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HAWAII ADMINISTRATIVE RULES

TITLE 17

DEPARTMENT OF HUMAN SERVICES

SUBTITLE 12 MED-QUEST DIVISION

CHAPTER 1722

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Historical Note: This chapter is based substantially - upon §17-742-2.02 [Eff 10/23/87; am 10/1/89; R 3/19/93]; and §17-742-2.1 [Eff 2/22/88; am 5/6/91; R 3/19/93]; and Chapter 17-752. [Eff 7/19/82; am 12/17/82; am 8/20/83; am 3/30/84; am 8/23/84; am

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8/9/85; am 5/5/86; am 3/2/87; am 10/23/87; am 6/5/89;
am 1/1/90; am 7/26/90; am 8/30/91; R 3/19/93].

SUBCHAPTER 1

GENERAL PROVISIONS

§17-1722-1 Purpose. The purpose of this chapter is to describe certain special coverages of the medical assistance program and to establish the requirements for eligibility and participation in the coverages. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: HRS §88-4, 42 U.S.C. §§1396a, 1396d; 42 C.F.R. §435.139)

§17-1722-2 (Reserved).

SUBCHAPTER 2

QUALIFIED SEVERELY IMPAIRED INDIVIDUALS

§17-1722-3 Purpose. The purpose of this subchapter is to describe the coverage of qualified severely impaired individuals and the eligibility criteria for that coverage group. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §§1396a(a)(10)(A)(i)(II), 1396d(q))

§17-1722-4 Eligibility requirements. (a) A qualified severely impaired individual is a person:

- (1) Who, for the month preceding the month to which this section applies;
 - (A) Received SSI, SSP, or both on the basis of blindness or disability; and
 - (B) Was eligible for medical assistance; and
- (2) Of whom, the Social Security Administration determines that:
 - (A) The individual continues to be blind or disabled, and except for the individual's earnings, continues to meet SSI eligibility requirements;
 - (B) Without medical assistance the individual's ability to continue or

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obtain employment would be seriously inhibited; and

- (C) The individual's earnings are not sufficient to provide a reasonable equivalent to the benefits from SSI/SSP, medical assistance, and publicly funded attendant care services for which the individual would be eligible, were it not for the individual's earnings.

(b) For the purposes of this section, an individual, who is eligible for special SSI/SSP payments or for work incentive allowances under provisions of 42 U.S.C. §1382h shall be considered to have met the requirements of subsection (a). Thus, an individual with 1619 status, meeting the provisions of subsection (a), shall be considered a qualified severely impaired individual.

(c) An individual who meets the definition of a qualified severely impaired individual shall be eligible for medical assistance, provided the individual remains in 1619 status, as determined by the Social Security Administration.

(d) When an individual has more than one period of eligibility under 1619 status in the SSI Program, the first month of the most recent period shall be used to determine eligibility for medical assistance.

[Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §431.10) (Imp: 42 U.S.C. §§1396a(a)(10)(A)(i)(II), 1396d(q))

§17-1722-5 Limitations of coverage. Individuals eligible as qualified severely impaired individuals shall be eligible for coverage of all services covered under the medical assistance program, except for the payment of medicare hospital insurance premiums.

[Eff 08/01/94] (Auth: HRS §346-14; 42 U.S.C. §431.10) (Imp: 42 U.S.C. §§1396a(a)(10)(A)(i)(II), 1396d(q))

§§17-1722-6 to 17-1722-8 (Reserved).

SUBCHAPTER 3

QUALIFIED MEDICARE BENEFICIARIES

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§17-1722-9 Purpose. The purpose of this subchapter is to establish the requirements for eligibility of qualified medicare beneficiaries and limitations of coverage for that assistance group. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §435.10) (Imp: 42 U.S.C. §1396d(p))

§17-1722-10 Eligibility requirements. A "qualified medicare beneficiary" shall meet all of the conditions as follows:

- (1) Entitled to hospital insurance benefits under the medicare program;
 - (2) In receipt of income which does not exceed the federal poverty limit;
 - (3) In possession of assets which do not exceed two hundred per cent of 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 legal resident 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 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §435.10) (Imp: 42 U.S.C. §1396d(p))

§17-1722-11 Treatment of income and assets. The income and assets of a qualified medicare beneficiary shall be treated like the aged and disabled individuals in the medical assistance only program, as specified in chapters 17-1721 and 17-1725, with the exceptions of sections 17-1722-10(2) and (3). [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §435.10) (Imp: 42 U.S.C. §1396d(p))

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§17-1722-12 Limitations of coverage.

Individuals eligible under this subchapter shall be limited to coverage of the premiums, deductibles, and co-insurance amounts under the Medicare Part A and B. [Eff 08/01/94; am 12/26/05] (Auth: HRS §346-14; 42 C.F.R. §435.10) (Imp: 42 U.S.C. §1396d(p); Pub. L. 108-173)

§17-1722-13 Effective date of coverage. (a)

Coverage as a qualified medicare beneficiary begins on the first day of the month after the month in which determination of eligibility is made.

(b) The three-month retroactive coverage provisions for normal medical assistance coverage does not pertain to qualified medicare beneficiary coverage. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §435.10) (Imp: 42 U.S.C. §1396d(p))

§§17-1722-14 to 17-1722-16 (Reserved).

SUBCHAPTER 4

SPECIFIED LOW INCOME MEDICARE BENEFICIARIES

§17-1722-17 Purpose. The purpose of this subchapter is to establish the requirements for eligibility of specified low income medicare beneficiaries and the limitations of coverage for that assistance group. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §435.10) (Imp: 42 U.S.C. §1396a(a)(10)(E))

§17-1722-18 Eligibility requirements. Effective January 1, 1993, a specified low income medicare beneficiary shall meet all of the conditions as follows:

- (1) Entitled to hospital insurance benefits under the medicare program;
- (2) In receipt of income which does not exceed one hundred ten per cent of the federal poverty limit in 1993 and 1994, and one hundred twenty per cent in 1995 and beyond;

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- (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 legal resident 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 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §435.10) (Imp: 42 U.S.C. §§1396a(a)(10)(E), 1396d(p))

§17-1722-19 Treatment of income and assets. The income and assets of a specified low income medicare beneficiary shall be treated like the aged and disabled individuals in the medical assistance only program, as specified in chapters 17-1721 and 17-1725, with the exception of section 17-1722-18(2) and (3).
[Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §435.10) (Imp: 42 U.S.C. §§1396a(a)(10)(E), 1396d(p))

§17-1722-20 Limitations of coverage. Individuals eligible under this subchapter shall be limited to the payment of the medicare supplemental medical insurance premium. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §435.10) (Imp: 42 U.S.C. §1396a(a)(10)(E))

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

§§17-1722-22 to 17-1722-24 (Reserved).

SUBCHAPTER 5

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QUALIFIED DISABLED AND WORKING INDIVIDUALS

§17-1722-25 Purpose. The purpose of this subchapter is to establish the requirements for eligibility of qualified disabled and working individuals and limitations of coverage for that assistance group. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §435.10) (Imp: 42 U.S.C. §1396a(a)(10)(E))

§17-1722-26 Eligibility requirements. A "qualified disabled and working individual" shall meet all of the following requirements:

- (1) Entitled "to enroll" for hospital insurance benefits under Part A of Medicare based on 42 U.S.C. §1395i-2(a) which requires that the individual:
 - (A) Is not yet sixty-five years of age;
 - (B) Has been entitled to Social Security disability insurance benefits;
 - (C) Continues to have a disabling physical or mental condition;
 - (D) Is found to be ineligible for continued Social Security disability insurance benefits due to earnings exceeding the substantial gainful activity (SGA) limits; and
 - (E) Is not otherwise entitled to Medicare.
- (2) Is in receipt of income which does not exceed two hundred per cent of the official poverty line, as established by the Office of Management and Budget, applicable to a family of the size involved;
- (3) In possession of assets which do not exceed two hundred per cent of the personal reserve allowed under the supplemental security income program;
- (4) Required to meet basic eligibility conditions, as follows:
 - (A) A resident of the State of Hawaii;
 - (B) A citizen of the United States or a legal resident alien;
 - (C) Not a resident of a public institution;
 - (D) Assign to the department any benefits from a third party for coverage of medical costs paid by the department; and

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- (E) Furnish a social security number and verification of that number; and
- (5) Not otherwise eligible for medical assistance under Title XIX. [Eff 08/01/94]
(Auth: HRS §346-14; 42 C.F.R. §435.10)
(Imp: 42 U.S.C. §1396a(a)(10)(E))

§17-1722-27 Treatment of income and assets. The income and assets of a qualified disabled and working individual shall be treated like that of aged and disabled individuals in the medical assistance program, as specified in chapters 17-1721 and 17-1725, with the exception of section 17-1722-26(2) and (3).
[Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §435.10) (Imp: 42 U.S.C. §1396 a(a)(10)(E))

§17-1722-28 Limitations of coverage. Individuals eligible under this subchapter shall only be entitled to coverage of the premiums for hospital insurance coverage under the medicare program.
[Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §435.10) (Imp: 42 U.S.C. §1396a(a)(10)(E))

§17-1722-29 Effective date of coverage. Coverage under the provisions of this subchapter 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. [Eff 08/01/94] (Auth: HRS §346-14; 42 C.F.R. §435.10) (Imp: 42 U.S.C. §1396a(a)(10)(E))

§§17-1722-30 to 17-1722-32 (Reserved).

SUBCHAPTER 6

MEDICAL PAYMENTS FOR PENSIONERS

§17-1722-33 Purpose. The purpose of this subchapter is to establish the program of medical coverage of persons receiving pensions or retirement payments from the state or counties of Hawaii.

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[Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §88-4)

§17-1722-34 Definitions. For the purpose of this subchapter:

"Actually" means truly and in fact.

"Pensioner" means those persons who are receiving pensions or retirement payments from the State or counties of the State.

"Solely" means only or purely.

"Third party resource" means any resource or benefits from any source to which an eligible person may be entitled. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §§88-4, 346-14)

§17-1722-35 Eligibility requirements. (a) A pensioner, a pensioner's spouse, or a pensioner's surviving spouse shall be eligible for coverage of medical services by meeting any of the following conditions.

- (1) The pensioner and the pensioner's spouse, if any, are actually and solely dependent on the state or county pension for maintenance and support;
- (2) The pensioner and the pensioner's spouse, if any, have total income from all sources, including the pension, social security benefits, interest and dividends, and any income of the spouse, of less than \$2,400;
- (3) The spouse of a pensioner is currently eligible for coverage of medical care under this subchapter; or
- (4) The spouse of a deceased pensioner who was or would have been eligible under this subchapter remains unmarried.

(b) The following persons shall not be eligible under this program:

- (1) Dependent children of eligible pensioners;
- (2) Divorced or separated spouses of pensioners; and
- (3) Parents or other non-spousal relatives of pensioners.

(c) Resources including, but not limited to savings, real property, medical benefit plans, bonds, stocks, insurance, and automobiles, shall not be taken into consideration in determining the pensioner's eligibility for coverage of medical care, under the

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provisions of this subchapter. [Eff 08/01/94]
(Auth: HRS §346-14) (Imp: HRS §88-4)

§17-1722-36 Treatment of income and assets. An eligible pensioner and the pensioner's spouse, if any, shall not be required to use any portion of the pensioner's or the pensioner's spouse's income or resources to meet medical costs covered under the provisions of this subchapter. [Eff 08/01/94]
(Auth: HRS §346-14) (Imp: HRS §88-4)

§17-1722-37 Limitations of coverage. (a) Eligible pensioners and pensioners' spouses shall be entitled to all health care coverage provided to medical assistance recipients, except for:

- (1) Payment of health insurance premiums payments, including that of medicare; and
- (2) Coverage of the portion of medical care expenses paid by a third party.

(b) Medical payments assistance for services covered by the department's medical assistance program shall be made available to eligible pensioners and pensioners' eligible spouses conditioned upon prior authorization for certain elective medical services, third party resources, and established payment practices in the medical assistance program.
[Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §88-4)

§17-1722-38 Application for payment of medical services. (a) A pensioner or a surviving spouse shall sign an application form as a condition for approval of the application.

(b) A relative, friend, or a designee may be asked to complete and sign the application form on behalf of a pensioner or spouse when the pensioner or spouse is determined by the department to be unable to do so. [Eff 08/01/94] (Auth: HRS §346-14)
(Imp: HRS §346-14)

§17-1722-39 Eligibility review. Eligibility reviews shall be conducted every six months or at intervals determined necessary by the eligibility worker. [Eff 08/01/94] (Auth: HRS §346-14)
(Imp: HRS §346-14)

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§§17-1722-40 to 17-1722-42 (Reserved).

SUBCHAPTER 7

CHILD WELFARE MEDICAL

Repealed

§§17-1722-43 to 17-1722-49 REPEALED. [Eff 08/01/94;
R 01/29/96]

§§17-1722-50 to 17-1722-55 (Reserved).

SUBCHAPTER 8

SPECIAL GROUP FOR INDIVIDUALS FORMERLY COVERED BY SHIP

§17-1722-56 Purpose. The purpose of this subchapter is to establish the eligibility requirements for a special group comprised of individuals who were enrolled the state health insurance program who were not eligible for inclusion in the Hawaii Med-QUEST program, and the coverage and limitations of coverage for that group. [Eff 11/13/95] (Auth: HRS §§346-14, 431N) (Imp: HRS §§346-14, 431N)

§17-1722-57 Definitions. For the purposes of this subchapter:

"Cost share" means the monthly payment a member, whose income exceeds one hundred per cent of the FPL, must remit to the department to be eligible for medical assistance in the special group;

"Department" means the department of human services;

"Dependent child" means an individual's natural child, stepchild, legally adopted child, hanai child, who is unmarried and under age nineteen, or unmarried and incapable of support due to mental or physical handicap incurred prior to age nineteen, and is wholly dependent on the individual or the individual's spouse for support and resides in the same dwelling place;

"Disqualification" means the loss of eligibility in the special group;

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"Member" means an individual who meets all eligibility requirements of the special group, and for whom all applicable expenditure shares have been paid;

"Family unit" means an individual, or the individual's spouse and the individual's dependent children all of whom reside together in a common dwelling place;

"FPL" means the federal poverty limit that is annually established by the U.S. Department of Health and Human Services;

"SHIP" means the discontinued state health insurance program that was administered by the department of health;

"Special group" means the grandfathered coverage group that was established to provide health coverage for individuals who were eligible for SHIP who could not participate in QUEST.

"State fiscal year" means the period July 1 through the following June 30 of consecutive calendar years. [Eff 11/13/95; am 01/29/96] (Auth: HRS §§346-14, 431N) (Imp: HRS §§346-14, 431N)

§17-1722-58 Eligibility requirements. (a) Members of this group must have been eligible for SHIP as of July 31, 1994 and would have maintained continued eligibility except for the discontinuance of SHIP, and were not eligible for inclusion in QUEST as of August 1, 1994.

(b) A member of this group shall:

- (1) Be a resident of the State of Hawaii who is a citizen of the United States or a legal resident alien;
- (2) Not be entitled to benefits under the medicaid program with the exception of those whose eligibility is dependent on a spenddown of income;
- (3) Not be entitled to insurance benefits under the Medicare program;
- (4) Not be entitled to coverage under CHAMPUS or another federally sponsored program except for benefits under the native Hawaiian Health Care Act;
- (5) Not be entitled for insurance benefits under the Hawaii Prepaid Health Care Act; and
- (6) Not have income exceeding three hundred percent of the FPL.

(c) An exception to subparagraph (b) (6) are state emergency appointments and their families who are

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ineligible for health insurance coverage through the employer.

(d) Any break in eligibility shall cause permanent exclusion from this group. [Eff 11/13/95] (Auth: HRS §§346-14, 431N) (Imp: HRS §§346-14, 431N)

§17-1722-59 Personal reserve standards. There are no personal reserve standards for individuals in the special group. [Eff 11/13/95] (Auth: HRS §§346-14, 431N) (Imp: HRS §§346-14, 431N)

§17-1722-60 Treatment of income. (a) The gross income of members in the family unit will be considered in determining eligibility, whether or not all family members are eligible for special group benefits.

(b) Income that can be used for the maintenance and support of the family members includes, but is not limited to:

- (1) Earned income from wages, salaries, tips, or commissions;
- (2) Net income from self-employment or rentals;
- (3) Interest income;
- (4) Royalties and dividends;
- (5) Pensions;
- (6) Social Security benefits;
- (7) SSI;
- (8) UIB;
- (9) TDI and workers' compensation; and
- (10) Monetary contributions and gifts.

(c) Gross family income shall be compared to the FPL for the family size. [Eff 11/13/95] (Auth: HRS §§346-14, 431N) (Imp: HRS §§346-14, 431N)

§17-1722-61 Eligibility review. (a) Eligibility reviews shall be conducted annually or at intervals determined necessary by the department.

(b) Individuals who fail to complete or fail to cooperate in the completion of the eligibility review shall be ineligible for benefits under this group. [Eff 11/13/95] (Auth: HRS §§346-14, 431N) (Imp: HRS §§346-14, 431N)

§17-1722-62 Verification and reporting requirements. (a) The department may require

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individuals to furnish verification of eligibility factors.

(b) Individuals shall furnish the requested information within ten days of the request.

(c) Individuals who fail to respond within ten days shall be given a second notice with a request to furnish the information within five days.

(d) Failure to respond to the second notice shall result in disqualification.

(e) Individuals are required to report to the department any changes that would affect their eligibility or monthly cost share responsibility within ten days. [Eff 11/13/95] (Auth: HRS §§346-14, 431N) (Imp: HRS §§346-14, 431N)

§17-1722-63 Disqualification. (a) Individuals may be disqualified from the special group for the following reasons:

- (1) Failure to meet the eligibility requirements of section 17-1722-58;
- (2) Request for disqualification by the individual;
- (3) Failure to recertify as provided in section 17-1722-61;
- (4) Failure to provide requested verification of eligibility factors as provided in section 17-1722-62;
- (5) Failure to pay the required cost share for two consecutive months.

(b) Disqualified individuals will be given a ten day advance notice of disqualification. The notice must specify the effective date of disqualification, the reason for disqualification, and procedures to appeal the disqualification.

(c) If an appeal is requested prior to the effective date of the disqualification, the disqualification will be stayed pending the outcome of the appeal, provided the individual otherwise remains eligible and makes all required cost share payments.

(d) The procedures for administrative hearings specified in chapter 17-1703 shall apply. [Eff 11/13/95] (Auth: HRS §§346-14, 431N) (Imp: HRS §§346-14, 431N)

§17-1722-64 Cost share. (a) Individuals shall be responsible for paying a monthly cost share according to a schedule established by the department. The

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amount of the cost share will be based on the gross family income and the number of family members.

(b) The monthly cost share for members with income less than three hundred per cent of the FPL is as follows:

<u>POVERTY LEVEL</u>	<u>COST SHARE</u>
100% or less	\$0
101% - 125%	\$10
126% - 150%	\$15
151% - 200%	\$20
201% - 250%	\$40
251% - 300%	\$60

(c) State emergency appointees and their eligible family members in the special group with income exceeding three hundred per cent of the FPL shall pay \$73.50 in monthly cost share per family member.

(d) The cost share shall be paid to the department by the tenth day of the benefit month.

(e) A member who fails to to pay the cost share for two consecutive months shall be disqualified.

[Eff 11/13/95] (Auth: HRS §§346-14, 431N)
(Imp: HRS §§346-14, 431N)

§17-1722-65 Covered services. (a) Inpatient hospital care shall be limited to five days per state fiscal year per individual for the following services:

- (1) Semi-private room and board and general nursing care;
- (2) Intensive care room and board and general nursing care;
- (3) Use of operating room and related facilities, labor and delivery room, inpatient anesthesia, radiology, laboratory and other diagnostic services agreed upon by the director;
- (4) Drugs and medications administered while an inpatient;
- (5) Medically necessary dressings, casts, blood derivatives and their administration, and general medical supplies; and
- (6) Five inpatient physician visits per fiscal year.

(b) Physician office visits, including diagnosis and treatment, consultations, and second opinions are limited to twelve visits per fiscal year. Excluded from this limitation are adult health assessments and bona fide emergency room visits.

(c) Maternity care is limited to the following:

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- (1) An all-inclusive fee that includes outpatient diagnostic tests, prenatal care, delivery, postpartum care, and complications of pregnancy; and
- (2) Two inpatient maternity days per fiscal year that will not count as an inpatient day in subsection (a) of this section.
- (d) Ambulatory surgical care is limited to three procedures per year and must be for medically necessary care and not excluded in sections 17-1722-66 and 17-1737-84.
- (e) Preventative services shall include:
 - (1) Health assessments comprised of services and tests appropriate to the age and sex of the individual; and
 - (2) Immunizations for diphtheria, measles, mumps, rubella, whooping cough, polio, tetanus, influenza/pneumovex, hemophilus, influenza, cholera, typhoid and typhus.
- (f) Emergency care is restricted by the following guidelines:
 - (1) Coverage is limited to those medical conditions manifesting in acute symptoms of such severity that the absence of medical attention could reasonably be expected to result in placing the enrollee's health in serious jeopardy, or serious impairment to bodily functions, or serious dysfunction of any body organ or part; and
 - (2) The need for emergency service shall be substantiated with appropriate documentation from the enrollee's medical record or a report from a hospital or treating physician;
- (g) Three mental health visits, to include alcohol or drug dependency conditions, per fiscal year, with one treatment per day.
- (h) The department shall not be responsible to pay for services that are not described in this section.
- (i) The department will only pay for services described in this section that are also allowable under chapter 17-1737.
- (j) Services to be provided by medicaid providers described in chapter 17-1736, and reimbursement for services will be based on the medicaid reimbursement schedule. [Eff 11/13/95] (Auth: HRS §§346-14, 431N) (Imp: HRS §§346-14, 431N)

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§17-1722-66 Excluded services. The department will not be responsible to pay for the following medical services or conditions:

- (1) Custodial or domiciliary care;
- (2) Charges for care in intermediate care or skilled nursing facilities or intermediate care facilities for the mentally retarded;
- (3) Personal or comfort items as television, telephone, guest trays, or a private room in a hospital unless deemed medically necessary by the treating physician;
- (4) Emergency facility services for non-emergency conditions;
- (5) Medical, surgical or other health care procedures, services, drugs or devices that are considered experimental or investigational;
- (6) Transplant and open heart surgery procedures and coverage of organ donor services;
- (7) Prescription and non-prescription drugs and hormones and their administration, except those provided as an inpatient hospital service;
- (8) Sex change operations, investigation of and treatment for infertility, reversal of sterilization, artificial insemination, in vitro fertilization, and contraceptive supplies and devices;
- (9) Vision care services to include eyeglasses, contact lenses, routine eye examinations, including eye refraction, except as provided as part of routine health assessments;
- (10) Hearing aids, prosthesis, orthopedic shoes, routine foot care;
- (11) Purchase or rental of hearing aids or durable medical equipment, including, but not limited to hospital beds, wheel chairs, walk-aids, or other medical equipment not specifically listed as a covered service, except as used while in the hospital;
- (12) Dental services for temporomandibular joint problems, except for repair necessitated by accidental injury to sound natural teeth or jaw provided such repair commences within ninety days of an accidental injury or as soon as medically feasible, and provided that the individual is eligible for covered services at the time services are provided and at the time of the accident;

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- (13) Orthopedic services and supplies;
- (14) Biofeedback and acupuncture;
- (15) Obesity treatment and weight loss programs;
- (16) Medical services rendered outside the state;
- (17) Services which are not medically necessary to diagnose, treat, or to improve the functioning of a malformed body member, even though such services are not specifically listed as exclusions;
- (18) Cosmetic surgery, including treatment for complications of cosmetic surgery;
- (19) Reconstructive surgery for congenital or acquired conditions that do not involve severe functional impairment including but not limited to keloids, mammoplasty except for radical mastectomy, deviated septum for which psychological or psychiatric impairment alone shall not be a sufficient basis for reconstructive surgery;
- (20) Medical services received and paid for by the Veterans Administration;
- (21) Medical services that are payable under the terms of worker compensation, automobile medical and no-fault, underinsured or uninsured motorist, or similar contract of insurance;
- (22) Conditions resulting from acts of war, declared or not;
- (23) Transportation to medical providers to include ambulance services;
- (24) Hospice services;
- (25) Early and Periodic Screening Diagnostic and Treatment (EPSDT) services;
- (26) Outpatient renal services;
- (27) Case management services;
- (28) Personal care services;
- (29) Private duty nursing and medical social worker services;
- (30) Services provided by the community long term care branch;
- (31) Home Health Agency (HHA) services;
- (32) Targeted case management services;
- (33) State funeral payments services;
- (34) Adult day health services;
- (35) Chore services;
- (36) Any service excluded by medicaid under chapter 17-1737; or

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- (37) Services not provided by medicaid providers.
[Eff 11/13/95] (Auth: HRS §§346-14,
431N) (Imp: HRS §§346-14, 431N)

§§17-1722-67 to 17-1722-68 (Reserved).

SUBCHAPTER 9

QUALIFYING INDIVIDUALS

§17-1722-69 Purpose. The purpose of this subchapter is to establish the requirements for eligibility of a qualifying individual effective January 1, 1998 and the limitations of coverage for this group. [Eff 05/02/98] (Auth: HRS §346-14; 42 C.F.R. §435.10) (Imp: 42 U.S.C. §1396a(a)(10)(E))

§17-1722-70 Eligibility requirements. A qualifying individual shall be:

- (1) Entitled to hospital insurance benefits under the medicare program;
 - (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 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] (Auth: HRS §346-

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14; 42 C.F.R. §435.10) (Imp: 42 U.S.C. §§1396a(a)(10)(E), 1396d(p))

§17-1722-71 Treatment of income and assets. The income and assets of a qualifying individual shall be treated like an aged or disabled individual in the medical assistance only program, as specified in chapters 17-1721 and 17-1725, with the exception of the income and personal reserve standards.

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

§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 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 supplemental medical insurance premium caused by the shifting of certain home health services from the medicare hospital insurance.

(b) A qualifying individual who receives assistance one month in a calendar year is eligible for coverage for the remaining balance of calendar year, provided all other eligibility requirements are met.

(c) Coverage under this subchapter is for a five year period from 1998 through 2002 and subject to allocation of funding for each calendar year.

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

§17-1722-73 Limit on the number of eligible individuals. (a) Participation in this group shall be limited in each calendar year to the estimated number of eligible qualifying individuals whose aggregate amount of assistance does not exceed the allocation of funds for that calendar year.

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(b) For the calendar year 1998, eligible qualifying individuals shall be provided assistance in the order in which they apply for assistance up to the estimated limit in subsection (a).

(c) For calendar years after 1998, the following individuals shall be given preference for participation providing they were eligible for coverage in the last month of the previous year and who continue to be or become qualifying individuals:

- (1) A qualifying individual;
- (2) A qualified medicare beneficiary;
- (3) A specified low income medicare beneficiary;
- or
- (4) A qualified disabled and working individual.
[Eff 05/02/98] (Auth: HRS §346-14;
42 C.F.R. §435.10) (Imp: 42 U.S.C.
§1396a(a)(10)(E))

§17-1722-74 Effective date of coverage. Coverage as a qualifying individual begins in the month in which eligibility starts. [Eff 05/02/98] (Auth: HRS §346-14; 42 C.F.R. §435.10) (Imp: 42 U.S.C. §1396a(a)(10)(E))

§§17-1722-75 to 17-1722-77 (Reserved).

SUBCHAPTER 10

MEDICAL ASSISTANCE FOR DISABLED CHILDREN

WHO LOSE SSI BENEFITS

§17-1722-78 Purpose. The purpose of this subchapter is to establish the requirements for eligibility of disabled children who lose SSI benefits because of provisions of the Personal Responsibilities and Work Opportunity Reconciliation Act of 1996. [Eff 05/02/98] (Auth: HRS §346-14; 42 C.F.R. §435.10) (Imp: 42 U.S.C. §1396a(a)(10)(A)(i)(II))

§17-1722-79 Eligibility requirements. Effective July 1, 1997, a disabled child eligible for this group shall meet all of the following conditions:

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- (1) The child lost SSI benefits because of the enactment of section 211(a) the Personal Responsibilities and Work Opportunity Reconciliation Act of 1996;
- (2) The child would continue to be be eligible for SSI but for the enactment of that section; and
- (3) The child shall 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 legal resident 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] (Auth: HRS §346-14; 42 C.F.R. §435.10) (Imp: 42 U.S.C. §1396a(a)(10)(A)(i)(II))

§17-1722-80 Treatment of income and assets. The income and assets of a child in this group shall be treated like an aged or disabled individual in the medical assistance only program, as specified in chapters 17-1721 and 17-1725. [Eff 05/02/98] (Auth: HRS §346-14; 42 C.F.R. §435.10) (Imp: 42 U.S.C. §1396a(a)(10)(A)(i)(II))

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

§17-1722-82 Effective date of coverage. Coverage under this group shall begin in the month in which eligibility starts. [Eff 05/02/98] (Auth: HRS §346-14; 42 C.F.R. §435.10) (Imp: 42 U.S.C. §1396a(a)(10)(A)(i)(II))

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§§17-1722-83 to 17-1722-85 (Reserved).

SUBCHAPTER 11

LOW INCOME SUBSIDY PROGRAM

§17-1722-86 Purpose. The purpose of this subchapter is to establish the requirements for the Low Income Subsidy program which provides assistance with the full or partial costs related to Medicare part D. Individuals who are deemed eligible shall automatically be enrolled into the Low Income Subsidy program while individuals who are not deemed eligible must apply for this extra benefit. [Eff 12/26/05] (Auth: HRS §346-14) (Imp: 42 C.F.R. §423.774; 423.904; Pub. L. 108-173)

§17-1722-87 Definitions. For the purpose of this subchapter:

"CMS" means the Centers for Medicare and Medicaid Services.

"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.

"Deemed eligible" means an individual who is automatically eligible for the Low Income Subsidy program. These individuals are those who are:

- (1) Eligible for both Medicare and Medicaid;
- (2) Supplemental security income recipients; or
- (3) Eligible for the Medicare savings programs.

"FPL" means the federal poverty level.

"Full benefit dual eligible" means an individual who is eligible for both Medicare and Medicaid.

"LIS" means the Low Income Subsidy program that assists with the cost of the monthly premiums and cost-sharing related to Medicare Part D.

"Low income benchmark premium amount" means the minimum monthly premium that is charged for the standard prescription drug coverage under Part D by the CMS approved prescription drug plans.

"Medicare savings programs" means the QMB, SLMB and the QI programs.

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"MMA" means the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

"Non-dual eligible" means an individual who does not meet the definition of a full benefit dual eligible.

"Non-deemed eligibles" means individuals who are not automatically eligible and must apply for the low income subsidy assistance.

"PACE" means a Program of All-Inclusive Care for the Elderly authorized by the Balanced Budget Act of 1997 that provides a comprehensive service delivery system.

"SSA" means the Social Security Administration.

"SSI" means the Supplemental Security Income program that provides cash assistance to eligible beneficiaries. [Eff 12/26/05] (Auth: HRS §346-14) (Imp: 42 C.F.R. §423.774; 423.904; Pub. L. 108-173)

§17-1722-88 Application and eligibility determination for the LIS. Individuals may apply for the LIS and have their eligibility determined by the department by submitting an application on a form designated by the SSA upon request. [Eff 12/26/05] (Auth: HRS §346-14) (Imp: 42 C.F.R. §423.774; 423.904; Pub. L. 108-173)

§17-1722-89 Eligibility requirements.
Individuals who are eligible for the LIS shall:

- (1) Have Medicare coverage;
- (2) Have income as evaluated under SSI regulations in 20 C.F.R. Part 416 Subparts K and L that does not exceed one hundred fifty percent of the FPL for the family of applicable size;
- (3) Have resources as evaluated under SSI regulations in 20 C.F.R. Part 416 Subparts K and L that do not exceed the resource requirement under the MMA;
- (4) Be a resident of the State;

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- (5) Not be an inmate of a public institution; and
- (6) Not be enrolled in PACE. [Eff 12/26/05]
(Auth: HRS §346-14) (Imp: 42 C.F.R.
§423.774; 423.904; Pub. L.
108-173)

§17-1722-90 Benefits of the LIS program. The LIS program provides full or partial assistance with the subsidy for the coverage of the monthly premiums and cost-sharing related to Medicare part D to individuals based on the countable income of their households:

- (1) Full benefit dual eligible individuals with countable income up to one hundred percent of the FPL shall be responsible for:
 - (A) The portion of the premium that exceeds the low income benchmark premium amount for basic coverage; and
 - (B) Co-payments.
- (2) Full benefit dual eligible individuals above one hundred percent of the FPL, Medicare Savings Program beneficiaries, SSI recipients, and non-dual eligible individuals with countable income that does not exceed one hundred thirty-five percent of the FPL shall be responsible for:
 - (A) The portion of the premium that exceeds the low income benchmark premium amount for basic coverage; and
 - (B) Co-payments.
- (3) Non-dual eligible individuals with income that exceeds one hundred thirty-five percent but does not exceed one hundred fifty percent of the FPL shall be responsible for:
 - (A) The portion of the monthly low income benchmark premium amount based on a sliding scale;
 - (B) A deductible;
 - (C) The co-insurance portion incurred with the Part D coverage gap; and
 - (D) Co-payments.
- (4) Full benefit dual eligible individuals who are residing in a medical institution will not be subject to any cost-sharing related to Medicare part D. [Eff 12/25/06] (Auth:

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HRS §346-14) (Imp: 42 C.F.R. §423.774;
423.904; Pub. L. 108-173)

§17-1722-91 Eligibility redeterminations. (a)
Eligibility redeterminations for individuals for whom
the LIS determination was made by the State shall be
completed annually on a form designed by SSA.

(b) Individuals who fail to complete or fail to
cooperate in the completion of the eligibility
redetermination shall be ineligible for benefits under
the LIS. [Eff 12/26/05] (Auth: HRS §346-14)
(Imp: 42 C.F.R. §423.774; 423.904; Pub. L. 108-173)

§17-1722-92 Reporting requirements. Individuals
who are deemed eligible are required to report changes
in circumstances to the department within ten working
days from the date of the change which may affect their
eligibility for the subsidy or the level of subsidy.
[Eff 12/26/05] (Auth: HRS §346-14) (Imp: 42
C.F.R. §423.774; 423.904; Pub. L. 108-173)

§17-1722-93 Termination of LIS benefits.
Benefits for the LIS shall be terminated effective the
first day of the month following the month in which the
recipient is found ineligible if the conditions of
adverse notice are met in accordance with chapter 17-
1713. Reasons for termination include, but are not
limited to, the following:

- (1) Loss of Medicare eligibility;
 - (2) An eligibility redetermination is not
completed as the recipient failed to provide
the department with requested verification or
provide a completed eligibility
redetermination form;
 - (3) Loss of residency;
 - (4) Inmate of a public institution; or
 - (5) Enrollment in PACE.
- [Eff 12/26/05] (Auth: HRS §346-14)
(Imp: 42 C.F.R. §423.774; 423.904; Pub. L.
108-173)

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§17-1722-94 Appeals and hearings. All beneficiaries for whom adverse actions were taken for the LIS by the State shall be entitled to the appeal process of chapter 17-1703. [Eff 12/26/05]
(Auth: HRS §346-14) (Imp: 42 C.F.R. §423.774; 423.904; Pub. L. 108-173)

§§17-1722-95 to 17-1722-115 (Reserved).

SUBCHAPTER 12

STATE PHARMACY ASSISTANCE PROGRAM

§17-1722-116 General Provisions. (a) This subchapter describes the eligibility requirements for participation in the state pharmacy assistance program. This program may pay all, or some of, the required co-payments for prescriptions under Medicare Part D to certain elderly and disabled individuals and facilitate the enrollment and coordination of benefits between the state pharmacy assistance program and the Medicare Part D Prescription Drug Benefit Program provided by the federal MMA.

(b) The department shall work with any CMS approved prescription drug plan to provide the coordination of benefits between the state pharmacy assistance program and the Medicare Part D Prescription Drug Benefit Program.

(c) The program shall conduct ongoing quality assurance activities determined by the department.

(d) The provisions of chapter 1702 addressing confidentiality shall apply to this program.

(e) The provisions of chapter 1703 addressing administrative appeals shall apply to this program. However, in applying chapter 1703 to this program, the terms "eligibility branch," "eligibility branch administrator," "med-QUEST eligibility office," and "eligibility worker" in chapter 1703 shall be replaced by the term "med-QUEST division staff or their designee."

(f) The provisions of chapter 1704 addressing fraud shall apply to this program. However, in applying chapter 1704 to this program, the terms "medical assistance" and "Medicaid" in chapter 1704

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shall be replaced by the term "state pharmacy assistance program."

(g) The provisions of subchapter 7 of chapter 1705 addressing recipient recovery shall apply to this program. However, in applying subchapter 7 to this program, the term "medical assistance" in subchapter 7 of chapter 1705 shall be replaced by the term "state pharmacy assistance program."

(h) This program shall be administered by the med-QUEST division and contractors identified by the department of human services for the purposes of this program. [Eff 12/29/05] (Auth: SLH 2005, Act 209) (Imp: SLH 2005, Act 209)

§17-1722-117 Definitions. For the purpose of this chapter:

"CMS" means Center of Medicare and Medicaid Services.

"MMA" means the Medicare Prescription Drug, Improvement and Modernization Act of 2003.

"Medicare Part D Prescription Drug Benefit Program" means the federal prescription benefit provided under the Medicare Modernization Act.

"PACE" means a Program of All-Inclusive Care for the Elderly authorized by the Balanced Budget Act of 1997 that provides a comprehensive service delivery system.

"PDP" means prescription drug plan.

"Prescription drug plan" means a plan provided by non-governmental entities under contract with the federal Centers for Medicare and Medicaid Services to provide prescription benefits under the MMA.

"QMB" means Qualified Medicare Beneficiaries".

[Eff 12/29/05] (Auth: SLH 2005, Act 209)
(Imp: SLH 2005, Act 209)

§17-1722-118 Application requirements. (a) Individuals who qualify for medical assistance with income not exceeding one hundred per cent of the federal poverty level and QMB's, shall be automatically eligible.

(b) All other individuals may apply for the state pharmacy assistance program on a form designated by the

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department. [Eff 12/29/05] (Auth: SLH 2005, Act 209) (Imp: SLH 2005, Act 209)

§17-1722-119 Eligibility requirements. An individual shall meet the following requirements to participate in the state pharmacy assistance program:

- (1) Is a resident of Hawaii;
- (2) Receive Medicare Part D Prescription Drug Benefits;
- (3) Has a countable income at or below one hundred per cent of the federal poverty level for a household of applicable size; and
- (4) Meets the asset test in accordance with the low income subsidy program addressed in subchapter 11;
- (5) Is not a member of a retirement plan who is receiving a benefit from the MMA;
- (6) Has public assistance prescription coverage other than Medicare and Hawaii Rx Plus;
- (7) Not be enrolled in PACE; and
- (8) Not be enrolled in a private sector plan or insurance providing payments for prescription drugs. [Eff 12/29/05] (Auth: SLH 2005, Act 209) (Imp: SLH 2005, Act 209)

§17-1722-120 Benefits. (a) For an individual eligible for state pharmacy assistance program, the program may pay all, or some of, the required co-payments under the federal Medicare Part D Prescription Drug Benefit Program.

(b) The state pharmacy assistance program is the payor of last resort. [Eff 12/29/05] (Auth: SLH 2005, Act 209) (Imp: SLH 2005, Act 209)

§17-1722-121 Eligibility reviews. (a) Eligibility reviews shall be conducted at intervals determined necessary by the department.

(b) Individuals who fail to complete or fail to cooperate in the completion of the eligibility review shall be ineligible for benefits under this program. [Eff 12/29/05] (Auth: SLH 2005, Act 209) (Imp: SLH 2005, Act 209)

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§17-1722-122 State pharmacy assistance program card. Program members may be issued a state pharmacy assistance program card from the department or the department's designee. [Eff 12/29/05]
(Auth: SLH 2005, Act 209) (Imp: SLH 2005, Act 209)

§17-1722-123 Quality control reviews. (a) Quality reviews shall be conducted at intervals determined necessary by the department.

(b) Pharmacies or PDP's selected for reviews shall furnish the requested information within ten working days of the request.

(c) Failure to cooperate in the completion of a review shall result in termination from the program. [Eff 12/29/05] (Auth: SLH 2005, Act 209)
(Imp: SLH 2005, Act 209)

§17-1722-124 Reporting requirements. Individuals are required to report changes in circumstances to the department within ten working days from the date of the change which may affect their eligibility. [Eff 12/29/05] (Auth: HRS §346-14; SLH 2005, Act 209)
(Imp: SLH 2005, Act 209)

§17-1722-125 Termination. (a) An individual's participation under this program shall be terminated for any of the following reasons:

- (1) Fails to meet the eligibility requirements set forth in section 17-1722-119.
- (2) The participant no longer resides in the State;
- (3) Has public assistance prescription coverage other than Medicare and Hawaii Rx Plus;
- (4) The participant voluntarily terminates participation in the program;
- (5) The participant failed to recertify;
- (6) The participant failed to cooperate with the quality control reviewer;
- (7) Death of the participating individual; or
- (8) There is insufficient funds in the program

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due to lack of revenues received from rebates paid by pharmaceutical manufacturers.

(b) An individual shall be given a ten day advance notice of termination. The notice must specify the effective date of termination, the reason for termination, and procedures to appeal the termination.

(c) If an appeal is requested prior to the effective date of termination, the termination shall be stayed pending the outcome of the appeal, provided the individual otherwise remains eligible.

[Eff 12/29/05] (Auth: SLH 2005, Act 209) (Imp: SLH 2005, Act 209)

§17-1722-126 Administration of the program. (a) The department may contract with a third party or parties to administer any component of the program, including outreach, eligibility, enrollment, claims, administration, rebate negotiations and recovery, and redistribution, in order to coordinate the prescription drug benefits of the state pharmacy assistance program and the federal Medicare Part D Prescription Drug Benefit Program.

(b) Any third party that contracts with the department to administer any component of the program shall be established either at no cost to the State or on a contingency-fee basis and with no up-front costs to the State.

(c) Any contract to administer any program component shall prohibit the contractor from receiving any compensation or other benefits from any pharmaceutical manufacturer participating in the program. [Eff 12/29/05] (Auth: SLH 2005, Act 209) (Imp: SLH 2005, Act 209)

§17-1722-127 Rebate agreement. (a) A drug manufacturer that sells prescription drugs in the State and who enters into a rebate agreement with the department shall be required to make rebate payments to the department according to a schedule established by the department. (b) The department or its designee shall attempt to obtain a rebate amount that is equal to or greater than the amount of any discount, rebate, or price reduction for prescription drugs provided to

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the federal government pursuant to 42 U.S.C. Section 1396r. [Eff 12/29/05] (Auth: SLH 2005, Act 209) (Imp: SLH 2005, Act 209)

§17-1722-128 Pharmacy or PDP reimbursement. (a) A pharmacy or a PDP shall submit claims to the department or its designee to verify the amount charged to program members. On a schedule to be determined by the department, the department shall reimburse each pharmacy or PDP for the co-payments or any portion thereof charged to, but not collected from, program members.

(b) The department or its designee shall collect prescription drug utilization data necessary to calculate the amount of the manufacturer rebate under section 17-1722-127. The department shall protect the confidentiality of the data as required under State or federal law, rule, or regulation.

(c) The department shall not impose transaction charges on participating pharmacies or PDPs that submit claims or receive payments under the program. [Eff 12/29/05] (Auth: SLH 2005, Act 209) (Imp: SLH 2005, Act 209)

§17-1722-129 State pharmacy assistance program special fund. (a) The state pharmacy assistance program special fund that is established within the State treasury and administered by the department, shall include:

- (1) All moneys received from manufacturers who pay rebates as provided in section 17-1722-127;
 - (2) Appropriations made by the legislature to the fund; and
 - (3) Any other revenues designated for the fund.
- (b) Moneys in this special fund shall be used for the following purposes:
- (1) Reimbursement payments to participating pharmacies for co-payments required under the federal Medicare Part D Prescription Pharmacy Benefit Program as provided to state pharmacy assistance program members; and

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- (2) The administration or operation of the state pharmacy assistance program, including but not limited to, salary and benefits of employees, computer costs, and contracted services as provided in section 17-1722-126;

All interest on special fund balances shall accrue to the special fund. Upon dissolution of the state pharmacy assistance program special fund, any unencumbered moneys in the fund shall lapse to the general fund.

(c) The department shall spend all revenues received from rebates paid by pharmaceutical manufacturers pursuant to section 17-1722-127 to pay for the benefits to enrollees in the state pharmacy assistance program and the costs of administering the program.

[Eff 12/29/05] (Auth: SLH 2005, Act 209) (Imp: SLH 2005, Act 209)

