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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF HAWAIʻI

TONY KORAB, TOJIO CLANTON, KEBEN ENOCH, CASMIRA AGUSTIN, ANTONIO IBANA, AGAPITA MATEO and RENATO MATEO, individually and on behalf of all persons similarly situated,

Plaintiffs,

vs.

PATRICIA MCMANAMAN, in her official capacity as Interim Director of the State of Hawaiʻi, Department of Human Services, and KENNETH FINK, in his official capacity as State of Hawaiʻi, Department of Human Services, Med-QUEST Division Administrator,

Defendants.

Case No. CV 10-00483 JMS KSC
[Civil Rights Action]
[Class Action]

PLAINTIFFS' MEMORANDUM IN OPPOSITION TO DEFENDANTS' MOTION FOR PARTIAL SUMMARY JUDGMENT REGARDING NEW RESIDENTS; PLAINTIFF'S STATEMENT OF UNDISPUTED MATERIAL FACTS; DECLARATION OF CATHERINE L. AUBUCHON; EXHIBITS "A" – "H"; CERTIFICATE OF WORD COUNT; CERTIFICATE OF SERVICE

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PLAINTIFFS' MEMORANDUM IN OPPOSITION TO DEFENDANTS' MOTION FOR PARTIAL SUMMARY JUDGMENT REGARDING NEW RESIDENTS

Plaintiffs TONY KORAB, TOJIO CLANTON, KEBEN ENOCH, CASMIRA AGUSTIN, ANTONIO IBANA, AGAPITA MATEO and RENATO MATEO, individually and on behalf of all persons similarly situated, by and through their attorneys, Lawyers for Equal Justice, Alston Hunt Floyd & Ing, and Bronster Hoshibata, oppose *Defendants' Motion for Partial Summary Judgment Regarding New Residents* filed on April 28, 2011, and request that the Motion be denied.

I. INTRODUCTION

Defendants' Motion for Partial Summary Judgment and this Opposition address Plaintiffs' claims with respect to the New Residents.[1] Defendants argue, *inter alia*, that their actions do not violate the Equal Protection Clause of the Fourteenth Amendment and are subject to and pass rational basis review. They are hanging their hat on the recent Connecticut Supreme Court decision in *Hong Pham v. Starkowski*, ---A.3d---, 2011 WL 1124005 (Conn.

[1] New Residents are legal permanent residents admitted to the United States for less than five years who are nineteen years and older and lawfully a resident in Hawai'i. HAR § 17-1722.3-1.

April 5, 2011), and hope that this Court will adopt the same narrow and misguided interpretation of the Equal Protection Clause and what constitutes a classification based on alienage. *Hong Pham* determined that Connecticut's provision of medical assistance benefits only to citizens and legal immigrants in the country for more than five years, while providing no benefits at all to recent immigrants who are otherwise identically situated, was not discrimination based on alienage and only rational basis review was triggered. *Id.* at *8.

Disingenuously, however, Defendants neglect to even address the analysis in this Court's prior *Order Denying Defendants' Motion To Dismiss For Failure to State a Claim Upon Which Relief May Be Granted As To COFA Residents*, Civ. No. 10-00482 JMS/KSC, 2010 WL 4688824 (D. Hawai'i November 10, 2010) (Doc. 30), which applies with equal force to New Residents. This Court found that Basic Health Hawai'i ("BHH"), State of Hawai'i's state-funded medical assistance program for COFA Residents and New Residents, on its face classifies individuals based on alienage. *Id.* at *11. The Court held that strict scrutiny applies. *Id.* at *11-*12. Likewise, BHH classifies based on alienage with respect to New

Residents. Applying strict scrutiny, Defendants' actions do not pass constitutional muster.

In addition, Defendants continue to misunderstand Plaintiffs' claim under the Americans With Disabilities Act ("ADA"). Rather than focusing on the integration mandate, Defendants contend Plaintiffs are not being discriminated against by reason of their disability because they are not entitled to receive Medicaid benefits under the Personal Responsibility and Work Opportunity Reconciliation Act ("PRWORA") of 1996 and had not received any medical assistance benefits from the State prior to BHH. *See* Def. Mem. (Doc. 62-1) at 27-31. Defendants' reasoning is flawed. By virtue of BHH, Defendants are placing Plaintiffs at risk of hospitalization and isolation which violates the integration mandate of the ADA and constitutes discrimination based on a disability. *See Olmstead v. L.C.*, 527 U.S. 581, 600 (1999); *Ball v. Rodgers*, 2009 WL 1395423, at *5 (D. Ariz. April 24, 2009).

Defendants' actions violate the Equal Protection Clause and the ADA. Their Motion for Partial Summary Judgment must be denied.

II. RELEVANT FACTS

A. Health Services for New Residents in Hawai‘i.

Until 1996, New Residents were eligible for health care under Medicaid, a cooperative federal-state program that provides federal funding for state medical services to the poor, disabled, and others in need. 42 U.S.C. § 1396 *et seq.* The PRWORA of 1996, however, eliminated federal health care coverage for all non-qualified aliens, 8 U.S.C. § 1612(a)(1), and for those legal aliens who have resided in the United States for less than five years, 8 U.S.C. § 1613. New Residents are among those whose eligibility for federal health care benefits ceased with the enactment of PRWORA.

Although PRWORA renders New Residents ineligible for federal Medicaid benefits, it does not prohibit the states from providing state-funded health care benefits to certain aliens, including New Residents. 8 U.S.C. § 1622. Specifically, 8 U.S.C. § 1622(a) 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), a non-immigrant under the Immigrant and Nationality Act [8 U.S.C.A. § 1101 et seq.], or an alien who is paroled into the United States under

> section 212(d)(5) of such Act [8 U.S.C.A. § 1182(d)(5)] for less than one year.

From 1997 to July 2010, the State of Hawai'i chose to provide state-funded health coverage under its then-existing health benefits programs, such as QUEST, QUEST-Net, QUEST-ACE, QExA, the State of Hawai'i Organ and Tissue Transplant ("SHOTT"), and fee-for-service programs (collectively, the "Other Programs"), to certain classes of aliens. For example, DHS provided health coverage to COFA Residents by enrolling them in the Other Programs, under which they received the same benefits as those provided to U.S. citizens. *See Korab*, 2010 WL 4688824, at *2.

DHS, however, did not continue health care coverage under the Other Programs to New Residents. *See* Declaration of Catherine L. Aubuchon ("Aubuchon Decl."), ¶ 3; Exhibit "A" at 5. Instead, the State opted to provide some medical benefits to New Residents through the state-funded Hawai'i Immigrant Health Initiative ("IHI"). *See* Aubuchon Decl., ¶ 4; Exhibit "B". Services provided through IHI included primary care, specialty care, and prescription drugs, but not emergency or inpatient care. *Id.* The benefits provided under IHI are inferior to the benefits provided under the Other

Programs. *Cf.* Exhibits "B" and "H".

On July 1, 2010, Defendants implemented BHH, Hawai'i Administrative Rules ("HAR") § 17-1714-2 *et seq.*, a new state-funded health benefits program expressly for New Residents and COFA Residents. The administrative rules describe BHH as the medical assistance program administered by DHS 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." HAR § 17-1714-2. Certain New Residents were purportedly deemed into BHH, HAR § 17-1722.3-33(b), but Defendants have not produced any verifiable evidence to establish this fact. The class representatives for New Residents in this action were recently denied state-funded medical assistance based upon their alienage or citizenship. *See* Aubuchon Decl., ¶¶ 6-9; Exhibits "D" (Agustin Decl.), ¶ 21; "F" (R. Mateo Decl.), ¶ 31, Exhibit "1". With the implementation of BHH, New Residents became ineligible for IHI.

BHH provides only minimal benefits such as:

- 10 days of medically necessary inpatient hospital care related to medical care, surgery, psychiatric

care, and substance abuse treat;

- 12 outpatient visits including adult health assessments, family planning services, diagnosis, treatment, consultations, to include substance abuse treatment, and second opinions;
- 6 mental health visits, limited to one treatment per day; and
- 4 medication prescriptions per calendar month;

which "shall not exceed a one-month supply." HAR § 17-1722.3-18. BHH does not have any special provisions related to cancer treatments, nor are such treatments covered as an emergency service. Among the exhaustive list of items excluded from BHH coverage are transportation services upon which many elderly, seriously ill, and disabled residents rely to get to and from doctors' visits.[2] HAR § 1722.3-19.

In contrast, the QUEST and QExA programs, from which New Residents are excluded, provide significantly greater benefits than BHH or IHI, and obviously greater benefits than being uninsured.

[2] Emergency services, however, are available to New Residents under HAR § 17-1723-5 of the State's Program for Medical Assistance to Aliens and Refugees ("MAAR").

Both QUEST and QExA provide comprehensive medical and behavioral health and unlimited necessary prescription drugs. QExA also delivers medical and behavioral health services to individuals who are aged, blind or disabled, as well as transportation services. *See* Aubuchon Decl., ¶ 10; *Evercare Member Handbook for the State of Hawai'i QUEST Expanded Access (QExA) Program*, attached as Exhibit "H", at 10-18.

BHH has a 7,000 person statewide enrollment cap, with open enrollment only when enrollment drops below 6,500. HAR § 17-1722.3-10. However, over 7,000 COFA Residents were already receiving state-funded medical assistance as of May 31, 2010. *See* Aubuchon Decl., ¶ 3; Exhibit "A". Eligible COFA Residents, after being disenrolled from the Other Programs, were supposed to have been "deemed into" BHH without regard to the enrollment cap. HAR § 17-1722.3-33; Exhibit "C". Because the current enrollment exceeds the cap by 20% or more, there is no chance of open enrollment for New Residents in the foreseeable future.

B. The Effect Of The Defendants' Discriminatory Policy On New Residents.

In light of their limited coverage or uninsured status, New Residents with serious illnesses do not know if, when or from where they will be able to get preventative care, essential medical treatment, and an adequate supply of prescription drugs. There are numerous compelling examples of the deleterious effects of Defendants' discriminatory policy on New Residents.

For example, Plaintiff Casmira Agustin ("Agustin"), a lawful permanent resident of the United States since 2009, was diagnosed with severe abdominal pain and a cystic mass on her ovary in February 2010. Agustin Decl., ¶ 8. After applying for insurance coverage under Med-QUEST for a one-time emergency service, Agustin underwent surgery at Kapiolani Women's and Childrens Hospital. *Id.*, ¶¶ 11, 13. In April of 2010, however, Agustin received notice from the DHS Med-Quest Division that she was denied medical coverage because of her failure to meet citizenship and alienage criteria, and further, that she was ineligible for emergency medical assistance for aliens. *Id.*, ¶ 21. Thus, Agustin became liable for over $50,000 in medical bills resulting from the

surgery at Kapiolani. *Id.*, ¶ 22.

Plaintiff Antonio Ibana ("Ibana") immigrated to the United States in August 2010 to join his family. Ibana Decl., ¶¶ 2-3. Due to his diabetes, he began to experience severe complications with his eyes and applied for medical coverage under Med-QUEST. *Id.*, ¶ 9. Med-QUEST denied Ibana medical and emergency coverage based on his alienage and immigration status, and Ibana were therefore forced to forego treatment on his eyes. *Id.*, ¶¶ 12-13. As a result, Ibana awoke to bleeding in his right eye a few months later and he has been informed by his doctors that his condition will not improve unless he gets eye surgery. *Id.*, ¶ 18. Ibana will likely go blind without appropriate treatment, but he cannot afford surgery. *Id.*, ¶¶ 10, 21, 22.

Plaintiffs Agapita Mateo ("A. Mateo") and Renato Mateo ("R. Mateo") immigrated from the Philippines in September of 2006, and are lawful permanent residents of the United States. A. Mateo Decl., ¶ 3; R. Mateo Decl., ¶ 3. A. Mateo has diabetes and needs insulin daily. A. Mateo Decl., ¶ 7. In January of 2007, her husband R. Mateo was diagnosed with colon cancer. R. Mateo Decl., ¶ 7. Although R. Mateo had health insurance coverage

through his employer for the surgery to remove the tumor, he was unable to work after the surgery and subsequently lost insurance coverage. *Id.*, ¶ 12. His follow-up chemotherapy treatments and other follow-up treatments cost more than $1,300 per month. *Id.* They struggled to make ends meet in order to pay these medical bills. *Id.*, ¶ 14.

In June of 2009, R. Mateo's cancer returned and spread to his liver. R. Mateo Decl., ¶ 17. By this time, R. Mateo had begun employment at a new job but was terminated prior to the second surgery thus ending his health coverage. *Id.*, ¶ 22. Eventually, the Mateos were unable to afford even the COBRA payments, their insurance policy was cancelled, and they began to rely on friends and family for money and food. *Id.*, ¶ 24. As a result, R. Mateo was unable to get chemotherapy treatment. *Id.*, ¶ 26. Although the Mateos applied for state-funded medical assistance, DHS denied their application on March 2, 2011 because R. Mateo did not satisfy DHS's citizenship or alienage requirements. *Id.*, ¶ 31, Exhibit "1".

C. Procedural Background.

Plaintiffs filed their initial Complaint on August 23, 2010 (Doc. 1). On September 9, 2010, Defendants filed their Motion to Dismiss (Doc. 8). On September 13, 2010, Plaintiffs filed the first Motion for Preliminary Injunction ("First PI Motion"). Although the briefing addressed Plaintiffs' claims with respect to both COFA Residents and New Residents, the parties agreed at the November 2, 2010 hearing that the Court would limit its analysis to COFA Residents only (Doc. 28).

On November 10, 2010, this Court issued the *Order Denying Defendants' Motion to Dismiss for Failure to State a Claim Upon Which Relief May Be Granted As to COFA Residents*, 2010 WL 4688824 (D. Hawai'i Nov. 10, 2010) (Doc. 30, "First Order"). On December 13, 2010, this Court granted the First PI Motion. *See Order Granting Plaintiffs' Motion for Preliminary Injunction*, 2010 WL 5158883 (D. Hawai'i Dec. 13, 2010) (Doc. 42, "Second Order"). Together, the Orders held that Defendants' discriminatory policy of denying benefits under the Other Programs based on alienage or immigration status was subject to heightened scrutiny and, absent compelling justification, violated Plaintiffs' constitutional rights.

On March 23, 2011, Plaintiffs filed a First Amended Complaint which identified the class representatives for New Residents (Casmira Agustin, Antonio Ibana, Agapita Mateo, and Renato Mateo) and replaced Lillian B. Koller, Director of the State of Hawai'i Department of Human Services, with the interim Director Patricia McManaman as a defendant (Doc. 57). All other substantive aspects of the complaint remained unchanged.

On April 28, 2011, Defendants filed the motion at issue here, Motion for Partial Summary Judgment Regarding New Residents (Doc. 62). On the same date, Plaintiffs filed their Motion for Preliminary Injunction Re: New Residents (Doc. 63). Both motions will be heard on June 2, 2011 (Doc. 60).

III. STANDARD FOR SUMMARY JUDGMENT

Rule 56 of the Federal Rules of Civil Procedure provides that summary judgment is warranted only when "there is no genuine issue as to any material fact and that the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(c). "Summary judgment is inappropriate if a reasonable juror, drawing all inferences in favor of the nonmoving party, could return a verdict in the nonmoving party's favor." *James River Ins. Co. v. Hebert*

Schenk, P.C., 523 F.3d 915, 920 (9th Cir. 2008).

In this case, summary judgment should be denied because there are disputed issues of fact and law underlying each of Defendants' proposed grounds for summary judgment. In particular, there are issues of material fact whether any New Residents were actually deemed into BHH on July 1, 2010 or whether any will be able to benefit from the program in the foreseeable future. In addition, Defendants are not entitled to judgment as a matter of law because their actions violate the Equal Protection Clause of the Fourteenth Amendment, are subject to strict scrutiny-not rational basis-review, and violate the integration mandate of the Americans with Disabilities Act ("ADA"). Accordingly, summary judgment cannot be granted as a matter of law, and Defendants' motion must be denied.

IV. ARGUMENT

A. Whether New Residents Were Deemed Into BHH Is A Disputed Issue Of Material Fact That Precludes Summary Judgment.

In order to prevail on a motion for summary judgment, Defendants must establish that there are no genuine issues of material fact. Defendants allege that "[c]ertain New Residents were

deemed into BHH pursuant to HAR § 17-1722.3-33(b)." Fact No. 5 in Defendants' Statement of Undisputed Material Facts (Doc. 62-2); Declaration of Kenneth S. Fink, ¶ 11. However, they provide no documentation to support this statement. In fact, the documentation that has been presented shows that New Residents were not deemed into BHH. *See* Aubuchon Decl., ¶¶ 3, 5; Exhibits "A", "C".

In a DHS Information Act Response, dated June 15, 2010, attached as Exhibit "A", DHS confirmed that as of May 31, 2010, 7,793 COFA Residents were receiving state-only funded medical assistance. *See* Aubuchon Decl., ¶ 3; Exhibit "A" at 4. DHS also confirmed that New Residents were not eligible for state-only funded medical assistance or Medicaid. *Id.*

In an August 25, 2009 memorandum to Medicaid physicians, dentists and other providers, Defendant Fink stated that "about 7,000 non-immigrants, namely those from the Compact of Free Association nations, will be transferred from QUEST and QExA into BHH" and New Residents "may also be eligible." *See* Aubuchon Decl., ¶ 5; Exhibit "C" at 1. The BHH administrative rules impose an enrollment cap of 7,000, and open enrollment can only occur

when the enrollment drops below 6,500. HAR § 17-1722.3-10.

Except for Defendant Fink's unsubstantiated statement that certain New Residents were deemed into BHH, Defendants have failed to produce any evidence that occurred. If there is an enrollment cap of 7,000 and over 7,000 COFA Residents were deemed into BHH on July 1, 2010, New Residents could not have been transferred into the program. This issue of fact is material because although the administrative rules state that New Residents are eligible for BHH and are to be deemed into that program, practically speaking, New Residents have not been able to participate in the program and likely cannot be enrolled in the foreseeable future because of the enrollment cap. In addition, the class representatives for the New Representatives have confirmed that they were denied enrollment in any state-funded medical assistance program because of their alienage or citizenship. *See* Aubuchon Decl., ¶¶ 6-8; Exhibits "D" (Agustin Decl.) ¶ 21, "E" (Ibana Decl.), ¶ 12, "F" (R. Mateo Decl.), ¶ 31.

The contradictory information about New Residents' enrollment in BHH is a genuine issue of material fact that precludes summary judgment. Plaintiffs are entitled to conduct discovery on

this issue pursuant to Fed. R. Civ. P. 56(d).

B. Defendants' Actions With Respect To New Residents Involve A Classification Based On Alienage And Are In Violation Of The Equal Protection Clause.

Defendants claim they have not violated Plaintiffs' right to equal protection under the United States Constitution, because they are not discriminating against aliens in a program that benefits both citizens and aliens. *See* Def. Mem. (Doc. 62-1) at 3-9. Defendants rely heavily on the recent Connecticut Supreme Court decision in *Hong Pham v. Starkowski*, ---A.3d---, 2011 WL 1124005 (Conn. April 5, 2011). However, the Connecticut Supreme Court is wrong, and this Court is not bound by that decision. *Hong Pham* adopts an extremely narrow view of the Equal Protection Clause, refusing to compare the treatment of the plaintiffs in their state-funded, alien only programs to the treatment accorded to United States citizens and other qualified aliens participating in their separate, state-administered federal and state funded program. This approach is misguided and does not comport with *Graham v. Richardson*, 403 U.S. 365 (1971), *Aliessa v. Novello*, 754 N.E.2d 1085 (N.Y. 2001), and *Ehrlich v. Perez*, 908 A.2d 1220 (Md. 2006).

The Equal Protection Clause of the Fourteenth Amendment provides that "[n]o State shall . . . deny to any person within its jurisdiction the equal protection of the laws." U.S. Const., amend. XIV, § 1. This directs the states to treat all persons similarly situated alike. *See City of Cleburne, Texas v. Cleburne Living Center*, 473 U.S. 432, 439 (1985), citing *Plyler v. Doe*, 457 U.S. 202, 216 (1982). The term "person" includes aliens as well as citizens within the jurisdiction of the state in which they reside. *See Graham v. Richardson*, 403 U.S. 365, 371 (1971).

Under any equal protection analysis, the court must first determine what type of classification is involved. *See Aleman v. Glickman*, 17 F.3d 1191, 1195 (9th Cir. 2000). It must next ascertain the appropriate level of scrutiny to employ in evaluating this claim. *Id.* at 1197. This will vary depending upon the types of classifications involved; whether the court is dealing with federal or state action; and if state action is involved, whether the federal government has prescribed a uniform rule which the states must follow that effectively shields them from strict scrutiny.

The focus of the equal protection clause analysis is whether a state in enacting legislation and operating is various programs treat similarly situated individuals differently. In the case of public benefits, there is nothing in the text of the Equal Protection Clause or in relevant case law suggesting that this inquiry depends on whether those benefits are provided in the same or different programs. The bottom line is whether or not the state is responsible for the different treatment.

In general, when a statute classifies by race, alienage, or national origin, strict scrutiny is triggered. *See City of Cleburne*, 473 U.S. at 440. As the *Cleburne* court explained:

> These factors are so seldom relevant to the achievement of any legitimate state interest that laws grounded in such considerations are deemed to reflect prejudice and antipathy-a view that those in the burdened class are not as worthy or deserving as others. For these reasons and because such discrimination is unlikely to be soon rectified by legislative means, these laws are subjected to *strict scrutiny* and will be sustained only if they are suitably tailored to serve a compelling state interest.

Id. (emphasis added). Where a statute classifies by race, alienage, or other "suspect" classification, there is no presumption of statutory validity and no requirement that the plaintiff show invidious or intentional discrimination was intended. *See Parham*

v. Hughes, 441 U.S. 347, 351-53 (1979).

The Defendants' reliance on *Hong Pham*, *Doe v. Comm'r of Transitional Assistance*, 773 N.E.2d 404 (Mass. 2002), *Soskin v. Reinertson,* 353 F.3d 1242 (10th Cir. 2004), and *Khrapunskiy v. Doar*, 909 N.E. 2d 70 (NY 2009), is misplaced. These cases took a narrow view of the Equal Protection Clause, upholding state action that clearly drew classification based on alienage.

In *Hong Pham*, the Supreme Court of Connecticut held the statute substantially eliminating the state medical assistance program for noncitizens did not discriminate against aliens so as to implicate the Equal Protection Clause. In reaching this conclusion, however, it took a narrow view of the Equal Protection Clause unwarranted by either its text or relevant case law. It reasoned that the state did not draw a classification on the basis of alienage because the state only medical assistance program does not benefit citizens as opposed to aliens. 2011 WL 1124005 at *8, *9. As a result, the Connecticut court found it unnecessary to reach the issue of whether it should apply rational basis review or strict scrutiny to state classifications based on alienage that are authorized by federal law. 2011 WL 1124005 at *6.

In reaching this holding, *Hong Pham* purportedly relied on three cases that are discussed below: *Doe*, *Soskin*, and *Khrapunskiy*. At its heart, however, its decision was predicated on its refusal to compare the medical benefits that plaintiff and other noncitizens would no longer receive to those that the state continued to provide to similarly situated citizens and qualified aliens through its participation in the federal Medicaid program.

The Connecticut Supreme Court reasoned that Connecticut's treatment of individuals within its alien only medical assistance program could not be compared to the state's treatment of individuals within its Medicaid program, because that program was "governed and funded substantially by a different government." 2011 WL 1124005 at *14. This reasoning, however, ignored three key facts: (1) Connecticut's participation in the federal Medicaid program was voluntary; (2) the state was responsible for administering the program and determining what, if any, optional benefits it would provide; and (3) it required a significant

expenditure of state funds, *i.e.* 50% of the cost of the program.[3]

The *Hong Pham* opinion did not cite any authority for the proposition that it should only look at the statute authorizing the alien only medical assistance program, and should not compare it to the entire state medical assistance statutory scheme. Its refusal to look beyond the single statute to the entire statutory scheme is based on a narrow view of the Equal Protection Clause that is not rooted in federal jurisprudence.

Hong Pham is a recipe for what states may now do to avoid equal protection challenges when they decide to save money by treating aliens differently than citizens. To illustrate the absurdity of *Hong Pham*'s reasoning, if a state creates a separate medical assistance program only for racial minorities, identical in every way to the medical assistance program provided to white individuals in the state, and then terminates the program for minorities entirely, there would be no classifications based on a suspect class. Since

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[3] Similarly, here, for FY2011, the State of Hawai'i's participation in the federal medicaid program is voluntary, the state is responsible for administering the program, and it pays for 48.21% of the cost of its Medicaid programs while the federal government pays 51.79% of it. *See* http://www.statehealthfacts.org/comparetable.jsp?ind=184&cat =4 (last accessed May 9, 2011).

only minorities were eligible for the "separate medical assistance program" and not white individuals, there was no discrimination. This Court should refuse to adopt such a narrow view of the Equal Protection Clause, particularly when there is no United States Supreme Court or Ninth Circuit case law supporting it.

The Connecticut court's holding in *Hong Pham* was also based on its wholesale adoption of the reasoning in *Soskin* that any discrimination against aliens was Congress's doing, not the states and therefore only subject to rational basis review. The *Soskin* decision is at odds with the Ninth Circuit's decision in *Sudomir v. McMahon*, 767 F.2d 1456, 1464-66 (9th Cir. 1985). To the extent that this Court disagrees with *Soskin*, it should reject *Hong Pham* as well.

Finally, the *Hong Pham* approach overlooks repeated, affirmative statements by the United States Supreme Court that Congress cannot authorize states to violate the equal protection clause of the Fourteenth Amendment, even where it seeks their participation in joint federal-state assistance programs. *See Graham*, 403 U.S. at 382 (Under art. I, § 8, cl. 4, of the Constitution, Congress's power is 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); *Saenz v. Roe*, U.S. 489, 508 (1999) (Congress is without power to enlist state cooperation in a joint federal-state program by legislation which authorizes the States to violate the Equal Protection Clause), citing *Shapiro v. Thompson*, 394 U.S. 618, 641 (1969); *Townsend v. Swank*, 404 U.S. 282, 291 (1971). The Connecticut court neither acknowledged nor recognized this limitation on Congressional authority, even though its reliance on *Soskin* clearly brings this question into play.

In *Doe v. Comm'r of Transitional Assistance*, 773 N.E.2d 404 (Mass. 2002), the plaintiffs were challenging a six-month residency requirement which they argued violated their right to equal protection. The majority held that the six-month residency requirement for state-funded supplemental benefits was subject to rational basis review and did not violate equal protection. *Id.* at 414-15. In doing so, the court acknowledged that PRWORA did not create a uniform rule that shielded the state from strict scrutiny.

Id. at 410. It concluded, however, that that state statute was a residency classification rather than a classification based on alienage. *Id.* at 414.

In reaching this startling conclusion, the *Doe* court claimed that the residency requirement did not harm aliens by barring them from the program completely, but only imposed a six month wait. *Id.* at 414-15. The court never explained how denying aliens cash assistance for up to six months after they moved to the State did not harm them. Assuming there was no harm in *Doe*, this is a far cry from the case presented here where Plaintiffs are essentially being deprived of all medical assistance. As in *Hong Pham*, the Massachusetts court took a narrow view of the Equal Protection Clause without citing to any relevant case law supporting this view.

Hong Pham's reliance on *Khrapunskiy v. Doar*, 909 N.E.2d 70 (N.Y. 2009), was also misplaced. Although the Court of Appeals of New York ruled against plaintiffs' equal protection claim, there is nothing in this decision to justify the conclusion that it would have reached the same holding in dealing with the situation before the Connecticut court. Rather, the New York court's previous decision in *Aliessa v. Novello*, 754 N.E.2d 1085 (N.Y. 2001), was directly

contrary. It held that New York had violated the Equal Protection Clause by denying Medicaid benefits funded solely by the state to plaintiffs based on their status as legal aliens, while provided similar benefits to other similarly situated state residents, but for their alienage. Although the Connecticut court purports to distinguish the case, its efforts are unpersuasive.

Khrapunskiy held that "[b]ecause the State did not create a program of benefits which excluded plaintiffs, levels of scrutiny are inapplicable and there is no basis for an equal protection challenge." *Id.* at 72. The court observed that public assistance to the indigent elderly, blind and disabled underwent a "federal takeover" in 1974. *Id.* It explained that the additional state payments funded by New York were provided simply because "Congress required the states to provide a mandatory minimum supplement" to SSI, and that failure to provide this state funding would have subjected New York to penalties to the state's Medicaid funding. *Id.* at 75, citing 42 U.S.C. § 1382g. It concluded by noting that there was no longer any state program and no state residents receiving assistance as requested by plaintiffs and that equal protection did not require the state to create a program "in order to

guarantee equal outcomes under wholly separate and distinct public benefit programs." *Id.* at 77.

Notably, in *Khrapunskiy*, the New York Court did not revisit its previous holding in *Aliessa*, but distinguished the case on the grounds that it involved a state-funded program, Medicaid, where the instant case involved only the federally administered SSI/ASP program:

> In *Aliessa*, the federal Medicaid program imposed a nationwide policy in which benefits were not available to aliens. However, federal law permitted the states to create a state-funded program. New York enacted such a program which provided benefits to citizens but excluded assistance to aliens. This Court found those exclusions impermissible.

Id. at 382. By contrast, the New York court emphasized that in *Khrapunskiy* there was no state program and no state residents receiving the assistance that plaintiffs sought.

The situation faced in *Khrapunskiy* is distinguishable from that faced by *Hong Pham* and by this Court. In *Khrapunskiy*, the court was dealing solely with a separate federal SSI cash assistance program, in which the State of New York had no role in administering or funding. While New York did fund a cash supplement for those on SSI, it was not responsible for

administering the additional assistance. By contrast, Connecticut did administer and partially fund what can only be called a state Medicaid program.

The case here is certainly more analogous to the Medicaid program in *Aliessa*, rather than the situation in *Khrapunskiy*. The Other Programs are not separate government programs like SSI administered exclusively by the federal government. The Other Programs are administered by the State and funded, in part, by the State. Through their actions, Defendants are denying medical assistance to Plaintiffs and other class members because of their alienage that Defendants continue to provide to U.S. citizens and other aliens through the Other Programs. Defendants are discriminating against Plaintiffs based on alienage.

C. Defendants' Actions Are Subject To Strict Scrutiny.

Defendants contend that their actions are subject to rational basis review, because they have chosen to provide medical benefits to New Residents who are ineligible for federal Medicaid under PRWORA. Doc. 62-1 at 18-25. They also claim that their decision to provide a lesser level of benefits to New Residents than those who are eligible for federally-funded Medicaid benefits satisfies rational

basis review. *Id.* at 25-27. Defendants' arguments are flawed. The Supreme Court has held that when classifications are based on alienage, strict scrutiny applies. *See Graham*, 403 U.S. at 376.

1. State Alienage Classifications Are Subject To Strict Scrutiny.

In general, state classifications based on alienage are subject to strict scrutiny. *See*, *e.g.*, *Bernal v. Fainter*, 467 U.S. 217, 227-28 (1984) (invalidating Texas statute that required notary publics to be citizens under strict scrutiny standard); *Nyquist v. Mauclet*, 432 U.S. 1, 7-12 (1977) (using strict scrutiny in striking down New York statute that restricted eligibility for college scholarships based on alienage).

In *Graham v. Richardson*, 403 U.S. 365 (1971), the Supreme Court applied strict scrutiny to invalidate Arizona and Pennsylvania statutes that denied welfare benefits to otherwise qualified recipients who are aliens. The Pennsylvania statute limited state welfare benefits to citizens or those who had filed a declaration of intent to become a citizen. *Id.* at 368. The Arizona statute limited benefits under federally-funded programs to citizens or individuals who had resided in the United States for at least fifteen years. *Id.*

at 367

The *Graham* court explained that strict scrutiny applies to these state classifications based on alienage:

> Under traditional equal protection principles, a State retains broad discretion to classify as long as its classification has a reasonable basis. This is so in "the area of economics and social welfare." But the Court's decisions have established that classifications based on alienage, like those based on nationality or race, are inherently suspect and subject to close judicial scrutiny. Aliens as a class are a prime example of a "discrete and insular" minority for whom such heightened judicial solicitude is appropriate. Accordingly, it was said in [Takahashi, 334 U.S. at 420], that "the power of a state to apply its laws exclusively to its alien inhabitants as a class is confined within narrow limits."

Id. at 371-72 (citations and footnotes omitted). Applying strict scrutiny to both statutes, Graham concluded that "a state statute that denies welfare benefits to resident aliens and one that denies them to aliens who have not resided in the United States for a specified number of years violate the Equal Protection Clause." *Id.* at 376.

In this case, the State of Hawai'i is unlawfully attempting to do what the *Graham* court said it cannot. It is discriminating against Plaintiffs and other legal immigrants based on their alienage or immigration status. Except as discussed below, such state-based

classification based on alienage is subject to strict scrutiny review.

2. This Case Deals With *State* Rather Than *Federal* Action.

Graham left open the applicable standard of review under the Equal Protection Clause when Congress, itself, enacts statutes providing or depriving benefits based on alienage. 403 U.S. at 382, fn. 14. Then in *Mathews v. Diaz*, 426 U.S. 67 (1976), the Supreme Court upheld a federal law that granted Medicare benefits to certain resident citizens yet denied eligibility to comparable aliens unless they were permanent aliens or had resided in the United States for at least five years. In doing so, the *Mathews* court explained that the federal statute was subject to rational basis review because the responsibility for "regulating the relationship between the United States and our alien visitors" rests exclusively with the political branches of the federal government. *Id.* at 81-82.

Since *Mathews*, courts have upheld ***federal*** classifications between citizens and aliens using a rational basis review. *See*, *e.g.*, *Lewis v. Thompson*, 252 F.3d 567, 582 (2d Cir. 2001) (upholding PRWORA's denial of prenatal Medicaid benefits to unqualified aliens based on rational basis review); *Aleman v. Glickman*, 217 F.3d

1191, 1197 (9th Cir. 2000) (applying rational basis review to challenge of the PRWORA's eligibility requirements for food stamps).

Courts have not handled ***state*** classifications of immigrants in the same way. The different standard of review between federal and state alien classifications is borne out of the different roles the federal and state governments hold regarding aliens. While the federal government has broad constitutional power to "establish a uniform Rule of Naturalization," under Article I, § 8, Cl. 4 of the United States Constitution, the states have no such power. *See Mathews*, 426 U.S. at 84-85.

Here, Plaintiffs are not challenging the citizenship or immigration requirements of federal law. Nor are they attacking the Defendants' rules as they pertain to federally-funded medical assistance. Plaintiffs are challenging the Defendants' denial of state-funded medical assistance benefits to them and other legal immigrants, while at the same time Defendants are providing state-funded medical assistance benefits to citizens and other aliens who are similarly situated.

3. There Is No Uniform Rule That Shields The Defendants' Actions From Strict Scrutiny.

Where Congress has established a uniform rule regarding alienage for the states to follow, however, a state's action in following that rule is subject to rational basis review. *See Plyler v. Doe*, 457 U.S. 202, 219 n. 19 (1982); *Sudomir v. McMahon*, 767 F.2d 1456, 1464-66 (9th Cir. 1985). As *Plyler* explains:

> With respect to the actions of the Federal Government, alienage classifications may be intimately related to the conduct of foreign policy, to the federal prerogative to control access to the United States, and to the plenary federal power to determine who has sufficiently manifested his allegiance to become a citizen of the Nation. No State may independently exercise a like power. But if the Federal Government has by uniform rule prescribed what it believes to be the appropriate standards for the treatment of an alien subclass, the State, may of course, follow the federal direction.

457 U.S. at 219, n. 19. *Plyler*, however, did not explain when the uniformity requirement has been met justifying the use of rational basis review rather than strict scrutiny.

The Ninth Circuit provided some guidance in *Sudomir v. McMahon*, 767 F.2d 1456, 1464-66 (9th Cir. 1985), as to what the uniformity requirement means, albeit only in the context of a

cooperative federal-state welfare assistance program, rather than in the context of a separate alien only program. In *Sudomir*, the plaintiffs raised an equal protection challenge to California's decision not to provide welfare benefits to plaintiff/aliens who had applied for, but not yet received, political asylum. *Id.* at 1457. The Ninth Circuit found that California was simply following a federal statute, which provided that to be eligible for the welfare benefits program, the "individual must be … [inter alia] an alien … permanently residing in the United States under color of law. *Id.* at 1466 (quoting 42 U.S.C. § 602(a)(33) (which was subsequently amended)).

Sudomir interpreted the federal statute to require participating states "not only to grant benefits to eligible aliens but also to deny benefits to aliens" that do not meet the federal standard. *Id.* Because California limited the welfare program benefits as required by the federal statute, *Sudomir* found that California had "employed both a federal classification and a uniform policy regarding the appropriate treatment of a particular subclass of aliens," which was subject to rational basis review. *Id.* Where, however, Congress has not enacted legislation prescribing a uniform rule, state alienage

classifications remain subject to strict scrutiny. That is the case here.

In contrast to *Sudomir*, PRWORA does not dictate any particular state action with respect to New Residents. Instead, states are given a choice as to whether legal immigrants not eligible for federal medical assistance benefits, should be eligible for state-funded medical assistance benefits. *See* 8 U.S.C. § 1622 (a) & (b). This broad grant of discretion in PRWORA creates neither a ***federal classification***, a ***uniform federal policy*** nor a ***mandate*** because the states can do as they please regarding legal aliens no longer eligible for federal benefits. Because of this lack of uniformity, PRWORA's provisions cannot shield state classifications from strict scrutiny, nor be used as justification for rational basis review, as urged by Defendants.

In the First Order (Doc. 30), this Court found the PRWORA did not dictate any particular state action with respect to COFA Residents but instead gave states a choice as to whether they should be eligible for state public benefits. 2010 WL 4688824 at *8.

The Court explained:

> This broad grant of discretion creates neither a federal classification nor a uniform federal policy because the states can do as they please regarding these individuals-under the PRWORA, states may provide these individuals no benefits, some benefits, or the same benefits provided to citizens and qualified aliens. By failing to provide any guidance to states regarding how to choose among these options, the 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 … In other words, the PRWORA's grant of discretion does not guarantee that each state will adopt the same laws regarding non-qualified aliens.

Id. The Court agreed with courts that found PRWORA did not establish a uniform rule that would subject BHH to rational basis review because PRWORA does not require that state defendants provide lesser benefits to Plaintiffs than it does to those qualified under the Other Programs. *Id.* Accordingly, Defendants' determination that COFA Residents should no longer receive the same benefits as citizens and other aliens was subject to strict scrutiny. *Id.* The Court's analysis with respect to COFA Residents applies equally to New Residents.

This case is almost identical to *Ehrlich v. Perez*, 908 A.2d 1220 (Md. 2006). There, lawful permanent aliens sued because the

Governor of Maryland eliminated state funds for a medical assistance program for resident alien children and pregnant women. Plaintiffs alleged that doing so violated their rights to equal protection. 908 A.2d at 1224. The *Ehrlich* court compared the medical benefits the state had been providing to the newly excluded class of aliens to the services it continued to provide to both citizens and resident aliens who met the five-year residency requirement under its joint federal/state-funded Medicaid program. *Id.* at 1227.

The *Ehrlich* court reviewed whether PRWORA prescribed a uniform federal rule that would shield that state from strict scrutiny. Assuming (but not necessarily conceding) that Congress had the power to establish such a rule, it held that PRWORA prescribed no such rule. *Id.* at 1243. Under the strict scrutiny standard, the court held that Maryland's desire to save money failed to justify its decision to eliminate the funding at issue. *Id.* at 1244.

The *Ehrlich* court explained why it disagreed with the decisions in both *Doe*[4] and *Soskin*. *Id.* at 1237, fn. 12. It noted that both cases were at odds with *Graham* and *Nyquist* and that *Soskin*'s view of the uniformity requirement was too narrow. *Id.* at 1237, fn. 12 and 1244, fn. 22. Other courts have considered the question in the medical benefits context and have applied strict scrutiny, concluding that PRWORA does not prescribe a uniform rule regarding alienage that states must follow. *See*, *e.g.*, *Aliessa v. Novello*, 754 N.E.2d 1085, 1098 (2001) (concluding that PRWORA prescribes no uniform rule such that state law denying medical

[4] In *Doe*, the court found that the State of Massachusetts could not point to a uniform federal policy or guideline that would justify a rational basis review standard, but nevertheless concluded that the state classification was not based on alienage but instead discriminated amongst aliens based on residency and therefore was subject to rational basis review. 773 N.E. 2d at 410, 414. As explained *supra* at 25-26, *Doe* is distinguishable. Its conclusion that the state classification was based on residency rather than alienage is not supported by *Nyquist* or *Graham*. More importantly, the Massachusetts court did not cogently and persuasively explain why it refused to compare the treatment of plaintiffs to the treatment of citizens in its separate state-administered federal-state funded program.

assistance to legal immigrants was subject to strict review).[5]

There is no uniform rule with regard to the provision of State funded Medicaid assistance benefits to New Residents. Accordingly, the Court must apply strict scrutiny.

D. Defendants' Actions Violate The Integration Mandate Of The ADA.

Defendants argue that they are entitled to summary judgment on Plaintiffs' ADA claim, because Plaintiffs are not qualified individuals with a disability and they have not been excluded from a public service, program, or activity by reason of their disability. Def. Mem. at 29-31. However, Defendants misunderstand Plaintiffs' ADA claim and the integration mandate.

Title II of the ADA states that "no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of a public entity, or be subjected to discrimination by

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[5] The court in *Aliessa* was the first to consider whether Congress through its enactment of PRWORA had shielded states from strict scrutiny when they chose to deny or terminate benefits based on alienage. It exhaustingly examined the applicable case law and explained why Congress through PRWORA had not adopted a uniform rule that would shield state alienage classifications from strict scrutiny. *Id.* at 1094-99.

any such entity." 42 U.S.C. § 12132. To prove that a public service or program violates the ADA, the plaintiff must show: (1) she is a "qualified individual with a disability;" (2) she was either excluded from participation in or denied the benefits of a public entity's services, programs, or activities or was otherwise discriminated against by the public entity; (3) the service, program, or activity receives federal financial assistance; and (4) such exclusion, denial of benefits, or discrimination was by reason of plaintiff's disability. *See Townsend v. Quasim*, 328 F.3d 511, 516 (9th Cir. 2003).

The purpose of the integration mandate is to end the isolation or segregation of disabled persons. ADA regulations provide: "A public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified persons with disabilities." 28 C.F.R. § 35.130(d). The "most integrated setting" means "a setting that enables individuals with disabilities to interact with non-disabled persons to the fullest extent possible." 28 C.F.R. pt. 35 app A.

As with the COFA Residents, Defendants argue that "Plaintiffs are not qualified individuals with a disability." Def. Mem. at 30. Like the COFA Residents, however, disabled New Residents are

qualified individuals with disabilities. *See Korab*, 2010 WL 4688824 at *13.

Defendants continue to misunderstand Plaintiffs' ADA claim. The ADA claim is based on Defendants' failure to provide care in the most integrated setting through BHH. *Id.* at *13, fn. 7. A state violates the integration mandate when it places individuals at risk of institutionalization. *See Fisher v. Okla. Health Care Auth.*, 335 F.3d 1175, 1181-82 (10th Cir. 2003) (denying motion for summary judgment where evidence established that imposition of cap on prescription medications would place participants in community-based program at high risk for premature entry into nursing homes in violation of ADA); *V.L. v. Wagner*, 669 F. Supp. 2d 1106, 1119-20 (N.D. Cal. 2009) (granting preliminary injunction where plaintiffs established that class members faced a severe risk of institutionalization as a result of losing services new health care plan eliminates); *Ball v. Rodgers*, 2009 WL 1395423, at *5 (D. Ariz. April 24, 2009) (finding violation of the ADA where defendants' "failure to provide Plaintiffs with the necessary services threatened Plaintiffs with institutionalization, prevented them from leaving institutions, and in some instances forced them into institutions in

order to receive their necessary care").

Here, the subclass of disabled New Residents are either unable to enroll in BHH because of the BHH's enrollment cap or cannot get adequate treatment and services for their disabilities. As a result, they are forced to seek care in an institutionalized setting which is in violation of the integration mandate. 28 C.F.R. § 35.310(d). Thus, Defendants are discriminating against the subclass based on their disability.

In fact, some of the Plaintiffs have already been forced to seek medical treatment in the hospital because Defendants denied them state-funded medical assistance. *See*, *e.g.*, Agustin Decl. (Exhibit "D"), ¶¶ 8, 11-14, 21. Other Plaintiffs will likely be hospitalized soon because they have had to forego treatment for serious medical conditions due to lack of health insurance, Defendants' denial of state-funded medical assistance, and Plaintiffs cannot afford to pay for these services without assistance. *See*, *e.g.*, A. Mateo Decl., (Exhibit "G"), ¶¶ 27, 28 (neglecting medical conditions and losing eyesight because she cannot afford to manage her diabetes).

Defendants claim that *Olmstead v. L.C.*, 527 U.S. 581 (1999) is not controlling, because before BHH was implemented, New

Residents had not been receiving any medical benefits from the State. Def. Mem. at 28. This is not true. After PRWORA and before BHH, New Residents did receive some medical benefits, albeit inadequate, through IHI. *See* Aubuchon Decl., ¶ 4; Exhibit "B".

In addition, *Olmstead* is applicable because it held that states must adhere to the ADA's nondiscrimination requirement with regard to the services they provide. 527 U.S. at 603, fn. 14. Unjustified institutional isolation of persons with disabilities is a form of discrimination. *Id.* at 600. BHH is so severally inadequate for disabled New Residents that it unjustifiably places them at risk of being institutionalized and isolated. Through BHH, Defendants are discriminating against the New Residents based on their disability. Defendants are not entitled to summary judgment on the ADA claim.

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V. CONCLUSION

Plaintiffs respectfully request that the Court DENY *Defendants' Motion for Partial Summary Judgment Regarding New Residents* filed on April 28, 2011.

DATED: Honolulu, Hawai'i, May 9, 2011.

/s/ CATHERINE L. AUBUCHON
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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF HAWAIʻI

TONY KORAB, TOJIO CLANTON KEBEN ENOCH, CASMIRA AGUSTIN, ANTONIO IBANA, AGAPITA MATEO and RENATO MATEO, individually and on behalf of all persons similarly situated,

Plaintiffs,

vs.

PATRICIA MCMANAMAN, in her official capacity as Interim Director of the State of Hawaiʻi, Department of Human Services, and KENNETH FINK, in his official capacity as State of Hawaiʻi, Department of Human Services, Med-QUEST Division Administrator,

Defendants.

Case No. CV 10-00483 JMS KSC
[Civil Rights Action]
[Class Action]

PLAINTIFFS' STATEMENT OF UNDISPUTED MATERIAL FACTS

PLAINTIFFS' STATEMENT OF UNDISPUTED MATERIAL FACTS

	FACT	EVIDENTIARY SUPPORT
1	Until 1996, New Residents were eligible for health care under Medicaid, a cooperative federal-state program that provides federal funding for state medical services to the poor, disabled, and others in need.	42 U.S.C. § 1396 *et seq.*
2	The Personal Responsibility and Work Opportunity Reconciliation Act ("PRWORA") of 1996 eliminated federal health care coverage for all non-qualified aliens and for those legal aliens who have resided in the United States for less than five years.	8 U.S.C. § 1612(a)(1); 8 U.S.C. § 1613.
3	New Residents are among those whose eligibility for federal health care benefits ceased with the enactment of PRWORA.	8 U.S.C. § 1612(a)(1); 8 U.S.C. § 1613.
4	PRWORA does not prohibit the states from providing state-funded health care benefits to New Residents.	8 U.S.C. § 1622.

5	From 1997 to July 2010, the State of Hawai‘i chose to provide state-funded health coverage under its then-existing health benefits programs, such as QUEST, QUEST-Net, QUEST-ACE, QExA, SHOTT, and fee-for-service programs (collectively, the "Other Programs"), to certain classes of aliens.	*Korab v. Koller*, 2010 WL 4688824, at *2 (D. Hawaii, November 10, 2010).
6	From 1997 to July 2010, DHS provided health coverage to COFA Residents by enrolling them in the Other Programs, under which they received the same benefits as those provided to U.S. citizens.	*Korab*, 2010 WL 4688824, at *2.
7	DHS did not continue health care coverage under the Other Programs to New Residents.	Aubuchon Decl.; Exhibits "A" and "C".
8	DHS opted to provide some medical benefits to New Residents through the state-funded Hawaii Immigrant Health Initiative.	Aubuchon Decl.; Exhibit "B".
9	Services provided through IHI included primary care, specialty care, and prescription drugs, but not emergency or inpatient care.	Aubuchon Decl.; Exhibit "B".

10	The benefits provided under IHI are inferior to the benefits provided under the Other Programs.	Aubuchon Decl.; Exhibits "B" and "H".
11	BHH is described as the medical assistance program administered by DHS 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."	HAR § 17-1714-2.
12	Certain New Residents were purportedly deemed into BHH, HAR § 17-1722.3-33(b).	HAR § 17-1722.3-33(b).
13	The class representatives for New Residents were recently denied state-funded medical assistance based upon their alienage or citizenship.	Aubuchon Decl.; Exhibits "D", "F" and "1".
14	BHH has a 7,000 person statewide enrollment cap, with open enrollment only when enrollment drops below 6,500.	HAR § 17-1722.3-10.

15	Over 7,000 COFA Residents were receiving state-funded medical assistance as of May 31, 2010.	Aubuchon Decl.; Exhibit "A".
16	Over 7,000 COFA Residents were deemed into BHH on July 1, 2010.	Aubuchon Decl.; Exhibit "C".

DATED: Honolulu, Hawai'i, May 9, 2011.

/s/ CATHERINE L. AUBUCHON
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Defendants.

Case No. CV 10-00483 JMS KSC
[Civil Rights Action]
[Class Action]

DECLARATION OF CATHERINE L. AUBUCHON

DECLARATION OF CATHERINE AUBUCHON

I, Catherine L. Aubuchon, under penalty of law declare as follows:

1. I am an attorney licensed to practice before the Court and am one of the attorneys for Plaintiffs in this action. I have personal knowledge of and am competent to testify to the matters set forth below.

2. I make this declaration in support of *Plaintiffs' Memorandum in Opposition to Defendants' Motion for Partial Summary Judgment Regarding New Residents*.

3. Attached as Exhibit "A" is a true and correct copy of the DHS Information Act Response dated June 15, 2010. Exhibit "A" was previously authenticated by the Declaration of Elizabeth M. Dunne, dated September 13, 2010 ("Dunne Decl."), ¶ 16, which was attached to *Plaintiffs' Motion for Preliminary Injunction*, filed September 13, 2010 (Doc. 10).

4. Attached as Exhibit "B" is a true and correct copy of a description of the Immigrant Health Initiative, available at http://www.hawaiipca.net/40/immigrant-health (last accessed May 9, 2011).

5. Attached as Exhibit "C" is a true and correct copy of a letter from Dr. Kenneth S. Fink to Medicaid Physicians and others, dated August 25, 2009, available at http://www.med-quest.us/PDFs/Provider%20Memos/ACSMEMO2009/ACS%20M09-21.pdf (last accessed May 9, 2011).

6. Attached as Exhibit "D" is a true and correct copy of the Declaration of Casmira Agustin dated March, 2011, originally filed with *Plaintiffs' Motion for Preliminary Injunction Re: New Residents*, filed April 28, 2011 (Doc. 63) ("Second PI Motion").

7. Attached as Exhibit "E" is a true and correct copy of the Declaration of Antonio Ibana dated March 7, 2010, originally filed with Plaintiffs' Second PI Motion.

8. Attached as Exhibit "F" is a true and correct copy of the Declaration of Renato Mateo dated March 10, 2011, originally filed with Plaintiffs' Second PI Motion. Included with Exhibit "F" is Exhibit "1", DHS's letter dated March 2, 2011 denying the applications of Renato and Agapita Mateo for State medical assistance due to alienage or citizenship.

9. Attached as Exhibit "G" is a true and correct copy of the Declaration of Agapita Mateo dated March 10, 2011, originally filed with Plaintiffs' Second PI Motion.

10. Attached as Exhibit "H" is a true and correct copy of the Evercare Member Handbook for the State of Hawaii QUEST Expanded Access (QExA) Program. Exhibit "H" was previously authenticated by the Dunne Decl., ¶ 14.

I declare under penalty of perjury that the foregoing statements are true and correct to the best of my knowledge.

DATED: Honolulu, Hawai'i, May 9, 2011.

/s/ CATHERINE L. AUBUCHON
CATHERINE L. AUBUCHON

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NOTICE TO REQUESTER

(Use multiple forms if necessary)

TO: Elizabeth Dunne – Lawyers for Equal Justice

FROM: Priscilla Thode – DHS Med-QUEST Division Office 692-8140 FAX 692-8173

(Agency/name & telephone number of contact person at agency)

DATE REQUEST RECEIVED: 05/28/10
DATE OF THIS NOTICE: 06/15/10

GOVERNMENT RECORDS YOU REQUESTED (attach copy of request or provide brief description below):

1. 1. Any document(s) reflecting the number of citizens of COFA nations and legal permanent residents eligible for and receiving state medical assistance or financial assistance, as those terms are defined in the BHH rules, HAR, Title 17, Chapter 1722.3 on July 31, 2009.

2. Any document(s) reflecting the number of citizens of COFA nations and legal permanent residents eligible for and receiving state medical assistance or financial assistance, as those terms are defined in the BHH rules, HAR, Title 17, Chapter 1722.3 on May 31, 2010.

3. Any document(s) reflecting the amount of money spent on state medical assistance for citizens of COFA nations for the years 2008, 2009 and 2010.

4. All documents concerning any agreement(s) between the State of Hawaii and the federal government regarding the provision of medical assistance, including dialysis, to aliens and refugees under Medicaid's emergency medical assistance provisions.

NOTICE IS PROVIDED TO YOU THAT YOUR REQUEST:

☒ **Will be granted in its entirety.**

☐ **Cannot be granted because**

- ☐ Agency does not maintain the records. Agency believed to maintain records: _____
- ☐ Agency needs a further description or clarification of the records requested. Please contact the agency and provide the following information: _____
- ☐ Request requires agency to create a summary or compilation from records not readily retrievable.

☐ **Is denied in its entirety** ☐ **Will be granted only as to certain parts**
based upon the following exemption provided in HRS § 92F-13 and/or § 92F-22 and other laws cited below (portions of records that agency will not disclose should be described in general terms).

RECORDS OR INFORMATION WITHHELD	APPLICABLE STATUTES	AGENCY JUSTIFICATION

OIP 4 (rev. 8/2[illegible])

EXHIBIT A

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REQUESTER'S RESPONSIBILITIES:

You are required to (1) pay any lawful fees assessed; (2) make any necessary arrangements with the agency to inspect, copy or receive copies as instructed below; and (3) provide the agency any additional information requested. If you do not comply with the requirements set forth in this notice within 20 business days after the postmark date of this notice or the date the agency makes the records available, you will be presumed to have abandoned your request and the agency shall have no further duty to process your request. Once the agency begins to process your request, you may be liable for any fees incurred. If you wish to cancel or modify your request, you must advise the agency upon receipt of this notice.

METHOD & TIMING OF DISCLOSURE:

Records available for public access in their entireties must be disclosed within a reasonable time, not to exceed 10 business days, or after receipt of any prepayment required. Records not available in their entireties must be disclosed within 5 business days of this notice or after receipt of any prepayment required. If incremental disclosure is authorized by HAR § 2-71-15, the first increment must be disclosed within 5 business days of this notice or after receipt of any prepayment required.

Method of Disclosure:

☐ Inspection at the following location: _____.
☒ Copy will be provided in the following manner:
  ☐ Available for pick-up at the following location: _____.
  ☒ Will be mailed to you.
  ☐ Will be transmitted to you by other means requested: _____.

Timing of Disclosure: All records, or first increment where applicable, will be made available or provided to you:

☐ On _____.
☐ After prepayment of fees and costs of $ _____ (50% of fees +100% of costs, as estimated below).
Payment may be made by: ☐ cash ☐ personal check ☐ other _____.

For incremental disclosures, each subsequent increment will be disclosed within 20 business days after:
  ☐ The prior increment (if one prepayment of fees is required and received).
  ☐ Receipt of each incremental prepayment required.
  Disclosure is being made in increments because the records are voluminous and the following extenuating circumstances exist:
    ☐ Agency must consult with another person to determine whether the record is exempt from disclosure under HRS chapter 92F.
    ☐ Request requires extensive agency efforts to search, review, or segregate the records or otherwise prepare the records for inspection or copying.
    ☐ Agency requires additional time to respond to the request in order to avoid an unreasonable interference with its other statutory duties and functions.
    ☐ A natural disaster or other situation beyond agency's control prevents agency from responding to the request within 10 business days.

ESTIMATED FEES & COSTS:

The agency is authorized to charge you certain fees and costs to process your request (even if no record is subsequently found to exist), but must waive the first $30 in fees assessed for general requesters and the first $60 in fees when the agency finds that the request made is in the public interest. See HAR §§ 2-71-19, -31 and -32. The agency may require prepayment of 50% of the total estimated fees and 100% of the total estimated costs prior to processing your request. The following is the estimate of the fees and costs that the agency will charge you, with the applicable waiver amount deducted:

Fees: Search Estimate of time to be spent: _____ $ _____
($2.50 for each 15-minute period)

	Review & segregation	Estimate of time to be spent: _____ ($5.00 for each 15-minute period)	$ _____
	Fees waived	☐ general ($30) ☐ public interest ($60)	<$ _____>
	Other	_____ (Pursuant to HAR § 2-7-31(B))	$ _____
	Total Estimated Fees:		$ _____
Costs:	Copying	Estimate of # of pages to be copied: _____ (@ $ _____ per page.)	$ _____
	Other	_____	$ _____
	Total Estimated Costs:		$ No Fee

For questions about this notice, please contact the person named above. Questions regarding compliance with the UIPA may be directed to the Office of Information Practices at 808-586-1400 or oip@hawaii.gov.

In response to your request for information, the following is provided:

(1) The number of citizens of Compact of Free Association nations who were receiving state-only funded medical assistance as of July 31, 2009 was 6,556.

Non-pregnant adult aliens legally residing in the United States for less than five years are currently not eligible for state-only funded medical assistance or Medicaid. Questions on the receipt of financial assistance should be directed to the Benefit, Employment and Support Services Division.

(2) The number of citizens of Compact of Free Association nations who were receiving state-only funded medical assistance as of July 31, 2009 was 7,793.

Non-pregnant adult aliens legally residing in the United States for less than five years are currently not eligible for state-only funded medical assistance or Medicaid. Questions on the receipt of financial assistance should be directed to the Benefit, Employment and Support Services Division.

(3) The following table contains the amount spent on medical assistance for citizens of Compact of Free Association nations for 2007, 2008, and 2009. The 2010 data will not be available until sometime later this year.

Year	Amount
2007	$28,798,721
2008	$33,492,322
2009	$43,053,881
2010	N/A

(4) A copy of the State Plan section on emergency medical assistance is attached.

Revision: HCFA-PM-98-1 (CMSO)
APRIL 1998

State: HAWAII

Citation

Sec. 245A(h) of the Immigration and Nationality Act

(a)(6) Limited Coverage for Certain Aliens

(i) Aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who meet the financial and categorical eligibility requirements under the approved State Medicaid plan are provided the services covered under the plan if they--

(A) Are aged, blind, or disabled individuals as defined in section 1614(a)(1) of the Act;

(B) Are children under 18 years of age; or

(C) Are Cuban or Haitian entrants as defined in section 501(e)(1) and (2)(A) of P.L.96-422 in effect on April 1, 1983.

(ii) Except for emergency services and pregnancy-related services, as defined in 42 CFR 447.53(b) aliens granted lawful temporary resident status under section 245A of the Immigration and Nationality Act who are not identified in items 3.1(a)(6)(i)(A) through (C) above, and who meet the financial and categorical eligibility requirements under the approved State plan are provided services under the plan no earlier than five years from the date the alien is granted lawful temporary resident status.

Revision: HCFA-PM-91- 4 (BPD) OMB No.: 0938-
AUGUST 1991

State/Territory: Hawaii

Citation			Amount, Duration, and Scope of Services: Limited Coverage for Certain Aliens (continued)
1902(a) and 1903(v) of the Act		(iii)	Aliens who are not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law who meet the eligibility conditions under this plan, except for the requirement for receipt of AFDC, SSI, or a State supplementary payment, are provided Medicaid only for care and services necessary for the treatment of an emergency medical condition (including emergency labor and delivery) as defined in section 1903(v)(3) of the Act.
1905(a)(9) of the Act		(a)(7)	Homeless Individuals. Clinic services furnished to eligible individuals who do not reside in a permanent dwelling or do not have a fixed home or mailing address are provided without restrictions regarding the site at which the services are furnished.
1902(a)(47) and 1920 of the Act	☐	(a)(8)	Presumptively Eligible Pregnant Women Ambulatory prenatal care for pregnant women is provided during a presumptive eligibility period if the care is furnished by a provider that is eligible for payment under the State plan.
42 CFR 441.55 50 FR 43654 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act		(a)(9)	EPSDT Services. The Medicaid agency meets the requirements of sections 1902(a)(43), 1905(a)(4)(B), and 1905(r) of the Act with respect to early and periodic screening, diagnostic, and treatment (EPSDT) services.

TN No. 94-010
Supersedes TN No. 92-05

Approval Date 9/22/94

Effective Date 8/1/94

HCFA ID: 7982E

Bookmark

Hawaii Primary Care Association

Immigrant Health

What is the Hawaii Immigrant Health Initiative program?

The Immigrant Health Initiative (IHI), provides for low-cost or free health care to recently arrived immigrants who meet certain qualifications. Participation in this program does not make the beneficiary a "public charge" for the purpose of immigration law.

Who administers IHI Program funds?

The Hawai'i Primary Care Association administers IHI funds under contract with the State of Hawaii Department of Human Services.

Who qualifies?

All legal permanent residents (green card holders), ages 19 and older who entered the United States on or after August 22, 1996 and who are not eligible for federally-funded medical assistance for the first five years of residency in the United States. All legal permanent resident aliens must provide proof of Hawaii residency in order to be eligible for this program.

What Medical Services are provided?

Participating community health centers will provide IHI patients with:

- Primary care for eligible adults, including physical exams, diagnoses, and treatment for chronic, episodic and acute conditions.
- Preventive care and education.
- Specialty care.
- Prescription drugs and supplies.
- Follow-up care.
- Tuberculin testing and immunizations.
- Gynecological services, family planning, yearly pap smears, contraceptive management and related follow-up.
- Specialty care services:
  - Outpatient diagnostic and radiology services.
  - Outpatient specialty services.
  - Outpatient therapeutic procedures.
  - Prescription and non-prescription drugs and supplies.
  - Referral services are paid at applicable Medicare rates and may include specialty, diagnostics and procedures as outlined above.

Services Not Included

Inpatient care.
Emergency care (except for emergency dental services).
Visits and treatment for pregnant immigrants (these services are now covered by Medicaid)

EXHIBIT B

Any benefit not provided by Medicaid or QUEST.

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LINDA LINGLE
GOVERNOR

LILLIAN B. KOLLER, ESQ.
DIRECTOR

HENRY OLIVA
DEPUTY DIRECTOR

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES
Med-QUEST Division
Clinical Standards Office
P. O. Box 700190
Kapolei, Hawaii 96709-0190

August 25, 2009

MEMORANDUM ACS M09-21

TO: Medicaid Physicians, Dentists, Other Providers with Prescriptive Authority and Pharmacy Providers

FROM: Kenneth S. Fink, MD, MGA, MPH KF
Med-QUEST Division Administrator

SUBJECTS: FEE-FOR-SERVICE (FFS) PROGRAM ONLY

1. BASIC HEALTH HAWAII, QUEST-NET AND QUEST-ACE FORMULARY EFFECTIVE SEPTEMBER 1, 2009
2. FIRST DATABANK AWP CALCULATION CHANGE EFFECTIVE SEPTEMBER 26, 2009

1. Basic Health Hawaii, QUEST-Net and QUEST-ACE Formulary Effective September 1, 2009

The Department of Human Services (DHS) is implementing a new health insurance program starting September 1, 2009 called Basic Health Hawaii (BHH). This program will provide basic medical care for low-income non-pregnant legally residing adults who are not eligible for federal medical assistance programs.

About 7,000 non-immigrants, namely those from the Compact Free Association nations, will be transferred from the comprehensive QUEST and QUEST Expanded Access (QExA) health care plans into BHH, which will have a benefit package identical to what low-income adults receive through QUEST-ACE and QUEST-Net programs. In addition, immigrants who have been legally residing in the United States for less than five (5) years may also be eligible.

BHH, QUEST-Net and QUEST-ACE will all receive an expanded prescription drug benefit. Some of the savings from the implementation of BHH will be used to fund the expanded drug coverage for more than 8,000 non-pregnant adult clients in QUEST-ACE and QUEST-Net.

Effective September 1, 2009, QUEST-ACE, QUEST-Net and BHH clients may receive up to five (5) generic prescriptions/paid claims per calendar month PLUS contraceptives. A prescription for Regular and NPH insulin may substitute for a generic prescription. Each paid claim is counted as one of the five (5) generic prescriptions. Diabetic supplies (specifically lancets, syringes and test

EXHIBIT C

strips) will also be covered and NOT counted as one of the five (5) generic prescriptions. Contraceptives will NOT count towards the limit of five (5) prescriptions (see Table 1). These are the only exceptions to the five (5) generic prescription limits.

Clients currently receiving medical assistance will be deemed eligible for BHH and will not have a break in coverage. However, during the period between when a newly eligible applicant applies and is enrolled in a BHH plan, Hawaii Medicaid FFS will reimburse services. FFS will be covering all generics available to Medicaid FFS recipients, and pharmacy claims are to be submitted to Affiliated Computer Services Pharmacy Benefit Manager (ACS PBM). Diabetic supplies are to be billed to ACS Fiscal Agent (FA).

The QUEST plans will provide ongoing care for BHH recipients and continue to provide services for QUEST-ACE and QUEST-Net. They will each establish their own drug formulary that will include at least one (1) generic per American Hospital Formulary Service (AHFS) therapeutic category. Prior authorization may be required for non-formulary generic products. For inquiries regarding the BHH, QUEST-Net and QUEST-ACE program pharmacy benefit, please contact the appropriate managed care health plans:

AlohaCare:	973-1650, for neighbor islands 1 (800) 434-1002
HMSA:	948-6486, for neighbor islands 1 (800) 440-0640
Kaiser:	432-5330, for neighbor islands 1 (800) 651-2237

2. First DataBank Average Wholesale Price Calculation Change Effective September 26, 2009

Effective September 26, 2009, First DataBank (FDB) will be changing the mark-up value used to calculate the Average Wholesale Price (AWP) for certain drugs in compliance with a lawsuit settlement. As a result, reimbursements to pharmacy providers are expected to be lower for a number of products. The calculation of the State Maximum Allowable Cost (SMAC) may also be impacted. Please see the excerpts below from a FDB notice issued March 31, 2009:

> "According to the terms of the amended settlement as approved by the court, First DataBank will adjust its reporting of Blue Book AWP for those prescription drugs identified in the plaintiffs' previously filed complaint (approximately 1,400 NDCs in number) by reducing the mark-up factor utilized in connection with the calculation of the Blue Book AWP data field to 1.20 times the WAC or Direct Price for those NDCs that are on a mark-up basis."
>
> "Independent of the settlement and on the same schedule as the Blue Book AWP adjustment noted above, First DataBank will apply the same 1.20 markup factor to all other NDCs whose Blue Book AWP is set based upon a markup to WAC or Direct Price in excess of 1.20. First DataBank will also independently discontinue publishing the Blue Book AWP data field for all drugs no later than two years following the date that the Blue Book AWP adjustments noted above are implemented."

For Medicaid FFS Pharmacy policy questions, please contact Lynn Donovan, R.Ph., Pharmacy Consultant, at (808) 692-8116.

Attachment

Med-QUEST Fee-For-Service (FFS)

FFS Window Coverage For Newly Eligible Recipients Waiting For Basic Health Hawaii, QUEST-Net and QUEST-ACE

New Formulary

Effective September 1, 2009

Table 1

Basic Health Hawaii, QUEST-Net and QUEST-ACE	**Formulary Coverage Effective September 1, 2009**	**Up to FIVE (5) generic prescriptions / paid claims every calendar month**
	Generic prescriptions are covered.*	These count toward the five (5) prescription limit.
	Regular and NPH Human Insulin are covered including combinations. Pens are not covered.	These count toward the five (5) prescription limit.
	Diabetic supplies (i.e., lancets, syringes and test strips) up to 100 units per calendar month are covered. Control solution is limited to one (1) bottle per month.	These do **NOT** count toward the five (5) prescription limit.
	Family planning drugs, supplies and devices are limited to generic contraceptive/birth control pills, contraceptive medroxyprogesterone acetate and diaphragms.	These do **NOT** count toward the five (5) prescription limit.

*Individual QUEST health plan may cover some brand medications to better manage health care.

Continue to bill drug claims to ACS PBM and supplies are to be billed to ACS FA.

Please notify the member prior to the health service being provided that it is not a covered benefit or that the coverage limit will be exceeded.

DECLARATION OF CASMIRA AGUSTIN

I, **CASMIRA AGUSTIN**, hereby declare:

1. I make this declaration based on my own personal knowledge and if called to testify I could and would do so competently as follows

2. I am from San Nicolas, Illocos Norte, Philippines. I am fifty two years old. I am a lawful permanent resident of the United States.

3. I have been living in Hawai'i since February 2009. My husband and I immigrated to Hawai'i to join my daughter Sherly and her family. Sherly has been living in the United States for over eight years.

4. Before I came to Hawaii in 2009, I did not have any health concerns. I saw my doctor in the Philippines for a complete physical before getting my visa to the United States. He issued a medical certificate to certify my good health.

5. When I first came to Hawaii, I visited KKV for a medical check-up. Usually the costs to see the doctor at KKV would be covered under insurance from the Hawaii Immigrant Health Initiative. That program ended soon after I came to Hawaii, sometime around August 2009.

6. On the night of about February 9, 2010, I started to have severe pain in my abdomen. I went to use the restroom, but I had to call my daughter in to help me. The pain was so severe I could not get up from the toilet, pull up my underwear or even stand to walk.

EXHIBIT D

7. On February 10, 2010, that next morning my daughter brought me to see a doctor in Waipahu because I was in so much pain. The doctor told me that I should be admitted to the Emergency Room because he thought I had acute appendicitis.

8. My daughter brought me to HMC-West emergency room and I was admitted immediately. At HMC-West they did an ultrasound, and they discovered that it was not appendicitis like the doctor thought causing the pain, but a cystic mass ~~pubic~~ pelvic on my ovary. I was discharged from HMC-West, however, because I did not have health insurance. I was told to follow up with an Ob/Gyn doctor, but they told me to come back to the ER to get medication each day.

9. For the next couple of days my daughter and I called around to find a doctor who could take me though I did not have insurance. We talked to doctors at KKV, but they did not have an opening for an Ob-Gyn appointment until March.

10. I was still experiencing such severe pain, my daughter was worried, so she started to call different hospitals to see if they would take me. Finally, she called Kapiolani Medical Center to ask to see a gynecology doctor. When she explained the situation, they told her to bring me to the ER immediately.

11. On February 12, 2010 I went to the ER at Kapiolani Women's and Children's Hospital. At the ER, my daughter was told that I may be eligible for insurance coverage for Med-Quest for a one time emergency, so we filled out the

application, and I was admitted immediately that same day for surgery to remove the cyst from my right ovary.

12. At Kapiolani, they found out that I had pneumonia and a fever because of the infection on my ovary. They could not perform the surgery while the infection remained. I had to remain in the hospital as an inpatient for three days while they waited for the infection to clear.

13. On February 16, 2010 the doctors at Kapiolani performed surgery to remove the cyst from my ovary. After removal, they found the cyst was not cancerous.

14. I stayed in the hospital two more days to recover from the surgery, and I was discharged from the hospital on February 18, 2010.

15. Soon, the medical bills started to arrive at my house. First we received a bill from HMC-West for my first ER visit.

16. We were billed separately for the ultrasound that was performed at HMC-West, a bill of around $5,000.

17. We received a bill from Kapiolani for the surgery to remove the cyst totaling $48,529.10.

18. The anesthesiologist from the surgery at Kapiolani bills separately, so we also receive a bill from his office of around $1000.00.

19. We had applied on February 12, 2010, and I thought that I would be eligible for the emergency medical insurance through Med-Quest. When the medical bills started coming to our house, I just waited to see if the insurance coverage would come through.

20. I started to pay the anesthesiologist just what I could afford, about $20.00 every month on the bill, just to show them we were not ignoring them. Now I owe him about $800.00.

21. In April I received in the mail a notice from DHS Med-Quest Division dated April 19, 2010 denying medical insurance. The notice said that I did not meet the citizen or alien status requirements and that I was not eligible for the medical assistance under emergency benefits for aliens.

22. I was so worried and I did not know how I would be able to pay for such a costly emergency surgery. I have medical bills that total almost $50,000.00. I called the eligibility worker at KKV to see how I could work out a plan to pay for my medical bills. She helped me apply for charity to help pay for some of the bills.

23. Finally on November 12, 2010 I found out that Catholic Charities had agreed to cover the cost of the surgery at Kapiolani. However, though they covered 100% the cost of my surgery, I do not know how I can afford to pay off

the remaining bills with the anesthesiologist and for my emergency room visit at HMC. Those bills are almost $7,000.

24. I do not have, and cannot pay for, any other medical insurance.

25. I declare under penalty of perjury under the laws of the State of Hawaii and the United States of America that the foregoing is true and correct.

Executed this____th day of March, 2011 in Kalihi, HI.

Casimira Agustin
CASMIRA AGUSTIN

DECLARATION OF ANTONIO IBANA

I, ANTONIO IBANA, hereby declare:

1. I make this declaration based on my own personal knowledge and if called to testify I could and would do so competently as follows:

2. I am a new resident who arrived in Hawaii on August 5, 2010 from Vintar, Illocos Norte, Philippines. I am fifty-two years old.

3. My parents, three brothers and two sisters are all U.S. residents, with my sister and brothers holding U.S. Citizenship. I came with my wife to join my family in the United States.

4. In the Philippines, I worked as a town councilman.

5. I am a diabetic, and must take both oral medication and insulin injections to manage my condition. I take oral medication and an insulin shot three times a day.

6. When I moved to Hawaii, I brought with me as much insulin and medication for my diabetes that I could afford. I brought only about a month supply, as costs to relocate to the U.S. were very high.

7. Late last year, my diabetes began to affect my eyesight. In October 2009, I had laser eye surgery in the Philippines.

8. I began to have problems again with my eyes earlier this month. I went to Kokua Kalihi Valley (KKV). KKV referred me to an eye specialist.

EXHIBIT E

9. I did not have money to pay for the eye specialist. I applied for Med-Quest insurance for new residents. They scheduled me for an interview for August 24, 2010.

10. While I was waiting for my application to Med-Quest, I went to see the eye specialist. He told me my eye condition was very serious and needed immediate attention. He warned me if I did not get surgery, I will go blind.

11. I went ahead with two procedures with my eyes, even though I did not know if I would have medical coverage. I paid the consultation fee of $160 out of my pocket and an extra $100 for those procedures with the eye specialist. I still owe for those two procedures to prepare me for surgery.

12. On the morning of August 24, 2010, right before I was going to leave the house for my interview, a Med-Quest representative called me and told me I did not need to come for my interview, because I was denied insurance coverage. I pleaded with her on the phone to let me come for my interview, or to reconsider, but she would not listen. The Med-Quest agent told me I would only get coverage for medical emergencies.

13. I was scheduled for another procedure with my eye specialist on that same day, August 24th. Instead of going to my eye appointment, I just went to work at McDonalds. I knew I was denied medical insurance, so there was no way I could pay for that procedure.

14. Later on I received a letter of denial in the mail from Med-Quest.

15. With no medical insurance, I decided to go to a community health clinic, Kokua Kalihi Valley. At KKV my doctor checked my eyes, and told me I must see a retina specialist before its too late. I told her I was only going to be covered for medical emergencies. My doctor submitted the paperwork to Med-Quest to get my eye surgery covered as she felt it was an emergency.

16. Later in September, my doctor told me I was denied for emergency surgery coverage for my eyes.

17. Even though I did not have coverage, I went to see the doctor three or four more times.

18. Around February 8, I woke up and I felt a bleeding in my right eye. I could not see clearly, so I went to the doctor. My doctor told me that continued laser treatment would not be effective. He told me again, my condition will not get any better, and I need surgery if my eyes get worse.

19. I have had trouble finding employment in the United States because of my health problems. When I first came, I had a job at McDonalds for five days. I transferred jobs because I knew I would not get continued full time employment. I worked at Utako Japanese Restaurant, but I had to leave the job because the affects on my health. I went back to work at McDonalds, but I still did not get full-time employment. I applied and got a job for G-Force security solutions. I was hired

for temporary employment. I got a call for a job in February, but I could not accept the position because of the problems with my bleeding eyes. Finally, I have found work through a contractor at the Ilikai hotel. I am only employed on an on call basis.

20. I am still unable to afford to see the retina specialists to get the surgery needed to take care of my eye problem. Even though I don't have insurance, I went to see my eye specialist. He was very alarmed with severity of the problems I have with my eyes. The doctor was kind enough to make an arrangement for me to pay what I can afford for my check ups. Right now, my bills are almost $3,000 as of March 7, 2011. I have no insurance to help cover the cost.

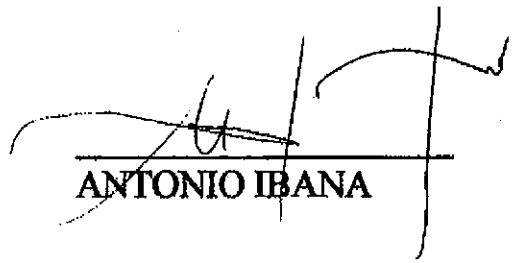
21. I am very concerned and worried about my eyesight. I get so desperate thinking that if I do not do something soon, I will go blind. My doctors keep telling me that I need the surgery, but I cannot pay for it, and I do not have health insurance. I have problems finding a job because of my eye problems. I do not know how I can continue to manage my condition with no health coverage.

22. I do not have, and cannot pay for, any other medical insurance.

23. I declare under penalty of perjury under the laws of the State of Hawaii and the United States of America that the foregoing is true and correct.

/

Executed this 7th day of March, 2010 in Honolulu, HI.



ANTONIO IBANA

DECLARATION OF RENATO MATEO

I, **RENATO MATEO**, hereby declare:

1. I make this declaration based on my own personal knowledge and if called to testify I could and would do so competently as follows

2. I am from Santa Ignacia, Tarlac City, Philippines. I am sixty one years old. I am a lawful permanent resident of the United States.

3. I have been living in Hawai`i since September 27, 2006. I immigrated to the United States with my wife. We joined my wife's family in the United States.

4. In the Philippines I worked for many years at Toyota.

5. When I came to Hawai`i, I got a job almost immediately with HBM, Hawai`i Building Maintenance. I worked for HBM full-time, bought a car and a van, and enjoyed our new life with extended family in the United States.

6. I had health insurance through my employer starting in October 2006.

7. Sometime in January 2007 I began to have paints in my rectal area and a pulling sensation like I needed to have a bowel movement. At first we thought it was a simple hemorrhoid. I went to the doctor and they performed a colonoscopy. When the results came back, my doctor told me it was colon cancer.

8. After finding out I had colon cancer, I was immediately scheduled for surgery on March 23, 2007 to remove the cancerous tissue.

EXHIBIT F

9. Even though my surgery was scheduled, I kept working. My last day of work was the day before my surgery in March 2007.

10. The surgery to remove the cancer in my colon was successful. My oncologist told me I would not need strong chemotherapy, but I would need to take chemo pills. My wife and I were hopeful that I would get better.

11. After the surgery I was contacted by my health insurance company. They told me that my health insurance through my employer would be cancelled because I was one week short of the probationary period. The insurance company agreed to cover the cost of my surgery but would not cover any more of my medical expenses.

12. I was unable to work and still needed to be able to pay for chemotherapy pills, which cost almost $1,300 per month. I also needed periodic CT scans to monitor my colon and be sure my cancer did not spread or return. I needed to have insurance to be able to afford the treatment I needed to fight the cancer.

13. My wife Agapita began to work long hours at her job as a caregiver so that we could afford to pay the COBRA payments to maintain my health insurance on our own.

14. By November 2007 we were having trouble with other bills even though we were able to pay the COBRA payments to maintain health insurance my

health insurance. I was still taking chemotherapy pills, but I applied with HBM again, my former employee. My monthly CT scans and blood tests to monitor my health showed I was improving, and my doctor cleared me to work.

15. I began work again with HBM in late November 2007. I started health insurance again with my employer. For the next year I had periodic CT scans and blood tests with positive results. My oncologist told me and my wife that the prognosis was good.

16. Around June 2009, I began to have trouble again, feeling the same pain and sensation that I felt previously. The pain became intense. I wanted to see my oncologist, but I had to wait for an appointment. Worried about my condition, my wife called my primary care physician and scheduled an appointment. My primary care physician suggested a new oncologist.

17. I went to see the new oncologist who performed a colonoscopy, endoscopy, rectal scan and CT scan. After these tests, I was told that my cancer had returned. This time, the cancer had metastasized to my liver.

18. My wife and I were devastated. I had gone many months with CT scans and blood tests with positive results. I could not believe that now the cancer had spread to my liver undetected. I questioned the doctor why he did not tell me earlier of any problems. I believed I was cancer free.

19. I was scheduled for surgery on December 19, 2009. I worked at HBM right up until my surgery date. After the surgery, I was told it was an 'open and close' surgery, where the oncologist was only able to biopsy the cancer.

20. The oncologist told me that this time I would need aggressive intravenous chemotherapy to fight the cancer. I started chemotherapy and was granted temporary disability insurance (TDI) for six months from my employer.

21. In January 2010 my wife suffered a back injury at work. Her insurance was terminated because she was not working. She receives workman's compensation payments, but she is unable to work anymore and needs back surgery.

22. In April I found out I was terminated from work and my insurance coverage was also terminated. We wanted to enroll in COBRA again, but the premiums would be $315.00 each per month for me and my wife. We decided to get the COBRA coverage only for myself because of the need to continue my chemotherapy.

23. My TDI expired in June 2010 and we began to really struggle financially. I asked my doctor if he would clear me to be able to work, even though I still need the chemotherapy treatment. My doctor completed the form, but I was unable to get work.

24. By July we were not able to make the $315 COBRA payment. My wife and I were both unemployed and we had only her small workman's compensation payment. We also had all our normal monthly expenses. We had started to rely on family and friends just to have money for food to eat and gas to drive to my chemotherapy appointments.

25. My wife wrote to the insurance company and pleaded with them not to cancel my insurance policy as we tried to get finances from other places to make the COBRA payment. My wife contacted the American Cancer Society (ACS) and also Catholic Charities (CC). I received a one time gas card from ACS, and CC started to give us canned food goods.

26. Despite calls and letters, HMSA cancelled our insurance policy in July and withheld chemotherapy treatment.

27. At this point, things started to feel like a nightmare and we got very desperate. I was starting to feel really sick and was very nauseous from the chemotherapy. I could not get work. My wife was walking with a cane after her back injury and her eyesight was cloudy because of her untreated diabetes.

28. Finally in November 2010 my wife heard about the community health center KKV from others and we went to see if we could somehow get help to start chemotherapy again. I was getting very sick and my wife was so worried.

29. The eligibility worker at KKV helped us fill out an application for Med-Quest insurance on November 17, 2010. We knew it would take some processing time but hoped maybe I would be able to get insurance coverage.

30. At KKV, my primary care physician was able to get a charity to cover my chemotherapy. I resumed treatment. However, they would not be able to get coverage to see any oncologist or specialist, or coverage for CT scans to monitor my progress. For this I would need insurance.

31. On March 2, 2011 I received a letter from Med-Quest denying insurance coverage. The letter is attached as Exhibit "1".

32. I continued to go to chemotherapy treatments every Thursday. I know I did not have insurance, but I believed that charity was going to pay for my bills.

33. On March 10, 2011 I went to my Thursday chemotherapy appointment. After waiting for four hours, I was told I could not be able to get chemotherapy, and I would not get the treatment in the future. I was shocked and extremely upset. I thought that charities would cover my chemotherapy treatment.

34. The staff at the chemotherapy office informed me that they found out the charity grant would provide free chemotherapy drugs. After that, it would only cover a maximum of $2,000 in fees for office visits and administration of the drug. When I first resumed treatment, they had mistakenly thought the charity would cover more of my bills. They told me that office visits and drug administration

costs at least $500. Since July, I have accrued over $85,000 in bills for the chemotherapy treatment. Because I have this much debt and no insurance, I was told they will no longer give me chemotherapy treatment because I can not pay for the office visits.

35. I feel extremely desperate. I can not pay for the treatment needed to get healthy and work again. My wife and I struggle to survive and our bills pile up. We live in one small room in the basement of a house and share a living space with another family. My wife's workman's compensation payment barely covers our rent. We rely on charity for our other needs, feeding ourselves on canned goods and the meal our church provides us each Thursday.

36. I do not have, and cannot pay for, any other medical insurance.

37. I declare under penalty of perjury under the laws of the State of Hawai`i and the United States of America that the foregoing is true and correct.

Executed this 10 th day of March, 2011 in Honolulu, HI.

RENATO MATEO

0004448
MQD-OAHU ON-GOING UNIT 11
801 DILLINGHAM, 3RD FLR
PO BOX 3490
HONOLULU HI 96811
(808) 587 3540

STATE OF HAWAII
DEPARTMENT OF HUMAN SERVICES

CASE NUMBER: 00528129
CASELOAD ID: 28 116

MAILING DATE: 03/02/11

AGAPITA F. MATEO
1930 UMALU PLACE
HONOLULU HI 96819

DEAR AGAPITA F. MATEO
APPLICATION FOR MEDICAL ASSISTANCE, RECEIVED ON NOVEMBER 17, 2010, WILL BE DENIED BECAUSE OF THE REASON(S) MARKED BELOW:

XX THE CITIZENSHIP OR ALIEN STATUS REQUIREMENTS WERE NOT MET FOR MATEO, RENATO
AUTH.: H.A.R. 17-1714-28, 17-1714-33.

RESIDENCY REQUIREMENTS NOT MET FOR
AUTH.: H.A.R. 17-1714-22, 17-1722.3-7.

IS RESIDING IN A PUBLIC INSTITUTION.
AUTH.: H.A.R. 17-1714-23, 17-1722.3-7.

POTENTIAL SOURCE(S) OF INCOME FOR
WAS NOT PURSUED. AUTH.: H.A.R. 17-1711-6.

POTENTIAL SOURCE(S) OF ASSETS FOR
WAS NOT PURSUED. AUTH.: H.A.R. 17-1711-6.

RIGHT TO PAYMENTS FROM A THIRD PARTY FOR
WERE NOT ASSIGNED TO THE DEPARTMENT. AUTH.: H.A.R. 17-1705-10.

RIGHT TO CHILD, SPOUSAL, OR MEDICAL SUPPORT PAYMENTS FOR
WERE NOT
ASSIGNED TO THE DEPARTMENT. AUTH.: H.A.R. 17-1705-17

IS ELIGIBLE FOR HEALTH
COVERAGE THROUGH HIS/HER EMPLOYER. AUTH.: H.A.R. 17-1727-13, 17-1728-8, 17-1722.3-7, .

IS COVERED BY A MEDICAL PLAN.
AUTH.: H.A.R. 17-1727-13, 17-1728-8, 17-1732-5, 17-1722.3-7.

DOES NOT HAVE A SOCIAL
SECURITY NUMBER. AUTH.: H.A.R. 17-1714-12.

XX OTHER: ADRC REFERRAL & DETERMINATION CAME BACK UNABLE TO DETERMINE. AUTH.: H.A.R. 17-1721-6

HEARING RIGHTS AND OTHER IMPORTANT INFORMATION ARE EXPLAINED ON THE BACK OF THIS NOTICE. YOU MAY REAPPLY AT ANYTIME, BUT YOU MAY BE SUBJECT TO THE HAWAII ADMINISTRATIVE RULES RELATING TO THE LIMITATIONS OF STATEWIDE ENROLLMENT. YOU DO NOT HAVE TO COMPLETE ANOTHER APPLICATION FORM IF YOU REAPPLY WITHIN 120 DAYS FROM THE DATE THAT THIS APPLICATION WAS RECEIVED. IF YOU HAVE ANY QUESTIONS, PLEASE CONTACT CUSTOMER SERVICE AT 587-3578.
WE ARE UNABLE TO COVER SERVICE DATE: 11/17/2010 AT QUEEN'S MEDICAL CENTER FOR: MATEO, RENATO BECAUSE OF THE ABOVE REASON.
THIS NOTICE ONLY APPLIES TO: MATEO, RENATO (ONLY ONE APPLYING FOR MEDICAL ASSISTANCE).
116/28 IA

NOTICE #M208 S M. SASAKI

EXHIBIT 1

DECLARATION OF AGAPITA MATEO

I, **AGAPITA MATEO**, hereby declare:

1. I make this declaration based on my own personal knowledge and if called to testify I could and would do so competently as follows:

2. I am from Camiling, Tarlac City, Philippines. I am fifty nine years old. I am a lawful permanent resident of the United States.

3. I have been living in Hawai`i for four and half years. I immigrated to the United States with my husband on September 27, 2006. My mother is a United States citizen. She was born in Hawai`i in 1919. My grandfather was a U.S. army serviceman, and my grandmother worked as a sakada here in Hawai`i. My mother returned to the Philippines when she was young. Later in 1982 she came to the United States and brought my 5 brothers and 2 sisters with her. There were immigration problems for my brother and I, and we could not immigrate with the rest of our family. My youngest brother and I had to remain in the Philippines and wait as my family petitioned for us separately. It took almost 25 years for the petition to process and I was finally able to join the rest of my family in 2006. By that time, my mother had passed.

4. In the Philippines I graduated with my bachelor's degree. I worked for many years as a mid-wife and health professional.

EXHIBIT G

5. When I came to Hawai`i, I did not immediately get a job. My husband was able to find work with HBM Hawai`i Building Maintenance.

6. We bought a car and a van, and enjoyed our new life with extended family in the United States.

7. I have diabetes and need to take daily insulin.

8. When we arrived in Hawai`i I started looking for work. However, it was difficult to find a job.

9. Sometime in January 2007 we found out my husband, Renato, had colon cancer. He had surgery in March to remove the cancerous tissue and started chemotherapy pills. I talked to the oncologist about his situation, and believed that the prognosis was good for total recovery.

10. In March after my husband's surgery I was contacted by his health insurance company. They informed me that they were cancelling his employer sponsored health insurance because he was one week short of the probationary period. The insurance company agreed to cover the cost of his surgery but would not cover further medical expenses.

11. I was very worried about my husband and I knew we could not afford the cost of his treatment. His chemotherapy pills alone cost $1,300 per month.

12. In May 2007 I finally found work as a caregiver. I finally had health insurance through my employer to cover my health needs. Because I did not have

health insurance for some time, I had not visited the doctor. Because of my untreated diabetes, I had to have laser procedure on my eyes. This was covered by my insurance.

13. With my income, we were able to make the COBRA payments to maintain health insurance for my husband while he was recovering and could not work.

14. Paying the COBRA payments to maintain health insurance was top priority, but we started to struggle financially. I would sometimes work 24 hour shifts and was very tired. My husband's health seemed to be improving, though he still needed chemotherapy pills. He asked the doctor if he could be cleared again for work, and they agreed he would be able to work.

15. In November 2007 my husband started to work again with HBM and he got health insurance through is employer. For the next year he continued to have periodic CT scans and blood tests. His doctor always told me everything was 'ok' so I believed that my husband was cancer free.

16. In June 2009 my husband started to complain to me again about always feeling the need have a bowel movement. He went to see a new oncologist. After a colonoscopy, endoscopy, rectal scan and CT scan the doctor told me it was what I most feared. I was devastated: the cancer was back and had spread to my husband's liver.

17. My husband had surgery on December 19, 2009. He worked at HBM right up until his surgery date. After surgery he needed aggressive intravenous chemotherapy to fight the cancer. He was not able to work, and was given six months temporary disability insurance (TDI) from his employer. I was still working as a caregiver and started working longer hours.

18. In January 2010 I injured my back at work and I could not work anymore. I had to start walking with a walker.

19. My back condition worsened and became very painful. I went to see a specialist, and I was told that my back was now 'bone on bone' and that I would need surgery.

20. I was cleared for back surgery to be covered and also receive $494.98 monthly payment as workman's compensation.

21. Before my surgery was scheduled, we found out in April that my husband was terminated from work and our insurance coverage was also terminated. We wanted to enroll in COBRA again, but the premiums would be total $630.00 each per month if both of us were to be covered. I needed insurance to be able to get my diabetes medication, but my husband's situation was much worse. He could not stop his chemotherapy treatments. We decided to get the COBRA coverage only my husband, paying $315.00 per month.

22. Our financial situation became very difficult in June 2010 and we began to really struggle even to find food to eat and gas to take my husband to chemotherapy. My husband wanted to get cleared to work by his doctor, but I knew that he was too weak. I had started to train myself to walk with a cane, not the walker because it was even too difficult for my husband to help me get my walker in and out of the car. We could not afford my insulin anymore.

23. By July we were not able to make the $315 COBRA payment. We also had all our normal monthly expenses. Previously, we had taken out a $1000 loan with our 1988 van as the collateral. I had also taken out pay-day loans to cover expenses. Before I was able to make the high interest payments, but now I could not. We defaulted on our auto loan. Debt collection agencies started to call every day. I did not let my husband know about these calls because I wanted him to focus on getting healthy. I wrote letters to all the debt collections letting them know that I would take responsibility for my debt, but my husband had cancer and we were struggling to keep his medical insurance. We had already relied so much on family and friends just to have money for food to eat and gas, but they were not able to help anymore.

24. I wrote to the insurance company and pleaded with them not to cancel my husband's insurance policy in July but to give me some time to try to get finances from other places to make the COBRA payment.

25. I heard about the American Cancer Society (ACS) and also Catholic Charities (CC). I wrote to them very hopeful that maybe I could receive help. Unfortunately, all that ACS could give me was one gas card. That only lasted us for one week. CC started to give us canned food goods that we still use to eat. None of this was enough to keep our insurance policy.

26. Despite my calls and letters, HMSA cancelled my husband's insurance policy in July and withheld chemotherapy treatment.

27. At this point, I started to get very depressed and even contemplated suicide. I was neglecting my own health because I was worried about my husband. My eyesight had started to become cloudy and we could not afford insulin. I did not sleep at night, and neither did my husband. We would lie in bed and cry together, wondering what we would do.

28. I was so desperate I kept asking for help. I heard about a community health center in Kalihi from others and we went to see if we could somehow get help. My back was very painful and my eye sight had become cloudy because I did not have the money to manage my diabetes.

29. We moved to Kalihi to live in a small room in the shared basement and get treatment at KKV. At KKV I visited the primary care physician. She was able to help me to get my insulin treatment covered by charities. She told me that my I had probably harmed my eyesight irreparably because I had stopped my

diabetes treatment for such a long time. She told me I need to see a retina specialist and may need eye surgery. I can not see a specialist because I do not have insurance coverage.

30. I asked my doctor about the possibility of back surgery. I knew that my workman's compensation would cover the surgery costs. My doctor told me that I could not be cleared for surgery because she thought I may have some problems with my kidney and because of the problems with my eyes. She recommended that I see a kidney specialist. I cannot afford to see a specialist, and they will not see me without health insurance. Now, I just try to deal with my back pain because I cannot get the surgery.

31. I feel very desperate when I think about the future. Our medical bill debts pile up and we worry each month how we have money to keep our housing or gas to see our doctor. Already since July 2010 we have over $85,000 in medical bill debts from my husband's chemotherapy alone. We also have other debts from credit cards and loans. Neither me nor my husband are healthy enough to work.

32. I do not know how I will ever pay back the debts and be able to afford health insurance.

33. I do not have, and cannot pay for, any other medical insurance.

//

34. I declare under penalty of perjury under the laws of the State of Hawai`i and the United States of America that the foregoing is true and correct.

Executed this 10 th day of March, 2011 in Honolulu, HI.

AGAPITA MATEO

Evercare®

Member Handbook for the State of Hawaii QUEST Expanded Access (QExA) Program

February 2009

Evercare Health Plan
QUEST Expanded Access
841 Bishop Street, Suite 725
Honolulu, HI 96813

Member Services **1-888-980-8728**
TTY: **711**
Monday – Friday
7:45 a.m. – 4:30 p.m. (H.S.T.)

EvercareHealthPlans.com/HI_QExA

Serving the islands of:
Hawaii, Kauai, Maui, and Oahu

EXHIBIT H

Ang dokumentong ito ay naglalaman ng mahalagang impormasyon. Tumawag sa 1-888-980-8728 upang makuha ang dokumento sa ibang wika o upang masabi ito sa inyo sa ibang wika.

Naglaon daytoy a dokumento iti napateg nga impormasion. Umawag iti 1-888-980-8728 tapno maalam ti dokumento iti sabali a lengguahe wenno maibasa kenka iti maawatam a lengguahe.

本文件包含重要資訊。請撥打 1-888-980-8728，以獲得本文件的其他語言版本，或讓人為您口譯該文件。

이 문서에는 중요한 정보가 수록되어 있습니다. 다른 언어로 번역된 문서를 받아보시거 나 구두번역을 원하시면 1-888-980-8728번으로 전화주십시오.

Names and Phone Numbers

QUEST Expanded Access (QExA) Member Services
1-888-980-8728; or for TTY access call **711**.

My primary care provider's name:

_____

My primary care provider's phone:

_____

My Service Coordinator's name:

_____

You can reach your Service Coordinator or the Service Coordinator on call by calling Member Services at **1-888-980-8728**.

IN CASE OF AN EMERGENCY DIAL: 911

Aloha! Welcome to Evercare QUEST Expanded Access (QExA)

Thank you for choosing Evercare! We will help you stay healthy and get good health care. We will help make sure you get the care you need.

Your guide to good health

Please read this handbook. It tells about your benefits. It will help you use your health plan. Look at your Evercare identification card. Make sure all the information is correct. We want to make it easy for you to use your plan. We can answer any questions you have.

If you have questions, call us. Our toll-free Member Services number is **1-888-980-8728**. There are people who can talk with you in English or other languages. If you need other languages or an interpreter, tell your Service Coordinator. Member Services will connect you to the AT&T Language Line. If you are speech or hearing impaired, call **711**. Call us if you need this handbook in large print, audio, or another language.

If you have BOTH Medicare and Medicaid coverage

If you are a QExA member and have Medicare and Medicaid, read every note with a check mark. With both types of coverage, you have more options. Reading the marked information tells how to get the most from your coverage. If you have questions, call Member Services at **1-888-980-8728**. Call **711** if you are speech or hearing impaired.

Our office location:
Evercare
841 Bishop Street, Suite 725
Honolulu, HI 96813

Regular Business Hours: 7:45 a.m. through 4:30 p.m. H.S.T.
Toll free **1-888-980-8728**; or for TTY access call **711**
24-Hour Nurse Line: **1-888-980-8728**

Table of contents

Where to find answers

About QUEST Expanded Access

QUEST Expanded Access (QExA) is a Medicaid managed care program from the Hawaii Department of Human Services (DHS). Managed care means that Hawaii hires a company to help you manage your health care.

The Evercare plan is one option for Hawaii residents who qualify. The Evercare plan:

- Offers medical coverage and services to help with daily life
- Promotes independent living
- Promotes checkups
- Lets you take part in decisions
- Provides a Service Coordinator to help you get care

If you have questions, call us. Our toll-free Member Services number is **1-888-980-8728**.

If you have both Medicare and Medicaid coverage

If you have both Medicare and Medicaid, you have more than one coverage. Your QExA benefits will not change your Medicare benefits. Your Service Coordinator will help set up your health care with Medicare or your Medicare Advantage Plan.

If you have both Medicare and QExA, Medicare Part D will cover your drugs. This will continue after you are on QExA. To learn about QExA drug coverage, call your Service Coordinator. If you have regular Medicare, you can use your current doctor. You can get Medicare-covered specialty services without approval from QExA.

We will work with your doctor for the services you get through QExA. Tell your Service Coordinator the name of your doctor. Tell him or her if you change doctors. We can help you pick a doctor if you do not have one. This doctor can provide and set up your QExA and Medicare services.

Bring your Medicare card and your Evercare ID card on all doctor's visits.

Your Evercare ID card

When and where do I use my Evercare ID card?

Every person who joins Evercare for QExA gets an ID card. Bring your ID card when you visit your doctor. Your ID card gives information about you. Evercare will send you a new ID card if you change your primary care provider.

About your ID card:

Your doctor or Service Coordinator must provide or help with your health care, except for emergencies or women's services. Call Evercare at **1-888-980-8728** within 24 hours after going to the emergency room. If you lose your ID card, call Evercare at **1-888-980-8728**. Make sure your name on your ID card is correct. If you find mistakes on your ID card, call Evercare at **1-888-980-8728**.

If you have Medicare, you will get your doctor, hospital, drugs, lab, x-ray and other acute care services from Medicare or your Medicare Advantage Plan.

Your Evercare ID card tells you:

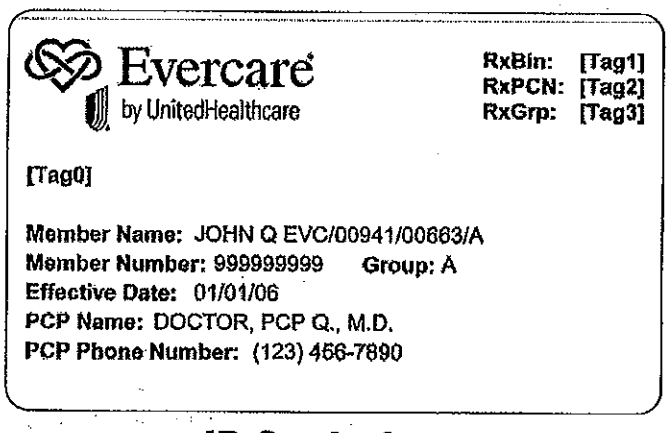
Member Name –
Your full name as listed with Medicaid.

Identification Number –
Your Medicaid number.

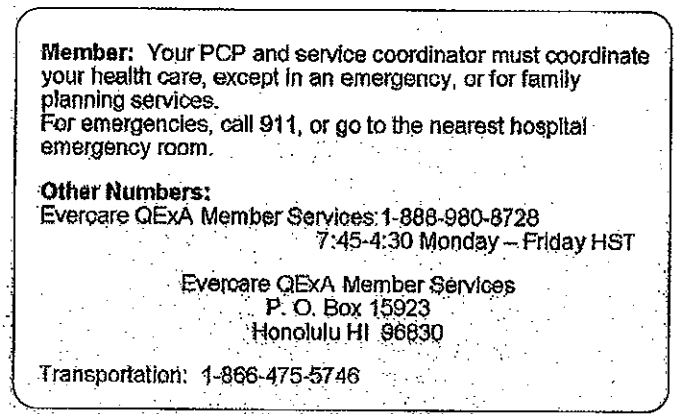
Effective Date –
The first date of your eligibility.

PCP Name –
Your primary care provider. See pages 7-9 of this handbook for more information on primary care providers.

PCP Phone –
Phone number for your primary care provider.



ID Card - front



ID Card - back

Member Services

Evercare has a Member Services Department for questions and information on:

- Membership.
- Choosing a primary care provider. Also see page 7 of this handbook.
- Finding specialists, hospitals, and other providers. Also see page 8 of this handbook.
- Covered services. Also see pages 9-14 of this handbook.
- Changing doctors. Also see page 8 of this handbook.
- Filing a complaint. Also see page 32 of this handbook.
- Making a name or address change. Also see page 28 of this handbook.
- Changing your Service Coordinator. Also see page 6 of this handbook.
- Medicaid and Medicare coverage. Also see page 2 of this handbook.
- Getting an interpreter. Also see page 24 of this handbook.
- Getting a ride to the doctor. Also see page 23 of this handbook.
- Other questions.

Member Services can give you information about health care, such as:

- Living with a chronic illness.
- How to get behavioral health care.
- Eating healthy foods.
- Safe sex and birth control.
- HIV/AIDS.
- Keeping children well with EPSDT services.

We are happy to help with other topics. Just call **1-888-980-8728**. If you are speech or hearing impaired, call **711**.

24-Hour Nurse Line

We offer a free hotline for QExA members to speak with a nurse. The Nurse Line is open 24 hours a day, seven days a week. Just call **1-888-980-8728**.

Health education classes

Many education classes and meetings are offered by Evercare for QExA. Call Member Services for details.

Service Coordination

Service coordination is given by Evercare. Service Coordinators review, plan, and help you meet your health needs.

Who is my Service Coordinator?

Evercare will choose your Service Coordinator. We will tell you in writing after you join Evercare.

When will I meet my Service Coordinator?

Your Service Coordinator will meet you for a face-to-face evaluation after you join Evercare. Your Service Coordinator will meet with you at least once a year for review. Your Service Coordinator will meet with you more often if needed. Your Service Coordinator will also meet with you if you have a change that requires a review. This review will be face-to-face, unless you request to do the review by telephone.

How can I contact my Service Coordinator?

You can contact your Service Coordinator by calling **1-888-980-8728**. You can contact your Service Coordinator as often as you need to.

What if I want a new Service Coordinator?

If you want to change Service Coordinators, call Member Services. We can provide a new Service Coordinator in five business days. In some cases, Evercare will need to assign you to a new Service Coordinator. If so, we will contact you in writing. We will make sure you know how to reach your new Service Coordinator.

Primary Care

What is a primary care provider?

A primary care provider is a doctor or a nurse who plans and oversees your health care. A primary care provider arranges a special doctor when you need it. All QExA members have a primary care provider. A primary care provider may be a family practitioner, general practitioner, general internist, pediatrician, obstetrician/gynecologist (for women), geriatrician, a nurse who can write prescriptions, or a clinic.

How do I choose or change my primary care provider?

Call Member Services at **1-888-980-8728** for help picking or changing a primary care provider. You must choose one for your QExA services if you do not have a primary care provider through Medicare.

What if I have Medicare?

If you have a primary care provider through Medicare, you do not have to pick another doctor or primary care provider. Your Medicare doctor will work with your Service Coordinator to set up all your QExA services. Tell your Service Coordinator the name of your Medicare doctor.

Can a specialist or a clinic be my primary care provider?

Your primary care provider can be a doctor, a nurse, or a clinic. If you are going to a doctor you like, you can keep going if he or she participates with Evercare. If your regular doctor is a specialist, he or she may be allowed to be your primary care provider, if he or she agrees. Your clinic can be your primary care provider if it agrees. Your clinic must offer the same services as a primary care provider. Call your Service Coordinator at **1-888-980-8728** if you have questions about who can be your primary care provider.

How do I receive services if I do not yet have a primary care provider?

Call Member Services at **1-888-980-8728** if you need services before you have a primary care provider. If it is an emergency, call **911**.

How many times can I change my primary care provider?

You can change your primary care provider anytime. Call Member Services at **1-888-980-8728** to tell them you want to change. If you don't know which doctor to change to, Member Services will help you pick one.

Can my request to change my primary care provider be denied?

Yes. If the provider you want is not taking new patients, your request may be denied. Your Service Coordinator will help you pick a new doctor.

What if I want to go to a doctor who is not my primary care provider?

Your primary care provider will help you get the care you need. If you want to see a doctor other than your primary care

provider, tell your primary care provider or call your Service Coordinator at **1-888-980-8728**.

What if I don't choose a primary care provider for my services?

If you don't choose a primary care provider within 15 days of joining Evercare, we will assign one to you. You will not lose any of your QExA benefits, but you will have to go to the provider chosen for you. You can change your primary care provider anytime by calling Member Services at **1-888-980-8728**. If you are also covered by Medicare, no primary care provider will be assigned to you for QExA. You can keep seeing your Medicare doctor.

What do I need to bring to see my primary care provider?

You must take your Evercare ID card with you when you get any health care services. If you are on Medicare, you should also bring your Medicare card.

Health care benefits under QExA

What are my health care benefits?

QExA can give you services that are medically necessary if you meet requirements.

A health intervention is **medically necessary** if it is recommended by the treating physician or treating licensed health care provider, is approved by the health plan's medical director or physician designee, and is:

1. For the purpose of treating a medical condition;
2. The most appropriate delivery or level of service, considering potential benefits and harms to the patient;

3. Known to be effective in improving health outcomes; provided that:
   - **A.** Effectiveness is determined first by scientific evidence;
   - **B.** If no scientific evidence exists, then by professional standards of care; and
   - **C.** If no professional standards of care exist or if they exist but are outdated or contradictory, then by expert opinion; and
4. Cost-effective for the medical condition being treated compared to alternative health interventions, including no intervention. For purposes of this paragraph, cost-effective shall not necessarily mean the lowest price.

When the treating licensed health care provider and the health plan's medical director or physician designee do not agree on whether a health intervention is medically necessary, a reviewing body, whether internal to the plan or external, shall give consideration to, but shall not be bound by, the recommendations of the treating licensed health care provider and the health plan's medical director or physician designee.

What are my primary and acute care benefits?

Evercare covers many primary and acute care services. See the table below.

Service	Description and Limitations
Inpatient Hospital Services	These services are for when you are very sick, injured, having a major operation, having a baby, or having a serious behavioral health problem.
Cognitive Rehabilitation Services	These services help with daily living if you have cognitive impairments. If you are making progress, you may receive this service for up to one year.

Service	Description and Limitations
Cornea Transplants and Bone Graft Services	These services are covered.
Durable Medical Equipment and Supplies	This is equipment and supplies used to serve a medical purpose. Examples include canes, oxygen tanks, and hearing aids.
Emergency and Post Stabilization Services	Emergency services are for when you have an emergency medical condition. Post-stabilization services are services you get after an emergency to keep your condition stable. You can get these services 24 hours a day, seven days a week at any hospital.
Family Planning Services	These services help you make informed choices and help you prevent pregnancy. These services also include emergency contraception, tests to see if you are pregnant, and tests to see if you have sexually transmitted diseases. All services are voluntary. Evercare will keep your information private.
Home Health Services	These services are part-time care that help prevent you from going back to the hospital or going to a nursing home.
Hospice Care	This is a service that provides care if you are terminally ill and have six months or less to live.

table continues on next page

Service	Description and Limitations
Maternity Services (Services for Pregnant Women)	These are services if you are pregnant. These services include care before the baby is born, delivery of the baby, and care after the baby is born.
Medical Services Related to Dental Needs	This includes medical services that are needed as part of dental treatment. If you need other dental services, Evercare will refer you to the State's dental program and coordinate your services.
Other Practitioner Services	These services are provided by other providers, such as nurses.
Outpatient Hospital Services	These services are for when you go to a hospital or ambulatory care center, but don't stay more than a day. You may use these services when you have an emergency or an urgent health problem.
Personal Assistance Services - Level I	These services provide help around the house so that you can live independently. These services may be self-directed.
Physician Services	These services are when you go to the doctor.
Prescription Services	These are drugs prescribed by your doctor. This also includes education about how to take the drugs.
Preventive Services	These services help keep you healthy. They include checkups, shots, and tests.
Radiology/Laboratory Diagnostic and Therapeutic Services	These services include x-rays and getting your blood drawn.
Rehabilitation Services	These services help improve your movement, hearing, and speech.

Service	Description and Limitations
Sterilizations, Hysterectomies, and Intentional Termination of Pregnancies (ITOPs)	Sterilization and hysterectomies are services to prevent you from having children. These are covered for men and women in certain cases. Evercare does not cover ITOPs.
Transportation Services	These services help you get medical care in emergencies and non-emergencies. For emergencies, Evercare will provide transportation even if you have another way to get to the hospital. For non-emergencies, Evercare will provide transportation to and from medical appointments if you have no other way to get there. Evercare will also provide transportation if you are referred to a provider that is on a different island.
Urgent Care Services	These services are for sudden problems that are not emergencies.
Vision Services	Vision services include one visit with an eye doctor in a 12-month period if you are under age 21 and one visit in a 24-month period if you are age 21 or older, unless you have a medical condition. Emergency eye care is covered no matter your age. You may receive eyeglasses, contact lenses, and other vision supplies if they are prescribed by your eye doctor. You cannot receive contact lenses for cosmetic reasons. You can get new lenses once in a 24-month period if you are age 21 or older or once in a 12-month period if you are under age 21. The following vision services are not covered: orthoptic training, prescription fees, progress exams, radial keratotomy, visual training, and Lasik procedure.

How do I get primary and acute services?

You can call your Service Coordinator, your primary care provider, or Member Services. You can find a list of Evercare specialists, hospitals, and other providers in the provider directory.

What are EPSDT services?

Children under 21 years of age may receive EPSDT services. EPSDT services include shots and screenings that children need to stay healthy. Your Service Coordinator can talk to you about the EPSDT services your child needs and help you schedule appointments.

What are behavioral health services?

Behavioral health services are services provided to people who have emotional problems, mental illness, or addictions to drugs or alcohol.

What are my behavioral health benefits?

You can get help if you use drugs or alcohol. When you feel very upset, or if you do not know what to do when life is hard, call us at **1-888-980-8728**.

There will be people who can speak with you in English or other languages. Member Services can also connect you to a translator. If you are speech or hearing impaired, call TTY: **711**. If it is a crisis, call **911** or go to the nearest emergency room.

For people with serious mental illness, many services will be covered by the state, not by Evercare. We can help you set up the services.

What are my long-term care services?

Evercare offers two types of long-term care:

- Services in your home or other residential setting
- Services in an institution

See the table below for Evercare's long-term care services.

Service	Description and Limitations
Adult Day Care	This is when you go to a center during the day that provides activities for you to do. It does not include health care related services.
Adult Day Health	This is when you go to a day program to receive social and health services. This is for adults with physical or mental impairments that need extra care.
Assisted Living Services	These services help you with chores and making meals if you live in an assisted living facility. Evercare cannot pay for room and board in assisted living facilities.
Attendant Care	This is hands-on care for medically fragile children. These services may be self-directed.
Community Care Management Agency (CCMA) Services	These are services you may get if you live in Community Care Foster Family Homes or other community settings.

table continues on next page

Service	Description and Limitations
Community Care Foster Family Home (CCFFH) Services	These services are help with chores, housekeeping, and other services. They are provided in a certified private home by a care provider who lives in the home. If you receive these services, you must be receiving ongoing CCMA services.
Counseling and Training	This is provided to you, your family, or your caregiver on a variety of topics.
Environmental Accessibility Adaptations	These are changes to your home that are needed to keep you healthy and safe and keep you from moving to a nursing home or hospital. These services must be required by your care plan and must be of direct medical benefit to you. They cannot add to the size of your home.
Home Delivered Meals	These are healthy meals delivered to your home. You cannot receive more than two meals per day. To receive this service, you must not be able to make healthy meals yourself and you must need this service to avoid moving to a nursing home or hospital. You may not live in a nursing home or residential facility.
Home Maintenance	This is a service to keep your home safe and clean. You may receive this if you cannot perform cleaning and minor repairs and need this service to avoid moving to a nursing home or hospital.

Service	Description and Limitations
Medically Fragile Day Care	This is a service for children who are medically and/or technology dependent. It is provided outside the home and helps the child live better.
Moving Assistance	This is provided in rare cases if your Service Coordinator finds that you need to move to a new home. When possible, you should use your family, neighbors, friends, or others who can provide this service for free.
Non-Medical Transportation	This helps you get to certain services and activities. When possible, you should use your family, neighbors, friends, or others who can provide this service for free. If you live in a residential care setting or a CCFFH, you cannot receive this service.
Nursing Facility Services	These services are when you need help from nursing staff 24 hours a day for a long period of time.
Personal Assistance Services - Level II	These services are when you need help to perform activities of daily living and activities to keep you healthy. This service may be self-directed.

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Service	Description and Limitations
Personal Emergency Response Systems (PERS)	This is a 24-hour service that helps you get help right away if you have an emergency. You can only get PERS if you live alone or are alone for long parts of the day and would otherwise need supervision. If you are in a nursing home or hospital, you cannot receive PERS.
Private Duty Nursing	This is when you need ongoing nursing care and it is listed in your care plan.
Residential Care Services	These services are help with chores, housekeeping, and other services provided in a Type I or Type II Expanded Adult Residential Care Home by a care provider who lives in the home.
Respite Care	These services are when you can't care for yourself. These services are provided on a short-term basis when the person who normally provides care cannot do so or needs a break. These services may be self-directed.
Specialized Medical Equipment and Supplies	These items help you perform activities of daily living or are needed for life-support. These items must be of direct medical benefit to you and your primary care provider must say you need them.

How do I get long-term care services?

To receive long-term care services, you must meet certain requirements and complete an assessment with your Service Coordinator. You can call your Service Coordinator or Member Services for more information.

How do I get dental services?

Dental services are provided by the state. You need a referral from Evercare to receive dental services. Call your Service Coordinator at **1-888-980-8728**.

Can I direct my own services?

In Evercare, we always want you to be involved in decisions about the services you get. If you get personal assistance, respite care, or attendant care (for kids), you have more options. For these services, you can direct your own care. This means you can hire, fire, and train your provider. In some cases, you can pick a friend or loved one to do this for you. Call your Service Coordinator if you want to learn more.

Requirements to get services

What is prior authorization?

You may need permission, called "prior authorization," to get some services under QExA. Call Member Services if you want to learn more about prior authorization. You do not need prior authorization for emergencies or to see a women's doctor if you are pregnant. You do not need a referral to see an OB/GYN for:

- Well-woman checkups.
- Care related to pregnancy.
- Care for any female medical condition.

If Evercare denies or limits your request for a service, you can ask for an appeal. Call Member Services at **1-888-980-8728**.

Emergencies

What are emergency services, and how soon can I expect to be seen?

Emergency services are for health problems that need care right away. Examples are an injury, a sudden serious illness, or severe pain. If you have an EMERGENCY, you should be seen IMMEDIATELY.

What is an emergency medical condition?

An emergency medical condition is a condition with sudden, severe symptoms, which you think could:

- Put your health at risk.
- Cause harm to your body or body functions.
- If you are pregnant, cause serious harm to your health or your unborn child.

If you think that emergency care from a hospital or clinic is needed to prevent serious harm, then you do not need to call Evercare and you should go right away.

Who do I call if there is an emergency?

If you have an emergency, call **911**. You do not need approval from Evercare or your doctor.

Where do I go if there is an emergency?

You can use **any** hospital or provider. You do not need approval from Evercare or your doctor.

What is post-stabilization care?

Post-stabilization care is a QExA covered service you get after emergency care to keep your condition stable.

Appointments

What do I do if I need a doctor and my doctor's office is closed?

It is best to call your doctor as soon as you need care. Do not wait until the evening or weekend. Your illness may get worse. If you get sick at night or on a weekend and cannot wait, call your doctor at the number on the front of your ID card. Some doctors can be reached on nights or weekends. If not, the Nurse Line is open 24 hours a day, seven days a week. You can always get help.

What is urgent medical care, and how soon can I expect to be seen?

If you have an URGENT situation, you should be seen within 24 HOURS. Urgent care is for sudden problems that are not emergencies. You will still need to go to the doctor soon to keep from getting worse. Examples are trouble breathing, burns, wounds, and illnesses like the flu.

How soon can I expect to be seen if I am sick, but it is not an emergency?

Your doctor should see you within 72 HOURS. Your doctor's phone number is on the front of your ID card.

How soon can I expect to be seen if my child is sick, but it is not an emergency?

If your child is a QExA member and is sick, the doctor should see your child within 24 HOURS. To see the doctor, call and explain that your child is sick. The doctor's phone number is on the front of your child's ID card.

What is routine medical care, and how soon can I expect to be seen?

If you need ROUTINE care, your doctor should see you within 21 DAYS. Routine care prevents problems and keeps you healthy. Examples are mammograms, pap smears, and prostate exams. If you need help making an appointment, call Member Services at **1-888-980-8728**.

When I need services in a hospital, but it is not an emergency, how soon can I expect to be seen?

If your doctor or a special doctor thinks you need services in a hospital, but it is not an emergency, the hospital should take you within 4 WEEKS.

When I need to see a special doctor, how soon can I expect to be seen?

A specialist, or special doctor, is a doctor who treats a special health problem, like a foot or heart doctor. Your PCP may want you to go to a specialist. Make your appointment with your specialist early.

Visits with specialists will occur:

- EMERGENCY appointments are IMMEDIATE.
- URGENT appointments are within 24 HOURS of the referral.
- Other appointments are within 4 WEEKS of the referral.

What is a referral?

A referral is permission from your doctor for you to see a specialist or get services. In many managed care plans, you need a referral before you get care from anyone except your primary care provider. If you don't get a referral first, the plan may not pay for your care.

What services need a referral?

To see most specialists, you need a referral from your primary care provider. You can see family planning providers, such as OB/GYNs, WITHOUT a referral from your primary care provider. If you have Medicare, you do not need a referral for Medicare-covered services. If you need specialty care, call Member Services at **1-888-980-8728** to see if you need a referral.

When you are away from home

What if I get sick when I am out of town or traveling?

When you are away from home you can still get medical help. To get help, you should:

- Call Member Services at **1-888-980-8728**. This number is on the back of your Evercare ID card.
- If you need to be treated right away, go to the nearest hospital emergency room.
- You can call the Nurse Line anytime at **1-888-980-8728**, even if you are far from home.

What if I am out of the country traveling?

If you are traveling in another country out of the United States and get sick, your care will not be covered.

Transportation

How do I get to the doctor's office?

If you have no other way to get to the doctor, you can call Evercare QExA Transportation Services at **1-866-475-5746** or TTY **1-866-288-3133**. Call for a ride as soon as you make your appointment or as early as possible. You must have a scheduled

medical appointment. Your Service Coordinator can help you make transportation arrangements for medical appointments on another island.

Interpretation Services

Can someone interpret for me when I talk with my doctor?

It is your right to talk with your doctor and Service Coordinator in the language you prefer. There is no charge for these services. You can also get written materials in alternate formats.

Who do I call for an interpreter?

If you need an interpreter with your doctor or Service Coordinator, call Member Services at **1-888-980-8728**. If you are hearing impaired, call **711**. Call as soon as you make your appointment. Please call at least 24 hours in advance, if possible.

How can I get a face-to-face interpreter in the doctor's office?

Once you call for an interpreter, as described above, the interpreter can meet you at your doctor's and help you talk face-to-face in your preferred language.

Women's health

What if I need an obstetrician/gynecologist (OB/GYN)?

You have the right to select an OB/GYN without a referral from your primary care provider. This is called "direct access." You must select an OB/GYN that participates with Evercare. The access to health care services of an OB/GYN includes:

- Well-woman checkups.
- Care related to pregnancy.

- Care for any female medical condition.

To choose an OB/GYN, you can pick from the provider directory or call your Service Coordinator for help.

Can I stay with my OB/GYN even if he or she doesn't participate with Evercare?

You do not have to choose an OB/GYN that participates with Evercare if you have Medicare. If you do not have Medicare, you must choose an OB/GYN that participates with Evercare. If you are in your second or third trimester, you can with stay with the OB/GYN you are seeing. You can stay with this doctor up to 60 days after your baby is born.

What if I am pregnant?

Call your Service Coordinator and primary care provider as soon as you know you are pregnant. They can talk to you about care before, during, and after you have your baby. Your primary care provider's name and phone number are on your ID card. You can call your Service Coordinator or Member Services if you need help.

Advance directives

What if I get too sick to make a decision about my health care?

You may obtain an advance directive before you get sick.

What are advance directives?

Advance directives put into writing what treatment you want or do not want. They tell actions you want done if you get too sick to make decisions. Your advance directive must be followed. By federal law, you have the right to fill out an advance directive.

How do I get an advance directive?

Contact your Service Coordinator about getting an advance directive.

Who has the right to make health care decisions?

You do, if you are an adult and able to let providers know your decisions. You decide what health care, if any, you will not accept.

What if I become unable to make or let providers know of my health care decisions?

You still have some control over these decisions if you have signed an advance directive. You may name another person whom you trust to make decisions for you. Your doctor must put in your medical record whether you have an advance directive. If you have not named someone in your advance directive, your doctor must seek a person allowed by law to make decisions.

What are my options for making an advance directive?

Under Hawaii law, you can make the following directives:

1) A Durable Power of Attorney for Health Care – this gives a person you choose the power to act in your place and make decisions about your health care.

2) A Living Will – this is a written statement about health care you want or do not want if you cannot make these decisions.

Your Service Coordinator can talk to you about these options.

Who should have a copy of my advance directive?

Give a copy to your doctor and any health care center you enter. If you have a Durable Power of Attorney for Health Care, give a copy to the person you have named. You may give a copy to your Service Coordinator, and you should keep copies for yourself.

Do I have to make an advance directive?

No. Whether you make an advance directive is entirely up to you. A provider cannot refuse care based on whether you have an advance directive.

Can I change or cancel my advance directive?

Yes. If you change or cancel it, let anyone who has a copy know.

What if I already have an advance directive?

You may want to review it or have it reviewed. If it has been prepared in another state, make sure it is valid under Hawaii law.

Who can legally make health care decisions for me if I cannot and I have no advance directive?

A court may pick a guardian to make health care decisions for you. Otherwise, your doctor will have to try to find someone to make health care decisions for you. Your doctor would probably select someone to make decisions for you from this list:

1. Your husband or wife, unless you are legally separated.
2. Your adult child or children.
3. Your mother or father.
4. Your adult brother or sister.
5. Your adult grandchild or grandchildren.
6. Another adult who has shown special care and concern for you and knows your values.

If these persons cannot decide on someone to make your decisions, they must go to court to get a guardian.

If your primary care provider cannot find a person to make health care decisions for you, he or she can decide. Your doctor can do this with the advice of an ethics committee or the approval of another doctor.

What if I am not happy with how Evercare handled my advance directive?

If you are not happy with how Evercare handled your advance directive, you may file a complaint with DHS by calling the Med-QUEST Division Health Plan Liaison at:

Oahu **524-3370 / 692-7182 (TTY)**
Neighbor Island **1-800-316-8005 / 1-800-603-1201 (TTY)**

Or you can mail your complaint to:

Med-QUEST Division
Health Coverage Management Branch
P.O. Box 700190
Kapolei, HI 96709-0190

What if I need help with advance directives?

If you need any help with advance directives or to order a copy of a Living Will, call Member Services at **1-888-980-8728**. If you are speech or hearing impaired, call **711**.

Updating your records

What happens if I have a change in family status?

Contact Member Services at **1-888-980-8728** or your Service Coordinator to let us know about your change in family status. A change in family status could be a marriage, divorce, birth of a child, taking a new job, getting other health insurance, or other big changes.

What do I have to do if I move?

Contact Member Services at **1-888-980-8728** or your Service Coordinator to let us know if you are moving.

Payment for services

Do I need to pay for services?

You do not pay anything for services covered by QExA. The only times you pay for services are when a service is not covered by QExA or when you get non-emergency services without following the Evercare rules for referrals or prior authorizations. In these cases, the provider must talk to you first about paying for services. Even if you fail to pay for those services, you can still keep your QExA eligibility.

What if I get a bill from my doctor?

If you get a bill from a doctor, hospital, or other provider, ask them why they are billing you and give them your QExA member information. You do not have to pay bills that QExA should pay.

Who do I call if I get a bill?

If you still get a bill, call Member Services at **1-888-980-8728**. Be sure you have your bill in front of you when you call.

What information will they need?

You will need to tell Member Services who sent the bill, the date of service, the amount and the doctor, hospital, or provider's address and phone number. You will also need to provide your name, ID number, and other information.

What if I have other health insurance in addition to QExA?

As a condition of QExA eligibility, you are required to report all insurance information to Medicaid. If your private health insurance is canceled, if you have new insurance coverage, or if you have questions about third party insurance, call Member Services at **1-888-980-8728**. Having other insurance does not affect whether you qualify for QExA.

Rights and responsibilities

What are my health care rights and responsibilities as a member of QExA?

As a QExA member, you have the **right** to:

- Get information in language you understand.
- Be treated with respect for your dignity and privacy.
- Have all records and medical and personal information kept private.
- Get information on treatment options.
- Take part in decisions on your care, including the right to refuse treatment.
- Be free from restraints or seclusion unless it is needed for your health.
- Ask for and get a copy of your records and ask to amend or correct them.
- Get health services.
- Use your rights and file a complaint or appeal without any effect on way you are treated.
- Have access to a women's doctor that participates with Evercare.
- Get a second opinion at no cost.
- Get services from non-Evercare doctors if the type of doctor you need does not participate with Evercare and not pay extra.
- Get services per waiting time standards.

- Get care in a way that works for your culture.
- Get coordinated services.
- Have your privacy protected.
- Take part in your care plan.
- Have access to special doctors (if you have need).
- Not have services denied or reduced solely due to diagnosis or condition.
- Choose between nursing homes or hospitals and services in your home or other community setting.
- Get facts on cost sharing, if any.
- **Not** be held liable for:
  - Evercare's debts if Evercare went out of business.
  - The covered services provided by Evercare for which the DHS does not pay Evercare.
  - Covered services for which DHS or Evercare does not pay the health care provider.
  - Payment of covered services given under a contract, referral, or other arrangement that is more than what you would owe if Evercare provided the services directly.
- Only be responsible for cost sharing that is allowed by the state.

As a QExA member, you have the **responsibility** to:

- Understand each right you have under QExA.
- Ask questions if you do not understand your rights.

- Follow the QExA and Medicaid policies and procedures. To:
  - Learn and follow Evercare and Medicaid rules.
  - Choose a primary care provider.
  - Make changes in your primary care provider as set up by Evercare.
  - Keep your appointments.
  - Cancel appointments in advance.
  - Contact your primary care provider first for non-emergency medical needs.
  - Be sure you have approval from your primary care provider before going to a specialist.
  - Understand when you should and should not go to the emergency room.
- Share information on your health with your primary care provider and be informed about treatment options. To:
  - Talk to your providers about your health and ask questions about your care.
  - Help your providers get your medical records.
- Take part in decisions about treatment, make choices, and take action to maintain your health. To:
  - Work with your provider to decide what care is best.
  - Understand how things you do affect your health.
  - Do the best you can to stay healthy.
  - Treat providers and staff with respect.

Complaints and appeals

What is a complaint?

A complaint is something you can file when you are not happy with Evercare. A complaint is different than an appeal.

What should I do if I have a complaint?

If you have a complaint about Evercare, call us toll-free at **1-888-980-8728**. Member Services can help you file a complaint.

What are the time limits for filing a complaint?

There is no time limit on filing a complaint with Evercare. Evercare will send you a letter telling you our response to your complaint.

How long will it take to process my complaint?

You will get a letter within 30 days from when your complaint got to Evercare.

What if I am not happy with Evercare's response to my complaint?

If you are not happy with Evercare's response to your complaint, you may also file a complaint with DHS by calling the Med-QUEST Division Health Plan Liaison at:

Oahu **524-3370 / 692-7182 (TTY)**.
Neighbor Island **1-800-316-8005 / 1-800-603-1201 (TTY)**.

Or you can mail a request to:

Med-QUEST Division
Health Coverage Management Branch
P.O. Box 700190
Kapolei, HI 96709-0190

You must tell DHS your complaint within 30 days of Evercare's decision.

What is an appeal?

An appeal is something you can file when you are not happy with an Evercare decision or action. For example, you can file an appeal when a covered service is denied, delayed, limited, or stopped.

How do I file an appeal?

You can start an appeal over the phone or in person. You must also send your appeal in writing, unless you are requesting an expedited appeal. You must appeal within 30 days of the date on the denial letter. You can give Evercare evidence to support your appeal in person or in writing. You can call Member Services to get help with your appeal.

How long will it take to process my appeal?

We will tell you and your doctor the outcome within 30 days. We will send a letter telling you the outcome.

What is an expedited appeal?

An expedited appeal is when Evercare or your provider thinks Evercare needs to make a quick decision based on your health. This is when taking the time for a standard appeal could risk your life or health. Call Member Services when you want an expedited appeal.

How long will it take to process my expedited appeal?

We will tell you and your doctor the outcome within seventy-two (72) hours. We will send a letter telling you and your doctor the outcome. If you ask for more time, we may extend the time frame for giving our decision for up to 14 days. If we need more information that will help your case, we may also extend the time frame for up to 14 days. We will send you a letter if we extend the time frame.

What happens if Evercare denies the request for an expedited appeal?

If Evercare denies an expedited appeal, the appeal is then processed through the normal appeal process which will be resolved within 30 days. Evercare will try to call you to tell

you that the appeal is not going to be processed as an expedited appeal, and will follow up in writing. You may make a complaint about this denial.

Can I ask for a State Administrative Hearing?

If you do not agree with Evercare's decision, you may ask for a State Administrative Hearing. You have 30 days after the date of Evercare's decision to ask for a hearing. You can ask for a hearing by writing to:

State of Hawaii Department of Human Services
Administrative Appeals Office
P.O. Box 339
Honolulu, HI 96809

You have the right to have someone represent you during the hearing.

Will I still get my benefits during an appeal or hearing?

You have the right to continue any service you are getting pending the decision if you request an appeal or hearing within 10 days of the date of Evercare's decision. If you do not ask for the appeal or hearing within 10 days, your service may be stopped.

If you get services during the appeal, but the decision is not in your favor, you may have to pay for the services you got during that time.

I have completed all of Evercare's complaints and appeals steps. What if I am still not happy with the response?

You, your authorized representative, or your doctor can ask for an external review by the State of Hawaii's Insurance Commissioner. You may only do this if you have used all

the steps available through Evercare. You can call Member Services at **1-888-980-8728** if you need help contacting the Insurance Commissioner.

What is the Hawaii Ombudsman Program?

The ombudsman is a person who can help you with QExA problems. The State of Hawaii, Department of Human Services oversees this program. Hawaii ombudsman phone number to come.

Fraud and abuse

How do I report someone who is misusing the QExA Program?

If you think a member or provider has committed waste, abuse, or fraud, you have a responsibility and a right to report it. Examples of waste, abuse, or fraud include a member sharing his or her ID card with someone else or a provider billing for services he or she did not perform.

To report waste, abuse or fraud, gather as many facts as possible. Report providers or members to:

Evercare Health Plan
QUEST Expanded Access
841 Bishop Street, Suite 725
Honolulu, HI 96813
Member Services **1-888-980-8728**

Or call our Fraud and Abuse Hotline at: **1-866-242-7727**

When reporting a provider, list:

- Name, address, and phone.
- Name and address of facility (hospital, nursing home, home health agency, etc.).
- Type of provider (physician, physical therapist, pharmacist, etc.).

- Names and numbers of other witnesses.
- Dates and summary of events.

When reporting a member, list:

- The person's name;
- The person's date of birth, if available;
- The city where the person lives; and
- Specific details about the waste, abuse or fraud.

Even if you do not know all of this information, you should still file a report.

Other information for QExA members

As a member of QExA you can get:

- Evercare practice guidelines.
- Annual member surveys.
- Procedures we use to control services and costs.
- The total number and outcomes of complaints and appeals filed by members.
- The structure and operation of Evercare and any plans Evercare uses to encourage doctors to provide appropriate, high-quality services to QExA members.
- An updated provider directory, including names, addresses, phone numbers, and languages spoken (other than English) and a list of providers who are not taking new patients. This includes, at a minimum, primary care providers, specialists, and hospitals.

Call Member Services at **1-888-980-8728** if you want any of this information.

Notice of Privacy Practices

Protection of Information

UnitedHealth Group has to get and keep information to provide its services. We have security to protect it from loss or misuse. We do audits to ensure safe handling.

PRIVACY PRACTICES

Effective 12/04/07

THIS TELLS HOW YOUR MEDICAL INFORMATION MAY BE USED. IT TELLS HOW YOU CAN GET ACCESS TO IT.

REVIEW THIS WITH CARE.

The law says we* must protect your privacy. We must send you this notice. It tells how we may use your information. It tells when we can disclose it. It lists your rights. By law we must abide by these terms.

The terms "information" or "health information" mean data the provider or health plan creates or gets about your health care. It includes payment for care.

We can change our privacy notice. If we do, we will mail you the new notice within 60 days. Or we will post it at **www.myuhc.com**.

*For this Notice of Privacy Practices, "we" or "us" refers to these UnitedHealthcare entities: ACN Group of California, Inc.; All Savers Insurance Company; American Medical Security Life Insurance Company; AmeriChoice of New Jersey, Inc.; AmeriChoice of New York, Inc.; AmeriChoice of Pennsylvania, Inc.; Arizona Physicians IPA, Inc.; Arnett HMO, Inc.; Dental Benefit Providers of California, Inc.; Dental Benefit Providers of Illinois, Inc.; Dental Benefit Providers of

Maryland, Inc.; Evercare of Arizona, Inc.; Evercare of Texas, L.L.C.; Golden Rule Insurance Company; Great Lakes Health Plan, Inc.; IBA Health and Life Assurance Company; MAMSI Life and Health Insurance Company; MD-Individual Practice Assocation, Inc.; Midwest Security Life Insurance Company; National Pacific Dental, Inc.; Neighborhood Health Partnership, Inc.; Nevada Pacific Dental, Inc.; Optimum Choice, Inc.; Oxford Health Insurance, Inc.; Oxford Health Plans (CT), Inc.; Oxford Health Plans (NJ), Inc.; Oxford Health Plans (NY), Inc.; Pacific Union Dental, Inc.; PacifiCare Behavioral Health of California, Inc.; PacifiCare Behavioral Health, Inc.; PacifiCare Dental; PacifiCare Dental of Colorado, Inc.; PacifiCare Insurance Company; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company; PacifiCare of Arizona, Inc.; PacifiCare of California; PacifiCare of Colorado, Inc.; PacifiCare of Nevada, Inc.; PacifiCare of Oklahoma, Inc.; PacifiCare of Oregon, Inc.; PacifiCare of Texas, Inc.; PacifiCare of Washington, Inc.; Rooney Life Insurance Company; Spectera, Inc.; U.S. Behavioral Health Plan, California; United HealthCare of Alabama, Inc.; United HealthCare of Arizona, Inc.; United HealthCare of Arkansas, Inc.; United HealthCare of Colorado, Inc.; United HealthCare of Florida, Inc.; United HealthCare of Georgia, Inc.; UnitedHealthcare of Illinois, Inc.; United HealthCare of Kentucky, Ltd.; United HealthCare of Louisiana, Inc.; UnitedHealthcare of the Mid-Atlantic, Inc.; United HealthCare of the Midlands, Inc.; United HealthCare of the Midwest, Inc.; United HealthCare of Mississippi, Inc.; UnitedHealthcare of New England, Inc.; UnitedHealthcare of New York, Inc.; UnitedHealthcare of North Carolina, Inc.; United HealthCare of Ohio, Inc.; United HealthCare of Tennessee, Inc.; United HealthCare of Texas, Inc.; United HealthCare of Utah; UnitedHealthcare of Wisconsin, Inc.; Unimerica Insurance Company; Unimerica Life Insurance

Company of New York; United Behavioral Health; United HealthCare Insurance Company; United HealthCare Insurance Company of Illinois; United HealthCare Insurance Company of New York; United HealthCare Insurance Company of Ohio; UnitedHealthcare Insurance Company of the River Valley; UnitedHealthcare Plan of the River Valley, Inc.

How We Disclose Information

We must disclose information:

- To you or someone who has the legal right to act for you.
- To Health and Human Services to protect your privacy.
- When stated by law.

We can use and share data to pay for your care and run our business. For example:

- **For Payment** of premiums and to process claims.
- **For Treatment.** To doctors or hospitals.
- **For Health Care Business.** To do business and manage your coverage. For example, to suggest a disease management or wellness program.
- **For Health Programs or Products.** Such as alternative treatments or health products and services.
- **To Plan Sponsors.** If your policy is with an employer plan, we may give the sponsor summary and enrollment data. We may give data to manage the plan if the sponsor agrees to limit its use.
- **For Reminders.** We may remind you of appointments.

We may use or share information in these special cases:

- **Persons Involved With Your Care.** Such as a family member, when you are incapacitated, in an emergency, or under the law.
- **Public Health.** Such as to report disease.
- **To Report Abuse or Neglect** to the authorities. This may be a social service agency.
- **Health Oversight.** Such as government audits and fraud or abuse investigation.
- **Legal Purposes.** Such as a court order, warrant, or subpoena.
- **Law Enforcement.** Such as to find a missing person.
- **Threat to Health or Safety.** For example, to public agencies.
- **Certain Government Functions.** Such as military, veteran, national security, protective services.
- **Workers Compensation.** Disclosures of job injuries per state laws.
- **Research.** Such as research on disease or disability, if it meets privacy laws.
- **Information on Decedents.** To a coroner to identify decedent, find cause of death, or per the law. To funeral directors to carry out their duties.
- **Organ Procurement.** To get, bank or transplant organs, eyes or tissue.

If none of the above applies, **we must get your written permission to use or share your information.** If another law applies, it is our intent to follow the stricter law. In some states, your permission may be required. Your permission may be

needed for highly confidential information. This is defined below. We cannot guarantee that the person to whom we give information will not disclose it. You may revoke your permission, unless we have already acted. To do so, call the number on your ID card.

Highly confidential information

Federal and state laws may give extra protection for "highly confidential information." This may include federal law on alcohol and drugs. It may include state laws on:

1. HIV/AIDS.
2. Mental health.
3. Genetic tests.
4. Alcohol and drug abuse.
5. Sexually transmitted diseases and reproductive health.
6. Child or adult abuse or neglect, and sexual assault.

Attached is a Summary of State Laws.

Your rights

These are your privacy rights.

- **To limit** use for treatment, payment, or health care business. To limit disclosure to family or others involved in your care or payment for it. We may have policies on dependent access. **We will try to grant requests, but we do not have to agree.**
- **To get confidential information** in another way or place. (For example, sent to a P.O. box instead of your home.)

- **To see and get a copy** of information that may be used to make decisions about you. This includes claims and medical records. You may get a summary. You must make a written request to see and copy it. We may deny your request.
- **To ask to amend** information if you think it is wrong. If we deny your request, you may add your opinion to your record.
- **To get a report** of disclosures we made for the past six years. This will not include disclosures before April 14, 2003. It will not include disclosures for treatment, payment, and health care business. It will not include disclosures made to you or with your permission. It will not include disclosures to correctional institutions or law enforcement. It will not include disclosures not required by federal law.
- **To get a copy of this notice.** You may ask for a copy anytime. If you got an electronic notice, you can get a paper copy. You may get a copy at **www.myuhc.com**.

Using your rights

- **Contacting your Health Plan.** If you have questions or want to use your rights, call the number on your ID card.
- **Filing a complaint.** If you think your rights have been violated, you may file a complaint at:

  United Healthcare
  Customer Service – Privacy Unit
  P.O. Box 740815
  Atlanta, GA 30374-0815

You may also notify the U.S. Department of Health and Human Services. We will not take any action against you for filing a complaint.

FINANCIAL PRIVACY

We (including our affiliates listed on this page)** commit to keep your financial information private. "Personal financial information" means non-health information that was obtained to give coverage.

We get this information from:

- Applications or other forms. This may include name, address, age and Social Security number.
- Your dealings with us, our affiliates or others. This may include premium payment.

We do not give out financial information on current or former enrollees to any third party except as allowed by law.

We restrict access to your financial information to employees and providers who handle your coverage and services. We have safeguards that meet federal standards.

**For purposes of this Financial Information Privacy Notice, "we" or "us" refers to the entities listed on the first page of the Notice of Privacy Practices, plus the following UnitedHealthcare affiliates: ACN Group IPA of New York, Inc; ACN Group, Inc.; AmeriChoice Health Services, Inc.; Behavioral Health Administrators; DBP Services of New York IPA, Inc.; DCG Resource Options, LLC; Dental Benefit Providers, Inc.; Disability Consulting Group, LLC; Exante Bank, Inc.; HealthAllies, Inc.; IBA Self Funded Group, Inc.; Lifemark Corporation; MAMSI Insurance Resources, LLC; Managed Physical Network, Inc.; Mid Atlantic Medical Services, LLC; Midwest Security Administrators, Inc.; Midwest Security Care, Inc.; National Benefit Resources,

Inc.; NPD Dental Services, Inc.; NPD Insurance Company, Inc.; OneNet PPO, LLC; Oxford Benefit Management, Inc.; Oxford Health Plans LLC; PacifiCare Health Plan Administrators, Inc.; PacificDental Benefits, Inc.; ProcessWorks, Inc.; RxSolutions, Inc.; RxSolutions NY IPA, Inc.; Spectera of New York, IPA, Inc.; Uniprise, Inc.; United Behavioral Health of New York I.P.A., Inc.; United HealthCare Service LLC; United HealthCare Services, Inc.; United Medical Resources, Inc.; UnitedHealth Advisors, LLC; UnitedHealthcare Services Company of the River Valley, Inc.; UnitedHealthOne Agency, Inc.

Summary of State Laws: Hawaii Privacy Policies

HIPAA is a federal act that protects your health information privacy. Some states have stricter rules. In such cases the state laws apply.

Information in these areas gets more protection by Hawaii law.

1. **Sexually transmitted disease and reproductive health.** The patient may limit this.
2. **Genetics.** The patient may limit this.
3. **Alcohol and drug abuse.** The patient may limit this. It may be prohibited in some cases.
4. **Mental health.** The patient may limit this. It may be prohibited in some cases.

Notes

Evercare Health Plan
QUEST Expanded Access
841 Bishop Street, Suite 725
Honolulu, HI 96813

Member Services **1-888-980-8728**
TTY: **711**
Monday – Friday
7:45 a.m. – 4:30 p.m. (H.S.T.)
EvercareHealthPlans.com/HI_QExA

Serving the islands of:
Hawaii, Kauai, Maui, and Oahu

2/2009

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IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF HAWAI'I

TONY KORAB, TOJIO CLANTON, KEBEN ENOCH, CASMIRA AGUSTIN, ANTONIO IBANA, AGAPITA MATEO and RENATO MATEO, individually and on behalf of all persons similarly situated,

Plaintiffs,

vs.

PATRICIA MCMANAMAN, in her official capacity as Interim 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.

Case No. CV 10-00483 JMS KSC
[Civil Rights Action]
[Class Action]

CERTIFICATE OF WORD COUNT

CERTIFICATE OF WORD COUNT

Pursuant to Local Rule 7.5(c) of the Local Rules of Practice for the United States District Court for the District of Hawai‘i, the undersigned certifies that *Plaintiffs' Memorandum in Opposition to Defendants' Motion for Partial Summary Judgment Regarding New Residents* contains 8,457 words.

DATED: Honolulu, Hawai‘i, May 9, 2011.

/s/ CATHERINE L. AUBUCHON
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ROBERT H. HATCH
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TONY KORAB, TOJIO CLANTON, KEBEN ENOCH, CASMIRA AGUSTIN, ANTONIO IBANA, AGAPITA MATEO and RENATO MATEO, individually and on behalf of all persons similarly situated.

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF HAWAIʻI

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Defendants.

Case No. CV 10-00483 JMS KSC
[Civil Rights Action]
[Class Action]

CERTIFICATE OF SERVICE

CERTIFICATE OF SERVICE

The undersigned herby certifies that on May 9, 2011, a copy of *Plaintiffs' Memorandum in Opposition to Defendants' Motion for Partial Summary Judgment Regarding New Residents* was duly served as described below upon the following parties:

Electronically through CM/ECF:

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DATED: Honolulu, Hawai‘i, May 9, 2011.

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