

33. Chapter 17-1720, Hawaii Administrative Rules, entitled "BENEFITS PACKAGE", is an addition of a new chapter to read as follows:

"HAWAII ADMINISTRATIVE RULES

TITLE 17

DEPARTMENT OF HUMAN SERVICES

SUBTITLE 12

MED-QUEST DIVISION

CHAPTER 1720

BENEFITS PACKAGE

Subchapter 1 General Provisions

§17-1720-1 Purpose
§§17-1720-2 to 17-1720-4 (Reserved)

Subchapter 2 Scope and Content of Services

§17-1720-5 Purpose
§17-1720-6 Covered Services
§§17-1720-7 to 17-1720-9 (Reserved)

Subchapter 3 Standard Benefits Package

§17-1720-10 Standard Benefits Package
§§17-1720-11 to 17-1720-13 (Reserved)

Subchapter 4 Specialized Behavioral Health Services

§17-1720-14 Specialized Behavioral Health Services
§§17-1720-15 to 17-1720-17 (Reserved)

Subchapter 5 Home and Community Based Services

§17-1720-18 Home and Community Based Services
§§17-1720-19 to 17-1720-21 (Reserved)

Subchapter 6 Institutional Care Services

§17-1720-22 Institutional Care Services
§§17-1720-23 to 17-1720-25 (Reserved)

Subchapter 7 Dental Services

§17-1720-26 Dental Services
§§17-1720-27 to 17-1720-30 (Reserved)

Subchapter 8 Exclusions and limitations

§17-1720-31 Exclusions and limitations
§§17-1720-32 to 17-1720-34 (Reserved)

Historical Note: This chapter is based substantially upon repealed subchapter 7 of chapter 17-1721.1 and subchapter 8 of chapter 17-1727.

The source note for subchapter 7 of chapter 17-1721.1 is: [Eff 9/31/09; am 06/25/12; R]

The source note for subchapter 8 of chapter 17-1727 is: [Eff 08/01/94; am 01/29/96; am 03/30/96; am 11/25/96; am 01/16/02; am 09/10/09; am 06/25/12; R]

SUBCHAPTER 1

GENERAL PROVISIONS

§17-1720-1 Purpose. This chapter describes covered services, exclusions and limitations provided to an enrolled individual by a participating health plan. [Eff] (Auth: HRS §346-14; 42 C.F.R. §§430.25, 438.6, 440.210) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 438.6, 440.210)

§§17-1720-2 to 17-1720-4 (Reserved).

SUBCHAPTER 2

SCOPE AND CONTENT OF SERVICES

§17-1720-5 Purpose. This chapter describes covered services provided by a participating health plan to an enrolled individual. [Eff]
(Auth: HRS §346-14; 42 C.F.R. §§430.25, 438.6, 440.210) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 438.6, 440.210)

§17-1720-6 Covered services. (a) The benefits minimally required to be provided by each participating health plan shall be known as the standard benefits package as described in section 17-1720-10.

(b) The standard benefits package as defined in section 17-1720-10 is based on a twelve-month benefits period. Benefits are pro-rated for any benefits period other than twelve-month period. If an individual changes health plans during a benefits period, the remaining unused benefits will be covered by the new health plan for the duration of the benefits period.

(c) Based on clinical eligibility and medical necessity, an enrolled individual may be provided services described in section 17-1720-14 by the health plan.

(d) Based on level of care eligibility, the enrolled individual shall be provided services described in sections 17-1720-18 or 17-1720-22 by the health plan.

(e) A health plan may, at the health plan's option, or as otherwise required by the contract between the health plan and the department or the state plan, provide medically necessary services which exceed the requirements of the standard benefits package.

[Eff] (Auth: HRS §346-14; 42 C.F.R. §§430.25, 438.6, 440.210) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 438.6, 440.210)

§§17-1720-7 to 17-1720-9 (Reserved).

SUBCHAPTER 3

STANDARD BENEFITS PACKAGE

§17-1720-10 Standard benefits package. (a)
Within a benefits period year, participating health plans shall provide the following medically necessary services which minimally include, but are not limited to, the following and which may require prior authorization and be subject to limitations as determined by the department:

- (1) Medical inpatient days for medically necessary inpatient hospital care related to medical care, surgery, post-stabilization, and acute rehabilitation and behavioral health inpatient days for psychiatric care and inpatient substance abuse treatment, to include, but are not limited to, the following:
 - (A) Semi-private room and board and general nursing care for inpatient stays related to medical care, surgery, psychiatric care, and substance abuse treatment;
 - (B) Intensive care room and board and general nursing care for medical care and surgery;
 - (C) Use of an operating room and related facilities, inpatient anesthesia, radiology, laboratory and other diagnostic services agreed upon by the plan medical director for medical care and surgery;
 - (D) Drugs, dressings, blood derivatives and their administration, general medical supplies, and diagnostic and therapeutic procedures as prescribed by the attending physician; and

- (E) Other ancillary services associated with hospital care except private duty nursing.
- (2) Outpatient services which include, are but not limited to, the following:
 - (A) Ambulatory surgical center procedures or outpatient hospital services;
 - (B) Behavioral health services;
 - (C) Bona fide emergency services, coverage shall be provided for bona fide emergency services including ground and air (fixed wing and rotor) ambulance for emergency transportation, emergency room services, and physician services in conjunction with the emergency room visits. Bona fide emergency room visits shall be restricted to those requiring services for emergency medical conditions;
 - (D) Diagnostic testing, including laboratory and radiology;
 - (E) Dialysis;
 - (F) Durable medical equipment including visual appliances, prosthetic devices, orthotics and medical supplies;
 - (G) Early and Periodic Screening, Diagnosis and Treatment services for an individual under age twenty-one years as described in chapter 17-1715 and 17-1715.1, who require benefits for which either coverage has been exhausted or not described under section 17-1720-10;
 - (H) 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) Habilitative services;
 - (J) Home health services;
 - (K) Hospice services;

- (L) Pregnancy related, maternity and newborn care services;
 - (M) Medical services related to dental needs;
 - (N) Methadone management;
 - (O) Non-emergency transportation;
 - (P) Organ and tissue transplant services;
 - (Q) Prescription or over-the-counter drugs with a prescription limited by a strict formulary and defined in the contract negotiated between the health plans and the department;
 - (R) Other practitioner services;
 - (S) Out-of-State services;
 - (T) Physician services;
 - (U) Preventative services;
 - (V) Rehabilitation services including physical, occupational, speech, and cognitive rehabilitation therapy;
 - (W) Sterilization services;
 - (X) Smoking cessation services;
 - (Y) Substance abuse treatment services;
 - (Z) Urgent care services;
 - (AA) Vaccinations; and
 - (BB) Vision services. [Eff]
- (Auth: HRS §346-14; 42 C.F.R. §§430.25, 438.6, 440.210) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 438.6, 440.210)

§§17-1720-11 to 17-1720-13 (Reserved)

SUBCHAPTER 4

SPECIALIZED BEHAVIORAL HEALTH SERVICES

§17-1720-14 Specialized behavioral health services. (a) In addition to services included in section 17-1720-10 and based on clinical eligibility and medical necessity, the following specialized behavioral health services may be provided for an

enrolled individual with a Serious and Persistent Mental Illness, Severe Mental Illness or requiring Support for Emotional and Behavioral Development:

- (1) Biopsychosocial rehabilitation;
- (2) Clubhouse;
- (3) Community based residential programs;
- (4) Crisis management;
- (5) Crisis residential services;
- (6) Hospital-based residential services;
- (7) Intensive case management;
- (8) Intensive family intervention;
- (9) Intensive outpatient hospital services;
- (10) Therapeutic living supports and therapeutic foster care supports;
- (11) Peer Specialist;
- (12) Representative payee;
- (13) Substance abuse treatment provided by a licensed or a certified substance abuse counselor;
- (14) Supportive employment; and
- (15) Supported housing.

(b) An enrolled individual age eighteen years or older, who is certified by an independent clinical evaluator as suffering from serious and persistent mental illness or severe mental illness shall receive behavioral health services through the adult mental health division, the health plan in which the individual is enrolled or community care services program as determined by the department.

(c) An enrolled individual under the age of eighteen years, who is certified by an independent clinical evaluator as suffering from severe emotional behavioral disorders, shall be referred to the child and adolescent mental health division within the department of health for services. [Eff
(Auth: HRS §346-14; 42 C.F.R. §430.25) (Imp: HRS §346-14; 42 C.F.R. §430.25)]

§§17-1720-15 to 17-1720-17 (Reserved).

SUBCHAPTER 5

HOME AND COMMUNITY BASED SERVICES

§17-1720-18 Home and Community Based Services (HCBS). (a) The participating health plan is not required to provide HCBS to an enrolled individual if:

- (1) The individual chooses institutional services;
- (2) The individual cannot be served safely in the community;
- (3) There are no adequate or appropriate providers for needed services; or
- (4) The cost of providing services in the home or community setting is expected to exceed the cost of providing care in an institution.

(b) The health plan must receive prior approval from the department or its designee prior to disapproving a request for HCBS.

(c) An individual must meet one of the following level of care criteria to receive home and community based services:

- (1) At risk of deteriorating to institutional level of care; or
- (2) At institutional level of care.

(d) The health plan shall provide the following benefits which minimally include, but are not limited to, the following for an individual described in paragraph (c)(1):

- (1) Adult day care services;
- (2) Adult day health services;
- (3) Home delivered meals;
- (4) Personal emergency response system; and
- (5) Skilled nursing services.

(e) The health plan shall provide the following benefits which minimally include, but are not limited to, the following and may require prior authorization for an individual described in paragraph (c)(2):

- (1) Adult day care services provided by a licensed facility maintained and operated by an individual, organization, or agency for the purpose of providing regular supportive care to four or more disabled adult participants, with or without charging a fee. Adult day care services include therapeutic, social, educational,

recreational, and other activities. Adult day care staff members may not perform healthcare related services such as medication administration, tube feedings, and other activities which require healthcare related training;

- (2) Adult day health services provided by an organized program of therapeutic, social and health activities and services provided to enrollees with functional impairments, for the purpose of restoring or maintaining the individual's optimal capacity for self-care. Adult day health facilities are licensed in accordance with chapter 11-96 and subchapter 2 of chapter 11-94.1;
 - (3) Home delivered meals that are nutritionally sound and delivered to a location where an individual resides (excluding residential or institutional settings). The meals will not replace or substitute for a full day's nutritional regimen (i.e., no more than two meals per day). Home delivered meals are provided to an individual who cannot prepare nutritionally sound meals without assistance and are determined, through an assessment, to require the service in order to remain independent in the community and to prevent institutionalization;
 - (4) Personal emergency response system that is an electronic system placed in homes of high risk enrollees who live alone or are alone significant parts of the day, have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision, to enable them to secure immediate help in the event of a physical, emotional, or environmental emergency; and
 - (5) Skilled nursing services.
- (f) The health plan shall provide the following benefits which minimally include, but are not limited

to, the following for an individual described in paragraph (c) (2):

- (1) The benefits included in section (d);
- (2) Assisted living services that include personal care and supportive care services (such as homemaker services, chore services, attendant services, meal preparation) that are furnished to enrollees who reside in an assisted living facility. Payment for room and board is prohibited;
- (3) Community care foster family home services provided in a home that is certified by the department to provide, for a fee, twenty-four hour living accommodations, including personal care, supportive services (such as homemaker services, chore services and attendant care and companion services) and medication oversight (to the extent permitted under State law). Services shall be provided in a certified private home by a principal care provider who lives in the home for not more than three adults at any one time, at least two of whom shall be Medicaid recipients, and all of whom are at nursing facility level of care, are unrelated to the foster family, and are being monitored in the home by a licensed community case management agency. It does not include expanded adult residential care homes and assisted living facilities, which shall continue to be licensed by the department of health;
- (4) Counseling and training services that involve counseling for the enrollee, family or caregiver, and professional and paraprofessional caregivers to provide the necessary support to build and enhance coping skills, as well as training that may include, but not limited to, enrollee care training for enrollees, family and caregivers regarding the nature of the disease and the disease process; methods of

transmission and infection control measures; biological, psychological care and special treatment needs-regimens; employer training for consumer directed services; instruction about the treatment regimens; use of equipment specified in the service plan; employer skills updates as necessary to safely maintain the individual at home; crisis intervention; supportive counseling; family therapy; suicide risk assessments and intervention; death and dying counseling; anticipatory grief counseling; substance abuse counseling; and nutritional assessment and counseling;

- (5) Community Care Management Agency (CCMA) services are provided to enrollees living in Community Care Foster Family Homes and other community settings, as required. The following activities are provided by a CCMA: continuous and ongoing nurse delegation to the caregiver in accordance with subchapter 15 of chapter 16-89; initial and ongoing assessments to make recommendations to health plans for, at a minimum, indicated services, supplies, and equipment needs of enrollees; ongoing face-to-face monitoring and implementation of the enrollee's care plan; and interaction with the caregiver on adverse effects and changes in condition of enrollees, or both. CCMA's shall: communicate with an enrollee's physician(s) regarding the enrollee's needs including changes in medication and treatment orders; work with families regarding service needs of enrollee and serve as an advocate for their enrollees; and be accessible to the enrollee's caregiver twenty-four hours a day, seven days a week.
- (6) Environmental accessibility adaptations that changes to the enrollee's living environment, but not including community care foster family homes and expanded adult

residential care homes (E-ARCH), to promote safety or facilitate the enrollee's self-reliance by enabling the enrollee to perform basic activities of daily living.

Modifications may include installation of ramps and handrails, widening of doorways, removal of other architectural barriers, bathroom modifications, electrical, plumbing or air conditioners and modifications to the telephone system which enable the individual to function with greater independence in the home, and without which the enrollee would require institutionalization. Window air conditioners may be installed when it is necessary for the health and safety of the enrollee. Excluded are those adaptations or improvements to the home that are of general utility, and are not of direct medical or remedial benefits to the enrollee, such as carpeting, roof repair, central air conditioning, etc. Adaptations which add to the total square footage of the home are excluded from these benefits. All services shall be provided in accordance with applicable State or local building codes;

- (7) Home maintenance that is a service necessary to maintain a safe, clean and sanitary environment. Home maintenance services are those services not included as a part of personal assistance and include heavy duty cleaning, which is utilized only to bring a home up to acceptable standards of cleanliness at the inception of service to an enrollee, minor repairs to essential appliances limited to stoves, refrigerators, and water heaters, and fumigation or extermination services. Home maintenance is provided to an individual who cannot perform cleaning and minor repairs without assistance and are determined, through an assessment, to require the service in order to prevent institutionalization;

- (8) Moving assistance that is provided in rare instances when it is determined through an assessment that an individual needs to relocate to a new home. The following are the circumstances under which moving assistance can be provided to an enrollee: unsafe home due to deterioration; the individual is wheel-chair bound living in a building with no elevator; multi-story building with no elevator, where the enrollee lives above the first floor; enrollee is evicted from their current living environment; or the enrollee is no longer able to afford the home due to a rent increase. Moving expenses include packing and moving of belongings. Whenever possible, family, landlord, community and third party resources who can provide this service without charge will be utilized;
- (9) Non-medical transportation that is the necessary transportation provided to and from facilities, resources, and appointments in order for the enrollee to receive the services included in the plan of care;
- (10) Personal assistance services that assist with activities of daily living such as ambulation, mobility, transfer and lifting, positioning and turning, bowel and bladder care, toileting, bathing, dressing, grooming, feeding, exercise and range of motion, and assisting with medications which are normally self-administered; and instrumental activities of daily living which are directly related to the wellbeing of the enrollee, such as meal preparation, bed, kitchen and bathroom cleanliness, essential errands, and maintenance of health records;
- (11) Residential care services are personal care services, homemaker, chore, attendant care and companion services, and medication oversight (to the extent permitted by law)

provided in a licensed private home by a principle care provider who lives in the home. Residential care is furnished in a:

- (A) Type I Expanded Adult Residential Care Home (EARCH), allowing not more than five residents provided that up to six residents may be allowed at the discretion of the department to live in a Type I home with not more than two of whom may be NF LOC; or
 - (B) Type II EARCH, allowing six or more residents, no more than twenty percent of the home's licensed capacity may be individuals meeting a NF LOC who receive these services in conjunction with residing in the home;
- (12) Respite care services;
 - (13) Specialized case management; and
 - (14) Specialized medical equipment and supplies, including the purchase, rental, lease, warranty costs, installation, repairs and removal of devices, controls, or appliances, specified in a plan of care, that enable an individual to increase or maintain their abilities to perform activities of daily living, or to perceive, control, participate in, or communicate with the environment in which they live. [Eff _____]
(Auth: HRS §346-14; 42 C.F.R. §430.25)
(Imp: HRS §346-14; 42 C.F.R. §430.25)

§§17-1720-19 to 17-1720-21 (Reserved).

SUBCHAPTER 6

INSTITUTIONAL CARE SERVICES

§17-1720-22 Institutional care services. (a)
Institutional care services are provided in a licensed

nursing facility to an enrolled individual who is referred by a physician.

(b) Institutional care services shall be provided either directly by or under the general supervision of a licensed practical nurse or registered professional nurse.

(c) Institutional care services shall be the following benefits which minimally include, but are not limited to:

- (1) Activities of the individual's choice (including religious activities) that are designed to provide normal pursuits for physical and psychosocial well-being;
- (2) Administration of medication and treatment;
- (3) Basic nursing and treatment supplies, such as soap, skin lotion, alcohol, powder, applicators, tongue depressors, cotton ball, gauzes, adhesive tape, bandages, incontinent pads, V-pads, thermometers, blood pressure apparatus, plastic or rubber sheets, enema equipment, and douche equipment;
- (4) Development, management, and evaluation of the written resident care plan based on physician orders that necessitate the involvement of skilled technical or professional personnel to meet the individual's care needs, promote recovery, and ensure the individual's health and safety;
- (5) Durable medical equipment and supplies used by residents but which are reusable;
- (6) Health education services provided by skilled technical or professional personnel to teach the individual self care, such as gait training and self administration of medications;
- (7) Laundry service for items of individual's washable personal clothing;
- (8) Nonrestorative or nonrehabilitative therapy, or both, provided by nursing staff;
- (9) Observation and assessment of the individual's unstable condition that requires the skills and knowledge of skilled technical or professional personnel to identify and evaluate the individual's need for possible medical intervention, modification of treatment, or both, to stabilize the individual's condition;

- (10) A review of the drug regimen of each individual at least once a month by a licensed pharmacist, as required for a nursing facility to participate in Medicaid;
- (11) Therapeutic diet and dietary supplements as ordered by the attending physician;
- (12) Social services provided by qualified personnel;
- (13) Room and board;
- (14) Provision of and payment for, through contractual agreements with appropriate skilled technical or professional personnel, other medical and remedial services ordered by the attending physician which are not regularly provided by the provider. Other services that may be needed, such as transportation to realize the provision of services ordered by the attending physician, shall also be arranged through contractual agreements. The contractual agreement shall stipulate the responsibilities, functions, objectives, service fee, and other terms agreed to by the NF and the person or entity that contracts to provide the service; and
- (15) Feeding assistance performed by a feeding assistant, nurse aide, or nurse. The feeding assistant must work under the supervision of a registered nurse or licensed practical nurse that is licensed to practice in Hawaii. [Eff]
(Auth: HRS §346-14; Pub. L. No. 100-203; 42 C.F.R. §§434.10, 440.40, 440.150, 483.1, 483.20) (Imp: Pub. L. No. 100-203; 42 C.F.R. §§434.10, 440.40, 440.150, 483.1, 483.20)

§§17-1720-23 to 17-1720-25 (Reserved).

SUBCHAPTER 7

DENTAL SERVICES

§17-1720-26 Dental Services. (a) Required preventive dental services and medically necessary

dental services, as described in section 17-1737-75(b), shall be provided to an individual under age twenty-one years.

(b) An individual age twenty-one years and older, shall have dental services in accordance with section 17-1737-75(d).

(c) The dental services described in subsections (a) and (b) shall be provided on a fee-for-service basis.

(d) The health plans shall coordinate with the department or its designee to refer eligible individual to the department's dental third party administrator for non-medically related dental services. [Eff _____] (Auth: HRS §346-14; 42 C.F.R. §430.25) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§§17-1720-27 to 17-1720-30 (Reserved).

SUBCHAPTER 8

EXCLUSIONS AND LIMITATIONS

§17-1720-31 Exclusions and limitations. A participating health plan shall not provide coverage for certain services, procedures, medications, supplies, equipment, or other items that are:

- (1) Specifically excluded from coverage by state or federal requirements;
- (2) Provided by providers not licensed or certified in the State of Hawaii to perform the service;
- (3) Available without charge to the general public through a separate state or federally administered federally-funded program;
- (4) Covered by a third party medical or liability insurance, including Medicare;
- (5) Required to receive prior authorization but did not receive it;
- (6) Experimental in nature and have not been approved by the United States Food and Drug Administration, or both;
- (7) Elective and do not improve outcomes such as decreasing risk of morbidity or mortality;

- (8) Without sufficient evidence of effectiveness or net benefits as determined by the department and not covered under the currently approved Medicaid State Plan, Medicaid waivers, or both;
- (9) Comparatively effective to a tolerated lower cost alternative; or
- (10) Otherwise determined by the department to be non-covered, excluded, or limited.
[Eff] (Auth: HRS §346-14; 42
C.F.R. §438.210) (Imp: HRS §346-14; 42
C.F.R. §438.210)

§§17-1720-32 to 17-1720-34 (Reserved)."

34. Chapter 17-1720.1 of Title 17, Hawaii Administrative Rules, entitled "FREEDOM OF CHOICE, ENROLLMENT AND DISENROLLMENT", is an addition of a new chapter to read as follows:

"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
 §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 3 and 4 of chapter 17-1721.1 and subchapters 4 and 5 of chapter 17-1727.

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

The source note for subchapters 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].

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] (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).

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] (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] (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.

(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] (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] (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.

(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] (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;

(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] (Auth: HRS §346-14; 42 C.F.R. §§430.25, 438.50) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 438.50)

§17-1720.1-18 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);
- (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.

(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 _____] (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 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] (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] (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 incurred in accordance with chapter 17-1730 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 the first (1st) day of the month following the date on which the department authorizes the enrollment change.
[Eff] (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] (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] (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;
- (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;

- (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:

