HAWAII ADMINISTRATIVE RULES

TITLE 17

DEPARTMENT OF HUMAN SERVICES

SUBTITLE 12

MED-QUEST DIVISION

CHAPTER 1722.3

BASIC HEALTH HAWAII

Subchapter 1 General Provisions

Subchapter 2 Basic Health Hawaii

SUBCHAPTER 1

GENERAL PROVISIONS

§17-1722.3-1 Purpose. This chapter is established to provide, subject to the availability of state funding, state medical assistance for citizens of COFA nations and legal permanent residents admitted to the United States for less than five years who are age nineteen years and older and lawfully present in the state. Except as otherwise specifically provided herein, this chapter supersedes any and all state medical assistance provided to such individuals through the former QUEST, QExA, QUEST-Net, or QUEST-ACE programs, or the fee-for-service or SHOTT programs prior to the implementation date of Basic Health

Hawaii. [Eff 04/01/10; am 09/30/13] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1722.3-2 REPEALED. [R 09/30/13]

§17-1722.3-3 Basic Health Hawaii Implementation. (a) The department shall determine the implementation date for Basic Health Hawaii when participating health plans shall begin delivering Basic Health Hawaii benefits.

(b) The implementation date shall be no later than July 1, 2010.

(c) When the department has established the implementation date, the department shall provide notice to deemed individuals as provided under subchapter 4. [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14)

§§17-1722.3-4 to 17-1722.3-5 (Reserved)

SUBCHAPTER 2

BASIC HEALTH HAWAII

§17-1722.3-6 Purpose. This subchapter describes individuals who are eligible to participate in Basic Health Hawaii, the benefits to be provided, enrollment and disenrollment provisions, and the financial responsibility of the enrollees. [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1722.3-7 Eligibility requirements. (a) An individual requesting health care services under this chapter must meet the following eligibility requirements:

(1) The basic eligibility requirements described in chapter 17-1714 with the exception of citizenship requirements;

(2) Is an alien who is not eligible for federal medical assistance and is either:
(A) A citizen of a COFA nation; or
(B) A legal permanent resident;
(3) Is age nineteen years or older; and
(4) Is not pregnant.

(b) An individual who is not eligible to participate under this chapter includes a person who:
(1) Does not meet the requirements of subsection (a);
(2) Does not meet the financial eligibility requirements described in this chapter;
(3) Is eligible for coverage under a health plan, as an active military enlistee, a retired military personnel, or a dependent of an active or retired military enlistee; or
(4) Is eligible for, or receiving, coverage under any health plan. [Eff 04/01/10; am 09/30/13] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1722.3-8 Treatment of income and assets. When determining financial eligibility for Basic Health Hawaii, the provisions for treatment of income and assets described in chapters 17-1724.1 and 17-1725.1, respectively, shall apply. [Eff 04/01/10, am 09/30/13] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1722.3-9 Financial eligibility requirements. (a) An individual whose countable family assets exceed the personal reserve standard for a family of applicable size shall be ineligible for Basic Health Hawaii.
(1) For a one-member family, the personal reserve standard shall be $2,000;
(2) For a two-member family, the personal reserve standard shall be $3,000;
(3) For a family of more than two members, the personal reserve standard shall be $3,000 plus $250 for each additional family member.

(b) An individual whose countable family income exceeds one hundred per cent of the federal poverty

level for a family of applicable size shall be ineligible for Basic Health Hawaii. An individual's countable family income shall be determined by adding the monthly gross earned income of each employed person and any monthly unearned income. [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14)

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

(1) For a specified duration; or

(2) Up to a statewide enrollment limit.

(b) During the open application period, applicants shall submit their application to the department and the following shall apply:

(1) Applications shall be processed in the chronological order of their receipt by the department;

(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 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; and

(3) Applications pending more than 45 days before a denial notification is issued shall not be subject to the provisions of subsection 17-1711.1-32(e). [Eff 04/01/10; am 04/12/13; am 09/30/13] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1722.3-11 Effective date of eligibility. The date of eligibility shall be one of the following:

(1) The date of application if the applicant is found to be eligible in the month of application; or
(2) If the applicant is found to be ineligible for the month of application, the first day of the subsequent month on which all eligibility requirements are met by the applicant. [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1722.3-12 Termination of eligibility. A recipient's eligibility for Basic Health Hawaii shall be terminated for any of the following reasons:
(1) The recipient fails to meet any one of the necessary requirements of sections 17-1722.3-7 and 17-1722.3-9;
(2) Death of the recipient;
(3) The recipient no longer resides in the State;
(4) The recipient voluntarily terminates coverage;
(5) The recipient is admitted to a public institution as defined in chapter 17-1714;
(6) The recipient's whereabouts are unknown;
(7) Lack of State funds; or
(8) The program is terminated or repealed [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14)

§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 be enrolled in a health plan for purposes of providing the individual with covered services effective the date of eligibility as described in 17-1722.3-11.
(c) After the individual is 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 (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.

(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.

(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 open enrollment period; or

(3) If disenrollment includes the first day of a new benefit year. [Eff 04/01/10; am 04/12/13] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1722.3-14 REPEALED. [R 04/12/13]

§17-1722.3-15 Disenrollment from a participating health plan. (a) The department shall have sole authority to disenroll a Basic Health Hawaii enrollee.

(b) The department shall disenroll an enrollee whose eligibility is terminated under section 17-1722.3-12.

(c) The department may disenroll an enrollee for reasons that include, but are not limited to, the following:

(1) Compliance with an administrative or judicial decision; or

(2) mutual agreement between the individual, the participating health plan involved, and the department.

(d) 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 time frame, the disenrollment is considered approved.

(e) If an enrollee qualifies for federal medical assistance, the effective date of disenrollment from the participating health plan shall be the date the individual has been determined eligible for federal medical assistance. [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1722.3-16 Effective date of enrollment. (a) The effective date of enrollment into a participating health plan shall be the effective date 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 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 participating 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; or

(2) If an individual changes residence from one service area to another, the date the enrollment process has been completed. [Eff 04/01/10; am 04/12/13] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1722.3-17 REPEALED. [R 04/12/13]

§17-1722.3-18 Basic Health Hawaii benefits. (a) A participating health plan shall be required to provide the benefits defined in this subchapter.

(b) Within a benefit year, a participating health plan shall provide each enrollee no more than ten days of medically necessary inpatient hospital care related to medical care, surgery, psychiatric care, and substance abuse treatment. The following hospital services shall be made available to each enrollee:

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

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

(3) Use of an operating room and related facilities, inpatient anesthesia, radiology,

laboratory and other diagnostic services agreed upon by the participating health plan medical director for medical care and surgery;

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

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

(6) Ten inpatient physician visits within a benefit year.

(c) Within a benefit year, a participating health plan shall provide each enrollee with coverage for the following outpatient services:

(1) A maximum of twelve outpatient visits including adult health assessments, family planning services, diagnosis, treatment, consultations, to include substance abuse treatment, and second opinions. The maximum of twelve outpatient visits shall not apply to:

(A) Emergency services as described in section 17-1722.3-20;

(B) An enrollee's first six mental health visits within a benefit year. After the first six mental health visits, an enrollee may choose to apply a maximum of six additional mental health visits toward the maximum of twelve physician outpatient visits; or

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

(2) Coverage of medically necessary ambulatory surgical care shall be limited to three procedures per benefit year;

(3) Maternity care coverage shall be limited to one routine visit to confirm pregnancy and any visits for the diagnosis and treatment of conditions related to medically indicated or elective termination of pregnancy such as ectopic pregnancy, hydatidiform mole, and missed, incomplete, threatened, or elective

abortions. Each of these visits shall count toward the twelve maximum outpatient visits, ten maximum inpatient days, or three maximum ambulatory surgeries.

(d) An enrollee shall be provided the following health assessments which shall be counted toward the maximum of twelve outpatient physician visits.

(1) An enrollee age nineteen to thirty-five years old, inclusive, shall be allowed one examination within a period of five benefit years.

(2) An enrollee thirty-six to fifty-five years old, inclusive, shall be allowed one examination within a period of two benefit years.

(3) An enrollee over fifty-five years old shall be allowed one examination within each benefit year.

(4) An annual pap smear for a woman of child bearing age shall be included in the health assessment for an enrollee age nineteen years or older.

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

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

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

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

(B) Inpatient alcohol abuse services shall be considered toward an enrollee's

maximum coverage of ten hospital days; and

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

(f) Coverage shall be provided for a maximum of four medication prescriptions per calendar month. Each prescription shall not exceed a one-month supply of a medication included in a participating health plan's formulary that consists of at least one prescription medication per therapeutic class. A participating health plan shall not be required to cover a brand name medication if a comparatively effective generic medication within the therapeutic class is available, with the exception of statutory requirements.

(g) Coverage shall be provided for diabetic supplies, including syringes, test strips and lancets.

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

(i) A participating health plan may, at the plan's option and expense, provide benefits which exceed those defined in this subchapter, with the exception of non-covered services identified in section 17-1722.3-19

(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 04/12/13] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1722.3-19 Medical services and items not available in Basic Health Hawaii. The following services and items shall not be covered by participating health plans or the department under Basic Health Hawaii:

(1) Custodial or domiciliary care;

(2) Services received in skilled nursing facilities, intermediate care facilities, and

intermediate care facilities for the mentally retarded;

(3) Personal care items such as shampoos, toothpaste, mouthwashes, denture cleansers, shoes including orthopedic footwear, slippers, clothing, laundry services, baby oils and powders, sanitary napkins, soaps, lip balms, and bandages;

(4) Non-medical items such as books, telephones, electronic transmitting and paging devices, radios, linens, clothing, television sets, computers, air conditioners, air purifiers, fans, household items and furnishings;

(5) Emergency facility services for non-emergency services;

(6) Out-of-state emergency and non-emergency services;

(7) Experimental and investigational services, procedures, drugs, devices, and treatments;

(8) Organ and tissue transplantation and transplantation services for either a recipient or a donor;

(9) Blood, blood products, and blood storage on an outpatient basis;

(10) Gender reassignment and related medical, surgical, and psychiatric services, drugs, and hormones;

(11) In vitro fertilization, reversal of sterilization, artificial insemination, sperm banking procedures, and drugs to test fertility;

(12) Eyeglasses, contact lenses, low vision aids, orthoptic training, and refractions;

(13) Hearing aids and related supplies and services, including fitting for, purchase of, rental of, and insuring of hearing aids;

(14) Durable medical equipment, prosthetic devices, orthotics, medical supplies, and related services including purchases, rental, repairs, and related services, except as supplied as part of an inpatient hospital stay;

(15) Biofeedback, acupuncture, naturopathic services, faith healing, Christian Science services, hypnosis, and massage treatment;
(16) Obesity treatment, weight loss programs, food, food supplements, health foods, and prepared formulas;
(17) All services, procedures, equipment, and supplies not specifically listed which are not medically necessary;
(18) Cosmetic surgery or treatment, cosmetic rhinoplasties, reconstructive or plastic surgery to improve appearance and not bodily function, piercing of ears and other body areas, electrolysis, hair transplantation, reduction and augmentation mammoplasties, paniculectomies and other body sculpturing procedures, excision or destruction of benign skin or subcutaneous lesions without medical justification;
(19) Transportation, including air (fixed wing or helicopter) ambulances;
(20) Hospice services;
(21) All home health agency services;
(22) Home and community based services to include, but not limited to, adult day care, adult day health, assistive living, pediatric attendant care, community care management agency (CCMA) services, community care foster family home services, counseling and training activities, environmental accessibility adaptations, expanded adult residential care homes (E-ARCH) or residential care services, home delivered meals, home maintenance, medically fragile day care, moving assistance, non-medical transportation, personal assistance services, personal emergency response systems, private duty nursing, and respite care;
(23) Personal care, chore services, social worker services, case management services, and targeted case management services;
(24) Tuberculosis services when provided without cost to the general public;
(25) Hansen's disease treatment or follow-up;

(26) Treatment of persons confined to a public institution;
(27) Penile and testicular prostheses and related services;
(28) Chiropractic services;
(29) Psychiatric care and treatment for sex and marriage problems, weight control, employment counseling, primal therapy, long term character analysis, marathon group therapy, and consortium;
(30) Routine foot care and treatment of flat feet;
(31) Swimming lessons, summer camp, gym membership, and weight control classes;
(32) Cardiac and coronary artery surgery involving cardio-pulmonary by-pass, cataract surgery with or without intraocular lens implants, and refractive keratoplasty;
(33) Physical therapy, occupational therapy, speech therapy, respiratory services, and sleep studies rendered on an outpatient basis;
(34) Medical services provided without charge by any other federal, state, municipal, territorial, or other government agency, including the Veterans Administration;
(35) Medical services for an injury or illness caused by another person or third party from whom the enrollee has or may have a right to recover damages;
(36) Medical services that are payable under the terms of any other group or non-group health plan coverage;
(37) Medical services that do not follow standard medical practice or are not medically necessary;
(38) Stand-by services by a stand-by physician and telephone consultation;
(39) Services provided for illness or injury caused by an act of war, whether or not a state of war legally exists, or required during a period of active duty that exceeds thirty days in any branch of the military;

(40) Treatment of sexual dysfunction including medical and surgical procedures, supplies, drugs, and equipment;
(41) All services excluded by the Hawaii Medicaid Program;
(42) All services not provided by providers licensed or certified in the State of Hawaii to perform the service;
(43) Medical services that are payable under terms of worker compensation, automobile medical and no-fault, underinsured or uninsured motorist, or similar contract of insurance;
(44) Physical examination required for continuing employment, such as taxi driver's or truck driver's licensing, or as required by government or private businesses;
(45) Physical examinations, psychological evaluations, and immunizations as a requirement for licenses or for purposes of securing insurance policies or plans;
(46) Allergy testing and treatment;
(47) Treatment of any complication resulting from previous cosmetic, experimental, or investigative procedures, or any other non-covered service;
(48) Rehabilitation services, either on an inpatient or outpatient basis, including cardiac, alcohol or drug dependence rehabilitation;
(49) All acne treatment, surgery, drugs for adults; removal or treatment of asymptomatic benign skin lesions or growth; and
(50) Inpatient hospital care related to maternity, such as prenatal, postpartum, and delivery services including all laboratory testing in both inpatient and outpatient setting. An exception is one outpatient visit to confirm pregnancy, as identified as a covered service in this chapter. [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1722.3-20 Emergency services. (a) Emergency medical services are available to enrollees under

chapter 17-1723, subchapter 2, and may be covered by a participating health plan or on a fee-for-service basis.

(b) Dental services shall be limited to emergency treatments which do not include services aimed at restoring or replacing teeth. Emergency dental treatment shall be covered on a fee-for-service basis and be limited to services for the following:

(1) Relief of dental pain;

(2) Elimination of infection; and

(3) Treatment of acute injuries to the teeth and supporting structures of the oro-facial complex. [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1722.3-21 Financial responsibility. An enrollee may be responsible for a copayment for certain benefits as determined by the department. [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1722.3-22 Reimbursement to participating health plans. Each participating health plan shall be paid a capitated payment, under the contract negotiated with the department, for individuals enrolled in the plan. [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1722.3-23 Enforcement and termination of contracts with participating health plans. The provisions pertaining to enforcement and termination of a contract with a health plan described in chapter 17-1727 shall apply to participating health plans. [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14)

§§17-1722.3-24 to 17-1722.3-26 (Reserved)

SUBCHAPTER 3

SPECIAL BENEFIT PROVISIONS

§17-1722.3-27 Purpose. This subchapter describes special provisions to continue providing state medical assistance to individuals who were receiving long-term care or SHOTT services prior to the implementation date. [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1722.3-28 Long-term care provisions. (a) An individual age nineteen years or older receiving state medical assistance for long-term care services on the last day of the second month prior to the implementation date, shall:

(1) Be enrolled in a participating health plan and receive state funded long-term care services, either through a participating health plan or through a program that provides benefits similar to a 1915(c) program; and

(2) Continue to receive the benefits as described in (1) under the following conditions:

(A) The individual maintains continuous categorical and financial eligibility as described under chapter 17-1719; and

(B) The individual maintains continuous eligibility for coverage of long-term care services.

(b) An individual under age nineteen years and receiving Medicaid for long-term care services in a nursing facility on the last day of the second month prior to the implementation date, if continuously receiving Medicaid for long-term care services until turning age nineteen years, shall upon turning age nineteen years:

(1) Be enrolled in a participating health plan and receive state funded long-term care services; and

(2) Continue to receive the benefits as described in paragraph (1) under the following conditions:

(A) The individual maintains continuous categorical and financial eligibility as described under chapter 17-1719; and

(B) The individual maintains continuous eligibility for coverage of long-term care services.

(c) If an individual who is initially eligible under subsections (a) or (b) loses eligibility:

(1) On or before the transition period end date, the individual shall be deemed into Basic Health Hawaii pursuant to subchapter 4;

(2) After the transition period end date, the individual shall be subject to the eligibility and enrollment provisions described in subchapter 2. [Eff 04/01/10; am 09/30/13] (Auth: HRS 346-14) (Imp: HRS §346-14)

§17-1722.3-29 SHOTT provisions. (a) An individual otherwise eligible under this chapter, who is participating in the SHOTT program, and has received an organ or tissue transplant as of the last day of the second month prior to the implementation date, shall continue to participate in SHOTT under the following:

(1) The individual maintains continuous eligibility; and

(2) The individual maintains continuous coverage under the SHOTT program.

(b) If an individual who is initially eligible under subsection (a) loses eligibility:

(1) On or before the transition period end date, the individual shall be deemed into Basic Health Hawaii pursuant to subchapter 4;

(2) After the transition period end date, the individual shall be subject to the eligibility and enrollment provisions described in subchapter 2. [Eff 04/01/10] (Auth: HRS 346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§§17-1722.3-30 to 17-1722.3-31 (Reserved)

SUBCHAPTER 4

INDIVIDUALS DEEMED INTO BASIC HEALTH HAWAII

§17-1722.3-32 Purpose. This subchapter describes provisions regarding the deeming of certain individuals into Basic Health Hawaii, the transition period, and the enrollment provisions that are applicable to these individuals. [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1722.3-33 Individuals deemed into Basic Health Hawaii. (a) A citizen of a COFA nation age nineteen years or older shall be deemed into Basic Health Hawaii effective on the implementation date if the individual:

(1) Was eligible for and was receiving state medical assistance through the former QUEST, QExA, QUEST-Net, or QUEST-ACE programs, or the Medicaid fee-for-service or SHOTT programs on the last day of the second month prior to the implementation date;
(2) Maintained continuous eligibility for state medical assistance through the last day of the month prior to the implementation date;
(3) Was not receiving long-term care services on the last day of the second month prior to the implementation date; and
(4) Was not participating in the SHOTT program or was participating in the SHOTT program, but had not received an organ or tissue transplant as of the last day of the second month prior to the implementation date.

(b) A legal permanent resident shall be deemed into Basic Health Hawaii on the implementation date if the individual:

(1) Was eligible for and was receiving financial assistance on the last day of the second month prior to the implementation date;
(2) Maintained continuous eligibility for financial assistance through the last day of the month prior to the implementation date;

(3) Has resided in the United States for less than five years; and
(4) Meets the eligibility requirements of this chapter.

(c) All deemed individuals shall be sent a written notice mailed at least twenty-one days prior to the implementation date that they are being deemed into Basic Health Hawaii. [Eff 04/01/10; am 08/06/10; am 09/30/13] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1722.3-34 Transition period for individuals deemed into Basic Health Hawaii. (a) A deemed individual shall remain continuously eligible for Basic Health Hawaii during the transition period, which shall be the three-month period beginning with the implementation date, and shall continue except as provided under subsection (c).

(b) After the last day of the second month following the implementation date, a deemed individual must meet the eligibility requirements under subchapter 2. An eligibility redetermination shall be initiated prior to the end of the transition period to ensure continued eligibility or timely termination of coverage.

(c) Eligibility of a deemed individual during the transition period may be terminated for the following reasons:

(1) The recipient qualifies for federal medical assistance;
(2) Death of the recipient;
(3) The recipient no longer resides in the State;
(4) The recipient voluntarily terminates coverage;
(5) The recipient is admitted to a public institution as defined in chapter 17-1714;
(6) Lack of State funds; or
(7) Basic Health Hawaii is terminated or repealed. [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1722.3-35 Enrollment procedures for individuals deemed into Basic Health Hawaii. A deemed

individual shall undergo the following health plan selection or assignment options:

(1) If the individual is a member of a health plan that is also a participating health plan, then the individual shall be assigned to that participating health plan;

(2) If the individual is not a member of a health plan that is also a participating health plan, then the individual shall, within ten days, select from among the participating health plans available in the service area in which the individual resides if there is more than one participating health plan;

(3) If an individual allowed to select a participating health plan does not select one within ten days of being determined eligible, the department shall assign and enroll the individual in a participating health plan; and

(4) 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 available participating health plan. [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)