (EAC) [or the average wholesale price (AWP) when the AWP is the average selling price for a drug product plus a reasonable dispensing fee;].

(2) Multiple source drugs shall not exceed the lower of:

(A) The [billed charge] provider's invoice price;

(B) The provider's usual and customary charge to the general public;

(C) The [estimated acquisition cost (EAC) or the average wholesale price (AWP) when the AWP is the average selling price for a drug product plus a reasonable dispensing fee] EAC;

(D) The federal upper limit (FUL) price [plus a reasonable dispensing fee]; or

(E) [If no federal upper limit, the] The state maximum allowable cost [(MAC) plus a reasonable dispensing fee] (SMAC).

[(3) Over-the-counter (OTC) drugs shall not exceed the lower of:

(A) The billed charge;

(B) The provider's usual and customary charge to the general public including any sale price which may be available on the day of service;

(C) The allowance set by the program (state maximum allowable cost);

(D) The estimated acquisition cost (EAC) or the average wholesale price (AWP) when the AWP is the average selling price for a drug product plus a reasonable dispensing fee; or

(E) The federal upper limit (FUL) price plus a reasonable dispensing fee; Under no circumstances shall the program pay more than the general public for the same prescription or item;

(4) Payments for medical supplies shall be the lower of:

(A) The rate set by the department; or

(B) Medicare's upper limit of payment;

(5) Payments for medical supplies shall be the lower of:
    (A) The rate set by the department;
    (B) The estimated acquisition cost (EAC) for a medical supply plus a reasonable dispensing fee; or
    (C) Medicare's upper limit of payment;
(6) The state medical assistance program requires that the lower cost equivalent drug product be dispensed if available in the marketplace and substitution is not prohibited by part VI, drug product selection of chapter 328, HRS. The recipient may refuse lower cost drug products but must pay the entire cost of the higher price equivalent;
(7) The federal upper limit price or the state maximum allowable cost shall not apply if the practitioner:
    (A) Certifies in his or her own handwriting that a specific brand is medically necessary for a particular recipient. A checkoff box is not acceptable but a notation of "brand medically necessary" or "do not substitute" is allowable;
    (B) Obtains medical authorization for medical necessity from the state medical assistance program for specific brands of medications designated by the program. In such cases, the payment shall not exceed the lower of:
        (i) The billed charge;
        (ii) The provider's usual and customary charge to the general public; or
        (iii) The estimated acquisition cost for a drug product plus a reasonable dispensing fee;
(8) Reimbursement for over-the-counter drugs shall be limited to the over-the-counter drug prescribed by the licensed practitioner and specifically designated by the medical assistance program. Over-the-counter drugs not specifically designated shall require medical authorization for medical necessity by the medical assistance program;
(9) The state Medicaid agency shall set the dispensing fee by taking into account the results of surveys of the cost of pharmacy

operations. The agency must periodically survey pharmacy operations; and

(10) Payment for prescribed drugs dispensed to outpatients and patients of long-term care facilities shall be made only upon the submission of an itemized claim by the dispensing provider (Form 204, hardcopy or electronic media claim (EMC) or via point-of-sale (POS).

(A) The dispensing fee for any maintenance or chronic medication shall be extended only once per thirty days without medical authorization from the medical assistance program. Other appropriate limits regarding the number of dispensing fees paid per interval of time shall be determined as necessary by the medical assistance program;

(B) Emergency calls by the pharmacist to the long-term care facility shall be paid up to a maximum of four calls for each one hundred beds in the facility at the time services are rendered, at $25 an emergency call. Any fraction of one hundred shall be prorated accordingly; and

(C) Facilities with less than twenty-five beds at the time services are rendered may charge up to one full emergency call per month. An emergency call shall be one that cannot be delayed, i.e. non-routine call to the patient of a facility by the pharmacist in a life-threatening situation. All other services shall be handled during the pharmacist's routine visits whenever possible.]

(3) The FUL price shall not apply if the practitioner:

(A) Certifies in his or her own handwriting or by an electronic method compliant with national standard approved by the Centers for Medicare and Medicaid Services that a specific brand medication is medically necessary for a particular recipient. A check-off box is not acceptable but a notation of

"brand medically necessary" or "do not substitute" is allowable; and

(B) Obtains prior authorization for medical necessity from the state medical assistance program. In such cases, the payment shall be according to the methodology in this section.

(4) The State medical assistance program requires that the lower cost equivalent drug product be dispensed if available in the marketplace and substitution is not prohibited by part VI of chapter 328, Hawaii Revised Statues, relating to drug product selection. The recipient may refuse lower cost drug products but must pay the entire cost of the higher price equivalent.

(5) If a published WAC is unavailable for the medication and the provider does not submit documentation of the invoice price, then the medication and dispensing fee shall not be reimbursed.

[(b) The following conditions shall apply to payment for drugs dispensed by physicians and dentists from the physicians' and dentists' offices:

(1) Physicians and dentists dispensing medications from the physicians' and dentists' offices shall be reimbursed at the estimated acquisition cost plus 50 cents; and

(3) If there is no pharmacy within five miles of the provider's office, special consideration for payment at the pharmacy rate may be made upon written request to the department's Med-QUEST administrator for approval.]

(b) The dispensing fee for prescription medications dispensed by a licensed pharmacy shall be:

(1) $5.00 (five and no/100 dollars) per prescription.

(2) The dispensing fee for any maintenance or chronic medication shall be extended only once per thirty (30) days without medical authorization from the medical assistance program. Other appropriate limits regarding the number of dispensing fees paid per interval of time shall be determined as necessary by the medical assistance program.

(c) The Department may cover selected over-the-counter medications.

(1) Reimbursement for over-the-counter medications shall be according to the methodology in subsection (a).

(2) Reimbursement for over-the-counter drugs shall be limited to the over-the-counter drugs prescribed by a licensed practitioner and specifically designated by the medical assistance program. Over-the-counter drugs not specifically designated shall require prior authorization for medical necessity by the medical assistance program.

(3) Under no circumstances shall the program pay more than the general public for the same prescription or item.

(d) The following conditions shall apply to payment for drugs dispensed by physicians and dentists from the physicians' and dentists' offices:

(1) Physicians and dentists dispensing medications from the physicians' and dentists' offices shall be reimbursed at the EAC plus $0.50 (fifty cents); and

(2) If there is no pharmacy within five miles of the provider's office, special consideration for payment at the pharmacy rate may be made upon written request to the department's med-QUEST division administrator for approval.

(e) Payment for prescribed drugs dispensed to outpatients and patients of long-term care facilities shall be made only upon the submission of an itemized claim by the dispensing provider (Form 204), hardcopy or electronic media claim or via point-of-sale.

(f) Emergency calls by the pharmacist to the long-term care facility:

(1) Shall be paid up to a maximum of four calls for each one hundred beds in the facility at the time services are rendered, at $25 (twenty-five and no/100 dollars) per emergency call. Any fraction of one hundred shall be prorated accordingly; and

(2) Facilities with less than twenty-five beds at the time services are rendered may charge up to one full emergency call per month.

(A) An emergency call shall be one that cannot be delayed, i.e. non-routine call to the patient of a facility by the pharmacist in a life-threatening situation.

(B) All other services shall be handled during the pharmacist's routine visits whenever possible.

(g) Payments for medical supplies shall be the lower of:

(1) The rate set by the department;

(2) Medicare's upper limit of payment; or

(3) The EAC for a medical supply." [Eff 10/26/01; am 05/10/03; am 05/05/05; am] (Auth: HRS §346-59) (Imp: 42 C.F.R. §§447.331, 447.332, 447.333)

18. Section 17-1739.1-12, Hawaii Administrative Rules, is repealed:

["§17-1739.1-12 Advisory estimated acquisition cost committee. (a) An advisory estimated acquisition cost committee shall be appointed by the director of the department, and shall consist of:

(1) One of the department's medical consultants;

(2) The department's pharmacy consultant who shall serve as chairperson;

(3) One practicing physician from the community;

(4) Three practicing pharmacists;

(5) Two members from either the pharmaceutical wholesale or manufacturing industry; and

(6) One lay person.

(b) The term of each committee member shall be two years and overlapped in such a way that expiration of terms do not cause a total membership change.

(c) A quorum shall consist of a simple majority of the total number of members.

(d) The duties of the advisory estimated acquisition cost committee shall be to:

(1) Meet semi-annually or when called by the chairperson;

(2) Review available data and advise the department of maximum estimated acquisition costs that should be paid for specific drug products that:

(A) Are available from multiple sources;

(B) Represent significant program expenditures;

(C) Could result in significant program savings; and

(D) Are considered to be bioequivalent by the food and drug administration.

(e) Actions of the advisory estimated acquisition cost committee shall be:

(1) Subject to the approval of the medical care administrator;

(2) Circulated to appropriate providers; and

(3) Effective upon receipt by providers unless otherwise stated."]

[Eff 10/26/01; R] (Auth: HRS §346-14) (Imp: 42 C.F.R. §447.332)

19. Material, except source notes, to be repealed is bracketed. New Material is underscored.

20. Additions to update source notes to reflect these amendments are not underscored.

21. The amendments to chapters 17-1722.3, 17-1725, 17-1727 and 17-1739.1, Hawaii Administrative Rules, shall take effect ten days after filing with the Office of the Lieutenant Governor.