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HAWAII ADMINISTRATIVE RULES

TITLE 17

DEPARTMENT OF HUMAN SERVICES

SUBTITLE 12 MED-QUEST DIVISION

CHAPTER 1722.3

BASIC HEALTH HAWAII

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SUBCHAPTER 1

GENERAL PROVISIONS

§17-1722.3-1 Purpose. This chapter is established to provide, subject to the availability of state funding, state funded medical assistance for citizens of COFA nations and legal permanent residents admitted to the United States for less than five years who are age nineteen years and older and lawfully are not eligible for federal medical assistance as a result of implementation of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996. Except as otherwise specifically provided herein, this chapter

supersedes any and all state medical assistance provided to such individuals through the QUEST, QExA, QUEST-Net, QUEST-ACE, fee-for-service, or SHOTT programs prior to the implementation date of Basic Health Hawaii. [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14)

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§17-1722.3-2 Definitions. As used in this chapter:

"§1915(c) program" means a program established under section 1915(c) of the Social Security Act that provides home and community based services to eligible participants.

"Annual plan change period" means the period as determined by the department under section 17-1722.3-14 when enrollees may disenroll from the enrollee's current participating health plan and enroll in another participating health plan.

"Basic Health Hawaii" means the State funded medical assistance program described in this chapter.

"Benefit year" means the period from the first day of July of one calendar year through the thirtieth day of June of the following calendar year.

"Capitated payment" means a fixed monthly payment paid per person by the department to a participating health plan for which the health plan provides a defined set of benefits.

"COFA nation" means the Federated States of Micronesia, Republic of the Marshall Islands, or Republic of Palau, which have entered into Compacts of Free Association with the United States that allow citizens of these nations to travel, work, and reside in the United States without visa requirements or durational limits. Citizens of these nations do not meet the definition of a qualified alien. The Compacts do not include any agreement regarding the provision of medical care or medical assistance by a state.

"Deemed individual" means an individual who meets the requirements of subchapter 4 and is allowed to enroll in Basic Health Hawaii without filing a new application for medical assistance.

"Effective date of eligibility" means the date on which health care services shall be covered either through fee-for-service reimbursement by the

department, its fiscal agent, or through enrollment in a participating health plan.

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

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

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"Federal medical assistance" means medical assistance in accordance with the State plan under Title XIX, or in accordance with a demonstration under Title XI of the Social Security Act.

"Fee-for-service" means the department's system of reimbursing health care providers for each eligible service provided.

"Financial assistance" means cash assistance provided by the Department of Human Services.

"Health plan" means an insurance company or other organization, which provides different health care benefit packages to one or more groups of enrollees.

"Implementation date" means the date determined by the department, but no later than July 1, 2010, when participating health plans begin delivering Basic Health Hawaii benefits to enrollees.

"Legal permanent resident" means an alien who is lawfully admitted as a permanent resident under the Immigration and Nationality Act.

"Managed care" means a method of health care delivery that integrates the financing, administration, and delivery of health services, or a coordinated delivery system made up of pre-established networks of health care providers providing a defined package of benefits under pre-established reimbursement arrangements.

"Non-returning plan" means a participating health plan that will not have its contract with the department renewed.

"Participating health plan" means a health plan contracted by the State to provide medical services through managed care in Basic Health Hawaii.

"Personal reserve standard" means the maximum amount of countable assets that may be held by an individual, a family, or a household while establishing or maintaining eligibility for medical assistance.

"QExA" means the QUEST Expanded Access program that delivers medical and behavioral health services through health plans employing managed care concepts, to certain individuals who are aged, blind or disabled

"QUEST" means the QUEST program that delivers medical and behavioral health services through health plans employing managed care concepts, to certain individuals who are not aged, blind or disabled.

"QUEST-ACE" means the QUEST-Adult Coverage Expansion program that delivers limited medical and

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behavioral health services through health plans employing managed care concepts.

"QUEST-Net" means the QUEST-Net program that delivers medical and behavioral health services through health plans employing managed care concepts.

"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 plan's contract with the department.

"SHOTT" means the State of Hawaii Organ and Tissue Transplant program.

"State medical assistance" means state funded medical assistance provided to eligible individuals through the QUEST, QUEST Expanded Access, QUEST-Net, QUEST-ACE, fee-for-service and SHOTT programs who are not eligible for federal medical assistance.

"Transition period end date" means the last day of the second month following the implementation date.

[Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1722.3-3 Basic Health Hawaii Implementation.

(a) The department shall determine the implementation date for Basic Health Hawaii when participating health plans shall begin delivering Basic Health Hawaii benefits.

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

(c) When the department has established the implementation date, the department shall provide notice to deemed individuals as provided under

subchapter 4. [Eff 04/01/10] (Auth: HRS §346-14)
(Imp: HRS §346-14)

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

SUBCHAPTER 2

BASIC HEALTH HAWAII

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

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

- (1) The basic eligibility requirements described in chapter 17-1714 with the exception of citizenship requirements;
 - (2) Is an alien who is not eligible for federal medical assistance and is either:
 - (A) A citizen of a COFA nation; or
 - (B) A legal permanent resident;
 - (3) Is age nineteen years or older; and
 - (4) Is not pregnant.
- (b) An individual who is not eligible to participate under this chapter includes a person who:
- (1) Does not meet the requirements of subsection (a);
 - (2) Does not meet the financial eligibility requirements described in this chapter;
 - (3) Is employed and is eligible for coverage under an employer sponsored health plan, with the exception of a financial assistance recipient and an individual who is participating in a department subsidized employment program;
 - (4) Is eligible for coverage under a health plan as an active military enlistee, a retired military personnel, or a dependent of an active or retired military enlistee; or
 - (5) Is eligible for, or receiving, coverage under any health plan. [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1722.3-8 Treatment of income and assets. (a) When determining financial eligibility for Basic Health

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Hawaii, the provisions for treatment of income and assets in the Hawaii QUEST program described in chapters 17-1724 and 17-1725, respectively, shall apply.

(b) When determining financial eligibility for Basic Health Hawaii, the definitions of financial support and responsibilities in the Hawaii QUEST program described in chapter 17-1724 shall apply. [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1722.3-9 Financial eligibility requirements.

(a) An individual whose countable family assets exceed the personal reserve standard for a family of applicable size shall be ineligible for Basic Health Hawaii.

- (1) For a one-member family, the personal reserve standard shall be \$2,000;
- (2) For a two-member family, the personal reserve standard shall be \$3,000;
- (3) For a family of more than two members, the personal reserve standard shall be \$3,000 plus \$250 for each additional family member.

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

§17-1722.3-10 Limitations to statewide enrollment in participating health plans.

(a) An open application period shall be announced by the department after enrollment has dropped below 6,500 on the last day of the previous calendar year that occurs after the implementation date.

(b) The maximum statewide enrollment in the participating health plans shall be 7,000.

(c) During the open application period, applicants shall submit their application to the med-QUEST division and the following shall apply:

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- (1) Applications shall be processed in the chronological order of their receipt by the med-QUEST division;
- (2) All pending applications received during the open application period shall be denied when the number of individuals that have been determined eligible, when enrolled in a participating health plan, would meet the maximum statewide enrollment allowed in subsection (b); and
- (3) Applications pending more than 45 days before a denial notification is issued shall not be subject to the provisions of subsection 17-1711-13(i).
- (d) An open application period shall not occur more than once per calendar year. [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14)

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

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

§17-1722.3-12 Termination of eligibility. A recipient's eligibility for Basic Health Hawaii shall be terminated for any of the following reasons:

- (1) The recipient fails to meet any one of the necessary requirements of sections 17-1722.3-7 and 17-1722.3-9;
- (2) Death of the recipient;
- (3) The recipient no longer resides in the State;
- (4) The recipient voluntarily terminates coverage;
- (5) The recipient is admitted to a public institution as defined in chapter 17-1714;
- (6) The recipient's whereabouts are unknown;
- (7) Lack of State funds; or

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- (8) The program is terminated or repealed
[Eff 04/01/10] (Auth: HRS §346-14) (Imp:
HRS §346-14)

§17-1722.3-13 Enrollment in and choice of a participating health plan. (a) The department has the sole authority to enroll and disenroll an individual in a participating health plan.

(b) An eligible individual shall within, ten days, select from among the participating health plans available in the service area in which the individual resides if there is more than one participating health plan.

(c) If an individual in subsection (b) does not select a participating health plan within ten days of being determined eligible, the department shall assign and enroll the individual in a participating health plan.

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

(e) An individual who is disenrolled from a participating health plan or a health plan contracted to provide federal or state medical assistance shall be allowed to select a plan of their choice:

- (1) If disenrollment extends for more than sixty calendar days in a benefit year;
- (2) If disenrollment occurred in a period involving the annual plan change period; or
- (3) If disenrollment includes the first day of a new benefit year. [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1722.3-14 Changes from one participating health plan to another. (a) An enrollee shall only be allowed to change from one participating health plan to another during the annual plan change period, which shall occur once each calendar year.

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

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- (2) If the enrollee is required to select a participating health plan, but does not select a participating health plan during the annual plan change period, enrollment in a participating health plan shall be assigned by the department;
 - (3) Changes in enrollment from one participating health plan to another during the annual plan change period shall be effective the first day of the month as determined by the department and shall generally extend to the following year;
 - (4) In the absence of a choice of participating health plans in a service area, an enrollee who resides in that particular service area shall not participate in the annual plan change period.
- (b) Exceptions to subsection (a) include the following:
- (1) Compliance with an administrative or judicial decision;
 - (2) Termination of the participating health plan contract;
 - (3) Mutual agreement by the participating health plans involved, the enrollee, and the department;
 - (4) As provided in sections 17-1727-61 and 17-1727-62;
 - (5) Change of residence by an enrollee from one service area to another with a choice of more than one participating health plan:
 - (A) The individual shall be allowed ten days to select a participating health plan servicing the new service area in which the individual resides; and
 - (B) If a selection is not made within ten days of request, enrollment in a participating health plan shall be assigned by the department.
 - (6) Change of residence by an enrollee from one service area to another with only one participating health plan shall result in enrollment into that participating health plan; or

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- (7) Other special circumstances as determined by the department. [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14)

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

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

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

- (1) Compliance with an administrative or judicial decision; or
- (2) mutual agreement between the individual, the participating health plan involved, and the department.

(d) If an enrollee requests disenrollment, the department shall determine whether to allow disenrollment no later than the first day of the second month following the month in which the enrollee made the request. If the department fails to make a determination within the time frame, the disenrollment is considered approved.

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

§17-1722.3-16 Effective date of enrollment. (a) The effective date of enrollment into a participating health plan shall be the date the enrollment process has been completed to enroll an individual in a participating health plan.

(b) The effective date of enrollment resulting from a change from one participating health plan to another during the annual plan change period, shall be the first day of the month as determined by the department and shall generally extend through the following year

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(c) The effective date of enrollment resulting from a change from one participating 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; or
- (2) The date the enrollment process has been completed to enroll the individual in a participating health plan if an individual changes residence from one service area to another. [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1722.3-17 Coverage of Basic Health Hawaii eligibles prior to the date of enrollment. (a) An applicant who is initially determined eligible for Basic Health Hawaii shall be eligible for Basic Health Hawaii benefits provided by the department on a fee-for-service basis as of the date of eligibility through the date of enrollment.

(b) Health care services received on a fee-for-service basis are limited to the benefits identified in this chapter. Benefits received during this period shall be applied to the maximum benefits allowable in a benefit year. [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14)

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

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

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

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- (3) Use of an operating room and related facilities, inpatient anesthesia, radiology, laboratory and other diagnostic services agreed upon by the participating health plan medical director for medical care and surgery;
 - (4) Drugs, dressings, blood derivatives and their administration, general medical supplies, and diagnostic and therapeutic procedures as prescribed by the attending physician;
 - (5) Other ancillary services associated with hospital care except private duty nursing; and
 - (6) Ten inpatient physician visits within a benefit year.
- (c) Within a benefit year, a participating health plan shall provide each enrollee with coverage for the following outpatient services:
- (1) A maximum of twelve outpatient visits including adult health assessments, family planning services, diagnosis, treatment, consultations, to include substance abuse treatment, and second opinions. The maximum of twelve outpatient visits shall not apply to:
 - (A) Emergency services as described in section 17-1722.3-20;
 - (B) An enrollee's first six mental health visits within a benefit year. After the first six mental health visits, an enrollee may choose to apply a maximum of six additional mental health visits toward the maximum of twelve physician outpatient visits; or
 - (C) Diagnostic testing, including laboratory and x-ray, directly related to a covered outpatient visit.
 - (2) Coverage of medically necessary ambulatory surgical care shall be limited to three procedures per benefit year;
 - (3) Maternity care coverage shall be limited to one routine visit to confirm pregnancy and any visits for the diagnosis and treatment of conditions related to medically indicated or elective termination of pregnancy such as ectopic pregnancy, hydatidiform mole, and missed, incomplete, threatened, or elective

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

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

- (1) An enrollee age nineteen to thirty-five years old, inclusive, shall be allowed one examination within a period of five benefit years.
- (2) An enrollee thirty-six to fifty-five years old, inclusive, shall be allowed one examination within a period of two benefit years.
- (3) An enrollee over fifty-five years old shall be allowed one examination within each benefit year.
- (4) An annual pap smear for a woman of child bearing age shall be included in the health assessment for an enrollee age nineteen years or older.

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

- (1) After exhausting the coverage of six mental health visits, an enrollee may use coverage of up to six of the enrollee's twelve outpatient physician visits per benefit year, as available, for additional mental health visits.
- (2) Services for alcohol abuse conditions shall be covered as mental health visits. The following restrictions on alcohol and substance abuse treatment apply:
 - (A) Outpatient alcohol abuse services shall be considered toward the maximum coverage of six mental health visits and six annual outpatient physician office visits if used for additional mental health visits;
 - (B) Inpatient alcohol abuse services shall be considered toward an enrollee's maximum coverage of ten hospital days; and

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

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

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

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

(i) A participating health plan may, at the plan's option and expense, provide benefits which exceed those defined in this subchapter, with the exception of non-covered services identified in section 17-1722.3-19. [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14)

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

- (1) Custodial or domiciliary care;
- (2) Services received in skilled nursing facilities, intermediate care facilities, and intermediate care facilities for the mentally retarded;
- (3) Personal care items such as shampoos, toothpaste, mouthwashes, denture cleansers, shoes including orthopedic footwear, slippers, clothing, laundry services, baby oils and powders, sanitary napkins, soaps, lip balms, and bandages;

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- (4) Non-medical items such as books, telephones, electronic transmitting and paging devices, radios, linens, clothing, television sets, computers, air conditioners, air purifiers, fans, household items and furnishings;
- (5) Emergency facility services for non-emergency services;
- (6) Out-of-state emergency and non-emergency services;
- (7) Experimental and investigational services, procedures, drugs, devices, and treatments;
- (8) Organ and tissue transplantation and transplantation services for either a recipient or a donor;
- (9) Blood, blood products, and blood storage on an outpatient basis;
- (10) Gender reassignment and related medical, surgical, and psychiatric services, drugs, and hormones;
- (11) In vitro fertilization, reversal of sterilization, artificial insemination, sperm banking procedures, and drugs to test fertility;
- (12) Eyeglasses, contact lenses, low vision aids, orthoptic training, and refractions;
- (13) Hearing aids and related supplies and services, including fitting for, purchase of, rental of, and insuring of hearing aids;
- (14) Durable medical equipment, prosthetic devices, orthotics, medical supplies, and related services including purchases, rental, repairs, and related services, except as supplied as part of an inpatient hospital stay;
- (15) Biofeedback, acupuncture, naturopathic services, faith healing, Christian Science services, hypnosis, and massage treatment;
- (16) Obesity treatment, weight loss programs, food, food supplements, health foods, and prepared formulas;
- (17) All services, procedures, equipment, and supplies not specifically listed which are not medically necessary;
- (18) Cosmetic surgery or treatment, cosmetic rhinoplasties, reconstructive or plastic surgery to improve appearance and not bodily

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- function, piercing of ears and other body areas, electrolysis, hair transplantation, reduction and augmentation mammoplasties, paniclectomies and other body sculpturing procedures, excision or destruction of benign skin or subcutaneous lesions without medical justification;
- (19) Transportation, including air (fixed wing or helicopter) ambulances;
 - (20) Hospice services;
 - (21) All home health agency services;
 - (22) Home and community based services to include, but not limited to, adult day care, adult day health, assistive living, pediatric attendant care, community care management agency (CCMA) services, community care foster family home services, counseling and training activities, environmental accessibility adaptations, expanded adult residential care homes (E-ARCH) or residential care services, home delivered meals, home maintenance, medically fragile day care, moving assistance, non-medical transportation, personal assistance services, personal emergency response systems, private duty nursing, and respite care;
 - (23) Personal care, chore services, social worker services, case management services, and targeted case management services;
 - (24) Tuberculosis services when provided without cost to the general public;
 - (25) Hansen's disease treatment or follow-up;
 - (26) Treatment of persons confined to a public institution;
 - (27) Penile and testicular prostheses and related services;
 - (28) Chiropractic services;
 - (29) Psychiatric care and treatment for sex and marriage problems, weight control, employment counseling, primal therapy, long term character analysis, marathon group therapy, and consortium;
 - (30) Routine foot care and treatment of flat feet;
 - (31) Swimming lessons, summer camp, gym membership, and weight control classes;

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- (32) Cardiac and coronary artery surgery involving cardio-pulmonary by-pass, cataract surgery with or without intraocular lens implants, and refractive keratoplasty;
- (33) Physical therapy, occupational therapy, speech therapy, respiratory services, and sleep studies rendered on an outpatient basis;
- (34) Medical services provided without charge by any other federal, state, municipal, territorial, or other government agency, including the Veterans Administration;
- (35) Medical services for an injury or illness caused by another person or third party from whom the enrollee has or may have a right to recover damages;
- (36) Medical services that are payable under the terms of any other group or non-group health plan coverage;
- (37) Medical services that do not follow standard medical practice or are not medically necessary;
- (38) Stand-by services by a stand-by physician and telephone consultation;
- (39) Services provided for illness or injury caused by an act of war, whether or not a state of war legally exists, or required during a period of active duty that exceeds thirty days in any branch of the military;
- (40) Treatment of sexual dysfunction including medical and surgical procedures, supplies, drugs, and equipment;
- (41) All services excluded by the Hawaii Medicaid Program;
- (42) All services not provided by providers licensed or certified in the State of Hawaii to perform the service;
- (43) Medical services that are payable under terms of worker compensation, automobile medical and no-fault, underinsured or uninsured motorist, or similar contract of insurance;
- (44) Physical examination required for continuing employment, such as taxi driver's or truck driver's licensing, or as required by government or private businesses;

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- (45) Physical examinations, psychological evaluations, and immunizations as a requirement for licenses or for purposes of securing insurance policies or plans;
- (46) Allergy testing and treatment;
- (47) Treatment of any complication resulting from previous cosmetic, experimental, or investigative procedures, or any other non-covered service;
- (48) Rehabilitation services, either on an inpatient or outpatient basis, including cardiac, alcohol or drug dependence rehabilitation;
- (49) All acne treatment, surgery, drugs for adults; removal or treatment of asymptomatic benign skin lesions or growth; and
- (50) Inpatient hospital care related to maternity, such as prenatal, postpartum, and delivery services including all laboratory testing in both inpatient and outpatient setting. An exception is one outpatient visit to confirm pregnancy, as identified as a covered service in this chapter. [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1722.3-20 Emergency services. (a) Emergency medical services are available to enrollees under chapter 17-1723, subchapter 2, and may be covered by a participating health plan or on a fee-for-service basis.

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

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

§17-1722.3-21 Financial responsibility. An enrollee may be responsible for a copayment for certain benefits as determined by the department.

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[Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14)

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

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

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

SUBCHAPTER 3

SPECIAL BENEFIT PROVISIONS

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

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

- (1) Be enrolled in a QExA participating health plan and receive state funded long-term care services, either through a QExA participating health plan or through a program that

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provides benefits similar to a 1915(c) program; and

- (2) Continue to receive the benefits as described in (1) under the following conditions:
 - (A) The individual maintains continuous categorical and financial eligibility for QExA as described under chapter 17-1721; and
 - (B) The individual maintains continuous eligibility for coverage of long-term care services.

(b) An individual under age nineteen years and receiving federal medical assistance for long-term care services in a nursing facility on the last day of the second month prior to the implementation date, if continuously receiving federal medical assistance for

long-term care services until turning age nineteen years, shall upon turning age nineteen years:

- (1) Be enrolled in a QExA participating health plan and receive state funded long-term care services; and
- (2) Continue to receive the benefits as described in (1) under the following conditions:
 - (A) The individual maintains continuous categorical and financial eligibility for QExA as described under chapters 17-1721, 17-1721.1, or 17-1732; and
 - (B) The individual maintains continuous eligibility for coverage of long-term care services.
- (c) If an individual who is initially eligible under subsections (a) or (b) loses eligibility:
 - (1) On or before the transition period end date, the individual shall be deemed into Basic Health Hawaii pursuant to subchapter 4;

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

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

- (1) The individual maintains continuous eligibility; and
 - (2) The individual maintains continuous coverage under the SHOTT program.
- (b) If an individual who is initially eligible under subsection (a) loses eligibility:
- (1) On or before the transition period end date, the individual shall be deemed into Basic Health Hawaii pursuant to subchapter 4;
 - (2) After the transition period end date, the individual shall be subject to the

eligibility and enrollment provisions described in subchapter 2. [Eff 04/01/10]

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

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

SUBCHAPTER 4

INDIVIDUALS DEEMED INTO BASIC HEALTH HAWAII

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

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

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

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

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- (1) Was eligible for and was receiving financial assistance on the last day of the second month prior to the implementation date;
- (2) Maintained continuous eligibility for financial assistance through the last day of the month prior to the implementation date;
- (3) Has resided in the United States for less than five years; and
- (4) Meets the eligibility requirements of this chapter.

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

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

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

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

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

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§17-1722.3-35 Enrollment procedures for individuals deemed into Basic Health Hawaii. A deemed individual shall undergo the following health plan selection or assignment options:

- (1) If the individual is a member of a health plan that is also a participating health plan, then the individual shall be assigned to that participating health plan;
- (2) If the individual is not a member of a health plan that is also a participating health plan, then the individual shall, within ten days, select from among the participating health plans available in the service area in which the individual resides if there is more than one participating health plan;
- (3) If an individual allowed to select a participating health plan does not select one within ten days of being determined eligible, the department shall assign and enroll the individual in a participating health plan; and
- (4) In the absence of a choice of participating health plans in a service area, an eligible individual who resides in that particular service area shall be enrolled in the available participating health plan. [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)