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§17-1722.3-2 REPEALED.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 1.5

EMERGENCY ADMINISTRATIVE RULES RELATING TO STATE MEDICAL ASSISTANCE FOR CERTAIN LAWFULLY PRESENT NON-CITIZENS

§17-1722.3-5.1 Definitions. The following definitions shall apply to this subchapter:

"Current beneficiary" means a non-pregnant adult non-citizen who is receiving, at the time this subchapter is adopted, State medical assistance benefits that exceed the benefits provided under section 17-1722.3-18.

"Exchange" means the Hawaii health insurance exchange established under the Affordable Care Act.

"New ABD Beneficiary" means an aged, blind or disabled non-citizen who applies for benefits under section 17-1722.3-5.6 and is determined eligible for benefits under section 17-1722.3-5.7.

"Qualified health plan" means a qualified health plan or a qualified health plan issuer, as those terms are defined in 45 C.F.R. §155.20, and as the context may dictate. [Eff 11/05/14] (Auth: HRS §§91-3, 91-4, 346-14) (Imp: HRS §346-14)

§17-1722.3-5.2 Basis for emergency administrative rules. (a) This subchapter is adopted as an emergency rule under section 91-3(b), Hawaii Revised Statutes, because the department finds that it must amend this chapter upon less than 30 days' notice of hearing in order to avoid imminent peril to public health or safety.

(b) Certain lawfully present non-pregnant adult non-citizens who are ineligible for federal medical assistance due to their immigration status are in receipt of State medical assistance benefits that exceed the Basic Health Hawaii benefits defined under this chapter because of an injunction order issued by the United States District Court for the District of Hawaii in the case of Korab v. McManaman, Civil No. 10-00483 JMS/KSC.

(c) The injunction order was vacated effective November 3, 2014. Therefore, the department is required by its current administrative rules to terminate the State medical assistance benefits received by the current beneficiaries and to redetermine their eligibility for the Basic Health Hawaii program.

(d) The Affordable Care Act requires most Hawaii residents, including lawfully present non-citizens, to have minimum levels of health coverage. Basic Health Hawaii does not provide the coverage required under the Affordable Care Act. Therefore, the department intends to repeal this chapter upon expiration of these emergency rules.

(e) Current beneficiaries who are not aged, blind or disabled, are at risk of losing State medical assistance coverage before they can be enrolled in a qualified health plan through the Exchange. Those with household income of less than one hundred percent of the federal poverty level get less financial help with paying their insurance premium than other people.

These emergency rules temporarily continue their current benefits while they are transitioning from State funded medical assistance to enrollment in a qualified health plan purchased through the Exchange, and temporarily provide help with paying the share of premiums dues to their qualified health plan until a permanent premium assistance program is established by the department.

(f) Current beneficiaries who are aged, blind or disabled have greater and more frequent healthcare needs, and will be more severely impacted if they purchase insurance through the Exchange since that coverage will impose copayments for many services that are currently provided at no cost, excludes many services that are important to aged, blind and disabled individuals, such as medical transportation, long term care, and home and community based services. These individuals will also get less financial help with paying the premiums if their household income is less than one hundred percent of the federal poverty level. These emergency rules temporarily continue their current benefits until a new State medical assistance program for certain lawfully present non-pregnant adult non-citizens who are aged, blind or disabled is established by the State, and allow new ABD beneficiaries to apply for this benefit.

(g) These emergency rules ensure that current beneficiaries and new ABD beneficiaries have access to needed health care, including services that are not available through the Exchange, without the burden and confusion of being terminated or excluded from existing benefits before appropriate replacement coverage is in place. [Eff 11/05/14] (Auth: HRS §§91-3, 91-4, 346-14) (Imp: HRS §346-14)

§17-1722.3-5.3 Purpose. (a) This subchapter provides temporary and emergency relief by:

(1) Continuing the same health coverage to current beneficiaries that they are receiving at the time this subchapter is adopted, pending repeal of this chapter;

(2) Providing new ABD beneficiaries with State medical assistance that is equivalent to

federal medical assistance benefits, pending adoption of administrative rules creating a new State funded medical assistance program for certain non-citizens who are aged, blind, and disabled;

(3) Transitioning certain current beneficiaries to qualified health plans purchased through the Exchange; and

(4) Providing premium assistance to certain non-pregnant adult non-citizens who are not aged, blind or disabled, who are determined eligible for and purchase a qualified health plan through the Exchange, pending adoption of administrative rules establishing a premium assistance program.

(b) Certain non-citizens who are eligible for federal medical assistance, including but not limited to pregnant women and children who are citizens of COFA nations, continue to be eligible for federal medical assistance and are not affected by these emergency administrative rules. [Eff 11/05/14] (Auth: HRS §§91-3, 91-4, 346-14) (Imp: HRS §346-14)

§17-1722.3-5.4 Effect of this subchapter. (a) This subchapter shall supersede any contrary administrative rules contained in this chapter, unless otherwise specifically noted in this subchapter.

(b) This subchapter shall apply to current beneficiaries, applicants under sections 17-1722.3-5.6 and 17-1722.3-5.7, new ABD beneficiaries, and individuals eligible for premium assistance under section 17-1722.3-5.14. [Eff 11/05/14] (Auth: HRS §§91-3, 91-4, 346-14) (Imp: HRS §346-14)

§17-1722.3-5.5 Continuation of eligibility for current beneficiaries. Current beneficiaries shall continue to remain eligible for benefits under section 17-1722.3-5.9 provided they continue meet the applicable eligibility requirements, other than citizenship and non-citizen status, of chapter 17-1715.1 (Former Foster Care Children Group), 17-1717 (Parents and Other Caretaker Relatives Group),

17-1717.1 (Transitional Medical Assistance), 17-1718 (Adults Group), 17-1719 (Aged, Blind and Disabled Group), 17-1730.1 (Medically Need Spenddown) or 17-1735.1 (Fee For Service). [Eff 11/05/14] (Auth: HRS §§91-3, 91-4, 346-14) (Imp: HRS §346-14)

§17-1722.3-5.6 Open application period. Within fifteen calendar days after the effective date of this subchapter, the department shall publish notice of an open application period for new ABD beneficiaries as provided under, and subject to the requirements of, section 17-1722.3-10. [Eff 11/05/14] (Auth: HRS §§91-3, 91-4, 346-14) (Imp: HRS §346-14)

§17-1722.3-5.7 Eligibility requirements for new aged, blind, and disabled beneficiaries. To be determined eligible for benefits under section 17-1722.3-5.9, an individual who applies during an open application period must:

(1) Meet the requirements set forth in chapter 17-1719 (Aged, Blind and Disabled Group), with the exception of citizenship and non-citizen status under section 17-1714.1-28;

(2) Be a qualified non-citizen, a nonimmigrant under the INA (including citizens of COFA nations), or a non-citizen paroled into the United States under section 212(d)(5) of the INA for less than one year;

(3) Not be eligible for federal medical assistance

(A) Solely due to citizenship or non-citizen status; or

(B) Under chapters:

(i) 17-1715, Children Group;

(ii) 17-1716, Pregnant Women Group; or

(iii) 17-1719, Aged, Blind and Disabled Group.

(4) Not be eligible for health coverage as an active military enlistee, a retired military personnel, or a dependent of an active or retired military enlistee. [Eff 11/05/14]

(Auth: HRS §§91-3,91-4, 346-14) (Imp: HRS §346-14)

§17-1722.3-5.8 Enrollment into a participating health plan. (a) All current beneficiaries and new ABD beneficiaries, except for adults identified in section 17-1735.1-2(a), shall be enrolled in a health plan as provided under chapter 17-1720.1.

(b) Current beneficiaries and new ABD beneficiaries who are adults identified in section 17-1735.1-2(a) shall not be enrolled in a health plan and will receive services on a fee-for-service basis. [Eff 11/05/14] (Auth: HRS §§91-3, 91-4, 346-14) (Imp: HRS §346-14)

§17-1722.3-5.9 Benefits. (a) All current beneficiaries and new ABD beneficiaries shall be provided a standard benefits package by a participating health plan and other services when appropriate as described in chapter 17-1720.

(b) Current beneficiaries and new ABD beneficiaries who are adults identified in section 17-1735.1-2(a) shall be provided coverage under the fee-for-service provisions as described in chapter 17-1737. [Eff 11/05/14] (Auth: HRS §§91-3, 91-4, 346-14) (Imp: HRS §346-14)

§17-1722.3-5.10 Eligibility review requirements. Eligibility shall be redetermined in accordance with chapter 17-1712.1 and subchapter 5 of chapter 17-1714.1. [Eff 11/05/14] (Auth: HRS §§91-3, 91-4, 346-14) (Imp: HRS §346-14)

§17-1722.3-5.11 Termination of eligibility. An individual’s eligibility for services under this subchapter shall be terminated for any of the following reasons:

(1) The individual fails to meet any of the eligibility requirements of sections 17-1722.3-5.5 and 17-1722.3-5.7;

(2) Death of the individual;
(3) The individual no longer resides in the State;
(4) The individual voluntarily terminates coverage;
(5) The individual is admitted to a public institution as defined in chapter 17-1714.1;
(6) The individual's whereabouts are unknown;
(7) Lack of State funds;
(8) The program is terminated; or
(9) Expiration of these emergency rules.
[Eff 11/05/14] (Auth: HRS §§91-3, 91-4, 346-14) (Imp: HRS §346-14)

§17-1722.3-5.12 Disenrollment from a participating health plan. An enrollee under this subchapter shall be disenrolled from a participating health plan as provided under subchapter 4 of chapter 17-1720.1. [Eff 11/05/14] (Auth: HRS §§91-3, 91-4, 346-14) (Imp: HRS §346-14)

§17-1722.3-5.13 Transition of current beneficiaries who are not aged, blind, and disabled. (a) The department shall send the individual's application information, which includes household and other applicable information, and may also send enrollment information, to the Exchange for purposes of calculating the individual's advance premium tax credit and cost-share reduction and for enrollment in a qualified health plan through the Exchange.

(b) To ensure continued health insurance coverage, individuals will need to complete the Exchange application process and enroll in a qualified health plan through the Exchange prior to termination of Basic Health Hawaii, which will occur no earlier than March 1, 2015.

(c) The department shall not be responsible for an individual completing the Exchange application process, enrolling in a qualified health plan through the Exchange, or for calculating an individual's advance premium tax credit or cost-sharing reduction.

[Eff 11/05/14] (Auth: HRS §§91-3, 91-4, 346-14) (Imp: HRS §346-14)

§17-1722.3-5.14 Premium assistance eligibility requirements. In order to receive the premium assistance described under sections 17-1722.3-5.14 to 17-1722.3-5.17, an eligible individual shall:

(1) Have selected or be enrolled in a 94% actuarial value silver level qualified health plan through the Exchange;

(2) Be determined eligible for advanced premium tax credit and the maximum cost-sharing reduction by the Exchange; and

(3) Have household income of less than one hundred percent of the federal poverty level for the applicable household size as determined by the Exchange and communicated by the Exchange to the qualified health plan selected by the individual.

(4) If the Exchange does not communicate this information to the qualified health plan, then the qualified health plan may contact the individual to obtain information necessary for the qualified health plan to determine whether the individual's household income is less than one hundred percent of the federal poverty level for the applicable household size. [Eff 11/05/14] (Auth: HRS §§91-3, 346.14) (Imp: HRS §346.14)

§17-1722.3-5.15 Premium assistance benefits. (a) The department shall, upon presentation of an invoice by a qualified health plan to the department, pay to the eligible individual's qualified health plan (referred to in this section as "the health plan") the share of premium that the eligible individual is required to pay to the health plan to receive coverage.

(b) The department shall pay the eligible individual's share of premium to the health plan only upon receipt by the department of an invoice from the health plan.

(c) The department shall not make any payments directly to eligible individuals.

(d) The department shall not pay, and the eligible individual shall be responsible for, any cost-sharing including, but not limited to, deductible, co-payment or co-insurance.

(e) The department is not responsible for ensuring that the health plan timely submits an invoice for premium payment to the department. Any complaints by an eligible individual regarding the health plan billing the individual for the individual's share of premium must be directed to the health plan. [Eff 11/05/14] (Auth: HRS §§91-3, 346-14) (Imp: HRS §346-14)

§17-1722.3-5.16 Termination of premium assistance. An individual's eligibility for premium assistance shall be terminated at any time for any of the following reasons:

(1) Fails to meet the eligibility requirements set forth in section 17-1731-5.14;
(2) Voluntarily terminates participation in the premium assistance program;
(3) No longer resides in the State;
(4) Death of the individual;
(5) Whereabouts are unknown;
(6) Insufficient State funds; or
(7) The premium assistance benefit under this subchapter is terminated.

[Eff 11/05/14] (Auth: HRS §§91-3, 346-14) (Imp: HRS §346-14)

§17-1722.3-5.17 Administration of premium assistance. The department may contract with a third party or parties to provide the premium assistance benefit and to provide administration including, but not limited to, payment, auditing, and recovery. The department's provision of premium assistance shall be administered at no cost to the eligible individual. [Eff 11/05/14] (Auth: HRS §§91-3, 346-14) (Imp: HRS §346-14)

§17-1722.3-5.18 Effective period of these emergency administrative rules. These emergency administrative rules shall take effect upon filing with the Lieutenant Governor's office and shall be effective for no longer than one hundred twenty calendar days. [Eff 11/05/14] (Auth: HRS §§91-3, 91-4, 346-14) (Imp: HRS §346-14)

§§17-1722.3-5.19 to 17-1722.3-5.21 (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)