HAWAII ADMINISTRATIVE RULES

TITLE 17

DEPARTMENT OF HUMAN SERVICES

SUBTITLE 12 MED-QUEST DIVISION

CHAPTER 1727

HAWAII HEALTH QUEST

Subchapter 1 General Provisions

Subchapter 2 Freedom of Choice

Subchapter 3 Eligibility

SUBCHAPTER 1

GENERAL PROVISIONS

§17-1727-1 Purpose. This chapter describes Hawaii QUEST, a demonstration project authorized by section 1115 of the Social Security Act. [Eff 08/01/94; am 01/29/96] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1727-2 Definitions. As used in this chapter:

"Adult" means a person who is age nineteen years or older.

"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.

"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.

"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, 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.

"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.

"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.

"Managed care" means a comprehensive approach to the provision of health care 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 that has a current, but no new contract with the department.

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

"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 and have been enrolled in that health plan.

"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 provider" or "PCP" 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, 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’s care.

"QUEST" means Hawaii QUEST.

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

"Section 1931 of the Social Security Act" means the section that was added to the Social Security Act by the Personal Responsibility and Work Opportunity Act of 1996, which established a new mandatory eligibility group of low-income families with children.

"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. [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 06/25/12] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §346-14)

§17-1727-3 (Reserved).

SUBCHAPTER 2

FREEDOM OF CHOICE

§17-1727-4 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 08/01/94; am 02/16/02; am 05/10/03; am 06/25/12] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 430.51)

§17-1727-5 REPEALED [R 06/25/12]

§17-1727-6 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 08/01/94; am 02/16/02] (Auth: HRS

§346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 430.51)

§17-1727-7 Assignment of primary care provider. If timely selection by an enrollee from among the available primary care providers within the plan is not made, the plan shall assign the individual's care to a primary care provider of the plan's choice. [Eff 08/01/94; am 02/16/02] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 430.51)

§§17-1727-8 to 17-1727-10 (Reserved).

SUBCHAPTER 3

ELIGIBILITY

§17-1727-11 Purpose. This subchapter describes the eligibility requirements for participation in the QUEST program. [Eff 08/01/94; am 01/29/96; am 06/25/12] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§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 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 06/25/12] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§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).

(A) This provision shall not apply to:

(i) Individuals and families covered under the provisions of section 1931 of the Social Security Act as described in chapter 17-1726;

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

(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.

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

(4) 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 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 06/25/12] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25; Pub. L. No. 105-33)

§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, 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) A newborn of a mother who is a QUEST recipient, 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), (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 three hundred per cent of the federal poverty level for a family of applicable size shall be financially eligible for participation in QUEST.

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

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

(1) For a pregnant woman, a child under nineteen years old, 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.

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

(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.

(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.

[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 06/25/12] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25; Pub. L. No. 105-33, §4901(a))

§17-1727-14.1 Special provisions for individuals who are claimed as federal or state tax dependents. (a) The provisions of this section shall apply to an individual age eighteen but less than age twenty-one who is claimed as a federal or state tax dependent.

(b) In situations in which the individual claimed as a tax dependent is residing in the household with a parent or legal guardian who is claiming the individual as a tax dependent, the income and needs of the entire family, as defined in section 17-1727-2, shall be used to determine the tax dependent's eligibility and premium-share to be assessed.

(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 Expanded program. [Eff 07/20/95; am 01/29/96; am 12/27/97; am 06/19/00, am 06/25/12] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-15 REPEALED. [R 06/25/12]

§17-1727-16 REPEALED. [R 06/25/12]

§17-1727-17 Eligibility for individuals eligible under Title IV-E. (a) The following individuals shall be automatically eligible for medical assistance:

(1) Individuals receiving Title IV-E foster care maintenance payments, who are:
  (A) Under twenty-one years of age;
  (B) Certified by a social worker of the department to be eligible for Title IV-E foster care maintenance payments; and
  (C) Placed in a licensed or authorized foster home or child caring institution appropriately supervised by a licensed child placement agency or the state family court; or

(2) Individuals covered under Title IV-E Adoption Assistance Agreements, regardless of the state with which the adoptive parents entered into the agreement, who are:
  (A) Under twenty-one years of age;
  (B) Reside in the State of Hawaii; and
  (C) Reside in a subsidized adoptive home.

(b) The continued eligibility of these individuals to receive medical assistance shall be contingent upon their eligibility for coverage under Title IV-E.

(c) These individuals shall be ineligible to receive medical assistance as specified in this section when they are no longer eligible for coverage under Title IV-E.

(d) Individuals eligible for coverage under Title IV-E who are not blind or disabled shall be provided coverage in QUEST.

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

(f) Upon determination of their ineligibility for coverage under Title IV-E, eligibility for continued medical assistance shall be determined in the following manner:

(1) Eligibility and participation in QUEST if all

conditions of this chapter are met; or

(3) Eligibility and participation in the blind or disabled programs if all conditions of both programs are met. [Eff 11/25/96; am 06/25/12](Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§§17-1727-18 to 17-1727-20 (Reserved).

SUBCHAPTER 4

ENROLLMENT

§17-1727-21 Enrollment of individuals into participating health plans. (a) Each individual found eligible to participate in QUEST shall be enrolled in a medical plan with the exception of children identified in subsection (b).

(b) After being found eligible for the QUEST, fee for service coverage shall be provided for children under age twenty-one who meet all of the following conditions:

(1) Receive child welfare services from the department of human services or court;

(2) Are residents of the State of Hawaii; and

(3) Are placed in another state.

Children meeting the above conditions shall not be enrolled in a QUEST medical plan. [Eff 08/01/94; am 01/29/96; am 02/16/02; am 05/10/03] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-22 Initial enrollment. (a) After being determined eligible for coverage under QUEST, 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).

(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 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. 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 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

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

(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.

(g) 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 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 06/25/12] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25; 431.51; 438.56)

§17-1727-23 Open enrollment period. (a) An eligible individual shall be allowed to change the individual's enrollment from one health plan to another participating health plan within the service area in which the individual or family resides that is open to receiving 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 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.

(e) Changes in enrollment resulting from an open enrollment period shall be implemented effective the first day of the month as determined by the department and shall generally extend for the benefit period.

(f) In the absence of a choice of health plan in a 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 06/25/12] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25; 431.51)

§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 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 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.

(d) The effective date of enrollment resulting from a change from QUEST-Net coverage to QUEST is the date the enrollment process has been completed to enroll an individual or family in a QUEST health plan.

(e) The effective date of enrollment for a newborn of an enrollee shall be the child's date of birth. [Eff 08/01/94; am 07/20/95; am 01/29/96; am 10/26/01; am 05/10/03; am 06/25/12] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25; 431.51)

§17-1727-25 REPEALED. [R 06/25/12]

§17-1727-26 REPEALED. [R 06/25/12]

§17-1727-27 (Reserved).

SUBCHAPTER 5

DISENROLLMENT

§17-1727-28 Authority to disenroll QUEST beneficiaries. (a) Department shall have sole authority to disenroll an individual from a QUEST Plan.

(b) Department shall consider disenrollment of an individual from a QUEST health plan:

(1) In compliance with administrative appeal decisions or court orders;

(2) In response to mutual agreements among enrollees, the plans, and the department; and

(3) When requested by the enrollee.

(c) If an enrollee requests disenrollment, the department shall determine whether to allow disenrollment no later than the first day of the second month following the month in which the enrollee made the request. If the department fails to make a determination within the timeframe, the disenrollment is considered approved. [Eff 08/01/94; am 05/10/03; am 09/17/07] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25; §438.56)

§17-1727-29 REPEALED. [Eff 08/01/94; am 12/03/01; R 05/10/03]

§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) 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;

(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 06/25/12] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-31 REPEALED. [Eff 08/01/94; am 01/29/96; R 05/10/03]

§§17-1727-32 to 17-1727-34 (Reserved).

SUBCHAPTER 6

REIMBURSEMENT TO PARTICIPATING PLANS

§17-1727-35 Capitated payments. (a) Each participating health plan shall be paid on a capitated

basis, as negotiated with the department, for individuals enrolled in that health 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 contracted coverage for the health plan's enrollees. [Eff 08/01/94; am 06/25/12] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-36 REPEALED. [Eff 08/01/94; R 07/20/95] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§§17-1727-37 to 17-1727-39 (Reserved).

SUBCHAPTER 7

FINANCIAL RESPONSIBILITIES OF QUEST ENROLLEES

§17-1727-40 REPEALED. [R 06/25/12]

§17-1727-41 REPEALED. [Eff 08/01/94; am 07/20/95; R 12/27/97]

§17-1727-42 REPEALED [Eff 08/01/94; am 07/20/95; am 01/29/96; am 03/30/96; am 11/25/96; am 12/27/97; am 12/03/01; R 09/10/09] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-43 REPEALED. Eff 08/01/94; am 03/30/96; am 11/25/96; am 06/19/00; R 12/03/01] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-44 REPEALED. [Eff 08/01/94; am 07/20/95; am 01/29/96; R 12/27/97]

§17-1727-45 REPEALED. [Eff 01/29/96; am 12/27/97; am 06/19/00; R 12/03/01] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§§17-1727-46 and 17-1727-47 (Reserved).

SUBCHAPTER 8

SCOPE AND CONTENT OF SERVICES

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

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

(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 QUEST benefits packages. [Eff 08/01/94; am 02/16/02; am 06/25/12] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-48.1 QUEST-Adult benefits package. (a) Participating health plans shall be required to provide coverage 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 coverage 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) Outpatient hospital procedures or ambulatory surgical center procedures.

(3) Diagnostic testing, including laboratory and x-ray.

(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.

(12) Urgent care shall be provided.

(13) Coverage shall be provided for vision services 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 04/12/13] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-48.2 QUEST-Keiki benefits package. (a) For an individual under age twenty-one years, each participating health plan shall provide the 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. [Eff 06/25/12; am 04/12/13] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25; 42 C.F.R. §430.25)

§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 06/25/12] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §456.3)

§17-1727-49 REPEALED. [R 06/25/12]

§17-1727-49.1 REPEALED. [R 06/25/12]

§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.

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

(c) The dental services described in subsections (a) through (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 06/25/12] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-51 REPEALED. [R 06/25/12]

§17-1727-52 REPEALED. [Eff 08/01/94; R 12/27/97]

§§17-1727-53 to 17-1727-57 (Reserved).

SUBCHAPTER 9

PARTICIPATING HEALTH PLANS

§17-1727-58 Health plan participation in QUEST. (a) The Department shall request proposals from managed health care plans for provision of medical or behavioral health services to persons eligible to participate in QUEST.

(b) The Department shall evaluate the proposals from managed care plans to ensure that the plans meet the conditions and requirements described in the Department's request for proposals.

(c) Contracts for participation in QUEST shall be awarded to qualified health plans upon finalization of financial agreements with the Department.

(d) The Department shall develop a request for proposals prior to the lapse of existing contracts with participating plans to ensure that individuals eligible for coverage through QUEST shall receive continued health care coverage. [Eff 08/01/94; am 01/29/96; am 02/16/02] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-59 Service areas. (a) The Department shall designate geographic areas as the areas for which health care plans will submit proposals to provide services.

(b) A health plan may submit proposals to service more than one service area.

(c) More than one health care plan may be contracted by the Department for each service area. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-60 Requirements of participating plans. (a) The plans participating in QUEST shall abide by

the provisions of their respective contracts with the department as well as federal and state statutes and regulations.

(b) The requirements of each participating plan shall include, but are not limited to, the following:

(1) Provision of all services required by the contract between the respective plan and the Department;

(2) Provision of a primary care provider for each eligible QUEST recipient who is enrolled in the in the respective plan;

(3) Provision of a case management system to ensure that health services identified by an enrollee's personal care provider as medically necessary are received;

(4) Development and maintenance of a sufficient network of health care providers to ensure that required health services are provided to enrollees in a timely manner;

(5) Maintenance of adequate support staff and systems to administer and conduct business functions;

(6) Development and maintenance of required information systems;

(7) Development and maintenance of a quality assurance program;

(8) Development and maintenance of a grievance system for dissatisfied enrollees;

(9) Development and maintenance of a toll-free telephone hotline to confirm enrollment, respond to inquiries from enrollees, and provide information to the general public; and

(10) Maintenance of a medical records systems which enable the plans to provide information pertinent to the care and management of enrollees to the Department.

[Eff 08/01/94; am 01/29/96; am 09/17/07] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1727-61 Enforcement of contracts with participating health plan. (a) The department may monitor a health plan’s performance during any contract period.

(b) The department may impose civil or administrative monetary penalties not to exceed the

maximum amount established by federal and state statutes and regulations if the participating health plan:

(1) Fails to provide medically necessary items and services that are required under law or under contract;
(2) Imposes upon beneficiaries excess premiums and charges;
(3) Acts to discriminate among enrollees;
(4) Misrepresents or falsifies information;
(5) Violates marketing guidelines established by the department;
(6) Violates other contract provisions and requirements; or
(7) Violates federal or state statutes or regulations.

(c) If a health plan violates the contract conditions between the health plan and the department, violates federal or state statutes or regulations, violates the Hawaii Administrative Rules, or if there is a substantial risk to the health of enrollees, the department may:

(1) Notify affected enrollees of the violations;
(2) Allow affected enrollees to change plans without cause;
(3) Suspend enrollment; or
(4) Suspend payment.

The department may also impose financial sanctions as described under the provisions of the contract between the respective plan and the department for inaccurate, incomplete, and untimely data and reports submitted to the department.

(d) If a health plan continues to violate the contract conditions between the health plan and the department, continues to violate federal or state statutes and regulations, or continues to violate the Hawaii Administrative Rules, regardless of any other penalty that may be imposed, the department shall:

(1) Appoint temporary management to oversee compliance efforts;
(2) Notify affected enrollees of the violations; or
(3) Allow affected enrollees to change plans without cause.

(e) Temporary management may continue until the department determines that the health plan can ensure that the behavior that caused the penalty will not recur.

(f) Before imposing a sanction, with the exception of appointing temporary management to oversee compliance efforts, the department shall give the health plan timely written notice, as specified in the contract with the participating plans.

(g) The department shall notify the insurance commissioner whenever a sanction under this section is contemplated specifying the reason. [Eff 06/19/00; am 09/17/07] (Auth: HRS §346-59.5) (Imp: HRS §346-14; 42 C.F.R. §§430.25; 438.700, 438.702; 438.706; 438.710)

§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;
(6) Failure by the health plan to abide by the contract conditions; or
(7) Meet federal or State statutes, or both.

(b) When termination of contract is due to reasons identified under subsection (a) paragraphs (1), (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), (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 06/25/12] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25; 438.708)