

# PROPOSED

## DEPARTMENT OF HUMAN SERVICES

Amendment of Chapters 17-1700, 17-1711, 17-1721,  
17-1722, 17-1723, 17-1727, 17-1730, 17-1732, 17-1733,  
17-1734, and 17-1735 and  
Adoption of Chapter 17-1721.1

### Hawaii Administrative Rules

1. Section 17-1700-2, Hawaii Administrative Rules, is amended to read as follows:

"§17-1700-2 Definitions. For the purpose of this subtitle unless the context otherwise indicates:

"Applicant" means an individual applying for or requesting medical assistance.

"Benefit, employment and support services division" or "BESSD" means the work unit within the department which administers the financial assistance and food stamp programs.

"Code of Federal Regulations [(C.F.R.)]" or "C.F.R." means the annual cumulation of executive agency regulations published in the daily Federal Register, combined with regulations issued previously that are still in effect. The C.F.R. contains the general body of regulatory laws governing practice and procedures before federal administrative agencies.

"Department (DHS)" means the department of human services.

"Director" means the administrative head of the department of human services unless otherwise specifically noted.

"Eligibility worker (EW) or income maintenance worker (IMW)" means an employee of the med-QUEST division responsible for the determination of medical assistance and for provisions of health care coverage to eligible individuals.

["Family and adult service division (FASD)" means the work unit within the department which administers the public assistance and food stamp programs.]

"Federal Register (Fed. Reg.)" means the daily publication for making available to the public federal agency regulations and other legal documents of the executive branch including proposed changes. The

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regulations and rules as finally approved appear thereafter in the C.F.R.

["Fee for service"] "Fee-for-service" means the component within the state administered medical assistance program which reimburses providers for each incident provided.

"Hawaii QUEST or QUEST" means the demonstration project developed by the department which will deliver medical, dental, and behavioral health services, through health plans employing managed care concepts, to certain individuals formerly covered by public assistance programs including the aid to families with dependent children (AFDC) related medical programs, general assistance (GA), and the state health insurance program (SHIP).

"Hawaii Revised Statutes [(HRS)]" or "HRS" means the official codification of all the laws of a general and permanent nature of the State of Hawaii.

"Medicaid" means the medical assistance program administered by the DHS med-QUEST division under Title XIX of the Social Security Act (42 U.S.C. §§[11396] 1396-1396j).

"Medical assistance (MA)" means health care coverage for individuals who meet the eligibility requirements of this subtitle.

"Med-QUEST division" means the work unit within the department which administers the medical assistance program.

"Med-QUEST administrator" means the administrative head of the med-QUEST division of the department of human services.

"QExA" means QUEST expanded access program.

"Recipient or client" means any person to whom a service is rendered.

"Supplemental security income [(SSI)]" or "SSI" means the financial assistance program of aid, based on need, to the aged, blind, and disabled, administered by the federal Social Security Administration under Title XVI of the Social Security Act (42 U.S.C. §§1381-1383).

"SSP" means the State supplementary payments program administered by the federal Social Security Administration under Title XVI of the Social Security Act (42 U.S.C. §1382e).

"United States Code [(U.S.C.)]" or "U.S.C." means the official codification of all the laws of a general and permanent nature of the United States. Every six years a new

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edition of the U.S.C. is published with cumulative supplement volumes issued during the intervening years.

"Vendor" means a third party who receives payment directly from the department in return for services or goods rendered on behalf of the recipient."

[Eff 08/01/94; am 01/29/96; am ] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §346-14)

2. Section 17-1711-10, Hawaii Administrative Rules, is amended to read as follows:

"§17-1711-10 Application for retroactive medical assistance [in the fee-for-service programs]. (a) Individuals applying for retroactive medical assistance [in the fee for service program] shall be required to:

- (1) Submit a completed application form to the appropriate office if the application is only for retroactive medical assistance coverage; or
- (2) Request retroactive medical assistance coverage:
  - (A) On the individual's or family's original application form; or
  - (B) By submitting a written request, if the request is made in conjunction with or after an application for financial or medical assistance only has been made[.] but prior to the date eligibility has been determined.

(b) The effective date of eligibility for retroactive medical assistance shall be determined no earlier than [the first day of the three months] thirty days prior to the [month] date in which the application form is received by the department if the applicant:

- (1) Received eligible services, at any time during that period; and
- (2) Would have been eligible at the time services were received had an application been submitted." [Eff 08/01/94; am ] (Auth: HRS §346-29) (Imp: 42 C.F.R. §435.914)

3. Section 17-1711-12, Hawaii Administrative Rules, is amended to read as follows:

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"§17-1711-12 Verification prior to approval. The department shall verify the following items of information on the application as appropriate, prior to the approval of eligibility. The items include, but are not limited to, the following: [and]

- (1) [assignment] Assignment of possible third party liability;
- (2) [and child] Child support benefits [forms in the manner specified below, prior to the approval of eligibility:];
- [(1)] (3) Gross non-exempt income of all individuals;
- [(2)] (4) Non-exempt resources of all individuals applying for coverage groups which require a resource limit;
- [(3)] (5) Blindness as determined in accordance with the provisions of chapter 17-1721;
- [(4)] (6) Disability as determined in accordance with the provisions of chapter 17-1721;
- [(5)] (7) Prior determination of blindness or disability is still valid by viewing any of the following items:
  - (A) Social Security Administration (SSA) Title II or SSI-SSP award letters indicating receipt of disability benefits, provided the re-examination date is not indicated;
  - (B) SSA notification that disability benefits have been increased or decreased;
  - (C) Railroad Retirement Board notification or a disability award;
  - (D) A signed statement from the SSA stating that the individual is eligible for Title II benefits on the basis of disability;
  - (E) Documentation of prior determination of disability by the department's Aid to Disabled Review Committee (ADRC);
  - (F) Data on the State Data Exchange (SDX) which shows that a person entering a long-term care facility was discontinued from SSI-SSP for reasons other than cessation of disability or blindness;
  - (G) Documentation of prior determination of blindness by the department's consultant ophthalmologist with the vocational rehabilitation and services for the

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- blind division [(Ho'opono)] at Ho'opono;  
[or]
- (H) SSA Title II check stating the payment is on the basis of disability; or
  - (I) BENDEX and SDX interface;
- [(6) United States citizenship, by examining:  
(A) Birth documents;  
(B) A valid United States passport;  
(C) Naturalization papers; or  
Other evidence or documents of probative value listed in 42 U.S.C. §1396b(x);]
- (8) U.S. citizenship or alien status as required under subchapter 4 of chapter 17-1714;
- [(7) Lawful admission for permanent residence in the United States by examining the recipient's:  
(A) Alien registration receipt card (INS Form I-151), commonly referred to as the "Green Card"; or  
(B) Re-entry permit, used for travel purposes by bearers who shall already have in possession an INS Form I-151 card, or other documentation from the Immigration and Naturalization Service (INS);]
- (9) Identity as required under section 17-1714-4;
- [(8) Permanent residence in the United States by examining the recipient's:  
(A) INS Form I-94 endorsed "Refugee" (8 U.S.C. §1157);  
(B) INS Form I-94 endorsed to show the applicant has been paroled for an indefinite period pursuant to Section 212(d)(5) of the Immigration and Nationality Act (8 U.S.C. §1255);  
(C) Documentation in the form of correspondence from the INS stating the applicant has been granted indefinite voluntary departure or an indefinite stay of deportation (8 U.S.C. §1253);  
(D) Evidence of continuous residence in the United States prior to January 1, 1972 pursuant to provisions of Section 249 of the Immigration and Nationality Act (8 U.S.C. §1259);  
(E) INS Form I-94 endorsed to show applicant is an asylee pursuant to Section 208 of the Immigration and Nationality Act

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- (8 U.S.C. §1158);
- (F) INS Form I-94 endorsed to show applicant is an American pursuant to 8 U.S.C. §1612;
- (G) Military service orders or letter to show applicant is a veteran or on active duty pursuant to 8 U.S.C. §1612;
- (H) INS Form I-94 endorsed to show applicant is a victim of abuse pursuant to 8 U.S.C. §1641;
- (I) Tribal Record to show applicant is an American Indian born in Canada or who is a member of an Indian tribe as defined in 25 U.S.C. §450e(b); or
- (J) Other evidence of probative value;]
- [(9)] (10) Age of applicant and recipient by examining:
  - (A) Birth documents;
  - (B) A valid United States passport;
  - (C) Naturalization papers;
  - (D) Baptismal papers; [and] or
  - (E) Other evidence or documents of probative value; and
- [(10)] (11) Application for child support and, where applicable, appropriately initiate an application to establish paternity."  
[Eff 08/01/94; am 07/10/06,  
am ] (Auth: HRS §346-14)  
(Imp: 42 C.F.R. §§435.403, 435.406, 435.408, 435.530, 435.540, 435.831, 435.845; 42 U.S.C. §1396b(x); 42 U.S.C. §1320b-7(d))

4. Section 17-1711-13, Hawaii Administrative Rules, is amended by amending subsection (a) to read as follows:

"17-1711-13 Requirements for disposition of application. (a) The eligibility worker [shall] may, if required to determine eligibility, contact the applicant through an office interview, [a] telephone contact, mailed notice, or a home visit before the application is approved."

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[Eff 08/01/94; am 01/29/96; am ] (Auth: HRS §346-14) (Imp: HRS §346-29; 42 C.F.R. §435.911)

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5. Section 17-1711-13, Hawaii Administrative Rules, is amended by amending subsection (c) to read as follows:

"17-1711-13 Requirements for disposition of application. \*\*\*

(c) Information on the application form shall be considered completed and substantiated when the individual or the authorized representative states that the information is true and correct by signing the application form, unless:

- (1) The applicant's statements do not conform to other facts in the case situation;
- (2) Any part of the information furnished is found to be unclear, inconsistent, or incomplete; or
- (3) The department has specific policies or procedures which require verification of facts, including, but not limited to, [such as] income, assets, citizenship, identity, residency, [birthdate,] birth date, disability and blindness."

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[Eff 08/01/94; am 01/29/96;  
am ] (Auth: HRS §346-14)  
(Imp: HRS §346-29; 42 C.F.R. §435.911)

6. Section 17-1711-13, Hawaii Administrative Rules, is amended by amending subsection (e) to read as follows:

"17-1711-13 Requirements for disposition of application. \*\*\*

(e) Timely dispositions of eligibility or ineligibility shall be made within:

- (1) [Sixty] Ninety days from the date of application for applicants who apply for medical assistance on the basis of disability; or
- (2) Forty-five days from the date of application for all other applicants."

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[Eff 08/01/94; am 01/29/96;  
am ] (Auth: HRS §346-14)  
(Imp: HRS §346-29; 42 C.F.R. §435.911)

7. Section 17-1711-13, Hawaii Administrative Rules, is amended by amending subsections (h) and (i) to read as follows:

"17-1711-13 Requirements for disposition of application. \*\*\*

(h) The department shall not use the time [standard] standards specified in subsection (e) as a:

- (1) Waiting period before determining eligibility; or
- (2) Reason for denying eligibility[.] because the department failed to determine eligibility within the time standards.

(i) A delay beyond the time standard which is attributable to the department shall not result in the withholding of medical assistance from the applicant. A presumption of medical eligibility shall be made effective on the ninety-first day for applicants applying on the basis of disability or on the forty-sixth day [or on the sixty-first day] for all other applicants until a determination is rendered."

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[Eff 08/01/94; am 01/29/96; am ] (Auth:  
HRS §346-14) (Imp: HRS §346-29; 42 C.F.R. §435.911)

8. Section 17-1711-16, Hawaii Administrative Rules, is amended by amending subsection (b) to read as follows:

"§17-1711-16 Requirements for individuals to be added to a recipient household. \*\*\*

(b) A newborn of a recipient who is receiving coverage through the blind or disabled pregnant women and children coverage group shall be added to the household in the following manner:

- (1) A newborn who is not blind or disabled shall receive coverage on a [fee for service]

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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.

(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 QExA health plan that the newborn is enrolled in a different QExA health plan.

- [(2)] (3) The household shall be notified of:
- (A) The newborn's coverage, if the newborn is not blind or disabled, on a [fee for service] fee-for-service basis[;] and the subsequent QUEST plan enrollment; or
  - (B) The blind or disabled newborn's coverage under a QExA plan; and
- [(B)] (C) The effective date of coverage for the newborn."

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[Eff 01/29/96; am 06/19/00; am 12/03/01;  
am 05/10/03; am ] (Auth:  
HRS §346-14) (Imp: 42 C.F.R.  
§§435.911, 435.912)

9. Section 17-1721-2, Hawaii Administrative Rules, is amended to read as follows:

"§17-1721-2 Definitions. For the purpose of this chapter:

"Categorically needy" means aged, blind, or disabled individuals:

- (1) Who are otherwise eligible for medical assistance and who meet the financial eligibility requirements for SSI or [an optional state supplement] SSP or are considered under section 1619(b) of the Social Security Act [(42 U.S.C. 1382h(b))] to be SSI recipients; or
- (2) Whose categorical eligibility is protected by statute.

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"Community" means the place of residence of an individual receiving long-term care services that is not a nursing facility or a medical facility.

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

"Community spouse" is the spouse of an institutionalized [spouse] individual who is not residing in a medical [institution] facility or nursing facility.

"Cost share" means the share of monthly medical expenses for long-term care services for an institutionalized individual who is subject to post-eligibility treatment of income.

"Cost-sharing related to Medicare Part D" means any premiums, deductibles, co-payments, co-insurance, and any cost incurred within the Part D coverage gap.

"Dependent family member" means the child, parent, or sibling of an institutionalized individual who is residing with the community spouse, or in the home of the institutionalized individual if there is no community spouse, who may be claimed as a tax dependent under the Internal Revenue Code by the institutionalized individual or the spouse of the institutionalized individual.

"Domiciliary care facility" means a licensed adult residential care facility which provides twenty-four hour living accommodation, personal care services, and appropriate medical care to adults by persons unrelated to the recipient. A treatment facility providing rehabilitative treatment services shall not be a domiciliary care facility.

"Family" means any persons requesting or receiving medical assistance, any legally responsible parents or spouses, and any other legally responsible persons residing in the same household.

"FPL" means the federal poverty levels that are issued by the United States Department of Health and Human Services used to determine eligibility for medical assistance programs.

"Home and community based services" or "HCBS" means long-term care services provided to an individual residing in a community setting who is certified by the department to be at nursing facility level of care and would be eligible for care provided to an individual in

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a nursing facility or a medical facility receiving nursing facility level of care.

"Income" means any monies received by an individual or family during a given month.

"Institutionalized individual" means an individual who is or is likely to be an inpatient at a medical [institution] facility receiving nursing facility level of care, or an inpatient at a nursing facility for a continuous period of institutionalization, or a recipient of home and community based [waiver] services.

["Institutionalized spouse" means the spouse of the community spouse who is an institutionalized individual.]

"Likely to remain" means that the attending or admitting physician, or [a medical consultant from] the department or its designee, indicates that the individual is expected to reside in a nursing facility or a medical [institution] facility receiving nursing facility level of care [or nursing facility] for at least thirty consecutive days. [This decision is generally made at the beginning of the continuous period of institutionalization.]

"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 for individuals residing in a community setting.

"Medical [institution] facility" means [an institution] a facility which:

- (1) Is organized to provide medical care, including nursing and convalescent care;
- (2) Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of the patients on a continuing basis in accordance with accepted standards;
- (3) Is authorized under State law to provide medical care; and
- (4) Is staffed by professional personnel who have clear and definite responsibility to the institution in the provision of professional medical and nursing services including adequate and continual medical care and supervision by a physician; sufficient registered nurse or licensed practical nurse

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supervision and services and nurse aid services to meet nursing care needs; and appropriate guidance by a physician on the professional aspects of operating the facility.

"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.

"Post-eligibility" is the process to determine an eligible individual's cost share of monthly medical expenses for an individual receiving long-term care services.

"RSDI" means Retirement, Survivors, and Disability Insurance benefits which are administered by the Social Security Administration under Title II of the Social Security Act.

"Spendedown" means the process by which a medically needy individual's monthly income in excess of the medically needy income standard is reduced by their incurred medical expenses.

"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.

"Spouse" means a person who is lawfully married under Hawaii law.

["SSI" means Supplemental Security Income, a financial assistance program for aged, blind, or disabled individuals administered by the Social Security Administration under Title XVI of the Social Security Act.]

"Standard of assistance" means a State need standard, expressed in a dollar amount, against which an individual's or family's income is compared, to determine eligibility for medical assistance."

[Eff 08/01/94; am 10/26/01; am ] (Auth: HRS §346-14; 42 C.F.R §431.10) (Imp: HRS §§346-4; 346-29; 42 C.F.R. §§435.4; 435.1008; 42 U.S.C. §1396r-5)

10. Section 17-1721-4, Hawaii Administrative Rules, is amended by amending subsection (a) to read as follows:

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"§17-1721-4 Eligibility requirements for aged individuals. (a) The categorical eligibility requirement for an aged individual is that the individual be at least [65] sixty-five years of age [within] in the [initial] month of eligibility."

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[Eff 08/01/94; am ] (Auth: HRS §346-14)  
(Imp: HRS §346-29; 42 C.F.R. §§233.39, 435.520,  
435.522)

11. Section 17-1721-8, Hawaii Administrative Rules, is amended by amending subsection (a) to read as follows:

"§17-1721-8 Medical assistance only for aged, blind, or disabled individuals. (a) Individuals who are certified as being aged, blind, or disabled shall be categorically eligible for medical assistance under one of the following coverage groups:

- (1) The mandatory categorically needy coverage for the aged, blind, or disabled, whose members are eligible for or receive SSI payments or SSP payments, or both;
- (2) The medically needy coverage for the aged, blind, or disabled, whose members are financially ineligible for SSI benefits, but whose income is insufficient to meet medical expenses; [or]
- (3) The optional categorically needy coverage for the aged or disabled, whose members are allowed to qualify under a higher assistance standard, as allowed under the provisions of [the Omnibus Reconciliation Budget Act (OBRA) of 1986 (42 U.S.C. §1396a(m)).] 42 C.F.R. §435.230(b)(2)(vi); or
- (4) The optional categorically needy coverage for individuals residing in the community who meet the requirements of 42 C.F.R. §435.217 as follows:
  - (A) The individual would be eligible for Medicaid if institutionalized;

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- (B) The individual does not have income that exceeds income standards for the:
  - (i) Mandatory categorically needy,
  - (ii) Optional coverage of aged and disabled under the provisions of 42 C.F.R. §435.230(b)(2)(vi), or
  - (iii) Individuals in domiciliary care facilities;
- (C) The individual has been determined to need home and community based services in order to remain in the community; or
- (D) The individual may be covered under the terms of a home and community based waiver."

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[Eff 08/01/94; am ]  
(Auth: HRS §346-14) (Imp: 42 C.F.R.  
§§435.121, 435.210, 435.217, 435.330; 42  
U.S.C. §1396(a) (m))

12. Section 17-1721-13, Hawaii Administrative Rules, is amended to read as follows:

“§17-1721-13 Personal reserve standards. (a) The personal reserve standard is 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.

(b) An individual, a family, or a household whose equity in non-exempt assets as determined in chapter 17-1725 exceeds the personal reserve standard for medical assistance shall be ineligible for medical assistance.

[(c) Assets shall not be considered in determining the eligibility of a blind or disabled pregnant woman or child born after 09/30/83, who meets the requirement in sections 17-1721-5 or 17-1721-6.]” [Eff 08/01/94; am 10/26/01; am ] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§435.3, 435.840, 435.843, 435.845)

13. Section 17-1721-20, Hawaii Administrative Rules, is amended to read as follows:

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"§17-1721-20 Standards of assistance for adults in domiciliary care facilities. (a) For adults in licensed domiciliary care facilities, both residential care facilities and [adult] community care foster family homes, the standards of assistance shall be[:]

- [(1) [Equivalent] equivalent to the rates of payment of the [federal Supplemental Security Income] SSI program and SSP for: [the respective levels of care under the department's point system; or]
- (1) Type I domiciliary care facility with not more than five residents; or
- [(2) For persons whose levels of care have not been certified by the department's social services staff, the department of health's staff, or any other agency designated by the department, the privately arranged board rates with a ceiling of the highest level of care rate established by the department.]
- (2) Type II domiciliary care facility with six or more residents.

(b) Costs incurred for medical care or any other type of remedial care not covered by the Medicaid program, shall not be deducted from income when determining financial eligibility for medical assistance under the provisions of this section. There are no spenddown provisions for these individuals in licensed domiciliary care facilities.

(c) If income exceeds the applicable standards of assistance under subsection (a), then the rules relating to persons with excess income at section 17-1721-36 shall apply." [Eff 08/01/94; am 11/25/96; am ] (Auth: HRS §346-14; 42 C.F.R. §435.10) (Imp: 42 C.F.R. §§435.812, 435.814, 435.831)

14. Section 17-1721-21, Hawaii Administrative Rules, is amended to read as follows:

"§17-1721-21 Standards of assistance for mandatory categorically needy aged, blind, or disabled individuals. (a) For all individuals who meet the requirements in section 17-1721-8(a)(1), the medical

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assistance [standards] standard shall be equal to the SSI standard for an individual or a couple.

(b) Costs incurred for medical care or any other type of remedial care not covered by the Medicaid program shall not be deducted from income when determining financial eligibility for medical assistance under the provisions of this section. There are no spenddown provisions for these mandatory categorically needy individuals who are eligible for or receive SSI payments.

(c) If income exceeds the applicable standards of assistance under subsection (a), then the rules relating to persons with excess income at section 17-1721-36 shall apply. [Eff 08/01/94;  
am ] (Auth: HRS §346-14; 42 C.F.R.  
§435.10) (Imp: 42 C.F.R. §§435.217; 435.812, 435.814,  
435.831)

15. Section 17-1721-23, Hawaii Administrative Rules, is repealed.

"[§17-1721-23 Standards of assistance for medically needy blind or disabled pregnant women and children born after September 30, 1983. For individuals who meet the requirements of sections 17-1721-5 or 17-1721-6, the medical assistance standards shall be:

- (1) One hundred eighty-five percent of the federal poverty level for a blind or disabled pregnant woman which includes the number of unborn children for her family size;
- (2) One hundred eighty-five percent of the federal poverty level for a blind or disabled infant under age one for a family of applicable size;
- (3) One hundred thirty-three percent of the federal poverty limit for a blind or disabled child age one but less than age six for a family of applicable size; and
- (4) One hundred percent of the federal poverty limit for a blind or disabled child age six born after September 30, 1983, for a family of applicable size. [Eff 10/26/01;

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R ] (Auth: HRS §346-14; 42  
C.F.R. §431.10) (Imp: HRS §346-29; 42  
C.F.R. §§435.116, 435.601, 435.814, 435.831)]

16. Section 17-1721-28, Hawaii Administrative Rules, is amended to read as follows:

"§17-1721-28 Determining monthly [net] countable income for aged or disabled persons. [(a)] Monthly countable income shall be determined by the following process:

- (1) Determine unearned income according to chapter 17-1724;
- (2) Determine earned income according to chapter 17-1724;
- (3) Deduct \$20 from income, first from unearned income and any remainder from earned income;
- (4) If employed, the following deductions shall apply to the gross earned income:[\$65 shall be deducted; plus one-half of the remainder of earned income; and]

(A) \$65;

(B) If disabled, all impairment-related work expenses shall be deducted from the disabled individual's earned income if the individual's disability is sufficiently severe to result in a functional limitation requiring assistance in order to work as may be necessary to pay for the following:

- (i) Costs for attendant care services;
- (ii) Medical devices;
- (iii) Durable medical equipment;
- (iv) Prosthetic and orthotic appliances;

and

(v) Similar items and services.

(C) Deduct one-half of the remainder of earned income;

[(5) The remaining income, both earned and unearned is countable income.]

[(b)] (5) Income of a disabled person may be excluded if needed to fulfill a plan to achieve self support. This exclusion applies to any income and in any amount[, ] of the disabled individual but shall not exceed in any month the amount of income remaining after application of all other income

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exclusions. The plan shall be approved by the department. After applying the exclusion based on a self-support plan to unearned income, if any portion of the exclusion is not applied, apply it to reduce the amount of the disabled individual's earned income[.]; and

[(c) After eligibility for medical assistance is determined, disabled beneficiaries may qualify for impairment related work expenses. These expenses shall be available if the individual's disability is sufficiently severe to result in a functional limitation requiring assistance in order to work as may be necessary to pay the costs of attendant care services, medical devices, equipment, prosthesis, and similar items and services.]

(6) The net earned and unearned incomes are countable income." [Eff 08/01/94; am ] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §435.812)

17. Section 17-1721-36, Hawaii Administrative Rules, is amended to read as follows:

"§17-1721-36 Persons with excess income. (a) For [a] an aged, blind or disabled person applying for or receiving medical assistance only as [a] an optional categorically needy individual, a mandatory categorically needy individual, or an individual in a domiciliary care facility, income in excess of the appropriate standard of assistance [standard for the coverage group] shall deem the individual ineligible for medical assistance under that coverage group.

[(b) For persons applying for or receiving medical assistance as a mandatory categorically needy aged, blind, or disabled individual, income in excess of the SSI standards shall deem the individual ineligible for medical assistance under that coverage group.

(c)] (b) When a person applies for or receives medical assistance [under the the coverage groups not addressed in subsections (a) and (b), and the person's] with income that exceeds the appropriate [medical assistance] standard of assistance[, ]for the groups in subsection (a), the person shall be entitled to receive medical assistance if[, ] the excess income can be spent down to the standard of assistance for the medically

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needy after [first] deducting incurred medical expenses [from months prior to the retroactive period:

- (1) The applicant's or recipient's monthly excess income is insufficient to meet the total monthly cost of medical care and services which are likely to be required on a continuing basis, whether at the level of [ambulating] ambulatory outpatient care, [or] long-term institutional care[;] or home and community based services; or
  - (2) The total monthly excess income is insufficient to meet medical expenses of an acute medical service in that given month.
- (d) The amount determined to be in excess of the [medical assistance] appropriate standard of assistance shall be applied to the cost of medical care and services in the following order:
- (1) Incurred medical expenses shall be deducted from excess income as provided in section 17-1721-37(a)(2); and
  - (2) The balance, if any, be used to spenddown to the medically needy income limit [cost sharing] as provided in section 17-1721-37(a)(3)." [Eff 08/01/94; am ]  
(Auth: HRS §346-14; 42 C.F.R. §431.10)  
(Imp: 42 C.F.R. §§435.831, [(b)]

18. Section 17-1721-37, Hawaii Administrative Rules, is amended by amending subsection (a) and (b) to read as follows:

"§17-1721-37 Incurred medical expenses. (a) The following shall be within the scope of incurred medical expenses:

- (1) Prior to the establishment of eligibility for medical assistance, the amount of health insurance premium an applicant or recipient is paying, whether for a private or government health plan, shall be deducted from excess income. If payment is made quarterly, or at longer intervals, the amount shall be prorated on a monthly basis;
- (2) Incurred medical expenses from months prior to the retroactive period, [except for that portion of medical bills which are subject to payment by a third party and past debts which have been forgiven by the provider,] shall:

## PROPOSED

- (A) [be] Be deducted from the applicant's or recipient's excess income in the following order:
- [(A)] (i) Medicare monthly premium payments effective from the month of eligibility for medical assistance up to the buy-in month;
  - [(B)] (ii) Other health insurance premiums, deductibles, or coinsurance charges;
  - [(C)] (iii) Expenses incurred for necessary medical and remedial services that are recognized under State law but not included in the medical assistance program and said expenses from months prior to the retroactive period which were not previously considered and which remain a current liability to the applicant or recipient; [and]
  - [(D)] (iv) Expenses for necessary medical and remedial services included in the medical assistance program or that exceed the limitations on the amount, duration, or scope of services and said expenses from months prior to the retroactive period which were not previously considered and which remain a current liability to the applicant or recipient; and
    - (v) QExA enrollment fees.
  - [(B)] Exclude that portion of medical bills which are subject to payment by a third party, and past debts which have been forgiven by the provider.
- (3) Incurred medical expenses from current month and for months in the retroactive period, [except for that portion of medical bills which are subject to payment by a third party, shall be applied to the cost sharing.] shall be deducted from the excess income except for:
- (A) Those expenses that were previously deducted from income in any month in establishing eligibility for that month;
  - (B) That portion of medical bills which are subject to payment by a third party; and

# PROPOSED

(C) Past debts which have been forgiven by the provider."

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[Eff 08/01/94; am ]  
(Auth: HRS §346.14; 42 C.F.R. §431.10)  
(Imp: 42 C.F.R. §435.831)

19. Section 17-1721-38, Hawaii Administrative Rules, is amended to read as follows:

"§17-1721-38 [Cost sharing] Spenddown of excess income for [medical care cost] a medically needy individual. (a) The monthly excess income of a person found eligible for medical assistance under section 17-1721-36[(c)](b) shall be applied to the person's medical expenses for the respective month.

(b) [For a] A person with excess income[, ] shall present evidence that incurred medical expenses not previously used to determine eligibility, [were] are greater than the excess income for a given month [shall be presented] before medical assistance coverage is provided.

(c) If a person over obligates [or under obligates] the [cost share] spenddown amount for a given month, the recipient's [cost share] spenddown amount for the following month remains unchanged.

(d) [For a] A person who is currently eligible for [medicare] Medicare benefits and medical assistance, the recipient's excess income shall be applied to [medicare's] Medicare's deductibles, and coinsurance, as well as [to] [medicare's] Medicare's non-covered services. The balance of remaining cost, if any, shall be paid by the medical assistance program according to the department's reimbursement rates.

(e) A medically needy individual who is enrolled in a OExA health plan shall meet the spenddown obligation by paying the OExA enrollment fee." [Eff 08/01/94; am ] (Auth: HRS §346.14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §§447.50, 435.800, 435.831)

20. Chapter 17-1721, Hawaii Administrative Rules, is amended by adding new section 17-1721-39 to read as follows:

## PROPOSED

- "§17-1721-39 Provision of coverage. (a) OExA health plans shall provide coverage for individuals eligible under this chapter, except for:
- (1) Medically needy individuals who are not expected to incur expenses sufficient to satisfy their spenddown obligation for a consecutive three-month period;
  - (2) Individuals who are eligible for medical assistance for a period that is less than thirty days;
  - (3) Children under age twenty-one who are residents of the State [of Hawaii], receive child welfare services or subsidized adoption from the department or court, and are placed in other states; and
  - (4) Individuals who enter the State of Hawaii organ and transplant (SHOTT) program.
- (b) Individuals in subsection (a) will be provided coverage on a fee-for-service basis for the services identified in chapter 17-1737.
- (c) Individuals enrolled in the Medicaid waiver program for persons with developmental disabilities or mental retardation (DD/MR) shall have their primary and acute care services covered by a OExA health plan, but shall have their HCBS and intermediate care facility for the mentally retarded (ICF/MR) benefits covered under fee-for-service.
- (d) Individuals who are enrolled in the Program for All-Inclusive Care for the Elderly (PACE) shall have all medical and long-term care services covered by the PACE program.
- (e) Medically needy individuals who are disenrolled from a health plan for being two months in arrears of the payment of their enrollment fee are not eligible for coverage under this chapter unless the individual:
- (1) Is no longer two full months in arrears in the payment of the enrollment fee; or
  - (2) Is a medically needy individual who is not expected to incur expenses sufficient to satisfy their spenddown obligation for a three-month period; or
  - (3) Qualifies as a mandatory categorically needy individual or an optional categorically needy individual under

# PROPOSED

section 17-1721-8."  
[Eff \_\_\_\_\_ ] (Auth: HRS  
§346-14) (Imp: HRS§346-14)

21. Chapter 17-1721 is amended by amending the title of Subchapter 7 to read as follows:

"[MEDICALLY INSTITUTIONALIZED INDIVIDUALS] FINANCIAL ELIGIBILITY AND LIABILITY OF INDIVIDUALS RECEIVING LONG-TERM CARE SERVICES"

22. Section 17-1721-42, Hawaii Administrative Rules, is amended to read as follows:

"§17-1721-42 Purpose. The purpose of this subchapter is to establish how financial eligibility and financial liability [of a recipient] for the cost of long-term care services will be determined for [medically] an institutionalized [individuals,] individual [as well as the penalties for the disposal of assets.] requesting coverage of long-term care services." [Eff 08/01/94; am \_\_\_\_\_ ] (Auth: HRS §346-14) (Imp: HRS §346-14)

23. Section 17-1721-43, Hawaii Administrative Rules, is amended to read as follows:

"§17-1721-43 Determination of the community spouse resource allowance. (a) At the time of initial eligibility determination, the community spouse of [a person] an institutionalized individual who received long-term care services on or after September 30, 1989, shall be allowed to maintain countable assets to the maximum allowed by federal statutes or regulations with provisions for increase, as allowed by the Secretary of Health and Human Services by means of indexing, court order, or fair hearing.

(b) At the time of initial eligibility determination of an institutionalized [spouse] individual, the total assets of both spouses, regardless of how the assets are held, shall be considered available to the institutionalized [spouse]

## PROPOSED

individual, except for the community spouse resource allowance, as defined by subsection (a).

(c) The assets retained by the community spouse, as allowed by subsection (a), shall not jeopardize the eligibility of the institutionalized [spouse] individual. After the initial eligibility of the institutionalized [spouse] individual is established, any assets of the community spouse, which do not include the institutionalized [spouse] individual as a co-owner, shall not be considered during the continuous period of both medical assistance eligibility and institutionalization of the institutionalized [spouse] individual.

(d) The post-eligibility interspousal transfer of assets shall be allowed for the legal transfer of assets from the institutionalized [spouse] individual to the community spouse. After a protective period of ninety days, which may be extended if there are legal reasons or extenuating circumstances that delay such a transfer, any assets still legally available to the institutionalized [spouse] individual shall be considered in the determination of continued eligibility of the institutionalized [spouse] individual.

(e) [As an individual admitted to a home and community-based services waiver program is considered to be institutionalized, the provisions of subsections (a) through (d) apply to such a person and the person's spouse.] The provisions of subsections (a) through (d) only apply to an institutionalized individual determined eligible for home and community based services who qualify for Medicaid as a medically needy individual or under the provisions of 42 C.F.R. §435.217. [Eff 08/01/94; am \_\_\_\_\_] (Auth: HRS §346-14; 42 C.F.R §431.10) (Imp: HRS §346-29; 42 U.S.C. §1396r-5, 42 U.S.C. §1315)

24. Section 17-1721-44, Hawaii Administrative Rules, is amended to read as follows:

"§17-1721-44 Post-eligibility treatment of income for an institutionalized [individuals] individual [in medical institutions]. (a) After an institutionalized individual has been determined eligible for medical assistance coverage of long-term care services on the

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basis of income, [and that individual has been in or is likely to remain in a medical institution for more than thirty days,] the income of that individual must be applied toward the individual's [institutional] cost share of long-term care and other medical care costs.

A cost share is applicable to the following:

- (1) An individual residing in a nursing facility or a medical facility where the individual is provided nursing facility level of care services;
- (2) A medically needy individual residing in the community who is eligible to receive home and community based services; and
- (3) An optional categorically needy individual who needs to have eligibility established under the provisions of 42 C.F.R. §435.217.

(b) [To determine the amount of the] An individual's [income to be applied to] cost share is determined by deducting [medical expenses,] the following [shall be deducted] from the individual's income:

- (1) A personal needs allowance of [\$30 monthly.]:
  - (A) \$50 for an individual residing in a nursing facility or medical facility receiving a nursing facility level of care;
  - (B) One hundred percent of the FPL for a household of one for an individual residing in a private home in the community; or
  - (C) The standard of assistance for the medically needy for a household of one for an individual residing in a community care foster family home.
- (2) An amount for maintenance of the institutionalized individual's [dependent] community spouse and dependent family member that shall be deducted first from the income of the institutionalized individual's income as follows:
  - (A) The contribution from the institutionalized [spouse] individual to the community spouse which shall be equal to the amount [by which] that the

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- maximum community spouse maintenance needs allowance exceeds the countable income [otherwise available to] of the community spouse. The maximum community spouse maintenance needs allowance is defined by federal statutes or regulations and is subject to increases by means of indexing, court order, or fair hearing decree; [and]
- (B) The family allowance for each dependent family member, [aside from] residing with the community spouse, which shall be equal to the amount [by which] that one third of the spousal allowance in [section 17-1721-44(b)(2)(A)] subparagraph (A) exceeds the amount of the monthly income of that family member; [For the purposes of this subparagraph, "family member" only includes minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse;] or
- (C) The family allowance for a dependent family member residing in the institutionalized individual's home, with no community spouse residing in the home, which shall be equal to the amount that the standard of assistance for the medically needy for a family of equal size, exceeds the amount of the monthly income of the family member.
- (3) Any incurred medical expenses as provided in section 17-1721-37, not covered by the medical assistance program[;] excluding any unpaid portion of long-term care services that were not payable by Medicaid during a penalty period for the transfer of assets for less than fair market value established under the provisions of this chapter;
- (4) [VA] Veterans Affairs benefits that have been reduced to \$90 for pensioners with no dependents; and

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(5) [VA] Veterans Affairs benefits for unusual medical expenses (UME).

(c) Any income remaining, rounded down to the whole dollar, after following the procedures of subsection (b), represents the amount of the individual's [income to be applied toward the cost of institutionalization] cost share." [Eff 08/01/94; am 11/13/95; am 11/25/96; am \_\_\_\_\_ ] (Auth: HRS §346-14) (Imp: 42 C.F.R. §§435.726, 435.733, 435.735, 435.831, 435.832; 38 U.S.C. §3203; 42 U.S.C. §§1396a(r), 1396r-5; 42 U.S.C. §1315)

25. Chapter 17-1721.1, Hawaii Administrative Rules, is adopted to read as follows:

## "HAWAII ADMINISTRATIVE RULES

### TITLE 17

#### DEPARTMENT OF HUMAN SERVICES

#### SUBTITLE 12 MED-QUEST DIVISION

#### CHAPTER 1721.1

#### QUEST EXPANDED ACCESS

##### Subchapter 1 General Provisions

§17-1721.1-1 Purpose  
§17-1721.1-2 Definitions  
§§17-1721.1-3 to 17-1721.1-5 (Reserved)

##### Subchapter 2 Freedom of Choice

§17-1721.1-6 Choice of participating health plans  
§17-1721.1-7 Choice of primary care provider  
§17-1721.1-8 Assignment of primary care provider  
§§17-1721.1-9 to 17-1721.1-15 (Reserved)

##### Subchapter 3 Eligibility and Enrollment

# PROPOSED

§17-1721.1-16 Individuals eligible for QExA  
§17-1721.1-17 Enrollment  
§17-1721.1-18 Annual plan change period  
§17-1721.1-19 Effective date of enrollment  
§17-1721.1-20 Limitations on health plan enrollment

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

## Subchapter 4 Disenrollment

§17-1721.1-36 Authority to disenroll QExA  
beneficiaries  
§17-1721.1-37 Disenrollment of enrollees from QExA  
health plans  
§§17-1721.1-38 to 17-1721.1-40 (Reserved)

## Subchapter 5 Reimbursement to Participating Health Plans

§17-1721.1-41 Capitated payments  
§§17-1721.1-42 to 17-17271-45 (Reserved)

## Subchapter 6 Financial Responsibilities of QExA Enrollees

§17-1721.1-46 Enrollment fee  
§§17-1721.1-47 to 17-1721.1-50 (Reserved)

## Subchapter 7 Scope and Content of Services

§17-1721.1-51 Standard benefits package  
§17-1721.1-52 Primary and acute care services to be  
provided by participating health plans  
§17-1721.1-53 Special provisions relating to  
behavioral health benefits  
§17-1721.1-54 Home and community based services (HCBS)  
§17-1721.1-55 Institutional care services  
§17-1721.1-56 Dental services  
§§17-1721.1-57 to 17-1721.1-65 (Reserved)

## Subchapter 8 Participating Health Plans

# PROPOSED

- §17-1721.1-66 Health plan participation in QExA
- §17-1721.1-67 Service areas
- §17-1721.1-68 Requirements of participating health plans
- §17-1721.1-69 Enforcement of contracts with participating health plan
- §17-1721.1-70 Termination of contract with participating health plans

## 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 ] (Auth: HRS §346-14) (Imp: HRS §346-14)

§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.

# PROPOSED

"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:

- (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:

## PROPOSED

- (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.

"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.

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"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 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

## PROPOSED

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 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

# PROPOSED

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, 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 \_\_\_\_\_] (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

# PROPOSED

§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 ] (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 ] (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 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 ] (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 OExA. The following individuals shall be eligible for QExA:

## PROPOSED

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

§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.

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(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 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;

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- (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 \_\_\_\_\_]  
(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 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.

## PROPOSED

(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 ] (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 within the immediate thirty days prior to the date 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.

(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:

- (2) A newborn who is not blind or disabled shall receive coverage on a fee-for-service basis effective the date of birth, regardless of

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- when the birth is reported, to the date the enrollment process has been completed to enroll the newborn in a QUEST plan, or
- (3) 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 ]  
(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 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

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- 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 \_\_\_\_\_ ]  
(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 \_\_\_\_\_ ] (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;
- (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

## PROPOSED

- 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 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

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

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

## SUBCHAPTER 6

### FINANCIAL RESPONSIBILITIES OF QExA ENROLLEES

# PROPOSED

§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 ] (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 ] (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.

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

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- (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 mammograms, screening and diagnostic laboratory tests, therapeutic radiology, and

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- 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, raking the lawn, trimming hedges, bundling rubbish for refuse collection;

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- (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 and home health aides) will not be covered.

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- 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

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health plan. If agreed to by the hospital, 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-

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stabilization services that it has not approved ends because:

- (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 \_\_\_\_\_ ] (Auth: HRS

## PROPOSED

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

§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.

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(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 care plan shall be covered by the health plan.

[Eff ] (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

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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 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,

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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. CCMAs shall:

- (A) communicate with an enrollee's physician regarding the enrollee's needs including changes in medication and treatment orders;
  - (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

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skills, as well as training that may include, but not limited to, enrollee care training for enrollees, family and caregivers regarding the nature of the disease and the disease process; methods of transmission and infection control measures; biological, psychological care and special treatment needs-regimens; employer training for consumer directed services; instruction about the treatment regimens; use of equipment specified in the service plan; employer skills updates as necessary to safely maintain the individual at home; crisis intervention; supportive counseling; family therapy; suicide risk assessments and intervention; death and dying counseling; anticipatory grief counseling; substance abuse counseling; and nutritional assessment and counseling;

- (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

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- 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, 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

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- 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 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

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- 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 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;

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- (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 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 ] (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

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- 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;
  - (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

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

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§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 ] (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:

- (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.

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[Eff ] (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;
- (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

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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.

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

§17-1721.1-70 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:



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Coverage as a specified low income Medicare beneficiary shall be limited to the payment of the [medicare] Medicare supplemental medical insurance premium.

(b) Coverage shall be effective in the month in which eligibility begins, not to exceed thirty days prior to the date the application was received by the department." [Eff 08/01/94; am ] (Auth: HRS §346-14; 42 C.F.R. §435.10) (Imp: 42 U.S.C. §1396a(a)(10)(E))

29. Section 17-1722-21, Hawaii Administrative Rules, is repealed.

"[§17-1722-21 Effective date of coverage. Coverage as a specified low income [medicare] Medicare beneficiary begins in the month in which eligibility starts.]" [Eff 08/01/94; R ] (Auth: HRS §346-14; 42 C.F.R. §435.10) (Imp: 42 U.S.C. §1396a(a)(10)(E))]

30. Section 17-1722-29, Hawaii Administrative Rules, is amended to read as follows:

"§17-1722-29 Effective date of coverage. Coverage [under the provisions of this subchapter] as a qualified disabled and working individual will coincide with the effective date of enrollment in Part A, as allowed under section 1818A of the Social Security Act (42 U.S.C. §1395i-2(a) and determined by the Social Security Administration[.] but not to exceed thirty days from the date the application is received by the department." [Eff 08/01/94; am ] (Auth: HRS §346-14; 42 C.F.R. §435.10) (Imp: 42 U.S.C. §1396a(a)(10)(E))

31. Section 17-1722-70, Hawaii Administrative Rules, is amended to read as follows:

"§17-1722-70 Eligibility requirements. A qualifying individual shall be:  
(1) Entitled to hospital insurance benefits under the [medicare] Medicare program;

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- (2) In receipt of income which exceeds one hundred twenty per cent of the federal poverty limit but does not exceed one hundred [seventy-five] thirty-five percent of the federal poverty limit;
- (3) In possession of assets which do not exceed twice the personal reserve allowed under the supplemental security income program; and
- (4) Required to meet basic eligibility conditions detailed in chapter 17-1714, including:
  - (A) A resident of the State of Hawaii;
  - (B) A citizen of the United States or a qualified alien;
  - (C) Not a resident of a public institution;
  - (D) Assign to the department any benefits from a third party for coverage of medical expenses, to the extent of medical costs paid by the department; and
  - (E) Furnish a social security number and verification of that number."  
[Eff 05/02/98; am ]  
(Auth: HRS §346-14; 42 C.F.R. §435.10)  
(Imp: 42 U.S.C. §§1396a(a)(10)(E), 1396d(p))

32. Section 17-1722-72, Hawaii Administrative Rules, is amended by amending subsection (a) to read as follows:

"§17-1722-72 Limitations of coverage. (a) Coverage for an individual eligible for assistance as a qualifying individual[:

- (1) For a qualifying individual] with countable income that exceeds one hundred twenty percent of the federal poverty limit but does not exceed one hundred thirty-five percent, the payment of the [medicare] Medicare supplemental medical insurance premium[; and]."
- [(2) For a qualifying individual with countable income that exceeds one hundred thirty-five percent of the federal poverty limit but does not exceed one hundred seventy-five percent, payment of the increment to the [medicare] Medicare supplemental medical insurance premium caused by the shifting of certain

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home health services from the [medicare]  
Medicare hospital insurance.]”

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[Eff 05/02/98; am ] (Auth:  
HRS §346-14; 42 C.F.R. §435.10) (Imp: 42  
U.S.C. §1396a(a)(10)(E))

33. Section 17-1722-74, Hawaii Administrative Rules, is amended to read as follows:

“§17-1722-74 Effective date of coverage. Coverage as a qualifying individual begins in the month in which eligibility starts[.] , no earlier than thirty days from the date the application is received by the department.” [Eff 05/02/98; am ] (Auth: HRS §346-14; 42 C.F.R. §435.10) (Imp: 42 U.S.C. §1396a(a)(10)(E))

34. Section 17-1722-81, Hawaii Administrative Rules, is amended to read as follows:

“§17-1722-81 Provision of coverage. Coverage for individuals eligible for assistance in this subchapter will be provided [on a fee for service basis] through enrollment in a QExA health plan per chapter [17-1737] 17-1721.1.” [Eff 05/02/98; am ] (Auth: HRS §346-14; 42 C.F.R. §435.10) (Imp: 42 U.S.C. §1396a(a)(10)(A)(i)(II))

35. Section 17-1722-82, Hawaii Administrative Rules, is amended to read as follows:

“§17-1722-82 Effective date of coverage. Coverage under this group shall begin [in the month in which eligibility starts.]:  
(a) On the date of application;  
(b) If specified by the applicant, retroactive coverage may begin no earlier than thirty days prior to the date the application is received by the department;  
or  
(c) If ineligible in the month of application, the date on which all eligibility requirements are met by the applicant in a subsequent month.”

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[Eff 05/02/98; am ] (Auth: HRS §346-14;  
42 C.F.R. §435.10) (Imp: 42 U.S.C.  
§1396a(a)(10)(A)(i)(II))

36. Section 17-1723-6, Hawaii Administrative Rules, is amended to read as follows:

"§17-1723-6 Limitations of coverage. (a) Medical assistance coverage for these aliens shall be limited to coverage of emergency medical services without which the individual's health would be placed in serious jeopardy and could result in serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

(b) Coverage will be provided through the existing fee for services program[.] no earlier than thirty days prior to the date the application is received by the department.

(c) Services related to organ transplant procedures are not covered." [Eff 08/01/94;  
am 05/17/97; am ] (Auth: HRS §346-14;  
42 C.F.R. §435.10) (Imp: 42 C.F.R §440.255(c))

37. Section 17-1727-25, Hawaii Administrative Rules, is amended by amending subsection (b) to read as follows:

"§17-1727-25 Coverage of QUEST eligibles prior to the date of enrollment. \*\*\*

(b) The date of coverage shall be one of the following:

- (1) The date of application;
- (2) If specified by the applicant, [any date on which appropriate emergency room or hospital expenses were incurred and which is within the immediate five calendar days] retroactive coverage may begin no earlier than thirty days prior to the date [of] the application[;] is received by the department;  
or
- (3) If [the applicant is found to be] ineligible [for] in the month of application, the date [of the subsequent month] on which all eligibility requirements are met by the applicant in a subsequent month."

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[Eff 07/20/95; am 12/03/01;  
am ] (Auth: HRS §346-14)  
(Imp: HRS §346-14; 42 C.F.R. §430.25)

38. Section 17-1730-28, Hawaii Administrative Rules, is amended to read as follows:

"§17-1730-28 Effective date of eligibility. (a) For applicants, the effective date of eligibility shall be one of the following:

- (1) The date of application;
- (2) If specified by the applicant, retroactive coverage may begin no earlier than thirty days [the date on which appropriate emergency room or hospital expenses were incurred and which is within the immediate five calendar days] prior to the date [of] the application[;] is received by the department;  
or
- (3) If [the applicant is] ineligible [for] in the month of application, the date [of the subsequent month] on which all eligibility requirements are met by the applicant in a subsequent month.

(b) For recipients, the effective date of eligibility in QUEST-Spenddown shall be one of the following:

- (1) The first day of the month following the last date of eligibility in QUEST; or
- (2) For a QUEST-Net recipient eligible for dual coverage, [eligibility may be] retroactive coverage may begin no earlier than thirty days [to the first day of the third month] prior to the [month] date of request for QUEST-spenddown, or retroactive to the effective date of eligibility for QUEST-Net, whichever is later." [Eff 12/27/97;  
am ] (Auth: HRS §346-14)  
(Imp: HRS §346-14; 42 C.F.R. §430.25)

39. Section 17-1732-15, Hawaii Administrative Rules, is amended to read as follows:

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"§17-1732-15 Method of coverage. (a) Eligible individuals shall be enrolled in a OExA health plan and provided coverage [on a fee for service basis.] under chapter 17-1721.1.

(b) A medical assistance identification card [or a temporary medical assistance identification coupon] shall be issued as described in chapter 17-1711."

[Eff 07/06/99; am 05/10/03 ; am 09/17/07;

am ] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §435.930)

40. Section 17-1732-16, Hawaii Administrative Rules, is amended to read as follows:

"§17-1732-16 Effective date of coverage. [(a)] Medical payment for covered services shall be authorized for eligible persons [beginning the first day of the month of application.] effective:

(1) The date of application;

(2) If specified by the applicant, retroactive coverage may begin no earlier than thirty days prior to the date the application is received by the department; or

(4) If ineligible for the month of application, the first day of the subsequent month on which all eligibility requirements are met by the applicant."

[(b) Medical assistance shall be authorized retroactively effective the first day of the third month prior to the month of application as described in the general provisions for fee for service medical assistance in this subtitle.]" [Eff 07/06/99;

am ] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 C.F.R. §435.914)

41. Section 17-1733-16, Hawaii Administrative Rules, is amended to read as follows:

"§17-1733-16 Method of coverage. (a) An eligible individual shall be enrolled in a QExA health plan and provided coverage [on a fee for service basis] under chapter 17-1721.1.

(b) A medical assistance identification card [or temporary medical assistance identification coupons] shall be issued as described in chapter 17-1711."

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[Eff 02/16/02, am 05/10/03; am ] (Auth:  
HRS§346-14) (Imp: Pub. L. No. 106-354)

42. Section 17-1733-17, Hawaii Administrative Rules, is amended to read as follows:

"§17-1733-17 Effective date of coverage. Medical payment for covered services shall be authorized for an eligible individual effective the date the individual is screened and initially diagnosed as having breast or cervical cancer or a pre-cancerous condition of the breast or cervix by HBCCCP but retroactive coverage may begin no earlier than [the first day of the third month] thirty days prior to the [month of] date the application is received by the department as described in chapter [1735] 1721.1." [Eff 02/16/02; am ] (Auth: HRS §346-14) (Imp: Pub. L. No. 106-354)

43. Section 17-1733-18, Hawaii Administrative Rules, is amended to read as follows:

"§17-1733-18 Scope and content. An individual who is eligible under the provisions of this chapter shall be entitled to the services allowed under the scope and contents of the [fee for service] QExA program described in chapter [1737] 1721.1." [Eff 02/16/02; am ] (Auth: HRS §346-14) (Imp: Pub. L. No. 106-354)

44. Section 17-1734-16, Hawaii Administrative Rules, is amended to read as follows:

"§17-1734-16 Method of coverage. (a) An eligible individual shall be enrolled in a QExA health plan and provided coverage [on a fee for service basis.] under chapter 17-1721.1.

(b) A medical assistance identification card [or temporary medical assistance identification coupons] shall be issued as described in chapter 17-1711." [Eff 02/16/02, am 05/10/03; am ] (Auth: HRS§346-14) (Imp: Pub. L. No. 106-354)

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45. Section 17-1734-17, Hawaii Administrative Rules, is amended to read as follows:

"§17-1734-17 Effective date of coverage. Medical payment for covered services shall be authorized for an eligible individual effective the date the individual is screened and initially diagnosed as having breast or cervical cancer or a pre-cancerous condition of the breast or cervix by HBCCCP but retroactive coverage may begin no earlier than thirty days prior to the date [the first day of the third month prior to the month of] the application is received by the department as described in chapter [1735.] 1721.1." [Eff 02/16/02; am ] (Auth: HRS §346-14) (Imp: HRS 346-59.2)

46. Section 17-1734-18, Hawaii Administrative Rules, is amended to read as follows:

"§17-1734-18 Scope and content. An individual who is eligible under the provisions of this chapter shall be entitled to the services allowed under the scope and contents of the [fee for service] QExA program described in chapter [1737] 1721.1." [Eff 02/16/02, am ] (Auth: HRS §346-14) (Imp: HRS 346-59.2)

47. Section 17-1735-3, Hawaii Administrative Rules, is amended as follows:

§17-1735-3 Individuals covered under [fee for service] fee-for-service medical assistance. (a) Individuals eligible for the [fee for service] fee-for-service component under the medical assistance program include, but are not limited to:

- (1) [Those described in chapter 17-1721, Medical Assistance to Aged, Blind and Disabled Individuals] Qualified Medicare Beneficiaries;
- (2) [Those described in chapter 17-1722, Special Medical Assistance Coverages and Programs;
- (3)] Children under age twenty-one who are

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- residents of the State [of Hawaii], receive child welfare services or subsidized adoption from the department [of human services] or court, and are placed in another state;
- [ (4) ] (3) Emergency services for illegal, ineligible, qualified and non-qualified aliens;
- [ (5) ] Persons who are eligible under QUEST but have not yet been enrolled in participating QUEST health plans;
- (6) Blind or disabled children described in chapter 17-1728, QUEST-Net;
- (7) Those described in chapter 17-1730, QUEST-spenddown program;
- (8) Those described in chapter 17-1732, coverage of blind or disabled pregnant women and children;
- (9) Those described in chapter 17-1733, coverage of individuals with breast and cervical cancer; and
- (10) Those described in chapter 17-1734, state funded coverage of individuals with breast and cervical cancer.]
- (4) Individuals who are eligible for medical assistance for a period that is less than thirty days;
- (5) Medically needy individuals who are expected to incur expenses sufficient to satisfy their spenddown obligation for less than a three-month period; and
- (6) Individuals who enter the State of Hawaii organ and transplant (SHOTT) program.
- (b) Individuals who are enrolled in health plans participating under QUEST, QUEST-Net, QUEST-ACE, and QExA are excluded from the fee-for-service program[.], except that the following services may be provided on a fee-for-service basis subject to approval by the department:
- (1) Services provided through the Medicaid waiver program for persons with developmental disabilities or mental retardation including HCBS, DD-MR case management, and ICF-MR services;
- (2) HCBS services provided through the Money Follows the Person (MFP) grant;
- (3) ICF-MR services;
- (4) School-based health related services from the department of education;

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- (5) Early intervention program services through the department of health; and
- (6) Serious and persistent mental illness and severe emotional behavioral disorder related services through the department of health."  
[Eff 08/01/94; am 07/20/95; am 07/06/99, am 02/16/02; am 05/10/03; am ]  
(Auth: HRS §346-14) (Imp: HRS §346-14)

48. Section 17-1735-5, Hawaii Administrative Rules, is amended to read as follows:

"§17-1735-5 Effective date of authorization. (a) Medical payment for covered services shall be authorized for eligible persons under the fee-for-service program beginning the [first day of the month of] date the application[.] is received by the department.

(b) Payment shall be authorized retroactively for medical care and services received, [effective the first day of the third month] no earlier than thirty days prior to the [month of] date the application is received by the department when:

- (1) The applicant's eligibility for medical assistance during the retroactive period is established:
  - (A) For the purpose of retroactive coverage, applicant includes a deceased individual on whose behalf a request for assistance is made by a relative, friend, or the department's representative after the individual's death; and
  - (B) The application form for a deceased individual shall be signed by the relative, friend, or the department's representative;
- (2) Part or all of the applicant's medical bills remain unpaid;
- (3) The expenses incurred by the applicant were for medical care and services within the scope of services covered under the department's medical assistance program and the department's medical consultant has approved the care received as medically necessary; and
- (4) The care and services have been provided by

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an eligible participating provider."  
[Eff 08/01/94; am ] (Auth:  
HRS §346-14; 42 C.F.R. §431.10) (Imp: 42  
C.F.R. §§435.914, 440.10, 440.20, 440.30,  
440.40, 440.50, 440.60, 440.70, 440.80,  
440.90, 440.100, 440.110, 440.120, 440.130,  
440.140, 440.150, 440.155, 440.160, 440.165,  
440.166, 440.167, 440.170, 440.180, 440.181)

49. Materials, except source notes, to be repealed are bracketed. New material is underscored.

50. Additions to update source notes to reflect these amendments are not underscored.

51. Amendment of Chapters 17-1700, 17-1711, 17-1721, 17-1722, 17-1723, 17-1727, 17-1730, 17-1732, 17-1733, 17-1734, and 17-1735 and adoption of Chapter 17-1721.1, Hawaii Administrative Rules, shall take effect ten days after filing with the Office of the Lieutenant Governor.