

85. Chapter 1735 is repealed.

86. Chapter 1735.1 of Title 17, Hawaii Administrative Rules, entitled "GENERAL PROVISIONS FOR FEE-FOR-SERVICE MEDICAL ASSISTANCE", 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 1735.1

GENERAL PROVISIONS FOR FEE-FOR-SERVICE MEDICAL ASSISTANCE

§17-1735.1-1	Purpose
§17-1735.1-2	An individual covered under fee-for-service medical assistance
§17-1735.1-3	Effective date of authorization
§§17-1735.1-4 to 17-1735.1-8	(Reserved)

Historical Note: This chapter is based substantially upon repealed chapter 17-1735. [Eff 08/01/94; am 07/20/95; am 02/10/97; am 07/06/99; am 02/16/02; am 05/10/03; 01/31/09; am 06/11/09; am 06/25/12;
R]

§17-1735.1-1 Purpose. This chapter describes an individual covered under the State's fee-for-service component of the medical assistance program. The fee-for-service program is discussed in the following chapters: 17-1722, special medical assistance coverages and programs; 17-1736, provider provisions; 17-1737, scope and contents of the fee-for-service

medical assistance program; 17-1738, targeted case management services; 17-1739, authorization, payment, and claims in the fee-for-service medical assistance program; 17-1740.1, reimbursement of federally qualified health centers and rural health clinics; and 17-1741, utilization control.

[Eff _____] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1735.1-2 An individual covered under fee-for-service medical assistance. (a) An individual eligible for fee-for-service coverage under the medical assistance program includes, but is not limited to:

- (1) A child in receipt of foster care, kinship guardianship or adoption assistance, under age twenty-one who is a resident of the State, and placed in another state as described in chapter 17-1715;
- (2) A non-citizen ineligible for Medicaid assistance who receives emergency medical services as described in chapter 17-1723.1;
- (3) An individual who enters the State of Hawaii Organ and Tissue Transplant (SHOTT) program as described in chapter 17-1737;
- (4) An incarcerated individual who is admitted as an inpatient in a medical institution not on the grounds of the incarceration facility;
- (5) An individual who receives a determination of eligibility on or after the start date of a new health plan contract period that is retroactive to a date prior to the start of the new health plan contract period with incurred services during the period from the effective date of coverage up to the start date of the new health plan contract period;
- (6) A medically needy individual who is not aged, blind or disabled as described in chapter 17-1730.1; or
- (7) An individual who is eligible for the Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLMB), Qualified Disabled and Working

Individuals (QDWI), or Qualifying Individuals (QI) program described in chapter 17-1722.

(b) While enrolled in a participating health plan, an individual is excluded from the fee-for-service program, except for the following additional services that may be provided on a fee-for-service basis, subject to approval by the department:

- (1) Services provided through the Medicaid waiver program for an individual with developmental disabilities or intellectual disabilities (DD-ID);
- (2) ICF-ID institutional services;
- (3) School-based health related services;
- (4) Early intervention program services;
- (5) Specialized behavioral health services; and
- (6) Dental services as described in section 17-1737-75.

(c) The department shall determine on a case-by-case basis, whether an individual enrolled in a managed care program may have additional services covered on a fee-for-service basis. [Eff] (Auth: HRS §§88-4, 346-14; 42 C.F.R. §§430.25, 435.1009, 435.1010, 440.150; 42 U.S.C. §1396d(a)(28)(A)) (Imp: HRS §§88-4, 346-14; 42 C.F.R. §§430.25, 435.1009, 435.1010, 440.150; 42 U.S.C. §1396d(a)(28)(A))

§17-1735.1-3 Effective date of authorization.

(a) The effective date for payments to be made for covered services under the fee-for-service program for an individual described in section 17-1735.1-2 shall be:

- (1) The date the application is received by the department as described in chapter 17-1711.1;
- (2) Any date specified by the individual on which appropriate Medicaid eligible services were incurred and is no earlier than the first day of the third month prior to the month the application is received by the department for an individual applying for the coverage of long-term care services, or the immediate ten calendar days prior to the date the application is received by the department for all other individuals; or

87. Chapter 17-1735.2 of Title 17, Hawaii Administrative Rules, entitled "GENERAL PROVISIONS FOR PARTICIPATING HEALTH PLANS", 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 1735.2

GENERAL PROVISIONS FOR PARTICIPATING HEALTH PLANS

§17-1735.2-1	Purpose
§17-1735.2-2	Health plan participation in the medical assistance program
§17-1735.2-3	Service areas
§17-1735.2-4	Requirements of participating health plans
§17-1735.2-5	Capitated payments
§17-1735.2-6	Enforcement of contracts with participating health plan
§17-1735.2-7	Termination of contract with participating health plan
§§17-1735.2-8 to 17-1735.2-10	(Reserved)

Historical Note: This chapter is based substantially upon repealed subchapters 5 and 8 of chapter 17-1721.1 and subchapter 9 of chapter 17-1727.

The source notes for subchapters 5 and 8 of chapter 17-1721.1 is: [Eff 01/31/09; R].

The source notes for subchapter 9 of chapter 17-1727 is: [Eff 08/01/94; am 01/29/96; am06/19/00; am 02/16/02; am 01/09/17/07; am 09/17/07; am 06/25/12; R].

§17-1735.2-1 Purpose. This chapter describes the requirements for the participation of health plans under the medical assistance program.
[Eff] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1735.2-2 Health plan participation in the medical assistance program. (a) The department shall request proposals from managed care health plans for provision of healthcare services to an eligible individual to participate in the medical assistance program.

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

(c) Contracts for participation in the medical assistance program shall be awarded to qualified health plans upon finalization of financial agreements with the department.

(d) The department shall develop a request for proposals prior to the lapse of existing contracts with participating plans to ensure that an eligible individual for coverage through the medical assistance program shall receive continued health care coverage.
[Eff] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1735.2-3 Service areas. (a) The department shall designate geographic areas as the areas for which health plans will submit proposals to provide services.

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

(c) More than one health plan may be contracted by the department for each service area.

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

§17-1735.2-4 Requirements of participating health plans. (a) Health plans participating in the medical assistance program shall abide by the provisions of their respective contracts with the department as well as federal and state statutes and regulations.

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

- (1) Provision of all services required by the contract between the respective plan and the department;
- (2) Provision of a primary care provider for each eligible individual who is enrolled in the health plan;
- (3) Provision of a case management system to ensure that health services identified by an eligible individual's primary care provider as medically necessary are received;
- (4) Development and maintenance of a sufficient network of health care providers to ensure the provision of required health services are provide to an eligible individual in a timely manner;
- (5) Maintenance of adequate support staff and systems to administer and conduct business functions;
- (6) Development and maintenance of required information systems;
- (7) Development and maintenance of a quality assurance program;
- (8) Development and maintenance of a grievance and appeal system for a dissatisfied eligible individual;
- (9) Development and maintenance of a toll-free telephone hotline in the State to confirm

- enrollment, respond to inquiries from an eligible individual, and provide information to the general public; and
- (10) Maintenance of a medical records system to enable the provision of information pertinent to the care and management of an eligible individual to the department.
[Eff _____] (Auth: HRS §346-14)
(Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1735.2-5 Capitated payments. (a) Each participating health plan shall be paid on a capitated basis, as negotiated with the department, for an eligible individual enrolled in that health plan.

(b) The department shall provide the capitated payment, as stipulated in the contract between the department and each health plan, in return for the health plan's provision of all contracted coverage for the health plan's eligible individuals. [Eff _____]
(Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1735.2-6 Enforcement of contracts with participating health plan. (a) The department may monitor a participating health plan's performance during any contract period.

(b) The department may impose civil or administrative monetary penalties not to exceed the maximum amount established by federal and state statutes and regulations if the health plan:

- (1) Fails to provide medically necessary items and services that are required under law or under contract;
- (2) Imposes upon beneficiaries excess premiums and charges;
- (3) Acts to discriminate among an eligible individual;
- (4) Misrepresents or falsifies information;
- (5) Violates marketing guidelines established by the department;

- (6) Violates other contract provisions and requirements; or
- (7) Violates federal or state statutes or regulations.

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

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

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

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

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

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

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

[Eff _____] (Auth: HRS §346-59.5) (Imp: HRS §346-14; 42 C.F.R. §§430.25; 438.700, 438.702; 438.706; 438.710)

§17-1735.2-7 Termination of contract with participating health plan. (a) The department shall have the authority to terminate the participating health plan's contract for any or all of the following reasons:

- (1) Convenience;
- (2) Default by the health plan;
- (3) Expiration of the medical assistance program;
- (4) Failure by the health plan to abide by the contract conditions;
- (5) Insolvency of or declaration of bankruptcy by the health plan;
- (6) Meet federal or state statutes, or both; or
- (7) Unavailability of funds.

(b) When termination of contract is due to reasons identified under subsections (a)(2), (4) or (6), the department shall provide a hearing for the affected health plan prior to termination of the contract.

(c) After the department notifies the health plan of its intent to terminate the contract due to reasons identified under subsections (a)(2), (4) or (6), the department may do the following:

- (1) Provide the affected eligible individual written notice of the department's intent to terminate the contract; and
- (2) Allow the affected eligible individual to change health plans immediately without cause. [Eff _____] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25; 438.708)

§§17-1735.2-8 to 17-1735.2-10 (Reserved)."