NO. 11-15132

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

TONY KORAB, et al.,

Plaintiffs-Appellees,

PATRICIA McMANAMAN, in her official capacity as Director of the State of Hawai'i, Department of Human Services and
KENNETH FINK, in his official capacity as State of Hawai'i, Department of Human Services, Med-QUEST Division Administrator

Defendants-Appellants

On Appeal From the Interlocutory Order Granting a Preliminary Injunction of the United States District Court for the District of Hawai'i
Case No. D.C. No. 1:10-cv-00483-JMS-KSC

ANSWERING BRIEF OF PLAINTIFFS-APPELLEES

CERTIFICATE OF COMPLIANCE

STATEMENT OF RELATED CASES

CERTIFICATE OF SERVICE

Attorneys for Plaintiffs-Appellees	LAWYERS FOR EQUAL JUSTICE VICTOR GEMINIANI 4354-0 P.O. Box 37952 Honolulu, Hawai`i 96837 Telephone: (808) 587-7605 Email: victor@lejhawaii.org

PAUL ALSTON 1126
J. BLAINE ROGERS 8606
ZACHARY A. MCNISH 8588
1001 Bishop Street, Suite 1800
Honolulu, Hawai`i 96813
Telephone: (808) 524-1800
Facsimile: (808) 524-4591
E-mail: palston@ahfi.com;
brogers@ahfi.com; zmcnish@ahfi.com

MARGERY S. BRONSTER 4750
ROBERT M. HATCH 7724
CATHERINE L. AUBUCHON 7661
1003 Bishop Street, Suite 2300
Honolulu, Hawai`i 96813
Telephone: (808) 524-5644
Facsimile: (808) 599-1881
Email: mbronster@bhhawaii.net;
rhatch@bhhawaii.net;
caubuchon@bhhawaii.net

TABLE OF CONTENTS

TABLE OF AUTHORITIES

FEDERAL CASES

STATE CASES

FEDERAL STATUTES

STATE STATUTES

HAWAII ADMINISTRATIVE RULES

ANSWERING BRIEF OF PLAINTIFFS-APPELLEES

I. INTRODUCTION

On December 13, 2010, Plaintiffs-Appellees (the "Class") obtained a preliminary injunction preventing the State of Hawai`i ("State") from denying health care to people from the Marshall Islands, Palau, and the Federated States of Micronesia solely on the basis of alienage. The State now claims that singling out a class of people who are lawfully residing in Hawai`i was lawful. The State is wrong.

As set forth below, the district court correctly held: (1) the State discriminated against the Class on the basis of alienage; (2) the State's actions are subject to strict scrutiny—not rational basis review; and (3) there is no federally-established "uniform rule" shielding the State's discriminatory actions from legal challenge. The district court's decision should be affirmed.

II. JURISDICTIONAL STATEMENT

The Class concurs with the Defendants-Appellants' Jurisdictional Statement.

III. STATEMENT OF ISSUES FOR REVIEW

(1) Did the district court correctly determine that the State's decision to disenroll lawfully-admitted resident aliens from superior state-funded and state-

administered medical assistance programs constituted alienage-based discrimination?

(2) Did the district court correctly apply strict scrutiny to the State's decision to disenroll lawfully-admitted residents from state-funded and state-administered medical assistance programs?

(3) Regardless what standard of review applies, was the State's action permissible under the equal protection clause?.[1]

IV. STATEMENT OF THE CASE

This case arises out of the State's[2] decision to cut state-funded medical benefits to individuals residing in Hawai`i under Compacts of Free Association ("COFA" or "the Compacts") between the United States and the governments of the Marshall Islands, Palau, and the Federated States of Micronesia. Under the Compacts, the citizens of these countries (the "COFA Residents") are allowed

[1] Pursuant to Ninth Circuit Rule 28-2.7, except for the following, all applicable statutes, etc., are contained in the brief or addendum of Defendants-Appellants: Hawaii Administrative Rules ("HAR") Chapters 17-1714. Copies of these pertinent regulations are bound with this brief as an addendum.

[2] "State" collectively refers to Defendants-Appellants Patricia McManaman, in her official capacity as Director of the State of Hawai`i Department of Human Services ("DHS"), and Kenneth Fink, in his official capacity as State of Hawai`i Department of Human Services, Med-QUEST Division Administrator. The State has noted that pursuant to Fed. R. App. P. 43(c)(2), Defendant McManaman is substituted for former DHS Director Lillian B. Koller. Opening Brief at 1 n.1.

freely to migrate to the United States. Understandably, many have chosen to live in Hawai`i.

For many years, COFA Residents in Hawai`i participated on equal footing with other lawful residents of Hawai`i in state-funded health care programs. In 2010, however, the State disenrolled thousands of COFA Residents[3] from those programs and allowed them only to enroll only in a new program called Basic Health Hawaii ("BHH"), which provided drastically inferior benefits and provided no coverage for life-sustaining services, such as dialysis and chemotherapy.

The Class moved for a preliminary injunction prohibiting the State from discriminating against COFA Residents. The district court granted the injunction, holding that the State's actions in disenrolling COFA Residents from state healthcare benefit programs on the basis of their alienage violated the equal protection clause because it could not pass strict scrutiny. The State now asserts that the district court wrongly concluded the Plaintiffs were likely to succeed on the merits of their equal protection claim. The State's arguments are contrary to the facts and the law. The District Court's decision should be affirmed.

[3] Not all were disenrolled. Children and pregnant women over the age of 18 are still allowed to participate in the more expansive program provided to other lawful residents of Hawai`i.

V. STATEMENT OF FACTS

A. The Class

The Republic of the Marshall Islands, Federated States of Micronesia, and the Republic of Palau each entered into a Compact of Free Association with the United States. *See* Pub. L. No. 99-239, § 101, 99 Stat. 1770, 1804 (1986) (Marshall Islands and Federated States of Micronesia) and Pub. L. No. 99-658, § 101, 100 Stat. 3672, 3682 (1986) (Palau) (codified at 48 U.S.C. § 1901 and 48 U.S.C. § 1931, respectively). As a result, their citizens may freely "enter into, lawfully engage in occupations, and establish residence as a nonimmigrant in the United States and its territories and possessions . . . ." Pub. L. No. 99-239, § 141; Pub. L. No. 99-658, § 141. If they choose to do so, they may stay indefinitely—from birth to death. In this case, the Class is comprised of COFA Residents residing in the State of Hawai`i. CR/SER[4] 10-3 at ¶ 2, 10-5 at ¶ 3, 10-6 at ¶ 3.

B. The Medicaid Act

Congress created the Medicaid program in 1965 "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs

[4] For simplicity, Appellees adopt the State's designations to the excerpts of record as set forth in its Opening Brief at 2 n.3. "CR" refers to the Clerk's Record and the docket number. "ER" refers to the Excerpts of the Record. Appellees are also submitting a supplemental excerpt of record ("SER") pursuant to Ninth Circuit Rule 30-1.7. Citations to large documents with multiple parts are given with the part number, as listed on the district court's docket.

of medical treatment for needy persons. Although participation in the Medicaid program is entirely optional, once a State elects to participate, it must comply with the requirements of Title XIX." *Harris v. McRae*, 448 U.S. 297, 301 (1980); 42 U.S.C. §§ 1396 *et seq*. Medicaid "provides federal funding to 'enabl[e] each State, as far as practicable . . . to furnish . . . medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services.' " *AlohaCare v. Hawaii, Dep't of Human Servs.*, 572 F.3d 740, 742 (9th Cir. 2009) (quoting 42 U.S.C. § 1396-1) (brackets in original). Medicaid is administered by the states, with the federal government partially reimbursing state expenditures according to a state-specific matching formula. *Children's Hosp. & Health Ctr. v. Belshe*, 188 F.3d 1090, 1093 (9th Cir. 1999); 42 U.S.C. § 1396b. Essentially, Medicaid is a voluntary, state-implemented, and largely state-funded program that provides for federal reimbursement of some of the expenditures that states incur.

As a condition of participation, states must cover certain populations and provide certain services. However, the states are free to expand coverage and federal matching funds for the costs of covering other populations and services, known as "optional" eligibility groups and services. 42 U.S.C. § 1396a(a)(10)(A)(ii). Coverage of these optional eligibility groups is not required by

federal law, but a state must comply with federal guidelines if it chooses to cover them.

In addition, states may choose to expand Medicaid eligibility to "expansion populations" by creating "experimental, pilot, or demonstration" projects. 42 U.S.C. § 1315; *AlohaCare*, 572 F.3d at 743. If these demonstration projects are approved, expenditures under such projects are also partially reimbursed by the federal government. *See Spry v. Thompson*, 487 F.3d 1272, 1273-1275 (9th Cir. 2007).

Finally, a state is free to expand the eligible population without a waiver, in which case its expenditures are neither reimbursed by the federal government nor subject to the federal laws that govern that Medicaid program. *Thompson*, 487 F.3d at 1277 (state may disregard federal requirements for enrollees ineligible for federally-reimbursed Medicaid).

C. The Hawai`i Medicaid Programs

In 1993, "Hawai`i obtained approval from CMS to operate a managed care model known as QUEST," under which it "provide[s] health care coverage to populations outside the normal reach of Medicaid." *AlohaCare*, 572 F.3d at 743. QUEST was the first of many federally-approved experimental or demonstration projects.[5] By definition, all of these programs are jointly funded by the federal and

[5] In the proceedings below, these programs were collectively referred to by the

State governments, the State administering and managing the programs through DHS. Haw. Rev. Stat. § 346-14.

D. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996

Before 1996, federal law did not bar reimbursement from the federal government for COFA Residents' participation in federally supported Medicaid programs. In 1996, however, Congress passed the Personal Responsibility and Work Opportunity Reconciliation Act ("PRWORA"). Pub. L. No. 104-193, 110 Stat. 2105 (1996) (codified at 8 U.S.C. §§ 1601 *et seq.*). PRWORA limited non-citizens' eligibility to receive federal money for welfare benefits.

PRWORA divided aliens into three categories. "Qualified aliens" are those who are lawfully admitted for permanent residence or fall into another of the categories in 8 U.S.C. § 1641(b). They are generally eligible for federal and state-funded[6] benefits just as they were before PRWORA, as long as they either entered the U.S. before 1996 or have been present in the U.S. for more than five years. 8 U.S.C. § 1612.[7] A second category of aliens are not eligible for either federal- or

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parties and the district court as the "Old Programs."

[6] In fact, PRWORA mandates that states **must** make eligible for state programs certain categories of "qualified aliens"– including lawfully-admitted permanent residents, veterans, and many refugees who have entered or been granted asylum within the last five years, among others. 8 U.S.C. § 1622(b).

[7] Qualified aliens who did not enter the U.S. before 1996 and have not been a

state-funded benefits. 8 U.S.C. § 1621. This category includes undocumented aliens. *Id*.

The third category includes non-immigrants, such as the COFA Residents, who lawfully reside in the United States under color of law but are not "qualified aliens." 8 U.S.C. § 1611, 1621(a). People in this group are ineligible for federally-subsidized services, but a state may provide them health benefits at its expense. 8 U.S.C. § 1622. Specifically, the statute provides:

> Notwithstanding any other provision of law . . . a State is authorized to determine the eligibility for any State public benefits of an alien who is a qualified alien (as defined in Section 1641 of this title), [or] a nonimmigrant under the Immigration and Nationality Act[.]

8 U.S.C. § 1622(a).[8]

Thus, while the Medicaid-PRWORA statutory framework is complex, its effect on the State's power to determine immigrants' eligibility for the Hawai`i Medicaid Programs is not: with the exception of those in the second category, the State has discretion to choose who it will cover.

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resident in the U.S. for five years are not eligible for federal benefits, but they are eligible for state benefits. 8 U.S.C. § 1613.

[8] The parties agree that as "non-immigrants," COFA Residents fall squarely into the category of immigrants over which PRWORA gives the State full discretion to determine eligibility of benefits. 8 U.S.C. § 1622; CR/ER 30 at 4 n.3.

E. Hawai`i Medicaid Programs Post-PRWORA

After PRWORA and until 2010, the State continued to provide the same level of benefits to COFA Residents under the Hawai`i Medicaid Programs that were provided before. As the District Court explained,

> . . . the State did not adopt any administrative rules to create a state-funded medical assistance program, and instead created a de facto state-funded medical assistance program by continuing to provide medical assistance benefits to COFA Residents and paying for those benefits entirely with State funds. COFA Residents used the same application as that used for applicants seeking federal Medicaid and state-funded medical assistance. So long as the COFA Resident met the income and asset eligibility requirements for Hawaii's Federal Medicaid program, the COFA Resident received the same benefits as those provided under the [Hawai`i Medicaid] Programs.

CR/ER 30 at 5 n.4; CR/ER at 29 ¶ 1.

This all changed in 2010, when the State disenrolled COFA Residents from the Hawai`i Medicaid Programs and allowed them only to enroll in BHH. In doing so, the State specifically targeted COFA Residents because of their alienage and immigrant status. Hawai`i Administrative Rules ("HAR") § 17-1714-2 (describing BHH as a medical assistance program administered by the State for "**aliens** age nineteen years and older who are **citizens** of a COFA nation, or legal permanent residents who have resided in the United States for less than five years") (emphasis added).

Under BHH, the State provided drastically reduced benefits to COFA Residents. CR/SER 10-7 ¶ 9. Compared to the Hawai`i Medicaid Programs, BHH provides only a minimal array of benefits, such as:

- no more than ten days of medically necessary inpatient hospital care related to medical care, surgery, psychiatric care, and substance abuse treatment;
- a maximum of twelve outpatient visits including adult health assessments, family planning services, diagnosis, treatment, consultations, to include substance abuse treatment, and second opinions;
- a maximum of six mental health visits, limited to one treatment per day; and
- a maximum of four medication prescriptions per calendar month, which "shall not exceed a one-month supply."

HAR § 17-1722.3-18.

BHH has a 7,000 person statewide enrollment cap, with open enrollment only when enrollment drops below 6,500. HAR § 17-1722.3-10. More than 7,700 COFA Residents were receiving state-funded medical assistance as of May 31, 2010. CR/SER 10-19. Eligible COFA Residents, after being disenrolled, were "deemed into" BHH without regard to the cap. HAR § 17-1722.3-33. Thus, because the current enrollment exceeds the cap by 20% or more, there is no chance of open enrollment in the foreseeable future. In some cases, limited medical treatments may be available through hospital emergency rooms, but hospitals are

unlikely to be able to provide these services over an extended period of time. CR/SER 10-7 at ¶ 12.

F. BHH Threatened COFA Residents With Imminent Harm

The threat of harm from the State's discriminatory actions was clear, imminent, and potentially catastrophic. Class members suffer from a variety of serious medical conditions that require medical treatment and monitoring, including stroke, cancer, coronary artery disease, diabetes, and kidney disease. CR/SER 10-9 at ¶ 10; 10-7 ¶¶ at 4-5; 10-3 at ¶¶ 10-11; 10-5 at ¶¶ 4-10. In light of BHH's limited coverage, COFA Residents with serious illnesses were not able to get important preventative care, essential medical treatment, or an adequate supply of prescription drugs. *E.g.,* CR/SER 10-6 ¶¶ 12-16; 10-5 ¶¶ 13-21; 10-3 ¶¶ 13-15. There is a risk that patients in need of acute care will end up being hospitalized or otherwise experience severe health problems, or possible death. CR/SER 10-10 ¶ 14. Physicians who treat COFA Residents witnessed the deleterious effects of BHH. CR/SER 10-7 at ¶¶ 9-15; 10-8 at ¶¶ 12-17; 10-9 at ¶¶ 16-34; 10-10 at ¶ 14-15; 10-11 at ¶¶ 10-16.

G. Proceedings Below

The Class filed its Complaint on August 23, 2010.[9] On September 9, 2010, the State moved to dismiss and, on September 13, 2010, the Class moved for preliminary injunction. On November 10, 2010, the district court issued an order denying the motion to dismiss (the "Order Denying Dismissal") based on its determination that strict scrutiny applied to the State's actions. CR/ER 30. On December 13, 2010, the district court issued the injunction (the "Injunction Order"). CR/ER 42.

1. The Order Denying Dismissal

In the Order Denying Dismissal, the district court held that: (1) the State discriminated based on alienage by cutting benefits to COFA Residents but not to similarly-situated Hawai`i residents; and (2) strict scrutiny applied to that discrimination because PRWORA's grant of discretion to States to determine COFA Residents' eligibility for State benefits was not a "uniform rule." CR/ER 30 at 24, 27-28. Applying strict scrutiny, the district court found that the State

[9] Although the underlying briefing addressed the Class' claims regarding (1) the State's discrimination against "New Residents," which refers to lawful aliens who have been U.S. residents for less than five years; and (2) the State's alleged violation of the "integration mandate" of the Americans with Disabilities Act ("ADA"), 42 U.S.C. § 12132, the Class subsequently withdrew their request for interim injunctive relief as to the New Residents and their ADA claim without prejudice. Accordingly, those issues are not part of this appeal. CR/ER 32.

failed to identify **any** particular State interest that was advanced by their decision to exclude COFA Residents from the Hawai`i Medicaid Programs. *Id.* at 28-29.

2. The Injunction Order

In the Injunction Order, the district court again applied strict scrutiny, finding that the Class had shown a "high degree of likelihood of success on the merits" because there was no compelling interest advanced by the State's discrimination against COFA Residents. CR/ER 42 at 11-12. The court further held that the Class had demonstrated a strong likelihood of irreparable harm; that the balance of equities weighed in favor of the Class; and that a preliminary injunction was in the public interest. *Id.* at 12-14. Accordingly, the district court granted the injunction and ordered the State to, among other things, "reinstate the benefits that [each] COFA Resident was receiving through the [Hawai`i Medicaid] Programs as of June 1, 2010, prior to being deemed into BHH . . . ." *Id.* at 14.

VI. SUMMARY OF ARGUMENT

As the district court correctly concluded, a state's decision to exclude certain groups of residents from state-planned, state-funded, and state-administered health benefits on the basis of alienage is subject to strict scrutiny. PRWORA does not insulate the State's actions from a constitutional challenge because it prescribes no uniform rule that the State must follow.

The State argues there is no basis for strict scrutiny because (1) BHH classifies based on federal Medicaid eligibility under PRWORA, not alienage *per se*, and (2) even if the classification was alienage-based, it is subject to rational basis review based on Congress' plenary power to establish rules regarding immigrants.

The State's arguments are unavailing. BHH expressly classifies, and discriminates in the allocation of health benefits, based on alienage. Hawai`i provided benefits to COFA Residents for almost 15 years after PRWORA; it stopped because of budgetary pressure, not federal law, and specifically targeted COFA Residents for its cuts.

The district court correctly determined that the State's discriminatory acts were subject to strict scrutiny review and, further, that PRWORA does not establish a uniform rule insulating the State from this scrutiny. Instead, as this Court has held, PRWORA gives states **complete discretion** to provide state benefits to COFA Residents. The State's actions, based only on its desire to save money by denying benefits to a discrete and unpopular minority, do not pass constitutional muster. The district court's decision should be affirmed.

VII. ARGUMENT

A. The District Court Did Not Abuse Its Discretion In Determining That BHH Discriminated Against Aliens

Rather than address the district court's analysis regarding the appropriate level of scrutiny,[10] the State attempts to skirt it, seizing on the Connecticut Supreme Court's recent decision in *Hong Pham v. Starkowski*, 16 A.3d 635 (Conn. 2011), for the proposition that there was no discrimination against COFA Residents because the State's classification here merely tracked the federal

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[10] The district court determined that: (1) pursuant to *Graham v. Richardson*, 403 U.S. 365 (1971), a state's decision to treat aliens differently from citizens is subject to strict scrutiny; (2) pursuant to *Mathews v. Diaz*, 426 U.S. 67 (1976), the federal government's decision to treat aliens differently from citizens is subject to rational basis review; and (3) pursuant to *Plyler v. Doe*, 457 U.S. 202 (1982), only where the federal government prescribes a uniform rule for how a state must treat aliens is a state's action pursuant to that rule subject to rational basis review because the state is merely following the federal government's mandate; otherwise, strict scrutiny applies. CR/ER 30 16-17. The district court determined that the decisive issue was whether PRWORA established a uniform rule, which guided the State's decisions. *Id.* at 17-18.

Following an extensive analysis of the relevant case law, the district court determined that this Court's decision in *Sudomir v. McMahon*, 767 F.2d 1456 (9th Cir. 1985) was determinative. *Sudomir* clarifies that the uniformity requirement is met only where the federal government outlines how a state must act regarding classification of aliens. CR/ER 30 at 23. And since PRWORA granted the states broad discretion as to eligibility for state-funded programs, the district court correctly found that it did not establish a uniform rule requiring the State to provide lesser benefits to COFA Residents. *Id.* Accordingly, the State's decision to provide COFA Residents with inferior benefits to those received by citizens was subject to strict scrutiny. *Id.* at 24.

government's classification regarding Medicaid eligibility. This argument fails for at least two reasons. First, it is not supported by the plain language of BHH. Second, the cases relied on by the State are poorly reasoned, distinguishable, and have no precedential value. The district court's holding, in contrast, is supported by pertinent case law from this Court and the United States Supreme Court.

1. BHH Explicitly Classifies COFA Residents on the Basis of Alienage

BHH was explicitly "established to provide . . . state funded medical assistance for **citizens** of COFA nations[.]" HAR § 17-1722.3-1 (emphasis added). The rule further provides that citizens of COFA nations are generally precluded from participating in the Hawai`i Medicaid Programs. *Id.* BHH's eligibility section confirms that the program applies only to "an **alien** who is not eligible for federal medical assistance and is either (A) A **citizen** of a COFA nation; or (B) A legal permanent resident . . . ." HAR § 17-1722.3-7 (emphasis added).

Simply put, the plain language of BHH is fatal to the State's argument. The Class specifically and COFA citizens generally were excluded from the Hawai`i Medicaid Programs **because they were aliens**, not because PRWORA defines them as "qualified aliens," as the State contends. BHH is an alienage-based classification on its face and as applied, and is therefore subject to equal

protection review.[11] This Court should reject the State's desperate attempt to evade strict scrutiny on this basis alone.[12]

2. The State's Inapposite, Foreign Cases do nothing to Undermine the District Court's Holding

The State's "no discrimination" argument also fails because it is based on poorly reasoned decisions that cannot withstand analysis. Essentially parroting *Hong Pham*, the State's brief disregards the district court's thorough and accurate analysis of **binding** case law and asks this Court to do the same. *Hong Pham* was

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[11] In rejecting a variation of this argument below, the district court stated that

> regardless of how Defendants attempt to characterize their actions, Defendants' implementation of the [Hawai`i Medicaid] Programs and BHH classify individuals based on alienage – citizens and certain groups of aliens are eligible to participate in the [Hawai`i Medicaid] Programs, while COFA Residents are eligible to participate in BHH. Because Defendants were not following any uniform rule established by federal law in making these distinctions, these classifications are subject to strict scrutiny.

CR/ER 30 at 27-28.

[12] The State's argument is further undermined by its misapprehension of the district court's ruling. The court did not hold that the State was "constitutionally required to be even more generous and to fully mitigate the federal government's discrimination." Opening Brief at 20. Instead, the district court held that a classification enacted by the State pursuant to PRWORA was not insulated from strict scrutiny review by any uniform rule. CR/ER 30 at 24. The district court said nothing about what the State had to do in response to PRWORA. In fact, the district court found that PRWORA does **not** require the State to provide COFA Residents with lesser benefits. *Id.* The State's attempt to re-characterize the district court's decision is baseless.

wrongly decided and the cases on which it relied are similarly unhelpful to the State.

a. This Court should reject *Hong Pham*

Hong Pham addressed Connecticut's termination of a state program that provided medical assistance to qualified aliens who did not meet the five-year requirement to participate in Medicaid. The relevant question, according to *Hong Pham*, was "whether the state program provides a benefit to citizens that it does not provide to some or all aliens because of their status as noncitizens." 16 A.3d at 648. *Hong Pham* answered this question in the negative because the eliminated program did not provide benefits to citizens. Thus, "because the state is not providing a benefit to citizens through that program that it denies to some or all aliens, the state cannot be discriminating against aliens in favor of citizens." *Id.* at 648.

Hong Pham rejected the proposition that Connecticut's participation in Medicaid required it to provide an equivalent level of assistance to those who cannot participate in Medicaid. *Id.* at 649. Relying on other cases applying rational basis review (addressed below), *Hong Pham* stated that "the equal protection clause does not require the state to treat individuals in a manner similar to how others are treated in a different program governed by a different government." *Id.* at 650. Finally, *Hong Pham* concluded that even if it compared

the treatment of aliens ineligible for Medicaid to citizens, "the state's decision to participate in federal Medicaid does not draw a classification based on alienage but, instead, draws a classification based on an individual's eligibility for federal Medicaid." *Id.* at 659.

Simply put, *Hong Pham* was wrong. The premise that equal protection analysis is limited to whether the state **program** provides a benefit to citizens that it does not provide to some or all aliens based on their status as noncitizens is absurd. *Id.* at 648. Limiting the inquiry to a particular program as opposed to a state's provision of medical benefits generally would conceivably allow a state to create separate programs providing different benefits based on suspect classifications like alienage, race, and gender. For example, a state could create one medical benefits program with limited benefits for Asian Americans, and another program with greater benefits for Caucasians. Under *Hong Pham*'s reasoning, there would apparently be no suspect classification based on race because neither individual **program** provides a benefit to one race that it does not provide to individuals of the other race. Such a result is clearly insidious and flouts the Equal Protection clause and the cases interpreting it.

Moreover, *Hong Pham's* distinction between programs funded by "different governments" flouts *Graham*. There, the Supreme Court stated that "Congress does not have the power to authorize the individual States to violate the

Equal Protection Clause," and, while Congress has the power to establish a uniform Rule of Naturalization," "[a] congressional enactment construed so as to permit state legislatures to adopt divergent laws on the subject of citizenship requirements for federally supported welfare programs would appear to contravene this explicit constitutional requirement of uniformity." 403 U.S. at 382.

Here, the State has elected to fund BHH **and** the Hawai`i Medicaid Programs. The fact that the latter (in which the State participates **voluntarily** and which the State itself designed and manages) is partially funded by the federal government does not give the State license to violate the constitution.

Hong Pham also fails for its reliance on *Soskin v. Reinertson*, 353 F.3d 1242 (10th Cir. 2004). As the district court determined, *Soskin* is instructive to the extent it recognized that Colorado's decision to no longer provide optional Medicaid coverage to legal aliens fell somewhere in between *Graham* and *Mathews* and the question of what level of scrutiny applied boiled down to whether Congress had clearly expressed its will regarding a matter related to aliens. CR/ER 30 at 24. Where *Soskin* goes astray, however, is with its uniformity analysis. *Id.* at 25. The Tenth Circuit reasoned that PRWORA's grant of discretion as to the benefits afforded to aliens reflected a national policy and the states effectuate that policy when they exercised that discretion. *Id.* Relying on *Mathews*, *Soskin* found

that courts must be deferential in reviewing the states' implementation of PRWORA's "national policy." *Id.*

As the district court pointed out, however, Soskin relied on a mistaken view of the uniformity requirement, "finding that it **might** not apply because Congress' authority to enact . . . PRWORA **may** come from a source other than the Naturalization Clause and the purpose of the uniformity requirement is limited to treating anyone admitted by citizenship by another state as a citizen in another state." *Id.* at 25-26.

The district court correctly determined that *Soskin* was inconsistent with both *Graham* and this Court's decision in *Sudomir v. McMahon*, 767 F.2d 1456 (9th Cir. 1985). *Graham* establishes that while Congress has the power to establish a uniform Rule of Naturalization, "a congressional enactment construed so as to permit state legislatures to adopt divergent laws on the subject of citizenship requirements for federally supported welfare programs would appear to contravene this explicit constitutional requirement of uniformity. 403 U.S. at 382. While the Tenth Circuit rejected this language as *dicta*, this Court views it differently.

Sudomir establishes that "congressional enactments permitting states to adopt divergent laws regarding the eligibility of aliens for federally supported welfare programs" are invalid. *Sudomir*, 767 F.2d at 1466-67. In that case, the

uniformity requirement was met when the state followed a specific **mandate** from the federal government regarding welfare eligibility for certain classes of aliens. *Id.* at 1466. Here, there is no such mandate, so the district court correctly rejected *Soskin*'s "refusal to recognize the uniformity requirement" and found instead that the uniformity rule is only met where the state relies on a federal statute as the basis for distinguishing between citizens and aliens. CR/ER 30 at 27. *Hong Pham*'s reliance on *Soskin* misses the mark.

b. The State's other cases are similarly unhelpful

The State's remaining "authority" is no more helpful to its cause. It cites *Doe v. Comm'r of Transitional Assistance*, 773 N.E.2d 404 (Mass. 2002), to support its contention that the "entirely optional" BHH provides no benefit to citizens and, therefore, does not discriminate. Opening Brief at 22. *Doe*, however, stands for no such thing.

In that case, the Massachusetts court held that a supplemental six-month residency requirement for welfare benefits did not violate equal protection. *Id.* at 414. While the court recognized that the supplemental program provided no benefit to citizens, and only "discriminate[d] between groups of qualified aliens on the basis of the length of their residency in Massachusetts," this was **not** the basis for the court's decision. Instead, the court applied rational basis because it was a **residency** classification rather than a classification based on alienage. *Id.* at 411.

In fact, even though the Massachusetts court concluded (improperly) that the classification only discriminated between subgroups of aliens, it explicitly stated that if "that classification were a suspect one such as race, gender, or national origin, **we would apply a strict scrutiny analysis.**" *Id.* at 414 (emphasis added). Furthermore, like *Soskin*, the court erroneously reasoned that "[the fact] that citizens are eligible to receive benefits from a different program on conditions less restrictive than those imposed on qualified aliens is a direct result of the enactment of uniform Federal policies[.]" *Id.* As discussed above, PRWORA establishes no such uniformity.

Moreover, the Supreme Judicial Court of Massachusetts departed from *Doe* in *Finch v. Commonwealth Health Ins. Connector Auth.,* 946 N.E.2d 1262 (Mass. 2011). There, the court held that strict scrutiny review applies to the exclusion of legal aliens from the state's Commonwealth Care Health Insurance Program[13] on the basis of alienage, because the action was carried out by the state, and PRWORA did not **require** the state to take such action. *Id.* at 1277. In discussing *Doe*, *Finch* noted that "we did not bridge the analytical gap [in *Doe*]

[13] Commonwealth Care is a public benefit program for which Massachusetts receives certain federal reimbursements through Medicaid demonstration projects under Section 1115 waivers. *Finch*, 946 N.E.2d at 1267. Similar to the Hawai`i Medicaid Programs, Massachusetts initially permitted all residents to enroll in Commonwealth Care, whether federally eligible or not; in the absence of federal reimbursement, Massachusetts simply paid for the benefits with 100% state funds. *Id.* In 2006, Massachusetts enacted a law excluding aliens who are federally ineligible under PRWORA from participating in Commonwealth Care. *Id.*

between congressional action 'dictating how States are to regulate and legislate issues relating to aliens' and the State's responsibilities where Congress enacts a noncompulsory rule and the Commonwealth voluntarily 'adopt[s] those national policies and guidelines.'" *Id.* at 1275 (quoting *Doe*, 773 N.E.2d at 409). *Finch* concludes that:

> In the context of Commonwealth Care, PRWORA is thus a statement by Congress that the Federal government will be subsidizing the State's provision of benefits to some residents (citizens and eligible aliens) but not to others (federally ineligible aliens). This is a financial impediment to State action but not a mandate under the supremacy clause that might require the application of rational basis review. Where the State is left with a range of options including discriminatory and nondiscriminatory policies, its selection amongst those options must be reviewed under the standards applicable to the State and not those applicable to Congress.

946 N.E.2d at 1277. Because Massachusetts **voluntarily** adopted an origin classification in its decision to exclude aliens from its joint federal-state funded program, this action was subject to strict scrutiny review. *Id.* at 1279-80. *Finch* debunks the State's effort to rely on *Doe,* and, along with it, its argument that disenrolling COFA Residents from the Hawai`i Medicaid Programs was not discriminatory.

The State's reliance on *Khrapunskiy v. Doar*, 909 N.E.2d 70 (N.Y. 2009) is also misplaced. *Khrapunskiy* involved a federal takeover of a public assistance program previously administered by New York State. After the state

program ceased to exist, New York no longer played any significant role in participating, managing, or administering the program because the federal government managed and made "all administrative and eligibility determinations" and payments. *Id.* at 72. Thus, *Khrapunskiy* is factually inapposite to the situation here, where the State's participation in the Medicaid program is voluntary and the State is responsible for managing, administering, and making decisions about which residents should be covered. Moreover, *Khrapunskiy's* unsupported conclusion that "the right to equal protection does not require the State to create a new public assistance program in order to guarantee equal outcomes" or "require the State to remediate the effects of PRWORA" are afflicted by the same logical fallacies of *Hong Pham*. *Id.* at 77.

The State's reliance on inapposite foreign case law does nothing to undermine the district court's cogent analysis of binding case law. And the State's argument that its explicit, alienage-based discrimination was not in fact discrimination simply does not hold water.[14] The district court did not err.

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[14] Despite the State's arguments and case law, whether the State was **obligated** to provide coverage to COFA Residents under the Hawai`i Medicaid Programs is irrelevant. The issue, as the district court accurately surmised, is whether a state may choose to exclude certain groups from existing, state-funded program based on alienage. CR/ER 30 at 28. In other words, even if the State's argument is taken as true and it was not "obligated" to offset the federal government's alleged discrimination, that does not insulate it from constitutional compliance (and an analysis as to level of scrutiny) per *Graham* and its progeny. What is at issue here is what the State did – not what it could or could not have done fifteen years ago.

B. The District Court Correctly Held That Strict Scrutiny Applies To The State's Alienage-Based Classification

Alternatively, the State argues that even if it did discriminate against COFA Residents via BHH then rational basis applies because it was only following PRWORA's "uniform rule." Opening Brief at 33. The district court's holding to the contrary, the argument goes, was therefore erroneous. Again, the State is wrong.

1. PRWORA Does Not Establish a Uniform Rule

As discussed above, this Court's holding in *Sudomir* is dispositive as to what constitutes a uniform rule under PRWORA. In *Sudomir*, the plaintiffs, who were aliens who had applied for asylum in the United States but had not yet received it, challenged California's denial of welfare benefits under the Aid to Families with Dependent Children ("AFDC") program. The AFDC program was "a cooperative federal-state effort established by Congress to furnish financial assistance to certain needy families with dependent children." 767 F.2d at 1457. The federal statute required the states to determine eligibility on the basis of whether an alien was "permanently residing in the United States under color of law . . . ." *Id.* (quoting 42 U.S.C. § 602(a)(33) (1982)).

The plaintiffs argued that the state's denial of benefits to them, which was based on the state's conclusion that plaintiffs' applications for asylum had not

been granted and they were therefore not yet considered aliens "permanently residing" in the United States, violated the equal protection clause by discriminating on the basis of alienage. *Id.* at 1457. This Court agreed with the state's argument that the plaintiffs were not "permanently residing" in the United States under the eligibility language of the statute. *Id.* at 1462. This Court, however, further determined that the federal statute **required** participating states "not only to grant benefits to eligible aliens but also to **deny** benefits to aliens" who did not meet the federal eligibility requirements. *Id.* at 1466 (emphasis in original). Thus, in denying benefits, the state was "employ[ing] both a federal classification and a **uniform** federal policy regarding the appropriate treatment of a particular subclass of aliens." *Id.* at 1466 (emphasis added and some emphasis omitted). In other words, a uniform rule is only established when the federal law strictly requires an alienage-based classification.

The district court correctly concluded that PRWORA established no such uniform rule, finding that its grant of discretion to the states "does not guarantee that each state will adopt the same laws regarding non-qualified aliens." CR/ER 30 at 24. By failing to provide any guidance to states regarding how to determine eligibility for state public benefits, ". . . PRWORA does not establish uniformity, but rather fosters a lack of uniformity between the states based on the

state's own considerations of who should receive benefits based on alienage." *Id.* at 23.

The State tries to evade *Sudomir* by arguing that the discretion PRWORA affords it to "voluntarily mak[e] up for Congress's discrimination against COFA Residents" is "beside the point." Opening Brief at 35. Relying exclusively on *Soskin* and its blind assertion that "[a]ny discrimination was Congress's doing[,]" the State again asserts that its voluntary provision of state-funded benefits only to aliens is constitutional. *Id.* at 35-36. No matter how many times the State raises this argument it still fails. The issue, as stated before, is not whether the State was obligated to compensate for the federal government's permissible discrimination, but whether the State's unilateral decision to remove COFA Residents from the Hawai`i Medicaid Programs and enroll them in the inferior BHH was an alienage-based classification. No matter how the State belatedly tries to characterize its action, it clearly was. And as this Court has previously held, that classification is clearly subject to strict scrutiny review where PRWORA provides discretion, instead of direction, as to what benefits a state may give.

The State's rambling arguments are unavailing. The district court correctly applied *Sudomir* and the State may not absolve itself of BHH's

constitutional infirmities by merely pointing the finger at the federal government. The State must live with the classification it made.

2. The State Waived its Meritless Uniform Rule Argument Regarding the Compacts

For the first time, the State argues that the underlying policies of the Compacts of encouraging self-sufficiency of COFA Residents is a "uniform federal policy" that subjects the State's classification to rational basis review. Opening Brief at 50. Because this argument was not raised before the district court, however, it was waived. *See, e.g., White v. Martel,* 601 F.3d 882, 885 (9th Cir. 2010) ("Generally, arguments not raised before the district court are waived on appeal."); *Smith v. Marsh*, 194 F.3d 1045, 1052 (9th Cir. 1999) (where appellants failed to present their contention to the district court and it only first appeared in their opening brief on appeal, appellate court refused to consider argument since, "[a]s a general rule, we will not consider arguments that are raised for the first time on appeal"). The State's novel argument should be rejected in the first instance.

Even if the argument is not rejected outright on the ground of waiver, however, it still fails. In fact, it is a mere variation on *Soskin*'s reasoning that a state's exercise of discretion to limit benefits to aliens is subject to rational basis when it effectuates PRWORA's policy that "individual aliens not burden the public benefits system." *Soskin*, 353 F.3d at 1255 (quoting 8 U.S.C. § 1601(4)). The

district court rejected *Soskin* because it is contrary to *Sudomir*, runs afoul of the uniformity requirement, and disregards the established rule that Congress may not otherwise authorize the states to violate the Fourteenth Amendment. CR/ER 30 at 25-27. The fact that the State's decision may or may not have been "consistent" with the general policy intentions of Congress is irrelevant to determining the standard of review for the State's discrimination where nothing in that policy **requires** the State to discriminate against aliens. *Sudomir*, 767 F.2d at 1466.[15]

The same holds true here. The Compacts express, at best, only vague and generalized policy intentions which do not even constitute a rule, let alone a uniform rule. First, there is the statement cited by the State regarding the deportability of COFA Residents who cannot show they have sufficient means of support. Opening Brief at 50. Yet this cannot be considered a uniform rule to guide state action, because states have no authority over deportation, which is the exclusive province of the federal government. *Hines v. Davidowitz*, 312 U.S. 52, 63 (1941). To the extent that this provision in the Compacts is a rule, it is not one that is aimed towards the states or demands state action, much less uniform state action.

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[15] *See also Aliessa v. Novello,* 754 N.E.2d 1085, 1098 (N.Y. 2001) (state's choice to deprive aliens of medical benefits is subject to strict scrutiny if, when looking at federal policy, "the States are free to discriminate in either direction -producing not uniformity, but potentially wide variation based on localized or idiosyncratic concepts of largesse, economics and politics.")

Second, the State points to the Compacts' provision of grant funds for health and medical assistance to the COFA countries. Opening Brief at 52. To argue that this provision of grant funds is a uniform rule instructing states to withhold health and medical benefits from citizens of those countries is absurd. The language the State cites to from the Compacts does not state that such funding is intended to be the sole and exclusive means by which citizens of COFA countries can receive health and medical assistance. *Id.* Again, the language the State points to does not even create a rule, and even if it did, it is not a rule aimed at the states, or one which instructs the states to act in a uniform manner.

The State's attempt to rely on the Compacts as a source for the uniform rule they so desperately seek is a last-ditch argument raised for the first time on appeal, and which should be disregarded by this Court. But even if it is not deemed waived, the argument fails because is unsupported by the language of the Compacts and by the standard set forth in *Sudomir*. Congress is entirely capable of enacting a uniform rule when it chooses to do so. Here, it has not. Neither PRWORA nor the Compacts of Free Association require uniform state action, and so strict scrutiny applies.

C. BHH Violates the Equal Protection Clause

Regardless what standard of review applies, the State's actions were not permissible under the equal protection clause. Under a strict scrutiny standard,

a state must show that the classification is "suitably tailored to serve a compelling state interest." *Cleburne v. Cleburne Living Center*, 473 U.S. 432, 440 (1985). There is no compelling State interest in denying COFA Residents superior health benefits that are provided to others. BHH and the State's policy of denying equal access to State health programs is premised exclusively on cutting costs, which the Supreme Court has explicitly held is a "particularly inappropriate and unreasonable" ground upon which to base an alienage classification. *Graham*, 403 U.S. at 376; *Mathews*, 426 U.S. at 85 ("Insofar as state welfare policy is concerned, there is little, if any, basis for treating persons who are citizens of another State differently from persons who are citizens of another country. Both groups are noncitizens as far as the State's interests in administering its welfare programs are concerned." (Footnote omitted.)). The district court did not abuse its discretion in concluding that the State's decision to deny COFA Residents superior medical benefits provided to citizens was not furthered by a compelling governmental interest. CR/ER 30 at 11.

Nor can the State establish that its classification satisfies rational basis. A state classification passes the rational basis test only "if there is a rational relationship between the disparity of treatment and some legitimate governmental purpose." *Heller v. Doe*, 509 U.S. 312, 320 (1993). Thus, a classification fails the test if it "rests on grounds wholly irrelevant to the achievement of the State's

objective." *Id*. at 324. Distinctions between similarly-situated groups can only be rational as a means to a legitimate public end, for discrimination itself is never rational. *Lockary v. Kayfetz*, 917 F.2d 1150, 1155 (9th Cir. 1990) ("[T]he rational relation test will not sustain conduct by state officials that is malicious, irrational or plainly arbitrary."), *superseded by statute on other grounds as recognized in* 140 F.3d 850. Moreover, a "State may not rely on a classification whose relationship to an asserted goal is so attenuated as to render the distinction arbitrary or irrational." *Cleburne Living Center*, 473 U.S. at 446.

Here, the State posits just one rational basis for its decision to discriminate against COFA Residents: saving money. However, rational basis review demands not just a legitimate goal such as saving money, but "a rational *relationship*" between that goal and the challenged classification. *See Heller*, 509 U.S. at 320 (emphasis added). In other words, *the discrimination itself* must be a rational way to save money, or, at the very least, a rational way to allocate the burden of saving money. The State does not give any reason why discriminating against COFA Residents, while not discriminating against similarly-situated Hawai`i residents, is not arbitrary. In fact, the discrimination is arbitrary. Therefore, the State's decision to single out the Class for benefit cuts "rests on grounds wholly irrelevant" to the legitimate objective of saving money. *See Heller*, 509 U.S. at 324; *Lockary*, 917 F.2d at 1150.

Furthermore, there is no evidence that the State's benefit cuts will save money in the first place. The State ignores the fact that the cuts in coverage for preventative care will end up costing the public (and therefore the State) more money as patients who are denied preventative care suffer serious – and costly – medical emergencies. When necessary treatments are cut, patients will have to wait until they have developed a serious medical condition posing a serious threat to bodily health, and then seek treatment in a hospital setting. CR/SER 10-7 at ¶ 13. Accordingly, any cost savings as a result of the benefit cuts will be short term and ephemeral. Ultimately, the public will suffer and the State will have to pick up the tab. Discriminating against COFA Residents is not rationally related to the State's goal of saving money.

Therefore, under no situation would the State's actions ever be considered permissible under the equal protection clause.

VIII. CONCLUSION

For the foregoing reasons, this Court should hold that (1) BHH is subject to strict scrutiny review, (2) the State's discriminatory, alienage-based classification is not insulated by any uniform rule, and (3) BHH does not advance a

compelling state interest and therefore violates equal protection. The preliminary injunction should be affirmed.

DATED: Honolulu, Hawai`i, August 3, 2011.

/s/ J. Blaine Rogers
PAUL ALSTON
J. BLAINE ROGERS
ZACHARY A. MCNISH
MARGERY S. BRONSTER
ROBERT M. HATCH
CATHERINE L. AUBUCHON
VICTOR GEMINIANI

Attorneys for Plaintiffs-Appellees

CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because this brief contains 7,953 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Times New Roman, 14 point.

DATED: Honolulu, Hawai`i, August 3, 2011.

/s/ J. Blaine Rogers
PAUL ALSTON
J. BLAINE ROGERS
ZACHARY A. MCNISH
MARGERY S. BRONSTER
ROBERT M. HATCH
CATHERINE L. AUBUCHON
VICTOR GEMINIANI

Attorneys for Plaintiffs-Appellees

STATEMENT OF RELATED CASES

(Circuit Rule 28-2.6)

The Class is aware of one related case, *Pimentel v. Dreyfus*, Appeal No. 11-35237, currently pending in this Court. *Pimentel* is related to this case because it involves a challenge to the State of Washington's elimination of its state-sponsored food assistance program based on alienage. The district court enjoined the State from terminating the program based on its determination that eliminating the program while continuing to administer a similar program for citizens and other aliens violated equal protection.

The Class understands that this Court is scheduled to hear *Pimentel* on August 29, 2011.

NO. 11-15132
Tony Korab, et al. v. Patricia McManaman, et al.

PLAINTIFFS-APPELLEES'
ADDENDUM OF PERTINENT STATUTES, RULES, AND REGULATIONS

[1] Although the copies of the Hawaii Administrative Rules attached to this addendum are marked "unofficial," they are taken from the website of the State of Hawai`i, Department of Human Services and represent the current version of the rules.

HAWAII ADMINISTRATIVE RULES

TITLE 17

DEPARTMENT OF HUMAN SERVICES

SUBTITLE 12 MED-QUEST DIVISION

CHAPTER 1722.3

BASIC HEALTH HAWAII

Subchapter 1 General Provisions

Subchapter 2 Basic Health Hawaii

SUBCHAPTER 1

GENERAL PROVISIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

behavioral health services through health plans employing managed care concepts.

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

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

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

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

"Transition period end date" means the last day of the second month following the implementation date. [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1722.3-3 Basic Health Hawaii Implementation. (a) The department shall determine the implementation date for Basic Health Hawaii when participating health plans shall begin delivering Basic Health Hawaii benefits.

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

(c) When the department has established the implementation date, the department shall provide notice to deemed individuals as provided under subchapter 4. [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14)

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

SUBCHAPTER 2

BASIC HEALTH HAWAII

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

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

(1) The basic eligibility requirements described in chapter 17-1714 with the exception of citizenship requirements;
(2) Is an alien who is not eligible for federal medical assistance and is either:
(A) A citizen of a COFA nation; or
(B) A legal permanent resident;
(3) Is age nineteen years or older; and
(4) Is not pregnant.

(b) An individual who is not eligible to participate under this chapter includes a person who:

(1) Does not meet the requirements of subsection (a);
(2) Does not meet the financial eligibility requirements described in this chapter;
(3) Is employed and is eligible for coverage under an employer sponsored health plan, with the exception of a financial assistance recipient and an individual who is participating in a department subsidized employment program;
(4) Is eligible for coverage under a health plan as an active military enlistee, a retired military personnel, or a dependent of an active or retired military enlistee; or
(5) Is eligible for, or receiving, coverage under any health plan. [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14)

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

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

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

§17-1722.3-9 Financial eligibility requirements. (a) An individual whose countable family assets exceed the personal reserve standard for a family of applicable size shall be ineligible for Basic Health Hawaii.

(1) For a one-member family, the personal reserve standard shall be $2,000;

(2) For a two-member family, the personal reserve standard shall be $3,000;

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

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

§17-1722.3-10 Limitations to statewide enrollment in participating health plans. (a) An open application period shall be announced by the department after enrollment has dropped below 6,500 on the last day of the previous calendar year that occurs after the implementation date.

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

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

(1) Applications shall be processed in the chronological order of their receipt by the med-QUEST division;

(2) All pending applications received during the open application period shall be denied when the number of individuals that have been determined eligible, when enrolled in a participating health plan, would meet the maximum statewide enrollment allowed in subsection (b); and

(3) Applications pending more than 45 days before a denial notification is issued shall not be subject to the provisions of subsection 17-1711-13(i).

(d) An open application period shall not occur more than once per calendar year. [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14)

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

(1) The date of application if the applicant is found to be eligible in the month of application; or

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

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

(1) The recipient fails to meet any one of the necessary requirements of sections 17-1722.3-7 and 17-1722.3-9;

(2) Death of the recipient;

(3) The recipient no longer resides in the State;

(4) The recipient voluntarily terminates coverage;

(5) The recipient is admitted to a public institution as defined in chapter 17-1714;

(6) The recipient's whereabouts are unknown;

(7) Lack of State funds; or

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

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

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

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

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

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

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

(2) If disenrollment occurred in a period involving the annual plan change period; or

(3) If disenrollment includes the first day of a new benefit year. [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14)

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

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

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

(3) Changes in enrollment from one participating health plan to another during the annual plan change period shall be effective the first day of the month as determined by the department and shall generally extend to the following year;

(4) In the absence of a choice of participating health plans in a service area, an enrollee who resides in that particular service area shall not participate in the annual plan change period.

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

(1) Compliance with an administrative or judicial decision;

(2) Termination of the participating health plan contract;

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

(4) As provided in sections 17-1727-61 and 17-1727-62;

(5) Change of residence by an enrollee from one service area to another with a choice of more than one participating health plan:

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

(B) If a selection is not made within ten days of request, enrollment in a participating health plan shall be assigned by the department.

(6) Change of residence by an enrollee from one service area to another with only one participating health plan shall result in enrollment into that participating health plan; or

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

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

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

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

(1) Compliance with an administrative or judicial decision; or

(2) mutual agreement between the individual, the participating health plan involved, and the department.

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

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

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

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

(c) The effective date of enrollment resulting from a change from one participating health plan to another, other than during the annual plan change period, shall be one of the following:

(1) The first day of the month following the date on which the department authorizes the enrollment change; or

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

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

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

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

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

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

(2) Intensive care room and board and general nursing care for medical care and surgery;

(3) Use of an operating room and related facilities, inpatient anesthesia, radiology, laboratory and other diagnostic services agreed upon by the participating health plan medical director for medical care and surgery;

(4) Drugs, dressings, blood derivatives and their administration, general medical supplies, and diagnostic and therapeutic procedures as prescribed by the attending physician;

(5) Other ancillary services associated with hospital care except private duty nursing; and

(6) Ten inpatient physician visits within a benefit year.

(c) Within a benefit year, a participating health plan shall provide each enrollee with coverage for the following outpatient services:

(1) A maximum of twelve outpatient visits including adult health assessments, family planning services, diagnosis, treatment, consultations, to include substance abuse treatment, and second opinions. The maximum of twelve outpatient visits shall not apply to:

(A) Emergency services as described in section 17-1722.3-20;

(B) An enrollee's first six mental health visits within a benefit year. After the first six mental health visits, an enrollee may choose to apply a maximum of six additional mental health visits toward the maximum of twelve physician outpatient visits; or

(C) Diagnostic testing, including laboratory and x-ray, directly related to a covered outpatient visit.

(2) Coverage of medically necessary ambulatory surgical care shall be limited to three procedures per benefit year;

(3) Maternity care coverage shall be limited to one routine visit to confirm pregnancy and any visits for the diagnosis and treatment of conditions related to medically indicated or elective termination of pregnancy such as ectopic pregnancy, hydatidiform mole, and missed, incomplete, threatened, or elective

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

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

(1) An enrollee age nineteen to thirty-five years old, inclusive, shall be allowed one examination within a period of five benefit years.

(2) An enrollee thirty-six to fifty-five years old, inclusive, shall be allowed one examination within a period of two benefit years.

(3) An enrollee over fifty-five years old shall be allowed one examination within each benefit year.

(4) An annual pap smear for a woman of child bearing age shall be included in the health assessment for an enrollee age nineteen years or older.

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

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

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

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

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

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

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

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

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

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

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

(1) Custodial or domiciliary care;

(2) Services received in skilled nursing facilities, intermediate care facilities, and intermediate care facilities for the mentally retarded;

(3) Personal care items such as shampoos, toothpaste, mouthwashes, denture cleansers, shoes including orthopedic footwear, slippers, clothing, laundry services, baby oils and powders, sanitary napkins, soaps, lip balms, and bandages;

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

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;

(19) Transportation, including air (fixed wing or helicopter) ambulances;

(20) Hospice services;

(21) All home health agency services;

(22) Home and community based services to include, but not limited to, adult day care, adult day health, assistive living, pediatric attendant care, community care management agency (CCMA) services, community care foster family home services, counseling and training activities, environmental accessibility adaptations, expanded adult residential care homes (E-ARCH) or residential care services, home delivered meals, home maintenance, medically fragile day care, moving assistance, non-medical transportation, personal assistance services, personal emergency response systems, private duty nursing, and respite care;

(23) Personal care, chore services, social worker services, case management services, and targeted case management services;

(24) Tuberculosis services when provided without cost to the general public;

(25) Hansen's disease treatment or follow-up;

(26) Treatment of persons confined to a public institution;

(27) Penile and testicular prostheses and related services;

(28) Chiropractic services;

(29) Psychiatric care and treatment for sex and marriage problems, weight control, employment counseling, primal therapy, long term character analysis, marathon group therapy, and consortium;

(30) Routine foot care and treatment of flat feet;

(31) Swimming lessons, summer camp, gym membership, and weight control classes;

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

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

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

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

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

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

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

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

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

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

SUBCHAPTER 3

SPECIAL BENEFIT PROVISIONS

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

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

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

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

(2) Continue to receive the benefits as described in (1) under the following conditions:

(A) The individual maintains continuous categorical and financial eligibility for QExA as described under chapter 17-1721; and

(B) The individual maintains continuous eligibility for coverage of long-term care services.

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

(1) Be enrolled in a QExA participating health plan and receive state funded long-term care services; and

(2) Continue to receive the benefits as described in (1) under the following conditions:

(A) The individual maintains continuous categorical and financial eligibility for QExA as described under chapters 17-1721, 17-1721.1, or 17-1732; and

(B) The individual maintains continuous eligibility for coverage of long-term care services.

(c) If an individual who is initially eligible under subsections (a) or (b) loses eligibility:

(1) On or before the transition period end date, the individual shall be deemed into Basic Health Hawaii pursuant to subchapter 4;

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

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

(1) The individual maintains continuous eligibility; and

(2) The individual maintains continuous coverage under the SHOTT program.

(b) If an individual who is initially eligible under subsection (a) loses eligibility:

(1) On or before the transition period end date, the individual shall be deemed into Basic Health Hawaii pursuant to subchapter 4;

(2) After the transition period end date, the individual shall be subject to the eligibility and enrollment provisions described in subchapter 2. [Eff 04/01/10]

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

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

SUBCHAPTER 4

INDIVIDUALS DEEMED INTO BASIC HEALTH HAWAII

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

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

(1) Was eligible for and was receiving state medical assistance through the QUEST, QExA, QUEST-Net, QUEST-ACE, Medicaid fee-for-service, or SHOTT programs on the last day of the second month prior to the implementation date;

(2) Maintained continuous eligibility for state medical assistance through the last day of the month prior to the implementation date;

(3) Was not receiving long-term care services on the last day of the second month prior to the implementation date; and

(4) Was not participating in the SHOTT program or was participating in the SHOTT program, but had not received an organ or tissue transplant as of the last day of the second month prior to the implementation date.

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

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

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

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

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

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

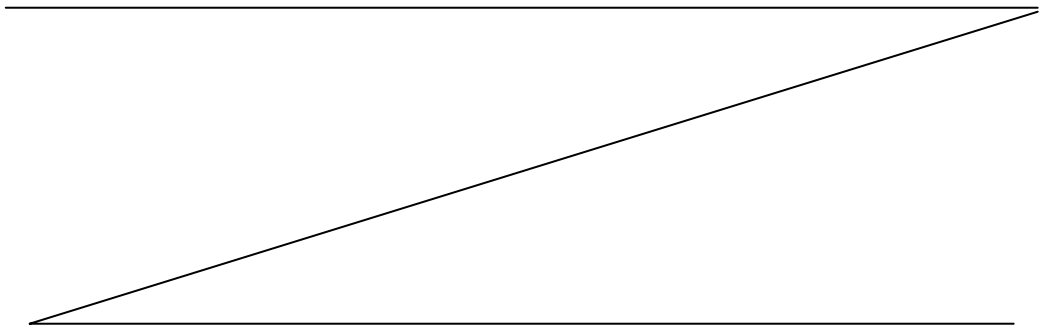
§17-1722.3-35 Enrollment procedures for individuals deemed into Basic Health Hawaii. A deemed individual shall undergo the following health plan selection or assignment options:

(1) If the individual is a member of a health plan that is also a participating health plan, then the individual shall be assigned to that participating health plan;

(2) If the individual is not a member of a health plan that is also a participating health plan, then the individual shall, within ten days, select from among the participating health plans available in the service area in which the individual resides if there is more than one participating health plan;

(3) If an individual allowed to select a participating health plan does not select one within ten days of being determined eligible, the department shall assign and enroll the individual in a participating health plan; and

(4) In the absence of a choice of participating health plans in a service area, an eligible individual who resides in that particular service area shall be enrolled in the available participating health plan. [Eff 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §430.25)



HAWAII ADMINISTRATIVE RULES

TITLE 17

DEPARTMENT OF HUMAN SERVICES

SUBTITLE 12 MED-QUEST DIVISION

CHAPTER 1714

GENERAL ELIGIBILITY REQUIREMENTS

SUBCHAPTER 1

GENERAL PROVISIONS

§17-1714-1 Purpose. The purpose of this chapter is to establish the non-financial general eligibility requirements related to rights, identity, age, furnishing of social security number, residency, institutional status, citizenship, and income eligibility verification requirements for the medical assistance programs. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1714-2 Definitions. As used in this chapter:

"Basic Health Hawaii" means the State funded medical assistance program for aliens age nineteen years and older who are citizens of a COFA nation, or legal permanent residents who have resided in the United States for less than five years.

"Beneficiary data exchange system (BENDEX)" means an automated exchange system in which the SSA transmits social security beneficiary data to the department.

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

"DRA" means the Deficit Reduction Act of 2005 enacted on February 8, 2006.

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

"INA" means the Immigration and Nationality Act (8 U.S.C. §§1101, et seq.).

"Income eligibility verification system (IEVS)" means a system of information acquisition and exchange for purposes of income and eligibility verification which meets the requirements of section 1137 of the Social Security Act (42 U.S.C. §1320b-7).

`"Individual" means an applicant for or recipient of medical assistance.

"Ineligible alien" means an individual whose alien status makes the individual ineligible for assistance.

"INS" means the United States Department of Justice, Immigration and Naturalization Service.

"Institution for mental disease" means an institution which is primarily engaged in providing diagnosis, treatment, or care of persons with mental disease, including medical attention, nursing care, and related services. Whether an institution is an institution for mental diseases is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of individuals with mental diseases, whether or not it is licensed as such.

"Institution for the mentally retarded" means an institution (or distinct part of an institution) that:

(1) Is primarily for the diagnosis, treatment, or rehabilitation of the mentally retarded or persons with related conditions; and

(2) Provides, in a protected residential setting, ongoing evaluation, planning, twenty-four hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at their greatest ability.

"Institution for tuberculosis" means an institution that is primarily engaged in providing diagnosis, treatment, or care of persons with tuberculosis, including medical attention, nursing care, and related services. Whether an institution is an institution for tuberculosis is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of tuberculosis, whether or not it is licensed as such.

"Long-term care facility" means a medical institution such as a skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, or any combination thereof, that furnishes health care services to inpatients.

"Medical institution" means an institution 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 responsibilities 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 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.

"Public institution" means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. Examples include, but shall not be limited to, jails, prisons, and correctional facilities.

"Qualified alien" means:

(1) An alien who is lawfully admitted as a permanent resident under the INA (8 U.S.C. §1101 et seq);

(2) An alien who is granted asylum under section 208 of the INA (8 U.S.C. §1158);

(3) A refugee admitted to the United States under section 207 of the INA (8 U.S.C. §1157);

(4) An alien who is paroled into the United States under section 212(d)(5) of the INA (8 U.S.C. §1182(d)(5)) for a period of at least one year;

(5) An alien whose deportation is withheld under section 243(h) of the INA (8 U.S.C. §1253) or section 241 of the INA (8 U.S.C. §1231);

(6) An alien who is granted conditional entry under section 203(a)(7) of the INA (8 U.S.C. §1153(a)(7)) as in effect before April 1, 1980;

(7) An alien who is a Cuban and Haitian entrant (as defined in section 501(e) of the Refugee Educational Assistance Act of 1980); and

(8) An alien who has been battered or subjected to extreme cruelty in the United States by a spouse or parent, and has been approved for or has a petition pending to be granted status by INS as a battered spouse, a child, or a parent of a battered child under clauses (ii), iii) and (iv) of section 204(a)(1)(A) or clauses (ii) and (iii) of section 204(a)(1)(B) of the INA.

"SSA" means the Social Security Administration of the United States Department of Health and Human Services.

"SSI" means supplemental security income made in the form of monthly cash payments by the SSA.

"SSN" means social security number issued by the SSA.

"State data exchange system (SDX)" means an automated exchange system in which the SSA transmits information on all persons currently receiving SSI benefits to the department.

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

"Third party query (TPQY) request" means a manual system in which the department requests SSA beneficiary or SSI information from the SSA.

"U.S." means the United States of America.

[Eff 08/01/94; am 01/29/96; am 05/17/97; am 12/27/97; am 07/10/06; am 09/10/09; am 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-14; 8 U.S.C. §1641)

§17-1714-3 Right to assistance. (a) The department shall provide medical assistance to any individual or family who meets all of the eligibility conditions set forth by the rules of the department.

(b) The department shall not provide assistance to any individual or family who fails to provide verification of all eligibility conditions or fails to meet all the conditions of eligibility set forth by the rules of the department.

(c) Persons who are eligible for or receiving financial assistance from the department shall receive medical assistance, unless determined ineligible for medicaid coverage due to the individual or family's failure to comply with a medicaid requirement.

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

§17-1714-4 Determination of identity. (a) The identity of family members shall be established by the

provision of documentation required by the DRA prior to the approval of assistance. Individuals who are exempt from the documentation provisions of the DRA are:

(1) Children in receipt of services or benefits under title IV-B or title IV-E of the Social Security Act;
(2) Individuals entitled to or enrolled in Medicare;
(3) Individuals in receipt of disability benefits under title II of the Social Security Act; and
(4) SSI recipients.

(b) The identity of an individual shall be verified through documentary evidence including, but not limited to, the following documents:

(1) U.S. passport;
(2) Certificate of Naturalization (Forms N-550 or N-570);
(3) Certificate of U.S. citizenship (Forms N-560 or N-561);
(4) Cross-match with a federal or state governmental, public assistance, law enforcement, or corrections agency's data system;
(5) State identification card or current state driver's license or permit with the individual's photo or containing other identifying information such as name, age, sex, race, height, weight, or eye color;
(6) Identification card issued by the federal, state, or local government with the same information included on driver's licenses;
(7) School identification card with a photo of the individual;
(8) U.S. military card, draft record, or military dependent's identification card;
(9) U.S. coast guard merchant mariner card;
(10) Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native tribal document with a photograph or other personal identifying information relating to the individual such as age, weight, height, race, sex, and eye color; or
(11) Affidavits signed under penalty of perjury

by a parent, guardian, or caretaker relative attesting to the child's identity if no other document such as a school identification card or a driver's license is available for children under age eighteen.

(c) Three or more documents that together reasonably corroborate the identity of an individual provided such documents have not been used to establish the individual's citizenship and the individual submitted second or third tier evidence of citizenship providing:

(1) There are no other evidence of identity is available to the individual prior to accepting such documents;

(2) The document must contain the individual's name, plus any additional information establishing the individual's identity;

(3) All documents must contain consistent identifying information which reasonably establishes the individual's identity shall be accepted, such as, but not limited to:

(A) Employer ID card;

(B) High school or college diploma from accredited institutions, including general education and high school equivalency diploma;

(C) Marriage certificate;

(D) Divorce decree; or

(E) Property deeds/titles.

(d) Individuals in a skilled nursing facility, intermediate care facility, intermediate care facility for the mentally retarded, or any combination thereof, may have their identity attested to by the facility director or administrator under penalty of perjury when the individual does not have, or cannot get any documents on the preceding list. [Eff 08/01/94; am 06/19/00, am 07/10/06; am 09/10/09] (Auth: HRS §346-14) (Imp: HRS §346-71; 42 C.F.R. §§435.401, 435.407, 435.510; 42 U.S.C. §1396b(x); 42 U.S.C. §1320b-7(d))

§17-1714-5 Determination of age. (a) Verification of an individual's age shall be required when age is a factor in determining eligibility for

assistance or exemption from a program or work requirement.

(b) The primary documentary source for establishing the age of an individual shall be a birth certificate.

(c) When the individual does not have a birth certificate, other documents may be used, such as, but not limited to:

(1) Baptismal certificate;

(2) School record;

(3) Marriage record; (4) Passport;

(4) Military record; or

(5) Social service agency record.

(d) When documentary sources are not available, the following shall be acceptable verification:

(1) Statements of relatives or friends who are knowledgeable of the individual's circumstances. The case record shall contain documentation of the:

(A) Name of the relatives or friends; and

(B) Facts on which the relatives' or friends' knowledge is based; or

(2) SSA determination of age established for SSI or social security benefits.

(e) When all reasonable efforts to establish age have failed, an estimate of age based upon an examination by a physician shall be used.

[Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS § 346-14; 42 C.F.R. §§435.401, 435.520)

§§17-1714-6 to 17-1714-10 (Reserved).

SUBCHAPTER 2

SOCIAL SECURITY NUMBER

§17-1714-11 Purpose. The purpose of this subchapter is to establish the social security number requirement for the medical assistance program.

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

§17-1714-12 Furnishing a social security number. (a) Each individual whose needs, income, or assets are considered in determining eligibility or the amount of assistance shall be required to furnish to the department a SSN.

(b) If the individual cannot furnish an SSN because an SSN has not been issued or is not known, the individual shall apply for a SSN from SSA.

(c) Individuals applying for a SSN shall submit proof to the department that an application to SSA was made and shall be required to report the SSN to the department immediately upon receipt of the SSN.

(d) If the individual applies for a SSN and SSA rejects the application, the individual shall be deemed to have met the requirement of applying for a SSN.

(e) If the individual has more than one SSN, all SSNs shall be submitted to the department.

(f) If the individual applying for a SSN is unable to obtain the documents required by SSA, the department shall make every effort to assist the individual in obtaining the documents.

[Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-71; 42 C.F.R. §435.910)

§17-1714-13 Participation pending receipt of SSN. (a) The department shall not deny, delay, or discontinue assistance or certification pending the issuance or verification of a SSN if the individual has complied with section 17-1714-12.

(b) The individual shall be required to report the SSN to the department immediately upon receipt.

[Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-71; 42 C.F.R. §435.910)

§17-1714-14 Verification of SSN. (a) The department shall verify the SSN reported by the family by submitting the SSN and identifying information to SSA for verification according to procedures established by SSA under the income and eligibility verification system.

(b) Once a SSN has been verified, the department

shall make a permanent annotation to its file to prevent the unnecessary reverification of the SSN.

(c) The department shall accept as verified a SSN which has been:

(1) Verified by another program participating in the income eligibility verification system;

(2) Provided directly to the department by SSA; or

(3) Provided directly to the department by another federal or federally assisted benefit program which has received the number from SSA or has submitted the SSN to SSA for verification. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-71; 42 C.F.R. §§435.10, 435.920)

§17-1714-15 Disqualification. Any individual who fails to obtain or furnish a SSN to the department shall be disqualified from receiving assistance. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: 42 C.F.R. §435.910)

§17-1714-16 Requirements for SSN and use of SSN. (a) The department shall notify the applicant or recipient that the furnishing of a SSN is a condition of eligibility for the following federally funded programs:

(1) AFDC;

(2) QUEST; and

(3) Medical assistance to aged, blind and disabled individuals.

(b) The department shall notify the applicant or recipient that the SSN shall be used in the administration of the program to:

(1) Verify income, eligibility, and benefits through computer matches authorized under the income and eligibility verification systems for the programs identified in subsection (a); and

(2) Complete computer matching to prevent duplicate participation or assistance, to facilitate mass changes in federal benefits, and to verify the accuracy and reliability

of the information provided by the household.

(c) To the extent determined necessary by the United States Department of Health and Human Services (USDHHS), the department shall have access to information regarding applicants and recipients who receive SSI benefits under Title XVI of the Social Security Act, (42 U.S.C. §§1381-1383), to determine the household's eligibility to receive assistance and the amount of assistance, or to verify information related to the benefits of the household. The department shall use the SDX to the maximum extent possible.

[Eff 08/01/94; am 01/29/96] (Auth: HRS §346-14) (Imp: 42 C.F.R. §435.910)

§§17-1714-17 to 17-1714-20 (Reserved).

SUBCHAPTER 3

RESIDENCY AND INSTITUTIONAL STATUS

§17-1714-21 Purpose. The purpose of this subchapter is to establish the residency requirements for applicants and recipients residing in the community or in an institution to receive medical assistance.

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

§17-1714-22 Residency requirements. (a) Residents of the State are individuals who:

(1) Live voluntarily in Hawaii with the intent to remain permanently or indefinitely;

(2) Reside in Hawaii and for whom an adoption assistance agreement is in effect under Title IVE of the Social Security Act, without regard to the state which entered into the agreement with individual;

(3) Reside in Hawaii and receive Title IVE foster care maintenance payments, without

regard to the state which makes the payment; or

(4) Receive state supplemental payments (SSP) under the supplemental security income (SSI) program.

(b) The department may have a written agreement with another state setting forth rules and procedures to resolve disputes involving place of residency.

(c) An individual retains residence in a given state until the individual abandons residence, such as but not limited to:

(1) Voluntarily indicating intent not to return at the point of or after leaving the state;

(2) Requesting to vote in another state or jurisdiction; or

(3) Declaring and paying taxes as a resident of another state.

(d) A resident who is eligible for medical assistance and who is temporarily absent from the State with the intention of returning to Hawaii when the purpose of the absence has been accomplished, does not interrupt a resident's State residency. Within ninety days of the date of departure, the department shall re-evaluate the individual's intent to return to the State.

(1) Notify the department of any intended out-of-state visit prior to the date of the individual's departure and inform the department of their date of departure and the date they intend to return to Hawaii; and

(2) Notify the department of their intended date of return to Hawaii if the date of return is extended beyond the date initially reported.

(e) The state of residency for institutionalized individuals who:

(1) Become incapable of indicating intent before age twenty-one is that of the:

(A) Individual's parents or guardian, if one has been appointed; or

(B) Parent applying for medical assistance on the individual's behalf if the parents reside in separate states and there is no appointed legal guardian;

(2) Become incapable of indicating intent at or

after age twenty-one is the state in which the individual was residing when the individual became incapable of indicating intent; or

(3) Are over twenty-one, in all other cases, is the state where the individual is living with intention to remain permanently or indefinitely.

(f) For purposes of subsection (e), an individual is considered incapable of indicating intent when:

(1) The individuals' IQ is forty-nine or less, or has a mental age of seven or less, based on tests acceptable to the mental retardation agency of the State;

(2) The individual is judged legally incompetent; or

(3) Medical documentation, or other documentation acceptable to the department, supports a finding that the individual is incapable of indicating intent.

(g) Medical assistance shall be provided to residents temporarily absent from the state who:

(1) Meet all the conditions of eligibility for medical assistance as specified in the department's rules; and

(2) Require medical services outside the State under circumstances where services were emergent or when it would have been impractical to return to Hawaii for the necessary medical services. [Eff 08/01/94; am 02/10/97; am 12/27/97] (Auth: HRS §346-14) (Imp: 42 C.F.R. §435.403; 42 U.S.C. §1396a(a))

§17-1714-23 Eligibility requirements for residents of public institutions. (a) The following individuals shall not be eligible for medical assistance:

(1) An inmate in a public institution; and

(2) A resident or patient in an institution for mental disease or tuberculosis.

(b) An individual may be eligible for medical assistance if the individual has been paroled from a public institution or is on conditional release or

convalescent leave from an institution for mental disease or tuberculosis.

(c) An inmate of a public institution may apply for medical assistance but assistance shall not begin until the inmate has left the institution.

(d) An individual shall not be considered an inmate of a public institution when the individual is in a public educational or vocational training institution for purposes of securing education or vocational training.

(e) An inmate of a public institution who is age sixty-five or older, or under age sixty-five and meets the categorical eligibility requirements for a blind or disabled individual, a pregnant woman, or an individual under nineteen years of age, may be eligible, provided all other requirements are met, for inpatient services that are provided in a medical institution that is not located on the grounds of the public institution. [Eff 08/01/94, am 09/10/09] (Auth: HRS §346-14) (Imp: HRS §346-29; 42 C.F.R. §§435.406, 435.407, 42 U.S.C. 1396d)

§17-1714-24 Medical assistance from another state. A person receiving medical assistance from another state shall be considered a resident of Hawaii from the date of arrival in Hawaii. Eligibility for medical assistance only from the State of Hawaii shall be determined from the date residency is established. [Eff 01/29/96] (Auth: HRS §346-53) (Imp: HRS §346-29; 42 C.F.R. §§435.731, 435.831, 435.851)

§§17-1714-25 to 17-1714-26 (Reserved).

SUBCHAPTER 4

CITIZENSHIP AND ALIEN STATUS

§17-1714-27 Purpose. The purpose of this subchapter is to establish the citizenship and alienage requirements an individual or family shall meet to be eligible for medical assistance.

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

§17-1714-28 Citizens and aliens. (a) In order to receive federal medical assistance, an otherwise eligible individual shall be:

(1) A citizen of the United States which shall include the fifty states, the District of Columbia, Puerto Rico, Guam, American Virgin Islands, and the Northern Mariana Islands;

(2) A national from American Samoa or Swain's Island;

(3) An alien who meets the definition of a qualified alien;

(4) An alien who entered the United States prior to January 1, 1972, or any date required by law, and has continuously maintained residency in the United States under section 249 of the INA (8 U.S.C. §1259);

(5) An alien who meets the qualifications of an Amerasian pursuant to 8 U.S.C. §1612;

(6) An alien who is a veteran or active on duty pursuant to 8 USC §1612;

(7) An American Indian born in Canada or who is a member of a Indian tribe described in 25 U.S.C. §450e(b); or

(8) A citizen of a COFA nation who is under age nineteen years, or is pregnant.

(b) The following aliens shall be excluded from receiving federal medical assistance, except for emergency services as described in chapter 1723:

(1) Aliens lawfully admitted for a temporary or specified time period as legal non-immigrants such as:

(A) Visitors;

(B) Tourists;

(C) Diplomats; and
(D) Students who enter the United States temporarily with no intention of abandoning residence in a foreign country;

(2) Aliens who were never legally admitted to the United States for any period of time, or were admitted for a limited time and did not leave when the time expired;
(3) Aliens who are not qualified aliens;
(4) Aliens unable to furnish the required identification. These aliens shall be advised that upon presentation of the proper documentation, the alien shall be eligible to apply for assistance; and
(5) Citizens of a COFA nation age nineteen years and older who are not pregnant.

(c) Citizens of a COFA nation age nineteen years and older who are not pregnant are eligible for state medical assistance provided they:
(1) Were determined eligible, based on the requirements as described in chapters 17-1721, 17-1721.1, 17-1726, 17-1727, 17-1728, 17-1728.1, 17-1730, 17-1732, 17-1733, and 17-1737 except for citizenship; and
(2) Continue to meet those eligibility requirements.

(d) Citizens of a COFA nation age nineteen years and older and not pregnant shall be ineligible for state medical assistance if the eligibility determination was made on or after the first day of the month prior to the implementation of the Basic Health Hawaii program.

(e) The state medical assistance program shall terminate on the day prior to the implementation date of Basic Health Hawaii under chapter 17-1722.3. Upon termination of the state medical assistance program, all enrollees shall be disenrolled. [Eff 08/01/94;

am 05/17/97; am 07/10/06; am 04/01/10] (Auth: HRS §346-14) (Imp: HRS §346-71; 42 C.F.R. §435.406; 42 U.S.C. §1320b-7(d))

§17-1714-29 REPEALED. [Eff 08/01/94; R 05/17/97]

§17-1714-30 Declaration of citizenship and alienage. (a) One adult member shall sign the declaration statement for the SAVE program attesting, under penalty of perjury, whether the individuals in the household are citizens or nationals of the United States or the individuals are qualified aliens and the department shall document each individual's citizenship at the household's initial application and at each subsequent eligibility review. The signature of one adult member at the time of the household's eligibility review is needed to cover any new members that may have been added to the household since the completion of the household's last declaration.

(b) One adult caretaker shall sign on behalf of applicant or recipient children. [Eff 08/01/94; am 01/29/96; am 05/17/97; am 09/10/09] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§435.406, 435.407; 42 U.S.C. §1320b-7; Pub. L. 103-432)

§17-1714-31 Documentation of citizenship. (a) The department shall require documentation of citizenship that meet the requirements of the DRA prior to the approval of assistance. Individuals who are exempt from the documentation provisions of the DRA are:

(1) Children in receipt of services or benefits under Title IV-B or title IV-E of the Social Security Act;

(2) Individuals entitled to or enrolled in Medicare;

(3) Individuals in receipt of disability benefits under Title II of the Social Security Act; and

(4) SSI recipients.

(b) Acceptable forms of documentation of citizenship include, but shall not be limited to:

(1) U.S. passport;

(2) Certificates of U.S. citizenship (Forms N-560 or N-561);

(3) Certificates of naturalization (Forms N-550 or N-570);

(c) If primary documentation of citizenship is unavailable, acceptable forms of secondary documentation of citizenship include, but shall not be limited to a:

(1) U.S. public birth certificate showing birth in:

(A) One of the fifty states;

(B) The District of Columbia;

(C) Guam (if born on or after April 10,1899);

(D) American Samoa;

(E) Swain's Island;

(F) Puerto Rico:

(i) If born on or after January 13,1941;

(ii) Evidence of birth in Puerto Rico on or after April 11, 1899 and the applicant's statement that he or she was residing in the U.S., a U.S. possession, or Puerto Rico on January 13, 1941; or

(iii) Evidence that the applicant was a Puerto Rican citizen and the applicant's statement that he or she was residing in Puerto Rico on March 1, 1917 and that he or she did not take an oath of allegiance to Spain.

(G) U.S. Virgin Islands:

(i) If born on or after January 17,1917);

(ii) Evidence of birth in the U.S. Virgin Islands, and the applicant's statement of residence in the U.S., a U.S. possession, or the U.S. Virgin Islands on February 25, 1927;

(iii) The applicant's statement indicating residence in the U.S.

Virgin Islands as a Danish citizen on January 17, 1917 and residence in the U.S., a U.S. possession, or the U.S. Virgin Islands on February 25, 1927, and that he or she did not make a declaration to maintain Danish citizenship; or

(iv) Evidence of birth in the U.S. Virgin Islands and the applicant's statement indicating residence in the U.S., a U.S. possession or Territory, or the Canal Zone on June 28, 1932.

(H) The Northern Mariana Islands

(i) If born on or after November 4, 1986 (NMI local time);

(ii) Evidence of birth in the Northern Mariana Islands, Trust Territory of the Pacific Islands citizenship and residence in the NMI, the U.S., or a U.S. Territory or possession on November 3, 1986 (NMI local time) and the applicant's Statement that he or she did not owe allegiance to a foreign State on November 4, 1986 (NMI local time);

(iii) Evidence of Trust Territory of the Pacific Islands citizenship, continuous residence in the Northern Mariana Islands since before November 3, 1981 (NMI local time) voter registration before January 1, 1975 and the applicant's statement that he or she did not owe allegiance to a foreign State on November 4, 1986 (NMI local time); or

(iv) Evidence of continuous domicile in the Northern Mariana Islands since before January 1, 1974 and the applicant's statement that he or she did not owe allegiance to a foreign State on November 4, 1986 (NMI local time).

(2) Certification of report of birth (Form DS-1350);
(3) Report of birth abroad of a U.S. citizen (Form FS-240);
(4) Certification of birth issued by the Department of State (Forms FS-545 or DS-1350);
(5) U.S. citizen identification card (Forms I-179 or I-197);
(6) Northern Mariana identification card (Form I-873);
(7) American Indian Card issued by the Department of Homeland Security with the classification code "KIC" (Form I-872);
(8) Final adoption decree with child's name and U.S. place of birth;
(9) Evidence of U.S. civil service employment by the U.S. government before June 1, 1976;
(10) U.S. military record of service showing a U.S. place of birth (Form DD-214) or similar official document;
(11) Verification with the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) database for naturalized citizens; or
(12) Child Citizenship Act whereby adopted or biological children born outside the U.S. may establish citizenship obtained automatically under section 320 of the Immigration and Nationality Act (8 U.S.C. 1431).

(d) If secondary documentation of citizenship is unavailable, acceptable forms of third level of evidence of citizenship shall be used only when the applicant or recipient alleges being born in the U.S., and includes, but shall not be limited to:

(1) An extract of an official hospital record on hospital letterhead established at the time of the person's birth that was created five years before the initial application date and that indicates a U.S. place of birth which is not a souvenir birth certificate.
(2) A life, health, or other insurance record showing a U.S. place of birth that was created at least five years before the

initial application date that indicates a U.S. place of birth.

(3) A religious official record recorded with the religious organization in the U.S. within 3 months of birth showing the birth occurred in the U.S. with either the date of the birth or the individual's age at the time the record was made.

(4) An early school record showing a U.S. place of birth with the name of the child, the date of admission to the school, the date of birth, a U.S. place of birth, and the name(s) and place(s) of birth of the applicant's parents.

(e) If third level of evidence of citizenship is unavailable, acceptable forms of fourth level of evidence of citizenship shall be used only in the rarest of circumstances when the applicant or recipient alleges being born in the U.S., and includes, but shall not be limited to:

(1) A Federal or State census record showing U.S. citizenship or a U.S. place of birth.

(2) One of the following documents that show a U.S. place of birth and was created at least five years before the date of application:

(A) Seneca Indian tribal census.

(B) Bureau of Indian Affairs tribal census records of the Navajo Indians.

(C) U.S. state vital statistics official notification of birth registration.

(D) A delayed U.S. public birth record that is recorded more than five years after the person's birth.

(E) Statement signed by the physician or midwife who was in attendance at the time of birth.

(F) The Roll of Alaska Natives maintained by the Bureau of Indian Affairs.

(3) Institutional admission papers from a nursing facility, skilled care facility or other institution created at least five years before the initial application date that indicates a U.S. place of birth which includes biographical information for the person including a U.S. place of birth.

(4) Medical (clinic, doctor, or hospital) record created at least five years before the initial application date that indicates a U.S. place of birth which includes biographical information for the person including a U.S. place of birth.

(f) Written affidavits should only be used in rare circumstances such as when an individual is homeless, a victim of amnesia, mentally impaired, or physically incapacitated, and who lacks someone who can act on their behalf, and cannot provide documentation of citizenship. If the documentation requirement needs to be met through affidavits, the following conditions shall apply to the affidavits:

(1) There must be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship.

(2) At least one of the individuals making the affidavits cannot be related to the applicant or recipient. Neither of the individuals making the affidavit can be the applicant or recipient.

(3) Persons making the affidavit must be able to prove their own citizenship and identity.

(4) If individuals making the affidavits have information which explains why documentary evidence establishing the applicant's claim of citizenship does not exist or cannot be readily obtained, the affidavit should contain this information as well.

(5) The State must obtain a separate affidavit from the applicant or recipient or other knowledgeable individual, guardian or representative explaining why the evidence does not exist or cannot be obtained.

(6) The affidavits must be signed under penalty of perjury and need not be notarized.

(g) Assistance to the family members who meet the citizenship documentation requirements shall not be delayed for lack of documentation of citizenship of an individual if the rest of the family meets all other eligibility criteria provided:

(1) The individual who fails to provide documentation of citizenship shall be ineligible;

(2) If the ineligible individual is the spouse, parent or legal guardian of another family member, until documentation of U.S. citizenship is obtained, that individual's income and assets shall be considered available to the remaining family members for the medical assistance program; and

(3) If the ineligible individual is under age nineteen, their income and resources shall not be considered in the determination of eligibility for the remainder of the household. This individual shall not be included in the household count.

[Eff 08/01/94; am 01/29/96; am 05/17/97; am 06/19/00; am 07/10/06; am 09/10/09] (Auth: HRS §346-14) (Imp: HRS §346-14; 7 C.F.R. §§273.2(f), 273.11(d); 42 C.F.R. §§435.406, 435.407; 42 U.S.C. §1320b-7)

§17-1714-32 Verification of alien status. (a) The department shall verify the alien status of each applicant and recipient. Applicants and recipients shall provide verification for each alien member as follows:

(1) Aliens lawfully admitted for permanent residence shall present INS form I-151 or I-551 or other documents which identify the aliens' immigration status and which the department determines are reasonable evidence of the aliens' immigration status;

(2) Aliens permanently residing in the United States under conditional residence shall present INS form I-94, court order, grant letter, or other documents which identify the aliens' immigration status and which the department determines are reasonable evidence of the aliens' immigration status. The form I-94 shall be acceptable verification if it is annotated with:

(A) Section 203(a)(7), section 207, section 208, section 212(d)(5), or section 243(h) of the INA; or

(B) One of the following terms or a combination of the following terms:

(i) Refugee;
(ii) Parolee or paroled;
(iii) Conditional entrant or entry;
(iv) Asylum;
(v) Battered or abused individual;
(vi) American Indian born in Canada or a recognized tribe;
(vii) Amerasian; or
(viii) Military veteran or active duty personnel and dependents.

(b) When the INS form does not bear an acceptable annotation and the alien has no other verification of alien classification in the alien's possession, the department shall advise the alien to submit form G-641, Application for Verification of Information from INS Records, to INS. The department shall accept form G-641 when presented by the alien and properly annotated at the bottom by the INS representative as evidence of lawful admission. The alien shall also be advised of the following:

(1) The classifications under sections of the INA that shall result in eligible status;
(2) The alien may be eligible if acceptable verification is obtained;
(3) The alien may contact the INS or otherwise obtain the necessary verification, or if the alien wishes and signs a written consent, the department shall contact INS to obtain clarification of the alien's status; and
(4) If the alien does not wish to contact the INS, the family shall be given the option of withdrawing the application or participating without that individual.

(c) When an alien is unable to provide any INS document, the department shall not be responsible for contacting INS on the alien's behalf. The department shall contact INS when the alien has an INS document that does not clearly indicate eligible or ineligible alien status. When the department accepts non-INS documentation determined to be reasonable evidence of the alien's immigration status, the department shall photocopy the document and transmit the photocopy attached to the INS form G-845 for INS for verification:

(1) Pending the receipt of the verification from the INS, the department shall not deny, delay, reduce, or terminate the individual's eligibility for assistance on the basis of the individual's immigration status; and
(2) The department is not required to obtain the alien's written consent in order to transmit the photocopy to INS.

(d) The department shall provide alien applicants with a reasonable opportunity to submit acceptable documentation of the applicant's eligible alien status prior to the forty-fifth day following the date of application for medical assistance. A reasonable opportunity shall be at least ten days from the date of the department's request for an acceptable document;
(1) An alien who has been given a reasonable opportunity to submit an acceptable document and who has not done so by the forty-fifth day following the date of application for medical assistance shall not be eligible until acceptable documents are received by the department; and
(2) When the department fails to provide an alien applicant with a reasonable opportunity to submit acceptable INS documents and non-INS documents or if the ten day reasonable opportunity period goes beyond the forty-fifth day, the department shall provide the family with medical assistance on the forty-sixth day and medical assistance shall continue until the applicant is determined ineligible.

(e) While awaiting verification, the alien member whose status is questionable shall be ineligible. The ineligible alien's income and assets shall be considered available in determining the eligibility of the remaining family members:
(1) When the department determines from discussions with the household that the alien either does not wish to contact INS or will not give permission for the department to contact the INS for the alien, the family shall be given the option of withdrawing the application or participating without the alien member; and

(2) When the department receives verification of eligible alien status, the department shall act on the information as a reported change in household composition if the family is receiving assistance without the alien member.

(f) When the date of expiration on the INS form has passed, the department shall request documentation from the alien indicating an extension from the expiration date:

(1) If an alien does not possess a document from INS indicating an extension, the alien shall be instructed to obtain the documentation from INS before the individual is determined eligible for initial or continuing assistance;

(2) Without proper documentation, the alien shall be ineligible for assistance; and

(3) At each eligibility redetermination or recertification, the alien status shall be verified if the department has reason to believe a change may have taken place.

[Eff am 08/01/94; am 05/17/97; am 07/10/06] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 U.S.C. §1320b-7; 42 U.S.C. §1396b(x); 42 U.S.C. §1320b-7(d))

§17-1714-33 Aliens who enter the United States on or after August 22, 1996. (a) Notwithstanding any other provision of this subchapter except as provided in subsection (b), an alien who enters the United States on or after August 22, 1996 shall be prohibited from participation in any medical assistance program under Title XIX of the Social Security Act for a period of five years beginning as of the date of the alien's entry into the United States.

(b) The following are exceptions to the provisions of subsection (a).

(1) Medical assistance for care and services that are necessary for treatment of an emergency medical condition of the alien involved and are not related to an organ transplant procedure may be provided to the alien involved, as described in Chapter 17-1723, who meets all other eligibility requirements for coverage; or

(2) The following aliens who enter the United States on or after August 22, 1996 are not subject to the five year prohibition of subsection (a).

(A) An alien who is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act;

(B) An alien who is granted asylum under section 208 of the Immigration and Nationality Act;

(C) An alien whose deportation is being withheld under section 243(h) of the Immigration and Nationality Act;

(D) An alien who is lawfully residing in the State and is either an honorably discharged veteran or active member of the United States armed forces and the spouse or dependent child of such an alien;

(E) An alien who is a Cuban or Haitian refugee or entrant as addressed in Title IV of the Immigration and Nationality Act and section 501 of the Refugee Education Assistance Act;

(F) An alien admitted to the United States as an Amerasian immigrant;

(G) American Indian born in Canada or who is a member of an Indian tribe as defined in 25 U.S.C. §450e(b);

(H) An alien receiving Supplemental Security Income (SSI); or

(I) An alien who is lawfully admitted as a permanent resident under the INA (8 U.S.C. §1101 et seq); and

(i) Is under age nineteen; or

(ii) Is a pregnant woman.

As part of the eligibility redetermination process, the State shall verify that the individual continues to lawfully reside in the United States using the documentation presented by the individual at initial eligibility. If the State cannot verify that the individual is lawfully residing in the United States in this manner, the individual shall be required to provide further documentation or other evidence to verify that the individual is

lawfully residing in the United States. [Eff 01/02/97; am 07/10/06; am 04/30/10] (Auth: HRS §346-14; Pub. L. No. 111-3, §214) (Imp: 8 U.S.C. §1612)

§§17-1714-34 to 17-1714-37 (Reserved).

SUBCHAPTER 5

INCOME AND ELIGIBILITY VERIFICATION SYSTEM (IEVS)

§17-1714-38 Purpose. The purpose of this subchapter is to identify the IEVS matches and how the department will use and process income and eligibility information obtained from the IEVS matches for the assistance programs. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-14)

§17-1714-39 Department responsibility. (a) The department shall maintain and use the IEVS to request citizenship, wage and benefit information from the agencies identified in subsection (b) to:

(1) Verify eligibility for and the amount of assistance due eligible applicants and recipients, including excluded, disqualified, or sanctioned individuals whose income and assets affect the family's eligibility for or amount of assistance;

(2) Investigate to determine whether an applicant or recipient received assistance to which they were not entitled; and

(3) Obtain information which will be used in conducting criminal or civil prosecutions based on receipt of assistance to which the applicant or recipient was not entitled.

(b) The department shall obtain written agreements with provider agencies to ensure that the provider agencies will not record any information about any financial, food stamp, or medical assistance applicant or recipient. The wage and benefit information and agencies are:

(1) Wage information maintained by the state wage information collection agency (SWICA);

(2) Information about net earnings from self-employment, wages, and payments of retirement income maintained by the Social Security Administration (SSA) and available under section 6103(1)(7)(A) of the Internal Revenue Code; and federal retirement, survivors, disability, SSI, and related benefit information from SSA;

(3) Unearned income information from the Internal Revenue Service (IRS) under section 6103(1)(7)(B) of the Internal Revenue Code; and

(4) Claim information from the agency administering the unemployment insurance benefits (UIB) and, in addition, any information about wages and UIB available from that agency which is useful for verifying eligibility and benefits, subject to the provisions and limitations of 42 U.S.C. §503(d).

(c) The department shall document its use of information obtained through the IEVS both when an adverse action is and is not initiated.

[Eff 08/01/94; am 07/10/06] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§435.945, 435.948; 42 U.S.C. §1396b(x))

§17-1714-40 Exchange of information. (a) The department shall, subject to formal exchange agreements, exchange information about a family's circumstances which may be of use in establishing or verifying eligibility or amount of assistance in the medical assistance program and with state agencies administering certain other programs in the IEVS, including agencies in other states when the same objectives are likely to be met. The other programs are:

(1) AFDC;

(2) Medicaid;

(3) Unemployment compensation;

(4) Any state program administered under a plan approved under Title I, X, XIV (adult categories);

(5) Title XVI of the Social Security Act (SSI program);

(6) Food stamp;

(7) Title IVD of the Social Security Act (child support program); and

(8) Title II of the Social Security Act (federal old age, survivors, and disability insurance benefits).

(b) Prior to requesting or exchanging information with other agencies, the department shall execute data exchange agreements with those agencies. [Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§435.945, 435.948)

§17-1714-41 Requesting and using information from IEVS for applicants. (a) The department shall request and use information about all applicants.

(b) Information shall be requested at the next available opportunity after the date of application even if the applicant has been determined eligible by that time. Information about applicants who cannot provide a social security number at application shall be requested at the next available opportunity after the department is notified of the social security number.

(c) Information received within the forty-five day application period for medical assistance shall be used to determine the applicant's eligibility and amount of assistance, if the information is received timely enough that it can be used for that determination.

(d) The department shall make eligibility and amount of assistance determinations without waiting for receipt of IEVS data.

(e) Information received from a source after an eligibility determination has been made shall be used as specified in section 17-1714-42. Eff 08/01/94] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §435.952)

§17-1714-42 Requesting and using information from IEVS for recipients. (a) For all recipients, the department shall:

(1) Request information from the SWICA quarterly, including all recipients who participated in any month of the quarter;

(2) Request information about recipients from SSA data bases no later than the second month of the eligibility or certification period, when

requests at application did not establish automatic reporting to the department of changes in SSA data. Requests shall be through the use of the BENDEX, SDX, and TPQY systems according to procedures specified by the commissioner of the SSA;

(3) Request information from IRS annually for all current recipients according to procedures specified by the commissioner of the IRS;

(4) Request information about UIB from the agency administering the unemployment compensation program as follows:

(A) For all family members about whom requests at application indicate no receipt of UIB, information shall be requested for the three months subsequent to the month of application or until the receipt of UIB is reported, whichever is earlier;

(B) For all family members who report a loss of employment, information shall be requested for the three months subsequent to the month the loss is reported or until the receipt of UIB is reported, whichever is earlier; and

(C) For all family members receiving UIB, information shall be requested monthly until the UIB is exhausted;

(5) Exchange information with other programs or agencies specified in section 17-1714-40 as the department and other agencies or programs may agree;

(6) Request from the unemployment compensation agency any other information besides UIB information which the department determines would be useful in verifying eligibility or amount of assistance of recipients. Requests shall be made by methods at intervals to which the department and the unemployment compensation agency agrees; and

(7) Request information from the department of health and attorney general for all recipients as of July 1, 2006 to implement the Deficit Reduction Act of 2005 through data exchange agreements.

(b) The department shall initiate and pursue action on information about recipients which is received from the sources specified in subsection (a)

so that case action is completed within forty-five days of receipt of that information by the department. Case action shall include:

(1) Review of the information and comparison of the information to case record information; and

(2) For all new or previously unverified information received, contact with the family or collateral sources, or both, to resolve discrepancies.

(c) If discrepancies warrant reducing assistance or terminating eligibility, notices of adverse action shall be sent to the recipient.

(d) When the actions specified in this section substantiate an overissuance, the department shall establish a claim and take recovery action on claims as specified in chapter 17-1705. [Eff 08/01/94, am 07/10/06;] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §435.953; 42 U.S.C. §1396b(x))

§17-1714-43 Processing IEVS information. (a) The department shall take action, including proper notices to households, to terminate, deny, or reduce assistance based on information obtained through the IEVS which is considered verified upon receipt. Information considered verified upon receipt includes:

(1) Social security and SSI benefit information obtained from SSA;

(2) AFDC benefit information;

(3) UIB information obtained from the agency administering the unemployment compensation program; and

(4) Birth certificate and state identification information.

(b) If the department has information that the IEVS-obtained information specified in subsection (a) is questionable, this information shall be considered unverified upon receipt and the department shall take action as specified in subsection (c).

(c) Prior to taking action to terminate, deny, or reduce assistance based on information obtained through the IEVS which is considered unverified upon receipt, the department shall independently verify the information. Information considered unverified includes:

(1) Unearned income information from the IRS;

(2) Wage information from the SSA and SWICA; and

(3) Questionable IEVS information specified in subsection (b).

(d) The requirement of independent verification specified in subsection (c) shall include verification of:

(1) The amount of income or asset involved;

(2) Whether the family has or had access to such income or asset such it would be countable income or asset; and

(3) The period during which such access occurred.

(e) Except with respect to unearned income information from the IRS, if the department has information which indicates that independent verification is not needed, such verification is not required.

(f) The department shall obtain independent verification of unverified information from IEVS by means of contacting the family or the appropriate income, asset, or benefit source, or both.

(g) If the department chooses to contact the family as specified in subsection (f), the department shall do so in writing and shall include:

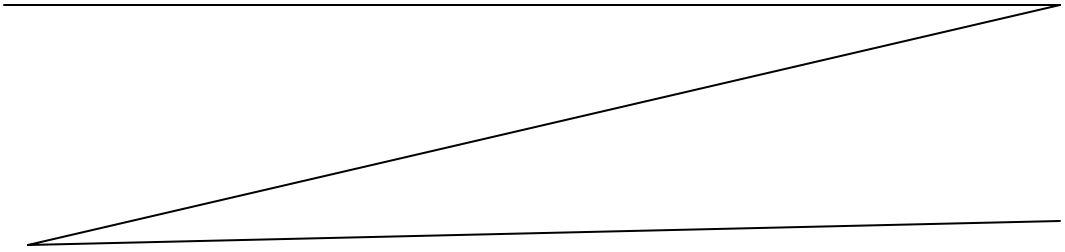
(1) The information which the department has received; and

(2) A request that the family respond within ten days.

(h) If the family fails to respond in a timely manner to the department's request, the department shall send the family a notice of adverse action.

(i) The department may contact the appropriate income, asset, or benefit source by the means best suited to the situation.

(j) When the household or appropriate income, asset, or benefit source provides the independent verification, the department shall properly notice the family of the action the department intends to take and provide the family an opportunity to request a hearing prior to any adverse action. [Eff 08/01/94; am 07/10/06;] (Auth: HRS §346-14) (Imp: HRS §346-14; 42 C.F.R. §§435.952, 435.955; 42 U.S.C. §1396b(x); 42 U.S.C. §1320b-7(d))



CERTIFICATE OF SERVICE

I certify that on August 3, 2011, I electronically filed the foregoing document with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system.

All participants in the case that are registered CM/ECF users will be served by the appellate CM/ECF system.

DATED: Honolulu, Hawai`i, August 3, 2011.

/s/ J. Blaine Rogers
PAUL ALSTON
J. BLAINE ROGERS
ZACHARY A. MCNISH

MARGERY S. BRONSTER
ROBERT M. HATCH
CATHERINE L. AUBUCHON

VICTOR GEMINIANI

Attorneys for Plaintiffs-Appellees
TONY KORAB, TOJIO CLANTON
and KEBEN KNOCH