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HAWAII ADMINISTRATIVE RULES

TITLE 17

DEPARTMENT OF HUMAN SERVICES

SUBTITLE 12 MED-QUEST DIVISION

CHAPTER 1721.1

QUEST EXPANDED ACCESS

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SUBCHAPTER 1

GENERAL PROVISIONS

§17-1721.1-1 Purpose. This chapter describes
QUEST expanded access, a demonstration project
authorized by section 1115 of the Social Security Act.
[Eff 01/31/09] (Auth: HRS §346-14) (Imp: HRS
§346-14)

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§17-1721.1-2 Definitions. As used in this chapter:

"Acute care services" means the short term medical treatment, usually in an acute care hospital, for patients having an acute illness or injury.

"Assisted living facility" is a facility, as defined in HRS section 321-15.1 that is licensed by the department of health. This facility shall consist of a building complex offering dwelling units to individuals and services to allow residents to maintain an independent assisted living lifestyle.

"Benefit period" means the period from the first day of the month following the close of the annual plan change period and extending for no more than twelve months thereafter, as designated by the department.

"Capitated rate" means the fixed monthly payment per person paid by the State to a medical, behavioral or catastrophic coverage plan.

"Catastrophic coverage" means the coverage purchased to protect the State when eligible medical costs incurred by recipients exceed a specified dollar threshold which is determined by contractual agreement between the department and the health plan.

"Community care foster family home" or "CCFFH" is a home that is certified by the department to provide a resident twenty-four hour living accommodations and home and community based services.

"Contract" means a contract between a participating health plan and the department to provide QExA services.

"Confirmation notice" is the document the individual receives from the department confirming their enrollment in a health plan.

"Cost share" means the share of monthly medical expenses for long-term care services for an institutionalized individual.

"Date of approval" means the date on which the department completes the administrative process to certify that an individual or a family is eligible for QExA.

"Early periodic diagnosis, screening, and treatment program" or "EPSDT" means early screening and diagnostic services, to identify physical or mental defects in recipients, and, to provide health care, treatment, and other measures to correct or ameliorate any defects and chronic condition discovered in accordance with section 1905r of the Social Security Act. EPSDT includes services to:

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- (1) Seek out recipients and their families and inform them of the benefits of prevention and the health services available;
- (2) Help the recipient or family use health resources, including their own talents, effectively and efficiently; and
- (3) Assure the problems identified are diagnosed and treated early, before they become more complex and their treatment more costly.

"Effective date of coverage" means the date on which eligibility is determined by the department and may precede the date upon which the health plan receives notification of enrollment.

"Effective date of enrollment" means the date as of which a participating health plan is required to provide benefits to an enrollee.

"Emergency medical condition" means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

- (1) Placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- (2) Serious impairment to body functions; or
- (3) Serious dysfunction of any bodily organ or Part;
- (4) Serious harm to self or others due to an alcohol or drug abuse emergency;
- (5) Injury to self or bodily harm to others; or
- (6) With respect to a pregnant woman having contractions:
 - (A) That there is adequate time to effect a safe transfer to another hospital before delivery; or
 - (B) That transfer may pose a threat to the health or safety of the woman or her unborn child.

An emergency medical condition shall not be defined or limited based on a list of diagnoses or symptoms.

"Emergency services" means covered inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition that is found to exist using a prudent layperson standard.

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"Enrollee" means an individual who has selected or is assigned by the department to be an enrollee of a health plan.

"Enrollment fee" means the amount an enrollee, except for an enrollee who is a resident of an ICF-MR, or a participant in the DD-MR waiver program, is responsible to pay that is equal to the spenddown amount for a medically needy individual or cost share amount for an individual receiving long term care services.

"Enrollment letter" means a letter informing an individual of their eligibility for QExA and their options to select a plan.

"Expanded adult residential care home" or "E-ARCH" is a facility, as defined in section 11-100.1.2 and licensed by the department of health, that provides twenty-four (hour living accommodations, for a fee, to adults unrelated to the family, who require at least minimal assistance in the activities of daily living, personal care services, protection, and healthcare services, and who may need the professional health services provided in a nursing facility.

"Health plan or participating health plan" means a QExA health plan contracted by the State to provide medical or behavioral health care services, through a managed care system, to individuals who are found eligible to participate in QExA and have been enrolled in that health plan.

"Home and community based services" or "HCBS" include, but are not limited to, adult day care, adult day health, assisted living, pediatric attendant care, community care management agency (CCMA) services, community care foster family home services, counseling and training activities, environmental accessibility adaptations, E-ARCH or residential care services, home delivered meals, home maintenance, medically fragile day care, moving assistance, non-medical transportation, personal assistance services - level II, personal emergency response systems, private duty nursing, respite care, and specialized medical equipment and supplies.

"ICF-MR" means intermediate care facility for the mentally retarded.

"Long-term care residential facility" means a facility that cares for enrollees who are at nursing facility level of care. These facilities are assisted

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living facilities, E-ARCHs, CCFFHs, nursing facilities, and sub-acute units.

"Long-term care services" means services provided to an inpatient in a medical facility receiving a nursing facility level of care or to a resident of a nursing facility, or home and community based services provided to individuals residing in a community setting.

"Managed care" means a comprehensive approach to the provision of healthcare that combines clinical services and administrative procedures within an integrated, coordinated system to provide timely access to primary care and other necessary services in a cost-effective manner.

"Medically needy" means aged, blind, or disabled individuals who are otherwise eligible for Medicaid, who are not categorically needy, and whose income and resources are within limits set under the Medicaid State Plan.

"Ninety-day grace period" means the first ninety-days after the date of the confirmation notice that an enrollee has to change health plans, with or without cause, provided the health plan is not at its maximum enrollment.

"Non-returning health plan" means a health plan that has a current, but no new contract with the department.

"Nursing facility" or "NF" is a facility, as defined in section 11-94-2, which provides appropriate care to persons referred by a physician. Such persons are those who need twenty-four hour a day assistance with the normal activities of daily living, need care provided by licensed nursing personnel and paramedical personnel on a regular, long-term basis, and may have a primary need for twenty-four hours of skilled nursing care on an extended basis and regular rehabilitation services. "Nursing facility level of care" means the determination that a member requires the services of licensed nurses, in accordance with chapter 16-89, in an institutional setting to carry out the physician's planned regimen for total care. These services can be provided in the home or in community-based programs as a cost-neutral, least restrictive alternative to institutional care in a hospital or nursing home.

"Personal reserve standard" means the maximum amount of countable assets that may be held by an

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individual or family while establishing or maintaining eligibility for medical assistance.

"Primary care services" means the provision of integrated, accessible health services by clinicians and providers of health care services who are accountable for addressing a broad spectrum of an individual's health care needs (including physical, mental and emotional).

"Primary care provider" or "PCP" means a provider who is licensed in Hawaii and is 1) a physician, either an M.D. (doctor of medicine) or a D.O. (doctor of osteopathy), and must generally be a family practitioner, general practitioner, general internist, pediatrician or obstetrician-gynecologist (for women, especially pregnant women) or geriatrician; or 2) an advanced practice registered nurse with prescriptive authority. PCPs have the responsibility for supervising, coordinating and providing initial and primary care to the enrollee and for initiating referrals and maintaining the continuity of enrollee care.

"Prudent layperson" means one who possesses an average knowledge of health and medicine.

"Prudent layperson standard" refers to the determination of an emergency medical condition based on the judgment of a prudent layperson.

"QExA" means QUEST expanded access program.

"Service area" means the geographical area defined by zip codes, census tracts, or other geographic subdivisions that is served by a participating health plan as defined in the health plan's contract with the department.

"Spendedown amount" means the amount of an individual's income in excess of the medically needy income standard identified by the department as available to meet a portion of the individual's health care cost.

"Standard benefits package" means the minimum benefits and services that must be provided by each participating health plan which is contracted under QExA.

"State plan" or "Hawaii Medicaid state plan" is the document approved by United States Department of Health and Human Services that defines how Hawaii operates its Medicaid program. The state plan addresses areas of state program administration,

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Medicaid eligibility criteria, service coverage, and provider reimbursement.

"Sub-acute unit" is a facility that provides care as defined in section 17-1737-116, that is needed by a patient not requiring acute care, but who needs more intensive skilled nursing care than is provided to the majority of patients in a nursing facility.

[Eff 01/31/09] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§§17-1721.1-3 to 17-1721.1-5 (Reserved).

SUBCHAPTER 2

FREEDOM OF CHOICE

§17-1721.1-6 Choice of participating health plans. (a) An eligible individual shall be allowed to choose from among the participating health plans which service the geographic area in which the individual resides. This provision shall not apply to an individual identified in subsection (b). If a health plan has reached its maximum enrollment, the eligible individual shall select another health plan that is available.

(b) In the absence of a choice of health plan in a rural service area, an eligible individual who resides in that particular service area shall be enrolled in the participating health plan.

[Eff 01/31/09] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 430.51)

§17-1721.1-7 Choice of primary care provider. An eligible individual shall be allowed fifteen days, under the procedures established by the health plan, to select a primary care provider from among those available within the health plan. [Eff 01/31/09]

(Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 430.51)

§17-1721.1-8 Assignment of primary care provider. If an enrollee does not select a primary care provider from among the available primary care providers within

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the health plan, the health plan shall assign the enrollee to a primary care provider of the health plan's choice. The enrollee may change their primary care provider as frequently as, and for whatever reasons, they choose. [Eff 01/31/09] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 430.51)

§§17-1721.1-9 to 17-1721.1-15 (Reserved).

SUBCHAPTER 3

ELIGIBILITY AND ENROLLMENT

§17-1721.1-16 Individuals eligible for QExA. The following individuals shall be eligible for QExA:

- (1) An aged, blind or disabled individual who meets the provisions of chapter 17-1721;
- (2) A blind or disabled individual who meets the provisions of subchapter 2 and of chapter 17-1722;
- (3) An aged individual who meets the provisions of subchapter 6 of chapter 17-1722;
- (4) A blind or disabled child who meets the provisions of subchapter 10 of chapter 17-1722;
- (5) An aged, blind or disabled individual who meets the provisions of subchapter 13 of chapter 17-1722;
- (6) A blind or disabled immigrant child who meets the provisions of chapter 17-1722.1;
- (7) A blind or disabled pregnant immigrant woman who meets the provisions of chapter 17-1721.2;
- (8) An aged, blind or disabled individual who meets the provisions of subchapter 3 of chapter 17-1723;
- (9) A blind or disabled child or pregnant woman who meets the provisions of chapter 17-1732;
- (10) Individuals found eligible under the provisions of chapter 17-1733; and
- (11) Individuals found eligible under the provisions of chapter 17-1734.

[Eff 01/31/09] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

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§17-1721.1-17 Enrollment. (a) An individual eligible to participate in QExA shall be enrolled in a health plan.

(b) The department may enroll an eligible individual in a health plan for purposes of providing the individual with covered services during the period between the date the individual is determined eligible for QExA and the date that the individual selects or is assigned to a health plan pursuant to subsections (c) and (d).

(c) After being found eligible for coverage under QExA, an individual shall be allowed fifteen days after the date of the enrollment letter to select from among the participating health plans available in the service area in which the individual resides.

(d) If an individual does not select a health plan within fifteen days after the date of the enrollment letter, enrollment in a health plan shall be assigned by the department.

(e) A confirmation notice will be mailed to the individual once the individual is enrolled in a health plan.

(f) After selecting or being assigned to a health plan, an enrollee shall have a ninety-day grace period to change health plans.

(g) Except for changes made by an enrollee during the ninety-day grace period, an enrollee shall only be allowed to change enrollment from one health plan to another during the annual plan change period. The exceptions to this provision include:

- (1) Change in residence by an enrollee from one service area to another:
 - (A) In this event the individual or family shall be allowed fifteen days after the date of the enrollment letter to select a health plan servicing the new service area in which the individual resides.
 - (B) If a selection is not made within fifteen days after the date of the enrollment letter, the individual shall remain enrolled in their current health plan, provided that health plan services that area.
- (2) Decisions from administrative hearings;
- (3) Provisions in federal or state statutes or administrative rules;
- (4) Legal decisions;
- (5) Change in foster placement or subsidized

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- adoption if it is in the best interest of the child;
- (6) 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;
 - (7) 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 PCP or another provider determines that receiving the services separately would subject the enrollee to unnecessary risk;
 - (8) Termination of the enrollee's health plan's contract;
 - (9) Mutual agreement by the health plans involved, the enrollee, and the department;
 - (10) Violations by a health plan as specified in sections 17-1721.1-69 and 17-1721.1-70;
 - (11) Lack of direct access to women's healthcare specialists for breast cancer screening, pap smears and pelvic exams;
 - (12) 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 healthcare 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
 - (13) Other special circumstances as determined by the department.
- (h) An enrollee who is disenrolled from a health plan shall be allowed to select a health plan of their choice:
- (1) If disenrollment extends for more than sixty calendar days in a benefit period;
 - (2) If disenrollment occurred during the annual plan change period; or
 - (3) If disenrollment includes the first day of a new benefit period. [Eff 01/31/09]
(Auth: HRS §346-14) (Imp: HRS §346-14;
42 C.F.R. §§430.25; 431.51)

§17-1721.1-18 Annual plan change period. (a)
Except as limited by section 17-1721.1-6, an enrollee

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shall be allowed to change enrollment from one health plan to another health plan within the service area in which the enrollee resides during the annual plan change period.

(b) The annual plan change period shall occur each calendar year at a time designated by the department, no more than twelve months after the start of the previous benefit period.

(c) An enrollee who is enrolled in a non-returning health plan shall be allowed to select from the available health plans.

(d) If the enrollee is required to select a health plan, but does not select a health plan during the annual plan change period, enrollment in a health plan shall be assigned by the department.

[Eff 01/31/09] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25; 431.51)

§17-1721.1-19 Effective date of enrollment. (a) For individuals newly approved for coverage, the effective date of enrollment shall be:

- (1) The date of application;
- (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 three months prior to the month of application; or
- (3) The date when all eligibility requirements are met by the applicant.

(b) The effective date of enrollment resulting from a change from one health plan to another during the annual plan change period shall generally be the first day of the second month after the annual plan change period ends.

(c) The effective date of enrollment resulting from a change from one health plan to another, other than during the annual plan change 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.
- (2) If an enrollee changes residence from one service area to another, the date the enrollment process has been completed to enroll an individual in a health plan in the new service area.

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(d) The effective date of enrollment resulting from a change from QUEST, QUEST-Net, or QUEST-ACE to a QExA health plan is the QExA eligibility start date. An exception to this provision is for an individual who attains the age of sixty-five. The effective date of enrollment in a QExA plan is the first day of the month the individual becomes age sixty-five.

(e) The effective date of enrollment for a newborn of a QExA recipient is as follows:

- (1) A newborn who is not blind or disabled shall receive coverage on a fee-for-service basis effective the date of birth, regardless of when the birth is reported, to the date the enrollment process has been completed to enroll the newborn in a QUEST plan, or
- (2) If the newborn is blind or disabled, the newborn shall receive coverage under the mother's QExA health plan effective the date of birth until the department notifies the health plan that the newborn is enrolled in a different health plan. [Eff 01/31/09; am 06/11/09] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25; 431.51)

§17-1721.1-20 Limitation on health plan enrollment. (a) On the fifteenth of each month or on the first business day following the fifteenth in the event the day falls on a weekend or holiday, the department will review the enrollments of the health plans. If the health plan has an enrollment equal to or exceeding its maximum enrollment allowed for the service area, the department will stop enrollment for that health plan effective the following business day. This provision will remain in effect until the fifteenth of the following month when the department will again review enrollment of the health plans. If the enrollment is below the maximum enrollment allowed for the island, the restriction from enrolling an individual into a health plan will be lifted for the following month. If the enrollment is equal to or exceeds its maximum enrollment allowed for the island, the restriction from enrolling an individual into a health plan will remain in effect.

(b) When a restriction from enrolling an individual into a health plan is imposed on a health plan, the health plan shall not be available as a recipient's selection or nor will the department assign

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an individual into that health plan until the restriction is lifted. The exceptions to this provision are:

- (1) Newborns who are eligible for the QExA program and born to a QExA mother who is currently enrolled in a QExA health plan that is at its maximum enrollment, shall be enrolled in the mother's health plan;
- (2) Enrollees enrolled in a health plan with a waiting list for HCBS or personal assistance services-level I may enroll in a health plan that has maximum enrollment; and
- (3) Enrollees who have lost eligibility for a period of sixty days or less shall be reenrolled into the same health plan, even if that health plan is identified as having maximum enrollment.
- (4) If the individual is enrolled in a health plan that has statewide service, the individual can continue to be enrolled in that health plan. [Eff 01/31/09]
(Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25; 431.51)

§§17-1721.1-21 to 17-1727-35 (Reserved).

SUBCHAPTER 4

DISENROLLMENT

§17-1721.1-36 Authority to disenroll QExA beneficiaries. The department shall have sole authority to disenroll an enrollee from a health plan. [Eff 01/31/09] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25; §438.56)

§17-1721.1-37 Disenrollment of enrollees from health plans. An enrollee may be disenrolled for reasons that include, but are not limited to, the following:

- (1) In compliance with administrative appeal decisions or court orders;
- (2) A mutual agreement between the enrollee, the participating health plan involved, and the department;

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- (3) A voluntary withdrawal from participation in QExA by the enrollee;
- (4) The enrollee 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 enrollee is not in control of their personal finances, and the arrearage is caused by the party responsible for the enrollee's finances, and action is being taken to remediate the situation, including but not limited to:
 - (i) Appointment of a new responsible party for the enrollee's finances;
 - (ii) Recovery of the enrollee's funds from the responsible party which will be applied to the enrollee's enrollment fee obligation;
 - (B) The enrollee is in control of their finances, and the arrearage is due to the unavailability of the enrollee's funds due to documented theft or financial exploitation, and action is being taken to:
 - (i) Ensure that theft or exploitation does not continue;
 - (ii) Recover the enrollee's funds to pay the enrollee's enrollment fee obligation;
- (5) The enrollee no longer meets QExA eligibility requirements;
- (6) Death of the enrollee;
- (7) Incarceration of the enrollee;
- (8) The enrollee enters the Hawaii State hospital;
- (9) The enrollee becomes a Program of All-Inclusive Care for the Elderly (PACE) participant;
- (10) The enrollee enters the State of Hawaii organ and transplant (SHOTT) program;
- (11) The enrollee is in foster care or a subsidized adoption agreement and has been moved out-of-state by the department;
- (12) The enrollee provides false information with the intent of enrolling in the QExA program under false pretenses;
- (13) The enrollee chooses another health plan

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- during the annual plan change period and that health plan is not capped;
- (14) The enrollee is enrolled in a health plan with a waiting list for HCBS or personal assistance level I and the other health plan does not have a waiting list for the necessary service(s);
 - (15) The enrollee's 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; or
 - (16) The enrollee's PCP 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. [Eff 01/31/09]
(Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§§17-1721.1-38 to 17-1721.1-40 (Reserved).

SUBCHAPTER 5

REIMBURSEMENT TO PARTICIPATING HEALTH PLANS

§17-1721.1-41 Capitated payments. (a) Each participating health plan shall be paid on a capitated basis, as negotiated with the department, for individuals enrolled in that health plan.

(b) The department shall provide the capitated payment, as stipulated in the contract between the department and each participating health plan, in return for the health plan's provision of all negotiated services for the health plan's enrollees.

(c) When an enrollee is responsible for paying an enrollment fee, this amount shall be deducted from the capitated rate that is paid to the health plan by the department for the enrollee's coverage. The health plan shall be responsible for collecting the enrollment fee from the enrollee. [Eff 01/31/09] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§§17-1721.1-42 to 17-1721.1-45 (Reserved)

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SUBCHAPTER 6

FINANCIAL RESPONSIBILITIES OF QExA ENROLLEES

§17-1721.1-46 Enrollment fee. (a) When an enrollee is determined responsible for paying an enrollment fee, this amount shall be applied to the capitated rate that is paid by the department to the enrollee's health plan for the enrollee's coverage.

(b) An enrollee shall pay the enrollment fee to the enrollee's health plan.

(c) If a medically needy enrollee is two full months in arrears in the payment of the enrollment fee to the enrollee's health plan, then the department shall initiate disenrollment procedures.

[Eff 01/31/09] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25; 42 U.S.C. §1396u-1)

§§17-1727-47 and 17-1727-50 (Reserved).

SUBCHAPTER 7

SCOPE AND CONTENT OF SERVICES

§17-1721.1-51 Standard benefits package. (a) Each of the participating health plans shall be required to provide a standard benefits package that minimally includes services identified in sections 17-1721.1-52, 17-1721.1-53, 17-1721.1-54, and 17-1721.1-55.

(b) A participating health plan may, at the health plan's option, provide benefits which exceed the requirements of the standard benefits package.

(c) The health plan shall coordinate services listed in section 17-1735-3 as appropriate.

[Eff 01/31/09] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1721.1-52 Primary and acute care services to be provided by participating health plans. (a) Participating health plans shall provide all medical services that are required by the Hawaii Medicaid state plan.

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(b) Participating health plans shall provide medically necessary preventive, psychiatric, diagnostic, and treatment services which minimally include, but are not limited to, the following:

- (1) Inpatient hospital services for medical, surgical, rehabilitative, maternity, and newborn care, including room and board, nursing care, medical supplies, equipment, drugs, diagnostic services, physical and occupational therapy, speech and language pathology, and other medically necessary services;
- (2) Outpatient hospital services, including emergency room services, post stabilization services, ambulatory surgery, urgent care services, medical supplies and equipment, drugs, diagnostic services, therapeutic services such as chemotherapy and radiation therapy, and other medically necessary services;
- (3) Preventive services, including initial and interval histories, physical examinations and developmental assessments, immunizations, diagnostic and screening laboratory and radiology services. Other preventative services includes screening (blood pressure measurement, weight-height measurement, total cholesterol measurement, tuberculosis, and screening for breast, cervical, colorectal, and prostate cancer), rubella serology or vaccine history, health education and counseling, and chemoprophylaxis;
- (4) Preventive services for children, including newborn screening, hospital stays for normal, term, healthy newborns for up to forty-eight hours after normal vaginal delivery or up to ninety-six hours after cesarean section delivery, other age appropriate laboratory screening tests, screening to assess health status, tuberculin skin testing, immunizations, age appropriate dental referral and oral fluoride, and age appropriate health education;
- (5) Prescribed drugs, blood, and blood products in accordance with the health plan's own formulary or prior authorization by the health plan.
- (6) Radiology, laboratory, and other diagnostic services including imaging, screening

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- mammograms, screening and diagnostic laboratory tests, therapeutic radiology, and other medically necessary diagnostic services;
- (7) Physician services, including services of psychiatrists provided at locations including, but not limited to, a physician's office, clinic, private home, licensed hospital, licensed nursing facility, or a licensed or certified residential setting;
 - (8) Maternity services such as prenatal visits and laboratory screening tests, health education and screening, diagnosis of premature labor, diagnostic amniocentesis, diagnostic ultrasound, fetal stress, and non-stress testing, treatment of missed, threatened, incomplete and elective abortions, hospital stays for delivery of infants, postpartum care, and prenatal vitamins including folic acid;
 - (9) Medical services related to dental needs that are provided in an inpatient hospital or ambulatory surgery center, including but not limited to referrals, follow-up, coordination and provision of appropriate medical services.
 - (10) Other practitioner services including podiatrists, optometrists, psychologists, certified nurse midwives, licensed advanced practice registered nurse services (including family, pediatric, geriatric, and psychiatric health specialists), and other health care professionals licensed or certified by the State;
 - (11) Personal assistance services - level I shall include one or more of the following activities:
 - (A) Routine housecleaning such as sweeping, mopping, dusting, making beds, cleaning the toilet and shower or bathtub, taking out rubbish;
 - (B) Care of clothing and linen by washing, drying, ironing, mending;
 - (C) Marketing and shopping for household supplies and personal essentials;
 - (D) Light yard work such as mowing the lawn,

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- raking the lawn, trimming hedges, bundling rubbish for refuse collection;
- (E) Simple home repairs such as mending screens, replacing light bulbs, replacing light fixtures, fixing leaky faucets, clearing stopped-up drains;
- (F) Preparing meals;
- (G) Running errands such as paying bills, picking up medication, escorting the recipient to medical care services, nutritional or recreational programs; or
- (H) Assistance with bathing, dressing, grooming.

Maximum enrollment for personal assistance level- I services may be limited by the department.

- (12) Rehabilitation services include physical therapy, occupational therapy, speech and language pathology, and audiology services, and other medically necessary therapeutic services;
- (13) Cognitive Rehabilitation services are provided to cognitively impaired persons that assess and treat communication skills, cognitive and behavioral ability, and cognitive skills related to performing activities of daily living (ADL);
- (14) Durable medical equipment, prosthetic devices, orthotics, and medical supplies including, but not limited to, oxygen tanks, oxygen concentrators, eyeglasses, ventilators, wheelchairs, crutches, canes, braces, hearing aids, pacemakers, and other medically necessary appliances, supplies, and artificial aids;
- (15) Home health services are part-time or intermittent care for enrollees who do not require hospital care. This service is provided under the direction of a physician in order to prevent re-hospitalization or institutionalization. The home health service provider must meet Medicare requirements. Medicaid services provided to enrollees receiving Medicare home health services that are duplicative of Medicare home health benefits (i.e., physical therapy

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- and home health aides) will not be covered. Home health services include skilled nursing, home health aides, therapeutic services (physical and occupational therapy, audiology and speech-language pathology), medical supplies and equipment, and other medically necessary home health services;
- (16) Hospice services is a program that provides care to terminally ill patients who have six months or less to live. A hospice provider must meet Medicare requirements. Medicaid will not cover hospice services that an enrollee is receiving from Medicare. Only when the service need is not related to the hospice diagnosis can the service be covered by Medicaid.
- (17) Organ and tissue transplant services, including cornea, kidney, allogenic and bone marrow;
- (18) Transportation services include both emergency and non-emergency ground and air services. Transportation shall be provided to and from medically necessary medical appointments for enrollees who have no means of transportation, who reside in areas not served by public transportation, or cannot access public transportation due to their disability. Transportation shall be provided to enrollees who are referred to a provider that is located in a different service area. Whatever modes of transportation that are available and can be safely utilized by the enrollee can be used. In cases where the enrollee requires assistance, an attendant may accompany the enrollee to and from medically necessary visits to providers. The health plan is responsible for the arrangement and payment of the travel costs for the enrollee and the attendant and the lodging and meals associated with off-island or out-of-state travel;
- (19) Sterilizations for both men and women only if all of the following requirements are met for the enrollee:
- (A) At least twenty-one years of age at the time consent is obtained;

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- (B) Mentally competent;
 - (C) Voluntarily gives informed consent by completing the informed consent for sterilization form DHS 1146;
 - (D) The provider completes form DHS 1146;
 - (E) At least thirty days, but not more than one-hundred eighty days, have passed between the date of informed consent and the date of sterilization, except in the case of premature delivery or emergency abdominal surgery; and
 - (F) An interpreter is provided when language barriers exist.
- (20) Additional requirements for sterilizations for women at the time of premature delivery or emergency abdominal surgery. At least seventy-two hours must have passed since informed consent for sterilization was signed. In the case of premature delivery, the informed consent must have been given at least thirty days before the expected date of delivery (the expected date of delivery must be provided on the consent form). Arrangements are to be made to effectively communicate the required information to an enrollee who is visually impaired, hearing impaired or otherwise disabled. The enrollee shall not be institutionalized in a correctional facility, mental hospital or other rehabilitative facility;
- (21) Hysterectomies are a covered service when:
- (A) The enrollee voluntarily gives informed consent by completing the hysterectomy acknowledgement form DSSH 1145;
 - (B) Has been informed orally and in writing that the hysterectomy will render the individual permanently incapable of reproducing (this is not applicable if the individual was sterile prior to the hysterectomy or in the case of an emergency hysterectomy); and
 - (C) The enrollee has signed and dated a "patient's acknowledgement of prior receipt of hysterectomy information form" prior to the hysterectomy.

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Regardless of whether the requirements listed above are met, a hysterectomy shall not be covered under the following circumstances:

- (A) It is performed solely for the purpose of rendering an enrollee permanently incapable of reproducing;
 - (B) There is more than one purpose for performing the hysterectomy but the primary purpose is to render the enrollee permanently incapable of reproducing; or
 - (C) It is performed for the purpose of cancer prophylaxis;
- (22) Urgent care services is the diagnosis and treatment of medical conditions which are serious or acute but pose no immediate threat to life and health but which require medical attention within twenty-four hours.
- (23) Vision services including vision examinations, ophthalmic examination with refraction, prescription lenses, cataract removal, and prosthetic eyes;
- (24) Services federally mandated by the Early and Periodic Diagnosis, Screening, and Treatment Program (EPDST);
- (25) Behavioral health services including preventive, diagnostic, therapeutic, and rehabilitative services, and subject to the limitations set forth in section 17-1721.1-53, including but not limited to:
- (A) Twenty-four hour care for acute psychiatric illnesses;
 - (B) Ambulatory services, with crisis services available twenty-four hours a day, seven days a week;
 - (C) Acute day hospital and partial hospitalization;
 - (D) Health plans are not required to provide behavioral health services to enrollees whose services are not medically necessary or who have been criminally committed for evaluation or treatment in an inpatient setting under HRS chapter 706; and

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- (E) Behavioral health services for individuals with serious and persistent mental illness or with severe emotional behavioral disorders may be provided pursuant to section 17-1721.1-53.
 - (26) Substance abuse services including preventive, diagnostic, therapeutic, and rehabilitative services, and including methadone-levo-alpha-acetyl-methadol (LAAM) services for acute opiate detoxification and maintenance. The health plan may utilize community-based substance abuse treatment programs that are accredited and monitored by the alcohol and drug abuse division (ADAD); and
 - (27) Family planning service including services to enrollees wishing to prevent pregnancies, plan the number of pregnancies, plan the spacing between pregnancies, or obtain confirmation of pregnancy. These services shall include, at a minimum, education and counseling necessary to make informed choices and understand contraceptive methods; emergency contraception; follow-up, brief and comprehensive visits; pregnancy testing; contraceptive supplies and follow-up care; diagnosis and treatment of sexually transmitted diseases; and infertility assessment.
- (c) Emergency and post stabilization services. The health plan shall provide emergency services twenty-four hours a day, seven days a week to treat an emergency medical condition.
- (1) Emergency services shall be covered when furnished by a qualified provider, even if the provider is not in the health plan's network.
 - (2) Emergency services shall not be subject to prior authorization.
 - (3) The emergency room physician or other provider that is qualified to furnish such services actually treating the enrollee is responsible for determining when an enrollee is sufficiently stabilized for transfer or discharge, which decision is binding upon the health plan. If agreed to by the hospital,

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the health plan may send one of its own physicians with appropriate emergency room privileges to assume the attending physician's responsibilities to stabilize, treat, and transfer the enrollee, provided that such arrangement does not delay the provision of medical services.

- (4) The health plan shall cover emergency services when the enrollee's PCP or other health plan representative instructs the enrollee to seek emergency services, without regard to whether the condition meets the prudent layperson standard.
- (5) Inpatient and outpatient post-stabilization services related to an emergency medical condition for purposes of maintaining the stabilized condition or, as prescribed in 42 CFR §438.114, to improve or resolve the enrollee's condition, shall be provided twenty-four hours a day, seven days a week.
- (6) Post-stabilization services are not subject to prior authorization or pre-certification by an in-network provider or health plan representatives, regardless of whether the services are provided within or outside the health plan's network of providers, if:
 - (A) The health plan does not respond to the provider's request for pre-certification or prior authorization within one hour;
 - (B) The health plan cannot be contacted;
 - (C) The health plan's representative and the enrollee's attending physician cannot reach an agreement concerning the enrollee's care and a health plan physician is not available for consultation.
 - (D) The health plan must give the attending physician the opportunity to consult with an in-network physician and the attending physician may continue with care of the enrollee until a health plan physician is reached or the health plan's responsibility for post-stabilization services that it has not approved ends because:

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- (i) An in-network provider with privileges at the treating hospital assumes responsibility for the enrollee's care;
 - (ii) An in-network provider assumes responsibility for the enrollee's care through transfer of the enrollee to another hospital;
 - (iii) The health plan's representative and the attending physician reach an agreement concerning the enrollee's care; or
 - (iv) The enrollee is discharged.
- (d) Out-of-State services:
- (1) If medically necessary covered services that are required by an enrollee are not available in the State or on the island on which the enrollee resides, the enrollee's health plan shall cover these services provided on another island or out-of-state, as applicable. This includes referrals to an off-island or out-of-state specialist or facility, transportation to and from the referral destination, lodging, and meals for the enrollee and any needed attendant. The health plan may require an enrollee to obtain the needed services from specified providers as long as the provider is in the same geographic location as the enrollee and the enrollee can be transferred.
 - (2) The health plan shall cover off-island and out-of-state emergency medical services and post-stabilization services, and all off-island and out-of-state medically necessary EPSDT covered services, without prior authorization.
 - (3) Medical services in a foreign country are not covered under QExA.
[Eff 01/31/09] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

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§17-1721.1-53 Special provisions relating to behavioral health benefits. (a) Behavioral health benefits provided through participating health plans are limited as follows:

- (1) Thirty days of hospitalization per benefit year.
- (2) Inpatient days not used in a benefit year shall not be added to the benefits for the following year;
- (3) The diagnosis and treatment of substance abuse shall be included in the inpatient and outpatient benefits for psychiatric treatment. Each day of inpatient hospital services may be exchanged for two days of non-hospital residential services, two days of partial hospitalization services, or two days of day treatment or two days of intensive outpatient services. Detoxification, whether provided in a hospital or in a non-hospital facility, shall be considered as a part of the inpatient benefit limit.

(b) A participating health plan may, at the health plan's option, exceed the limits on behavioral health services.

(c) For an enrollee below the age of twenty-one, the health plan shall cover all services deemed medically necessary under EPSDT.

(d) For an enrollee who is certified by an independent clinical evaluator as suffering from serious and persistent mental illness, behavioral health services shall be provided in accordance with this section.

(e) Individuals who are certified by an independent clinical evaluator as suffering from serious and persistent mental illness may be referred to the adult mental health division within the department of health or, if not eligible for adult mental health division services, may be eligible for enrollment in a behavioral health capitated care plan contracted by the department to treat these individuals.

(f) Individuals who are certified by an independent clinical evaluator as suffering from severe emotional behavioral disorders may be referred to the child and adolescent mental health division within the department of health.

(g) Any behavioral health need not covered by the department of health or the behavioral health capitated

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care plan shall be covered by the health plan.
[Eff 01/31/09] (Auth: HRS §346-14) (Imp: HRS
§346-14; 42 C.F.R. §430.25)

§17-1721.1-54 Home and community based services (HCBS). (a) Individuals who are determined to be at nursing facility level of care are eligible to receive home and community based services when they are available and are cost neutral.

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

(c) The health plan is not required to provide HCBS if:

- (1) The enrollee chooses institutional services;
- (2) The enrollee cannot be served safely in the community; or
- (3) There are no adequate or appropriate providers for needed services.

(d) The following are HCBS covered services as described in the QExA program:

- (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 section 11-94-5;
- (3) Assisted living services are services that include personal care and supportive care services (homemaker, chore, attendant

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- services, meal preparation) that are furnished to enrollees who reside in an assisted living facility. Payment for room and board is prohibited;
- (4) Pediatric attendant care services is the hands-on care, both supportive and health-related in nature, provided to medically fragile children. The service includes enrollee supervision specific to the needs of a medically stable, physically handicapped child. Attendant care may include skilled nursing care to the extent permitted by law. Housekeeping activities that are incidental to the performance of care may also be furnished as part of this activity. Supportive services, a component of attendant care, are those services that substitute for the absence, loss, diminution, or impairment of a physical or cognitive function;
- (5) Community care management agency (CCMA) services are provided by a person, agency, or organization that is licensed by the department to locate, coordinate, and monitor comprehensive services to meet the needs of enrollees whom the case management agency serves in community care foster family homes or enrollees in expanded adult residential care homes, or assisted living facilities. CCMA's provides activities, to include but not limited to, continuous and ongoing nurse delegation to the caregiver in accordance with chapter 16-89 subchapter 15, initial and ongoing assessments to make recommendations to 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. CCMA's shall:
- (A) communicate with an enrollee's physician regarding the enrollee's needs including changes in medication and treatment orders;

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- (B) Work with an enrollees family regarding service needs of an enrollee;
 - (C) Serve as an advocate for the enrollee;
 - (D) Train caregivers on specific care requirements to ensure care is delivered correctly; and
 - (E) Be accessible to the enrollee's caregiver twenty-four hours a day, seven days a week;
- (6) Community care foster family homes (CCFFH) services are services provided in a home that is certified by the department to provide, for a fee, twenty-four-hour living accommodations, including personal care, homemaker services, supportive services, chore, 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 care 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;
- (7) Counseling and training services 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

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- 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;
- (8) Environmental accessibility adaptations are 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 benefit 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 this benefit. All services shall be provided in accordance with applicable State or local building codes;
- (9) Expanded adult residential care home (E-ARCH) or residential care services is any facility providing twenty four hour living accommodations, for a fee, to adults unrelated to the family, who require at least minimal assistance in the activities of daily living, personal care services, protection,

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- and health care services, and who may need the professional health services provided in an intermediate care facility or skilled nursing facility;
- (10) Home delivered meals are nutritionally sound meals 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 individuals 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;
- (11) Home maintenance 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 individuals who cannot perform cleaning and minor repairs without assistance and are determined, through an assessment, to require the service in order to prevent institutionalization;
- (12) Medically fragile day care is a non-residential service for children who are medically or technology dependent, or both. The service includes activities focused on meeting the psychological as well as the physical, functional, nutritional and social needs of children. Services are furnished four or more hours per day on a regular scheduled basis for one or more days per week in an outpatient setting encompassing both

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- health and social services needed to ensure the optimal function of the individual;
- (13) Moving assistance 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;
- (14) Non-medical transportation 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;
- (15) Personal assistance service - level II is the assistance 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;
- (16) Personal emergency response system 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

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- who would otherwise require extensive routine supervision, to enable them to secure immediate help in the event of a physical, emotional, or environmental emergency;
- (17) Private duty nursing is the provision of skilled nursing services including, but not limited to:
- (A) Observation and assessment of the enrollee's changing condition;
 - (B) Enrollee education;
 - (C) Skilled rehabilitation services;
 - (D) Intravenous, intramuscular or subcutaneous injections and intravenous feedings;
 - (E) Tube feedings;
 - (F) Nasopharyngeal and tracheostomy aspiration;
 - (G) Insertion, sterile irrigation and replacement of catheters;
 - (H) Application of dressings involving prescriptive medicines and aseptic techniques;
 - (I) Treatment of extensive decubitus ulcers or other widespread skin disorders;
 - (J) Heat treatments which have been specifically ordered by a physician as part of active treatment and which require observation by a nurse to adequately evaluate the enrollee's progress;
 - (K) Initial phases of a regimen involving administration of oxygen therapy nebulizer; and
 - (L) Rehabilitation nursing procedures including the related teaching and adaptive aspects of nursing that are part of active treatment;
- (18) Respite care is temporary institutional, community or home-based services needed to allow persons, who ordinarily care for the enrollee, relief from these duties; and
- (19) Specialized medical equipment and supplies entails the purchase, rental, lease, warranty costs, installation, repairs and removal of

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devices, controls, or appliances, specified in a plan of care, that enable individuals 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 01/31/09] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§440.180, 430.25, 435.232)

§17-1721.1-55 Institutional care services. (a) Institutional care services are provided in a licensed nursing facility to enrollees who are 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 include, but not be limited to:

- (1) Room and board;
- (2) Administration of medication and treatment;
- (3) 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 resident's care needs, promote recovery, and ensure the resident's health and safety;
- (4) Observation and assessment of the resident's unstable condition that requires the skills and knowledge of skilled technical or professional personnel to identify and evaluate the resident's need for possible medical intervention, modification of treatment, or both, to stabilize the resident's condition;
- (5) Health education services provided by skilled technical or professional personnel to teach the recipient self care, such as gait training and self administration of medications;
- (6) Provision of therapeutic diet and dietary supplements as ordered by the attending physician;

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- (7) Laundry service for items of recipient's washable personal clothing;
- (8) 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;
- (9) Durable medical equipment and supplies used by residents but which are reusable, such as ice bag, hot water bottle, urinal, bedpan, commode, cane, crutch, walker, wheelchair, and siderail and traction equipment;
- (10) Activities of the resident's choice (including religious activities) that are designed to provide normal pursuits for physical and psychosocial well-being;
- (11) Social services provided by qualified personnel;
- (12) A review of the drug regimen of each resident at least once a month by a licensed pharmacist, as required for a nursing facility to participate in Medicaid;
- (13) Nonrestorative or nonrehabilitative therapy, or both, provided by nursing staff; and
- (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.
[Eff 01/31/09] (Auth: HRS §346-14; Pub. L. No. 100-203; 42 C.F.R. §§431.10, 483.1) (Imp: Pub. L. No. 100-203; 42 C.F.R. §§440.40, 440.150, 483.1, 483.20)

§17-1721.1-56 Dental services. (a) Dental services are not covered through a health plan, but are

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provided to enrollees by the department on a fee-for-service basis. The health plans shall coordinate with the department or its designee to refer enrollees to the department's dental third party administrator. [Eff 01/31/09] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§§17-1721.1-57 to 17-1721.1-65 (Reserved).

SUBCHAPTER 8

PARTICIPATING HEALTH PLANS

§17-1721.1-66 Health plan participation in QExA.

(a) Health plans shall be selected through a competitive purchase of services under HRS chapter 103F.

(b) Contracts for participation in QExA shall be awarded to qualified health plans upon finalization of financial agreements with the department.

(c) The department shall develop a request for proposals prior to the lapse of existing contracts with participating health plans to ensure that individuals eligible for coverage through QExA shall receive continued health care coverage. [Eff 01/31/09] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1721.1-67 Service areas. (a) The department may designate geographic areas as the areas for which health plans will provide services.

(b) More than one health plan may be contracted by the department for any service area. [Eff 01/31/09] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1721.1-68 Requirements of participating health plans. (a) The health plans shall abide by the provisions of their contracts with the department as well as federal and state statutes and regulations.

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

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- (1) Provision of all services required by the contract between the respective health plan and the department;
 - (2) Provision of a primary care provider for each enrollee in the health plan;
 - (3) Provision of service coordinators to ensure coordination of primary, acute, HCBS and institutional care services for all of the health plan's enrollees;
 - (4) Development and maintenance of a sufficient network of health care providers to ensure that required health services are provided to enrollees 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 system for dissatisfied enrollees;
 - (9) Development and maintenance of a toll-free telephone hotline to confirm enrollment, respond to inquiries from enrollees, and provide information to the general public; and
 - (10) Maintenance of a medical records systems that enables the health plans to provide information pertinent to the care and management of enrollees to the department.
- (c) Each health plan will perform a face-to-face health and functional assessment for each enrollee.
[Eff 01/31/09] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1721.1-69 Enforcement of contracts with participating health plan. (a) The department will monitor a health plan's performance during any contract period.

(b) The contract shall provide for civil or administrative monetary penalties not to exceed the maximum amount established by federal and state statutes and regulations if the participating health plan:

- (1) Fails to provide medically necessary items and services that are required under law or under contract;

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- (2) Imposes upon beneficiaries excess premiums and charges;
- (3) Acts to discriminate among enrollees;
- (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) The department may also impose financial sanctions as described under the provisions of the contract between the health plan and the department for inaccurate, incomplete, and untimely data and reports submitted to the department.

(d) If a health plan violates the contract, violates federal or state statutes or regulations, or if there is a substantial risk to the health of enrollees, the department may take any one or more of the following actions:

- (1) Notify affected enrollees of the violations;
- (2) Allow affected enrollees to change health plans without cause;
- (3) Suspend enrollment;
- (4) Suspend payment; or
- (5) Terminate the contract in accordance with section 17-1721.1-70.

(e) If a health plan continues to violate the contract conditions or continues to violate federal or state statutes and regulations, regardless of any other penalty that may be imposed, the department may take any one or more of the following:

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

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

(g) 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 plans.

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(h) The department shall notify the insurance commissioner whenever a sanction under this section is contemplated. [Eff 01/31/09] (Auth: HRS §346-59.5) (Imp: HRS §346-14; 42 C.F.R. §§430.25; 438.700, 438.702; 438.706; 438.710)

§17-1721.1-70 Termination of contract with participating health plans. (a) The department shall have the authority to terminate the health plan's contract for any or all of the following reasons:

- (1) Default by the health plan;
- (2) Failure by the health plan to abide by the contract conditions or to meet federal statutes;
- (3) Convenience;
- (4) Expiration of QExA;
- (5) Insolvency of or declaration of bankruptcy by the health plan; or
- (6) Unavailability of funds.

(b) When termination of contract is due to reasons identified under subsection (a) paragraphs (1) and (2), the department shall provide a hearing for the affected health plan prior to termination of contract.

(c) After the department notifies the health plan of its intent to terminate the contract due to reasons identified under subsection (a) paragraphs (1) and (2), the department may do the following:

- (1) Provide the affected enrollees written notice of the department's intent to terminate the contract; and
- (2) Allow the affected enrollees to change health plans immediately without cause.

[Eff 01/31/09] (Auth: HRS §346-14)
(Imp: HRS §346-14; 42 C.F.R. §§430.25;
438.708)