

UNOFFICIAL

HAWAII ADMINISTRATIVE RULES

TITLE 17

DEPARTMENT OF HUMAN SERVICES

SUBTITLE 12

MED-QUEST DIVISION

CHAPTER 1720.1

FREEDOM OF CHOICE, ENROLLMENT AND DISENROLLMENT

Subchapter 1 General Provisions

- §17-1720.1-1 Purpose
- §§17-1720.1-2 to 17-1720.1-6 (Reserved)

Subchapter 2 Freedom of Choice

- §17-1720.1-7 Purpose
- §17-1720.1-8 Choice of health plans
- §17-1720.1-9 Choice of primary care providers
- §§17-1720.1-10 to 17-1720.1-14 (Reserved)

Subchapter 3 Enrollment

- §17-1720.1-15 Purpose
- §17-1720.1-16 Selection of a health plan for a newly eligible individual
- §17-1720.1-17 Assignment to a health plan for a newly eligible individual
- §17-1720.1-18 Change of health plan for an individual prior to the annual plan change period
- §17-1720.1-19 Exemptions to a health plan's enrollment limit
- §17-1720.1-20 Annual plan change period

UNOFFICIAL

§17-1720.1-21 Effective date of enrollment
§§17-1720.1-22 to 17-1720.1-26 (Reserved)

Subchapter 4 Disenrollment

§17-1720.1-27 Purpose
§17-1720.1-28 Authority to disenroll
§17-1720.1-29 Disenrollment
§§17-1720.1-30 to 17-1720.1-34 (Reserved)

Historical Note: This chapter is based substantially upon repealed subchapters 2, 3 and 4 of chapter 17-1721.1 and subchapters 2, 4 and 5 of chapter 17-1727.

The source note for subchapters 2, 3 and 4 of chapter 17-1721.1 is: [Eff 01/31/09; am 06/11/09; am 06/25/12; R 09/30/13].

The source note for subchapters 2, 4 and 5 of chapter 17-1727 is: [Eff 08/01/94; am 01/29/96; am 11/25/96; am 12/27/97; am 10/26/01; 02/16/02; am 05/10/03; am 09/17/07; am 08/19/11; am 06/25/12; R 09/30/13].

SUBCHAPTER 1

GENERAL PROVISIONS

§17-1720.1-1 Purpose. This chapter describes the freedom of choice, enrollment and disenrollment provisions for individuals participating in the demonstration project authorized by Section 1115 of the Social Security Act. [Eff 09/30/13] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 438.50)

§§17-1720.1-2 to 17-1720.1-6 (Reserved).

UNOFFICIAL

SUBCHAPTER 2

FREEDOM OF CHOICE

§17-1720.1-7 Purpose. This subchapter describes the provisions regarding an eligible individual's freedom of choice in the selection of a participating health plan and a primary care provider.

[Eff 09/30/13] (Auth: HRS §346-14; 42 C.F.R. §§430.25, 431.51, 438.52) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 431.51, 438.52)

§17-1720.1-8 Choice of health plans. (a) Except for the conditions in section 17-1720.1-13, an eligible individual shall be allowed to select from among the participating health plans, of which the individual is not subject to an enrollment limit, servicing the geographic area in which the individual resides. This provision shall not apply to an enrolled individual identified in subsection (c).

(b) If a health plan has reached its maximum enrollment, the eligible individual shall select another participating health plan that is available. If only one other participating health plan is available, subsection (c) shall apply.

(c) In the absence of a choice of health plans in a service area, an eligible individual shall be enrolled in the participating health plan accepting new members. [Eff 09/30/13] (Auth: HRS §346-14; 42 C.F.R. §§430.25, 438.52) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 438.52)

§17-1720.1-9 Choice of primary care providers.

(a) In accordance with the procedures established by the participating health plan, an eligible individual shall be allowed to select a primary care provider from among those available within the health plan's provider network.

UNOFFICIAL

(b) In the absence of a timely selection among the available primary care providers within the health plan's provider network, the enrolled individual shall be assigned to a primary care provider by the health plan.

(c) An enrolled individual may change their primary care provider as frequently as, and for whatever reason, they choose. Exceptions to this provision shall be determined by the department.

[Eff 09/30/13] (Auth: HRS §346-14; 42 C.F.R. §§430.25, 431.51) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 431.51)

§§17-1720.1-10 to 17-1720.1-14 (Reserved).

SUBCHAPTER 3

ENROLLMENT

§17-1720.1-15 Purpose. The purpose of this subchapter is to describe the selection and subsequent enrollment provisions into a participating health plan. An eligible individual described in section 17-1735.1-2(a) shall be provided fee-for-service coverage and will not have the freedom to choose and be enrolled in a participating health plan.

[Eff 09/30/13] (Auth: HRS §346-14; 42 C.F.R. §§430.25, 438.50) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 438.50)

§17-1720.1-16 Selection of a health plan for a newly eligible individual. (a) With the exception of conditions in section 17-1720.1-17, at the time of notification of application approval, an eligible individual shall be provided the opportunity to select a participating health plan to provide the covered services effective the applicable date described in section 17-1720.1-21.

UNOFFICIAL

(b) In the absence of a choice of health plan open to new members in a service area, an individual who resides in that particular service area shall be auto-assigned to the participating health plan open to new members.

(c) If the individual selects a health plan at the time of notification of application approval, the department shall send an enrollment notice identifying the selected health plan and informing the enrolled individual of the sixty (60) calendar days grace period from the date of enrollment to select a different health plan available in the service area in which the individual resides and which is open to new members.

(d) If the individual does not select a health plan at the time of notification of application approval, the individual shall be auto-assigned to a health plan by the department to provide the covered services effective the applicable date described in section 17-1720.1-21. [Eff 09/30/13] (Auth: HRS §346-14; 42 C.F.R. §§430.25, 438.50) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 438.50)

§17-1720.1-17 Assignment to a health plan for a newly eligible individual. (a) An individual meeting one of the following conditions will be auto-assigned to a health plan at the time of determination of eligibility.

- (1) A newborn of an enrolled individual shall be enrolled into the health plan of the mother, retroactive to the date of birth. The newborn auto-assignment shall be effective for at least the first (1st) thirty (30) calendar days following the birth;
- (2) An individual who lost eligibility for a period of six (6) months or less shall be re-enrolled into their previous health plan;
- (3) An enrolled individual who enters into the child welfare system shall remain in their current health plan;

UNOFFICIAL

(b) Following the enrollment of a newly eligible individual into an auto-assigned health plan by the department, the individual shall be sent an enrollment notice that identifies the auto-assigned health plan and provides the individual the opportunity to select a different health plan, which is available in the service area in which the individual resides and open to new members, within the fifteen (15) calendar days grace period from the date of enrollment into an auto-assigned health plan.

- (1) If an individual does not select a different health plan within the fifteen (15) calendar days grace period, enrollment shall continue in the health plan to which auto-assigned, and the individual will be informed of the sixty (60) calendar days grace period from the date of initial enrollment to change health plans.
 - (2) If the individual selects a different health plan during the fifteen (15) calendar days grace period, the date of enrollment into the selected health plan shall be the first of the next month following the month in which the selection occurred, and the department shall send an enrollment notice identifying the selected health plan and inform the individual of the sixty (60) calendar days grace period from the date of enrollment to select a different health plan available in the service area in which the individual resides open to new members.
 - (3) If during the sixty (60) calendar days grace period an individual selects to change health plans, the date of enrollment into the selected health plan shall be the first (1st) of the next month following the month in which the selection occurred, and the department shall send a new enrollment notice identifying the selected health plan.
- [Eff 09/30/13] (Auth: HRS §346-14; 42 C.F.R. §§430.25, 438.50) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 438.50)

UNOFFICIAL

§17-1720.1-18 Change of a health plan for an individual prior to the annual plan change period.

(a) Except for changes made by a newly eligible individual during the fifteen (15) or sixty (60) calendar days grace periods, an enrolled individual shall only be allowed to change enrollment from one health plan to another during the annual plan change period.

(b) Exceptions to (a) can occur for cause, which include the following circumstances:

- (1) A decision from an administrative appeals office allowing participating health plan change;
- (2) A court order allowing participating health plan change;
- (3) Provisions in federal or State statutes or administrative rules;
- (4) A non-returning plan or termination of the individual's health plan's contract or the start of a new contract;
- (5) Mutual agreement by the participating health plans involved, the enrolled individual and the department;
- (6) Violations by a participating health plan specified in chapter 17-1735.2;
- (7) Change in foster placement if necessary for the best interest of the child;
- (8) The individual's PCP or long-term care residential facility is not in the health plan's provider network and is in the provider network of a different participating health plan provided the health plan is not at its maximum enrollment;
- (9) The individual is eligible to receive HCBS or personal assistance services level I and is enrolled in a health plan with a waiting list for HCBS or personal assistance services level I and another health plan does not have a waiting list for the necessary service(s);

UNOFFICIAL

- (10) The participating health plan's refusal, because of moral or religious objections, to cover the service the individual seeks as allowed for in the department's contract with the participating health plan;
- (11) The individual's need for related services(e.g., 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 individual's primary care physician or another provider determines that receiving the services separately would subject the individual's to unnecessary risk;
- (12) Lack of direct access to women's health care specialists for breast cancer screening, pap smears and pelvic exams;
- (13) Other reasons, including but not limited to, poor quality of care, lack of access to covered services, or lack of access to providers experienced in dealing with the individual'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 individual resides;
- (14) Relocation of the individual to a service area where the health plan in which they were enrolled does not provide services;
- (15) The individual missed the annual plan change period due to a temporary loss of Medicaid eligibility and was re-enrolled in their previous health plan; or
- (16) Other special circumstances as determined by the department.

(c) When changing health plans, an individual shall select among health plans participating in the service area in which the individual resides that are open to new members except as described in section 17-1720.1-19.

UNOFFICIAL

(d) In the absence of choice of health plans participating in the service area in which the individual resides and open to new members, except as described in section 17-1720.1-19, the individual shall be enrolled in the available health plan accepting new members. [Eff 09/30/13] (Auth: HRS §346-14; 42 C.F.R. §§430.25, 438.50) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 438.50)

§17-1720.1-19 Exemptions to a health plan's enrollment limit. (a) The department may implement an enrollment limit on any health plan that has an enrollment equal to or exceeding the maximum enrollment allowed for the service area as determined by the department and the enrollment limit shall be effective at the start of and remain in effect for the benefit year.

(b) Subject to approval by the department, a health plan may self-impose an enrollment limit, and the enrollment limit shall be effective when enrollment has reached the self-imposed limit as determined by the department.

(c) When a health plan has an enrollment limit, the health plan may not be available for selection and shall not be available for auto-assignment until the restriction is lifted.

(d) The following eligible individuals shall be exempt from a participating health plan's enrollment limit:

- (1) A newborn born to an enrolled individual shall be enrolled in the mother's health plan for a minimum of thirty (30) days, or if the mother is not eligible, enrolled in the health plan of the:
 - (A) Youngest enrolled household member; or
 - (B) Primary household member if there is no sibling enrolled.
- (2) An enrolled individual in a health plan with a waiting list for HCBS or personal assistance services-level I when another health plan in the same service area open to

UNOFFICIAL

new members does not have a waitlist for these services;

- (3) An enrolled individual who lost eligibility for a period of six (6) months or less shall be re-enrolled into their previous health plan;
- (4) A child under Foster Care, previously under Foster Care, Kinship Guardianship or Subsidized Adoption; or
- (5) A newly determined eligible individual who has seen a PCP, exclusive to a capped health plan, within the previous six (6) months or longer as determined by the department.
[Eff 09/30/13] (Auth: HRS §346-14; 42 C.F.R. §§430.25, 435.150, 438.50) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 435.150, 438.50)

§17-1720.1-20 Annual plan change period. (a) An individual shall be allowed to change enrollment from one participating health plan to another participating health plan within the service areas in which the individual resides that is open to receiving new members during the annual plan change period.

(b) The annual plan change period shall occur each calendar year at a time designated by the department.

(c) An individual who does not request to change health plan enrollment during annual plan change shall remain in their current health plan.

[Eff 09/30/13] (Auth: HRS §346-14; 42 C.F.R. §§430.25, 438.50) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 438.50)

§17-1720.1-21 Effective date of enrollment. (a) The effective date of enrollment for a newly eligible individual shall be one of the following:

- (1) The date a completed application is received by the department;
- (2) Any date specified by the applicant on which appropriate Medicaid eligible services were

UNOFFICIAL

incurred in accordance with chapter 17-1730.1 and is no earlier than the first (1st) day of the third (3rd) month prior to the month the application is received by the department for individuals applying for the coverage of long-term care services or the tenth (10th) calendar day immediately prior to the date the application is received by the department for all other individuals;

(3) The start date of the participating health plan contract period in which an eligibility determination is made for retroactive coverage; or

(4) The date when all eligibility requirements were met.

(b) For an individual with cause as defined in section 17-1720.1-18 who changes health plans, the effective date of enrollment in the new health plan shall be the first (1st) day of the month as designated by the department.

(c) For an eligible individual disenrolled from a health plan due to temporary loss of eligibility for a period of six (6) months or less and as a result missed the annual plan change period, the effective date of enrollment shall be the same date as subsection (a)(4).

(d) For an enrolled individual who relocates to a service area where the health plan does not provide service, the effective date of enrollment shall be the date of the individual's relocation.

(e) For a newborn born to an eligible individual, the effective date of enrollment shall be the date of birth.

(f) For an individual changing from one health plan to another during the annual plan change period the effective date of enrollment shall be the first (1st) day of the second (2nd) month after the annual plan change period ends or as determined by the department.

(g) For all other changes from one health plan to another, the effective date of enrollment shall be

UNOFFICIAL

the first (1st) day of the month following the date on which the department authorizes the enrollment change.
[Eff 09/30/13] (Auth: HRS §346-14; 42 C.F.R. §§430.25, 438.50) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 438.50)

§§17-1720.1-22 to 17-1720.1-26 (Reserved)

SUBCHAPTER 4

DISENROLLMENT

§17-1720.1-27 Purpose. The purpose of this subchapter is to describe the requirements for disenrollment from a participating health plan.
[Eff 09/30/13] (Auth: HRS §346-14; 42 C.F.R. §§430.25, 438.56) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 438.56)

§17-1720.1-28 Authority to disenroll. The department shall have the sole authority to disenroll an individual from a participating health plan.
[Eff 09/30/13] (Auth: HRS §346-14; 42 C.F.R. §§430.25, 438.56) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 438.56)

§17-1720.1-29 Disenrollment. An individual may be disenrolled for reasons that include, but are not limited to, the following:

- (1) A decision by an administrative appeals office for disenrollment from a participating health plan;
- (2) A court order for disenrollment from a participating health plan;
- (3) Provisions in federal or State statutes or administrative rules;

UNOFFICIAL

- (4) A non-returning plan or termination of the health plan's contract or the start of a new contract;
- (5) Mutual agreement by the participating health plans involved, the individual and the department;
- (6) Violations by a participating health plan specified in chapter 17-1735.2;
- (7) Change in foster placement if necessary for the best interest of the child;
- (8) The individual selects a health plan that is not capped during the annual plan change period;
- (9) The individual's PCP or long-term care residential facility is not in the health plan's provider network and is in the provider network of a different health plan, provided the health plan is not at its maximum enrollment;
- (10) The individual is eligible to receive HCBS or personal assistance services level I and is enrolled in a health plan with a waiting list for HCBS or personal assistance services level I and the other health plan does not have a waiting list for the necessary service(s);
- (11) The participating health plan's refusal, because of moral or religious objections, to cover the service the individual seeks as allowed for in the contract with health plan;
- (12) The individual's need for related services (e.g., 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 individual's primary care physician or another provider determines that receiving the services separately would subject the individual to unnecessary risk;

UNOFFICIAL

- (13) Lack of direct access to women's health care specialists for breast cancer screening, pap smears and pelvic exams;
- (14) 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 individual'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 individual resides;
- (15) Relocation to a service area where the health plan in which the individual was enrolled does not provide services;
- (16) The individual missed the annual plan change period due to a temporary loss of Medicaid eligibility and was re-enrolled in the previous health plan;
- (17) Voluntary withdrawal from participation in the medical assistance program by the individual or a authorized representative;
- (18) Not meeting the eligibility requirements;
- (19) Death of the enrolled individual;
- (20) The enrolled individual is a medically needy individual who is two full months in arrears in the payment of the designated enrollment fee, unless the failure to pay occurs because:
 - (A) The individual is not in control of the individual's personal finances, and the arrearage is caused by the party responsible for the individual's finances, and action is being taken to remediate the situation, including but not limited to:
 - (i) Appointment of a new responsible party for the individual's finances; or
 - (ii) Recovery of the individual's funds from the responsible party which

UNOFFICIAL

will be applied to the individual's enrollment fee obligation.

- (B) The individual is in control of the individual's finances, and the arrearage is due to the unavailability of the individual's funds due to documented theft or financial exploitation, and action is being taken to:
 - (i) Ensure that theft or exploitation does not continue; or
 - (ii) Recover the individual's funds to pay the individual's enrollment fee obligation;
- (21) Incarceration of an enrolled individual into a public facility;
- (22) Admission to the State hospital;
- (23) Enrollment into the State of Hawaii Organ and Tissue Transplantation (SHOTT) program;
- (24) Relocation out-of-state by the State;
- (25) Provision of false information with the intent of enrolling in the medical assistance program under false pretenses;
- (26) Eligible for Medicare Special Savings benefits;
- (27) Other special circumstances as determined by the department; or
- (28) An individual disenrolled for cause.
[Eff 09/30/13] (Auth: HRS §346-14; 42 C.F.R. §§430.25, 438.56) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 438.56)

§§17-1720.1-30 to 17-1720.1-34 (Reserved).