HAWAII ADMINISTRATIVE RULES

TITLE 17

DEPARTMENT OF HUMAN SERVICES

SUBTITLE 12

MED-QUEST DIVISION

CHAPTER 1728.1

QUEST-ADULT COVERAGE EXPANSION (ACE)

Subchapter 1 General Provisions

Subchapter 2 Freedom Of Choice

Subchapter 3 Eligibility

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SUBCHAPTER 1

GENERAL PROVISIONS

§17-1728.1-1 Purpose. This chapter describes the QUEST-ACE Program that provides medical benefits to childless adults who are unable to enroll in QUEST due to the limitations of the statewide enrollment, as provided in section 17-1727-26. [Eff 05/24/07] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1728.1-2 Definitions. As used in this chapter:

“Aged” means an individual age sixty-five years or older.

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

"Blind" means, in relation to an individual applying for or receiving medical assistance from the department, meeting the Social Security Administration certification requirements for blindness.

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

"Childless adult" means a person who is between age nineteen through sixty-four and is not a child under age twenty-one who is in foster care placement or is covered by a subsidized adoption agreement and does not have a dependent child in the home.

"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 QUEST.

"Dependent child" means a person under age nineteen who is dependent on and living with a parent, caretaker relative, or guardian. A person under age twenty-one who is in foster care placement or covered by a subsidized adoption agreement is also considered a dependent child.

"Disabled" means, in relation to an individual applying for or receiving medical assistance from the department, meeting the Social Security Administration certification requirements for disability.

"Effective date of coverage" means the date on which health care services shall be covered by QUEST-ACE either through fee-for-service reimbursement by the department or its fiscal agent, or through enrollment in a QUEST-ACE health plan.

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

"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 a member of a participating health plan.

"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 assistance programs, general assistance (GA), and the state health insurance program (SHIP).

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

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

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

"Participating health plan" means a health plan contracted by the State to provide medical services, through a managed care system.

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

"Primary care provider" means a physician or a nurse practitioner who is licensed to practice in the State and is contracted by a participating health plan to assess an enrollee's health care needs and provide services to meet those needs either directly or through the plan's provider network. A primary care provider who is a nurse practitioner shall be a family nurse practitioner, pediatric nurse practitioner, or, if the enrollee is a pregnant women, a nurse midwife.

"Premium-share" means that part of the unadjusted contracted rate that certain individuals, based on their income, are required to remit to the department to be eligible to be enrolled in a health plan.

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

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

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

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

"Unadjusted contracted rate" means the monthly payment paid by the State to a participating health plan for each member of the participating health plan assuming the application of risk adjustments across the entire population.

[Eff 05/24/07] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§§17-1728.1-3 to 17-1728.1-5 (Reserved)

SUBCHAPTER 2

FREEDOM OF CHOICE

§17-1728.1-6 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).

(b) In the absence of a choice of 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 05/24/07] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25, 431.51)

§17-1728.1-7 Assigned enrollment in participating health plans. (a) An eligible individual shall be allowed ten days to select an available participating health plan in which to enroll. This provision shall not apply to an individual identified in subsection (c).

(b) If timely selection among available participating health plans is not made, the department

shall assign the enrollment of the individual to a participating health plan.

(c) In the absence of a choice of a participating 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 05/24/07] (Auth: HRS §346-14) (Imp: HRS §346-15; 42 C.F.R. §§430.25, 431.51)

§§17-1728.1-8 to 17-1728.1-10 (Reserved).

SUBCHAPTER 3

ELIGIBILITY

§17-1728.1-11 Purpose. This subchapter describes the eligibility requirements for participation in the QUEST-ACE Program. [Eff 05/24/07] (Auth: HRS §346-14) (Imp HRS §346-14; 42 C.F.R §430.25)

§17-1728.1-12 Basic eligibility requirements. To be eligible for QUEST-ACE, a childless adult shall meet the basic eligibility requirements, which include, but are not limited to, U.S. citizenship or legal resident alien status, state residency, not residing in a public institution, and provision of social security numbers, as described in chapter 17-1714. [Eff 05/24/07] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728.1-13 Categorical eligibility requirements. An applicant for QUEST-ACE shall be a childless adult and meet all of the requirements of the QUEST program set forth in chapter 17-1727, but is unable to enroll in QUEST due to the limitations of the statewide enrollment, as provided in section 17-1727-26. [Eff 05/24/07] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728.1-14 Financial eligibility requirements. (a) A person shall meet the financial eligibility requirements for applicants and recipients of medical

assistance for the Hawaii QUEST program described in chapter 17-1727.

(b) A person whose countable income exceeds the financial assistance payment standard and is equal to or below one hundred per cent of the federal poverty level for a family of applicable size shall be eligible to participate in QUEST-ACE. [Eff 05/24/07] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728.1-15 Treatment of income and assets. (a) When determining financial eligibility for QUEST-ACE, the provisions for treatment of income and assets in the Hawaii QUEST program described in chapter 17-1727 shall apply.

(b) When determining financial eligibility for QUEST-ACE, the definitions of financial support and responsibilities of Hawaii QUEST as described in chapter 17-1727 shall apply.
[Eff 05/24/07] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§§17-1728.1-16 to 17-1728.1-20 (Reserved)

SUBCHAPTER 4

COVERAGE

§17-1728.1-21 Purpose. This subchapter describes the coverage and benefits that will be provided to recipients of the QUEST-ACE program. This subchapter also describes the enrollment provisions of the QUEST-ACE program. [Eff 05/24/07] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728.1-22 Standard benefits package. (a) A participating health plan shall be required to provide the benefits defined in this chapter, which shall be known as the standard benefits package.

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

[Eff 05/24/07] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728.1-23 Hospital services to be covered by the participating health plan. (a) Within a benefit year, a participating health plan shall provide each enrollee no more than ten days of medically necessary inpatient hospital care related to medical care, surgery, psychiatric care, and substance abuse treatment. The following hospital services shall be made available to each enrollee:

(1) Semi-private room and board and general nursing care for inpatient stays related to medical care, surgery, psychiatric care, and substance abuse treatment;
(2) Intensive care room and board and general nursing care for medical care and surgery;
(3) Use of an operating room and related facilities, inpatient anesthesia, radiology, laboratory and other diagnostic services agreed upon by the participating health plan medical director for medical care and surgery;
(4) Drugs, dressings, blood derivatives and their administration, general medical supplies, and diagnostic and therapeutic procedures as prescribed by the attending physician;
(5) Other ancillary services associated with hospital care except private duty nursing; and
(6) Ten inpatient physician visits within a benefit year.

(b) The following services are not included in the standard benefits package: inpatient hospital care related to maternity, newborn nursery, neonatal intensive care, and inpatient services in a freestanding rehabilitation hospital. [Eff 05/24/07] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728.1-24 Outpatient services to be covered by the participating health plan. (a) Within a benefit year, a participating health plan shall provide each enrollee with coverage for the following outpatient services:

(1) A maximum of twelve outpatient visits including adult health assessments, family planning services, diagnosis, treatment, consultations, to include substance abuse treatment, and second opinions. The maximum of twelve outpatient visits shall not pertain to:
    (A) Bonafide emergency room visits.
    (B) An enrollee's first six mental health visits within a benefit year. After the first six mental health visits, an enrollee may choose to apply a maximum of six additional mental health visits toward the maximum of twelve physician outpatient visits.
    (C) Diagnostic testing, including laboratory and x-ray, directly related to a covered outpatient visit.
(2) Coverage of medically necessary ambulatory surgical care shall be limited to three procedures per benefit year.
(3) Maternity care coverage shall be limited to one routine visit to confirm pregnancy and any visits for the diagnosis and treatment of conditions related to medically indicated or elective termination of pregnancy such as ectopic pregnancy, hydatiform mole, and missed, incomplete, threatened, or elective abortions. These visits shall count toward the twelve maximum outpatient visits, ten maximum inpatient days, or three maximum ambulatory surgeries.

(b) An enrollee shall be provided the following health assessments which shall be counted toward the maximum of twelve outpatient physician visits.
(1) An enrollee age twenty-one to thirty-five years old, inclusive, shall be allowed one examination within a period of five benefit years.
(2) An enrollee thirty-six to fifty-five years old, inclusive, shall be allowed one examination within a period of two benefit years.
(3) An enrollee over fifty-five years old shall be allowed one examination within each benefit year.
(4) An annual pap smear for a woman of child bearing age shall be included in the health

assessment for an enrollee age twenty-one or older.

(c) Coverage of immunizations for diphtheria and tentanus shall be provided.

(d) Coverage shall be provided for bonafide emergency room visits including ground ambulance, emergency room services, and physician services in conjunction with the emergency room visits. Bonafide emergency room visits shall be restricted to those requiring services for medical conditions manifesting themselves 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 of bodily functions, or serious dysfunction of any body organ or part.

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

(1) After exhausting the coverage of six mental health visits, an enrollee may use coverage of up to six of the enrollee's twelve outpatient physician visits per benefit year, as available, for additional mental health visits.

(2) Services for alcohol abuse conditions shall be covered as mental health visits. The following restrictions on alcohol and substance abuse treatment apply.

(A) Outpatient alcohol abuse services shall be considered toward the maximum coverage of six mental health visits and six annual outpatient physician office visits if used for additional mental health visits.

(B) Inpatient alcohol abuse services shall be considered toward an enrollee's maximum coverage of ten hospital days.

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

(f) Coverage shall be provided for

over-the-counter and prescription drugs limited by a strict formulary and defined in the contract negotiated between the participating health plans and the department.

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

(h) A participating health plan may, at the plan's option, provide coverage of any service not required by its contract with the department, not covered under this section, or excluded under section 17-1728.1-17.

(i) Except for capitated payments to the plans, the department shall not be responsible for coverage of any service for any adult in QUEST-ACE.

[Eff 05/24/07] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728.1-25 Medical services not available in QUEST-ACE. The following services are not covered benefits under the QUEST-ACE program:

(1) Custodial or domiciliary care;
(2) Services received in skilled nursing facilities, intermediate care facilities, and intermediate care facilities for the mentally retarded;
(3) Personal care items such as shampoos, toothpaste, mouthwashes, denture cleansers, shoes including orthopedic footwear, slippers, clothing, laundry services, baby oils and powders, sanitary napkins, soaps, lip balms, and bandages;
(4) Non-medical items such as books, telephones, electronic transmitting and paging devices, radios, linens, clothing, television sets, computers, air conditioners, air purifiers, fans, household items and furnishings;
(5) Emergency facility services for non-emergencies;
(6) Out-of-state emergency and non-emergency services;
(7) Experimental and investigational services, procedures, drugs, devices, and treatments;

(8) Organ and tissue transplantation and transplantation services for either a recipient or a donor;
(9) Blood, blood products, and blood storage on an outpatient basis;
(10) Gender reassignment and related medical, surgical, and psychiatric services, drugs, and hormones;
(11) In vitro fertilization, reversal of sterilization, artificial insemination, sperm banking procedures, and drugs to test fertility;
(12) Eyeglasses, contact lenses, low vision aids, orthoptic training, and refractions;
(13) Hearing aids and related supplies and services, including fitting for, purchase of, rental of, and insuring of hearing aids;
(14) Durable medical equipment, prosthetic devices, orthotics, medical supplies, and related services including purchases, rental, repairs, and related services, except as supplied as part of an inpatient hospital stay;
(15) All dental services, including orthodontic services and supplies, except emergency dental services as defined in this subchapter;
(16) Biofeedback, acupuncture, naturopathic services, faith healing, Christian Science services, hypnosis, and massage treatment;
(17) Obesity treatment, weight loss programs, food, food supplements, health foods, and prepared formulas;
(18) All services, procedures, equipment, supplies not specifically listed which are not medically necessary;
(19) Cosmetic surgery or treatment, cosmetic rhinoplasties, reconstructive or plastic surgery to improve appearance and not bodily function, piercing of ears and other body areas, electrolysis, hair transplantation, reduction and augmentation mammoplasties, paniculectomies and other body sculpturing procedures, excision or destruction of benign skin or subcutaneous lesions without medical justification;
(20) Transportation, including air (fixed wing or helicopter) ambulances;

(21) Hospice services;
(22) All home health agency services;
(23) Personal care, chore services, adult day health, private duty nursing, social worker services, case management services, targeted case management services, and community care long term care branch services;
(24) Funeral payment services;
(25) Tuberculosis services when provided without cost to the general public;
(26) Hansen's disease treatment or follow-up;
(27) Treatment of persons confined to a public institution;
(28) Penile and testicular prostheses and related services;
(29) Chiropractic services;
(30) Psychiatric care and treatment for sex and marriage problems, weight control, employment counseling, primal therapy, long term character analysis, marathon group therapy, and consortium;
(31) Routine foot care and treatment of flat feet;
(32) Swimming lessons, summer camp, gym membership, and weight control classes;
(33) Outpatient renal dialysis, cardiac and coronary artery surgery involving cardio-pulmonary by-pass, cataract surgery with or without intraoccular lens implants, and refractive keratoplasty;
(34) Physical therapy, occupational therapy, speech therapy, respiratory services, and sleep studies rendered on an outpatient basis;
(35) Medical services provided without charge by any other federal, state, municipal, territorial, or other government agency, including the Veterans Administration;
(36) Medical services for an injury or illness caused by another person or third party from whom the enrollee has or may have a right to recover damages;
(37) Medical services that are payable under the terms of any other group or non-group health plan coverage;
(38) Medical services that do not follow standard medical practice or are not medically necessary;

(39) Stand-by services by a stand-by physician and telephone consultation;
(40) Services provided for illness or injury caused by an act of war, whether or not a state of war legally exists, or required during a period of active duty that exceeds thirty days in any branch of the military;
(41) Treatment of sexual dysfunction including medical and surgical procedures, supplies, drugs, and equipment;
(42) All services excluded by the Hawaii Medicaid Program;
(43) All services not provided by providers licensed or certified in the State of Hawaii to perform the service;
(44) Medical services that are payable under terms of worker compensation, automobile medical and no-fault, underinsured or uninsured motorist, or similar contract of insurance;
(45) Physical examination required for continuing employment, such as taxi driver's or truck driver's licensing, or as required by government or private businesses;
(46) Physical examinations, psychological evaluations, and immunizations as a requirement for licenses or for purposes of securing insurance policies or plans;
(47) Allergy testing and treatment;
(48) Treatment of any complication resulting from previous cosmetic, experimental, or investigative procedures, or any other non-covered service;
(49) Rehabilitation services requiring intensive continuous care, either on an inpatient or outpatient basis, including cardiac, alcohol or drug dependence rehabilitation;
(50) All acne treatment, surgery, drugs for adults; removal or treatment of asymptomatic benign skin lesions or growth; and
(51) Prenatal, postpartum, and delivery services including all laboratory testing in both inpatient and outpatient setting. An exception is one outpatient visit to confirm pregnancy, as identified as a covered service in this chapter. [Eff 05/24/07] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728.1-26 Dental services in QUEST-ACE. (a) Dental services shall be limited to emergency treatments which do not include services aimed at restoring or replacing teeth and shall include services for the following:

(1) Relief of dental pain;

(2) Elimination of infection; and

(3) Treatment of acute injuries to the teeth and supporting structures of the oro-facial complex.

(b) Emergency dental treatment is covered on a fee-for-service basis. [Eff 05/24/07] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728.1-27 Requirements of QUEST-ACE recipients requesting a change in coverage to QUEST or the fee-for-service coverage for the aged, blind and disabled. (a) A QUEST-ACE recipient may verbally request a change in coverage to QUEST or the fee-for-service coverage for the aged, blind and disabled as applicable, provided all conditions of eligibility are met.

(b) The recipient shall have fifteen calendar days to provide a written request to the department for such change in coverage.

(c) Upon the timely submittal of a written request, (i) the date of a verbal request for coverage shall be the effective date of QUEST coverage. (ii) The effective date of fee-for-service coverage shall be the first day of the month in which the verbal request was received.

(d) The request to change health coverage shall be denied if a written request is not received within fifteen calendar days. The recipient's coverage in QUEST-ACE shall continue, if the recipient continues to meet the QUEST-ACE eligibility requirements. [Eff 05/24/07] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§§17-1728.1-28 to 17-1728.1-31 (Reserved).

SUBCHAPTER 5

REIMBURSEMENT

§17-1728.1-32 Reimbursement to participating health plans. Each participating health plan shall be paid a capitated payment, under the contract negotiated with the department, for individuals enrolled in the plan. [Eff 05/24/07] (Auth: HRS §346-14) (Imp: HRS §346-16; 42 C.F.R. §430.25)

§§17-1728.1-33 to 17-1728.1-34 (Reserved).

SUBCHAPTER 6

ENROLLMENT AND DISENROLLMENT

§17-1728.1-35 Enrollment in QUEST-ACE medical plans. (a) After being found eligible for coverage under QUEST-ACE, an individual shall be allowed ten days to select from among the participating health plans available in the service area in which the individual resides. This provision shall not apply to an individual identified in subsection (d).

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

(c) An individual who is disenrolled from a participating health plan shall be allowed to select a plan of their choice:

(1) If disenrollment extends for more than sixty calendar days in a benefit year;

(2) If disenrollment occurred in a period involving the annual open enrollment period; or

(3) If disenrollment includes the first day of a new benefit year.

(d) In the absence of a choice of 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 05/24/07] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25; 431.51)

§17-1728.1-36 Effective date of enrollment. (a) For applicants newly approved for coverage, the

effective date of enrollment shall be one of the following:

(1) The date the enrollment process has been completed to enroll an individual in a participating health plan.

(2) If the applicant is found to be ineligible for the month of application, the first day of the subsequent month in which all eligibility requirements are met by the applicant.

(b) The effective date of enrollment resulting from an open enrollment period shall be implemented effective the first day of the month as determined by the Department and shall generally extend through the following year.

(c) The effective date of enrollment resulting from a change from one plan to another, other than during the open enrollment 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 individual changes residence from one service area to another, the date the enrollment process has been completed to enroll the individual in a participating health plan.

(d) The effective date of enrollment resulting from a change from QUEST-ACE coverage to QUEST is the date the enrollment process has been completed to enroll an individual in a QUEST health plan. [Eff 05/24/07] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25; 431.51)

§17-1728.1-37 Coverage of QUEST-ACE eligibles prior to the date of enrollment. (a) An applicant who is initially determined eligible under QUEST-ACE shall be eligible for coverage of health care costs within the scope of QUEST-ACE coverage by the department on a fee-for-service basis as of the date of coverage through the date of enrollment.

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

(1) The date of application; or

(2) If the applicant is found to be ineligible for the month of application, the first day of the subsequent month on which all

eligibility requirements are met by the applicant.

(c) The provisions of the fee-for-service program as described in chapter 17-1735, 17-1736, and 17-1737 shall apply from the date of eligibility to the date of enrollment for those who are initially determined eligible for QUEST-ACE. [Eff 05/24/07] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728.1-38 Limitations to statewide enrollment in participating health plans. (a) The maximum statewide enrollment in the QUEST-ACE participating health plans shall be twelve thousand enrollees.

(b) The department shall not accept applications for QUEST-ACE coverage when the statewide enrollment as of the last day of the previous calendar year exceeds the maximum allowed by this section.

(c) The department shall accept applications for QUEST-ACE coverage during an open application period to be announced by the department.

(1) Applications received during this open application period shall be processed within each Med-QUEST Division eligibility office in the chronological order of their receipt by the Med-QUEST Division.

(2) Individuals who are found eligible during this open application period shall be enrolled in participating health plans until the maximum enrollment allowed in subsection (a) is reached.

(3) All pending applications received during the open application period shall be discontinued when the maximum enrollment is reached.

(4) The open application period is the only period during which applications shall be accepted from individuals subject to the maximum statewide enrollment provision described in subsection (a). This period shall be established when the statewide enrollment on the last day of the previous calendar year is below ten thousand enrollees. The open application period shall occur in May of the following calendar year. An open application period shall not occur more than once per calendar year.

[Eff 05/24/07] (Auth: HRS §346-14)

(Imp: HRS §346-14; 42 C.F.R. §§430.25, 431.51; 42 U.S.C. §1396u-1)

§17-1728.1-39 Changes from one QUEST-ACE plan to another. (a) The annual QUEST-ACE open enrollment period shall generally occur in May of each calendar year.

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

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

(3) Changes in enrollment resulting from an open enrollment period shall be implemented effective the first day of the month as determined by the Department and shall generally extend to the following year.

(4) In the absence of a choice of plan in a rural service area, an enrollee who resides in that particular service area shall not participate in the annual open enrollment period.

(b) An enrollee shall only be allowed to change from one QUEST-ACE plan to another during the annual QUEST-ACE open enrollment period.

(c) Exceptions to subsection (b) include the following:

(1) Decisions from administrative hearings;

(2) Legal decisions;

(3) Termination of the participating health plan contract;

(4) Mutual agreement by the participating health plans involved, the enrollee, and the department;

(5) Violations by a participating health plan as specified in sections 17-1727-61 and 17-1727-62.

(6) Change of residence by an enrollee from one service area to another and:

(A) The individual shall be allowed ten days to select a health plan servicing the new service area in which the individual resides; and

(B) If a selection is not made within ten days of request, enrollment in a health

plan shall be assigned by the department; or

(7) Other special circumstances as determined by the department. [Eff 05/24/07] (Auth: HRS §346-14) (Imp HRS §346-14; 42 C.F.R. §430.25)

§17-1728.1-40 Financial responsibility of enrollees. An enrollee who is self-employed or is the spouse of a self-employed individual, with the exception of a financial assistance recipient, shall be responsible for a premium-share equal to fifty per cent of the capitated payment made to the enrollee's participating health plan under QUEST-ACE. [Eff 05/24/07] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)

§17-1728.1-41 Disenrollment from QUEST-ACE plans. (a) The department shall have sole authority to disenroll a QUEST-ACE enrollee.

(b) An individual who does not meet the QUEST-ACE eligibility requirements shall be disenrolled from the QUEST-ACE plan in which the individual is enrolled.

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

(1) The enrollee's or family's designated premium-share payments QUEST-ACE coverage is two months in arrears;

(2) To comply with an administrative appeal decision or a court order;

(3) A mutual agreement between the individual, the participating health plan involved, and the department; or

(4) An individual's voluntary withdrawal from participation in QUEST-ACE.

(d) If an enrollee requests disenrollment, the department shall determine whether to allow disenrollment no later than the first day of the second month following the month in which the enrollee made the request. If the department fails to make a determination within the timeframe, the disenrollment is considered approved. [Eff 05/24/07] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25; §438.56)

§17-1728.1-42 Enforcement and termination of contract with participating health plan. The provisions pertaining to enforcement and termination of a contract with a health plan described in chapter 17-1727 shall apply to participating health plans participating in QUEST-ACE. [Eff 05/24/07] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§430.25; 438.708)