

# Chapter 388-438 WAC

## EMERGENCY ASSISTANCE FOR MEDICAL NEEDS

### WAC

388-438-0110	Alien medical programs.
388-438-0115	Alien emergency medical program (AEM).
388-438-0120	Alien medical for dialysis and cancer treatment (state-only).
388-438-0125	State-funded long-term care services program .

### DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-438-0100	Medically indigent (MI) program. [Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-438-0100, filed 7/31/98, effective 9/1/98. Formerly 388-503-0370, 388-518-1805, 388-518-1810 and 388-518-1850.] Repealed by 04-07-141, filed 3/22/04, effective 4/22/04. Statutory Authority: RCW 74.08.090, 74.09.530, and 2003 1st sp.s. c 25.
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**Notice of Objection (1):** It is the opinion of the Joint Administrative Rules Review Committee that the Department of Social and Health Services has not modified, amended, withdrawn or repealed WAC 388-100-005 to conform with the intent of the legislature, as expressed in both chapters 70.48 and 74.09 RCW.

Although the department has statutory authority in chapter 74.09 RCW, to determine who is eligible to receive assistance under the limited casualty medical program, that authority is not without limitation. The City and County Jail Act of 1977 requires the Department of Social and Health Services to reimburse the local government for inmate medical costs, provided that inmate is otherwise eligible for such care. Inmates have not been denied coverage based on their status as inmates since the enactment of the City and County Jail Act.

In determining legislative intent, a portion of a statute cannot be examined in a vacuum. Rather, all statutes relating to the same subject should be read together and given a harmonious interpretation. The legislature is presumed to enact law with knowledge of existing law. RCW 70.48.130 is made moot by the department's administrative denial of inmate medical coverage, and the legislature does not intend to enact "moot" legislation.

The Joint Administrative Rules Review Committee objects to WAC 388-100-005 and herewith directs the code reviser to publish this Notice of Objection...pursuant to RCW 34.04.240.

[Joint Administrative Rules Review Committee, Memorandum, July 10, 1987—Filed July 27, 1987, WSR 87-16-031]

**Notice of Objection (2):** The Joint Administrative Rules Review Committee (JARRC) held on July 27, 1987, that WAC 388-100-005 did not conform with the intent of the Legislature. This rule, adopted by the Department of Social and Health Services (DSHS), excluded inmates of federal or state prisons from eligibility for the limited casualty-medically indigent program of medical assistance.

As authority for its opinion, the committee cited RCW 70.48.130 of the City and County Jail Act of 1977 which requires DSHS to reimburse local governments for inmate medical costs provided to otherwise eligible inmates.

There has been no amendment to RCW 70.48.130 changing its meaning since 1986. Effective May 15, 1993, an amendment resulted in even further emphasis of the intent of the Legislature that all jail inmates receive cost-effective medical care. (1993 C 409 § 2)

On May 31, 1994, DSHS refiled a permanent rule, WSR 94-10-065, WAC 388-503-0370 which recodified WAC 388-100-005. The eligibility requirement that an applicant for the medically indigent program not be an inmate of a federal or state prison is retained in the new rule.

Since neither the statutory authority nor the substance of the rule has changed since the JARRC decision of July 27, 1987, the committee is of the opinion that DSHS has not modified, amended, withdrawn or repealed WAC 388-100-005 to conform with the intent of the Legislature. This being the case, pursuant to RCW 34.05.640 (5) and (6), the committee respectfully requests that the notice of objection published along with WAC 388-100-005 continue to be published along with WAC 388-503-0370.

(9/15/11)

[Joint Administrative Rules Review Committee, Memorandum February 21, 1995—Filed February 27, 1995, WSR 95-06-053.]

**Reviser's note:** The substance of WAC 388-503-0370 was moved into WAC 388-438-0100 filed as WSR 98-16-044 on July 31, 1998.

**WAC 388-438-0110 Alien medical programs.** (1) To qualify for an alien medical program (AMP) a person must:

(a) Be ineligible for medicaid or other DSHS medical program due to the citizenship/alien status requirements described in WAC 388-424-0010;

(b) Meet the requirements described in WAC 388-438-0115, 388-438-0120, or 388-438-0125; and

(c) Meet categorical eligibility criteria for one of the following programs, except for the social security number or citizenship/alien status requirements:

(i) WAC 388-475-0050, for an SSI-related person;

(ii) WAC 388-505-0220, for family medical programs;

(iii) WAC 388-505-0210, for a child under the age of nineteen;

(iv) WAC 388-462-0015, for a pregnant woman;

(v) WAC 388-462-0020, for the breast and cervical cancer treatment program for women; or

(vi) WAC 388-523-0100, for medical extensions.

(2) AMP medically needy (MN) coverage is available for children, adults age sixty-five or over, or persons who meet SSI disability criteria. See WAC 388-519-0100 for MN eligibility and 388-519-0110 for spending down excess income under the MN program.

(3) The department does not consider a person's date of arrival in the United States when determining eligibility for AMP.

(4) The department does not consider a sponsor's income and resources when determining eligibility for AMP, unless the sponsor makes the income or resources available.

(5) A person is not eligible for AMP if that person entered the state specifically to obtain medical care.

(6) A person who the department determines is eligible for AMP may be eligible for retroactive coverage as described in WAC 388-416-0015.

(7) Once the department determines financial and categorical eligibility for AMP, the department then determines whether a person meets the requirements described in WAC 388-438-0115, 388-438-0120, or 388-438-0125.

[Statutory Authority: RCW 74.04.050, 74.08.090, and 2009 c 564 §§ 1109, 201, 209. 10-19-085, § 388-438-0110, filed 9/17/10, effective 10/18/10. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530. 07-07-024, § 388-438-0110, filed 3/9/07, effective 4/9/07; 06-04-047, § 388-438-0110, filed 1/26/06, effective 2/26/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-057, § 388-438-0110, filed 7/13/04, effective 8/13/04. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530, and Section 1903 (v)(2)(c) of the Social Security Act. 03-24-058, § 388-438-0110, filed 12/1/03, effective 1/1/04. Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-438-0110, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.08.090 and C.F.R. 436.128, 436.406(c) and 440.255. 01-05-041, § 388-438-0110, filed 2/14/01, effective 3/17/01. Statu-

tory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530, 42 C.F.R. 435.139 and 42 C.F.R. 440.255. 99-23-082, § 388-438-0110, filed 11/16/99, effective 12/17/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-438-0110, filed 7/31/98, effective 9/1/98.]

**WAC 388-438-0115 Alien emergency medical program (AEM).** (1) A person nineteen years of age or older who is not pregnant and meets the eligibility criteria under WAC 388-438-0110 is eligible for the alien emergency medical program's scope of covered services described in this section if the person meets (a) and (b) below, or (c) below:

(a) The department's health and recovery services administration determines that the primary condition requiring treatment meets the definition of an emergency medical condition as defined in WAC 388-500-0005, and the condition is confirmed through review of clinical records; and

(b) The person's qualifying emergency medical condition is treated in one of the following hospital settings:

- (i) Inpatient;
- (ii) Outpatient surgery;

(iii) Emergency room services, which must include an evaluation and management (E&M) visit by a physician; or

(c) Involuntary Treatment Act (ITA) and voluntary inpatient admissions to a hospital psychiatric setting that are authorized by the department's inpatient mental health designee (see subsection (5) of this section).

(2) If a person meets the criteria in subsection (1), the department will cover and pay for all related medically necessary health care services and professional services provided:

(a) By a physician in his office or in a clinic setting immediately prior to the transfer to the hospital, resulting in a direct admission to the hospital; and

(b) During the specific emergency room visit, outpatient surgery or inpatient admission. These services include, but are not limited to:

- (i) Medications;
- (ii) Laboratory, X ray, and other diagnostics and the professional interpretations;
- (iii) Medical equipment and supplies;
- (iv) Anesthesia, surgical, and recovery services;
- (v) Physician consultation, treatment, surgery, or evaluation services;
- (vi) Therapy services;
- (vii) Emergency medical transportation; and
- (viii) Nonemergency ambulance transportation to transfer the person from a hospital to a long term acute care (LTAC) or an inpatient physical medicine and rehabilitation (PM&R) unit, if that admission is prior authorized by the department as described in subsection (3) of this section.

(3) The department will cover admissions to an LTAC facility or an inpatient PM&R unit if:

(a) The original admission to the hospital meets the criteria as described in subsection (1) of this section;

(b) The person is transferred directly to this facility from the hospital; and

(c) The admission is prior authorized according to LTAC and PM&R program rules (see WAC 388-550-2590 for LTAC and WAC 388-550-2561 for PM&R).

(4) The department does not cover any services, regardless of setting, once the person is discharged from the hospital

after being treated for a qualifying emergency medical condition authorized by the department under this program. Exception: Pharmacy services, drugs, devices, and drug-related supplies listed in WAC 388-530-2000, prescribed on the same day and associated with the qualifying visit or service (as described in subsection (1) of this section) will be covered for a one-time fill and retrospectively reimbursed according to pharmacy program rules.

(5) Medical necessity of inpatient psychiatric care in the hospital setting must be determined, and any admission must be authorized by the department's inpatient mental health designee according to the requirements in WAC 388-550-2600.

(6) There is no precertification or prior authorization for eligibility under this program. Eligibility for the AEM program does not have to be established before an individual begins receiving emergency treatment.

(7) Under this program, certification is only valid for the period of time the person is receiving services under the criteria described in subsection (1) of this section. The exception for pharmacy services is also applicable as described in subsection (4) of this section.

(a) For inpatient care, the certification is only for the period of time the person is in the hospital, LTAC, or PM&R facility - the admission date through the discharge date. Upon discharge the person is no longer eligible for coverage.

(b) For an outpatient surgery or emergency room service the certification is only for the date of service. If the person is in the hospital overnight, the certification will be the admission date through the discharge date. Upon release from the hospital, the person is no longer eligible for coverage.

(8) Under this program, any visit or service not meeting the criteria described in subsection (1) of this section is considered not within the scope of service categories as described in WAC 388-501-0060. This includes, but is not limited to:

(a) Hospital services, care, surgeries, or inpatient admissions to treat any condition which is not considered by the department to be a qualifying emergency medical condition, including but not limited to:

- (i) Laboratory X ray, or other diagnostic procedures;
- (ii) Physical, occupational, speech therapy, or audiology services;
- (iii) Hospital clinic services; or
- (iv) Emergency room visits, surgery, or hospital admissions.

(b) Any services provided during a hospital admission or visit (meeting the criteria described in subsection (1) of this section), which are not related to the treatment of the qualifying emergency medical condition;

(c) Organ transplants, including preevaluations, post operative care, and anti-rejection medication;

(d) Services provided outside the hospital settings described in subsection (1) of this section, including but not limited to:

- (i) Office or clinic-based services rendered by a physician, an ARNP, or any other licensed practitioner;
- (ii) Prenatal care, except labor and delivery;
- (iii) Laboratory, radiology, and any other diagnostic testing;
- (iv) School-based services;

- (v) Personal care services;
- (vi) Physical, respiratory, occupational, and speech therapy services;
- (vii) Waiver services;
- (viii) Nursing facility services;
- (ix) Home health services;
- (x) Hospice services;
- (xi) Vision services;
- (xii) Hearing services;
- (xiii) Dental services;
- (xiv) Durable and non durable medical supplies;
- (xv) Nonemergency medical transportation;
- (xvi) Interpreter services; and
- (xvii) Pharmacy services, except as described in subsection (4).

(9) The services listed in subsection (8) of this section are not within the scope of service categories for this program and therefore the exception to rule process is not available.

(10) Providers must not bill the department for visits or services that do not meet the qualifying criteria described in this section. The department will identify and recover payment for claims paid in error.

[Statutory Authority: RCW 74.04.050, 74.08.090, and 2009 c 564 §§ 1109, 201, 209, 10-19-085, § 388-438-0115, filed 9/17/10, effective 10/18/10.]

**WAC 388-438-0120 Alien medical for dialysis and cancer treatment (state-only).** (1) A person nineteen years of age or older who is not pregnant and meets the eligibility criteria under WAC 388-438-0110 may be eligible for the scope of service categories under this program if the condition requires:

- (a) Surgery, chemotherapy, and/or radiation therapy to treat cancer;
  - (b) Dialysis to treat acute renal failure or end stage renal disease (ESRD); or
  - (c) Anti-rejection medication, if the person has had an organ transplant.
- (2) When related to treating the qualifying medical condition, covered services include but are not limited to:
- (a) Physician and ARNP services, except when providing a service that is not within the scope of this medical program (as described in subsection (7) of this section);
  - (b) Inpatient and outpatient hospital care;
  - (c) Dialysis;
  - (d) Surgical procedures and care;
  - (e) Office or clinic based care;
  - (f) Pharmacy services;
  - (g) Laboratory, X ray, or other diagnostic studies;
  - (h) Oxygen services;
  - (i) Respiratory and intravenous (IV) therapy;
  - (j) Anesthesia services;
  - (k) Hospice services;
  - (l) Home health services, limited to two visits;
  - (m) Durable and nondurable medical equipment;
  - (n) Nonemergency transportation; and
  - (o) Interpreter services.

(3) All hospice, home health, durable and nondurable medical equipment, oxygen and respiratory, IV therapy, and dialysis for acute renal disease services require prior authorization. Any prior authorization requirements applicable to

the other services listed above must also be met according to specific program rules.

(4) To be qualified and eligible for coverage for cancer treatment under this program, the diagnosis must be already established or confirmed. There is no coverage for cancer screening or diagnostics for a workup to establish the presence of cancer.

(5) Coverage for dialysis under this program starts the date the person begins dialysis treatment, which includes fistula placement and other required access. There is no coverage for diagnostics or predialysis intervention, such as surgery for fistula placement anticipating the need for dialysis, or any services related to preparing for dialysis.

(6) Certification for eligibility will range between one to twelve months depending on the qualifying condition, the proposed treatment plan, and whether the client is required to meet a spenddown liability.

(7) The following are not within the scope of service categories for this program:

- (a) Cancer screening or work-ups to detect or diagnose the presence of cancer;
- (b) Fistula placement while the person waits to see if dialysis will be required;
- (c) Services provided by any healthcare professional to treat a condition not related to, or medically necessary to, treat the qualifying condition;
- (d) Organ transplants, including preevaluations and post operative care;
- (e) Health department services;
- (f) School-based services;
- (g) Personal care services;
- (h) Physical, occupational, and speech therapy services;
- (i) Audiology services;
- (j) Neurodevelopmental services;
- (k) Waiver services;
- (l) Nursing facility services;
- (m) Home health services, more than two visits;
- (n) Vision services;
- (o) Hearing services;
- (p) Dental services, unless prior authorized and directly related to dialysis or cancer treatment;
- (q) Mental health services;
- (r) Podiatry services;
- (s) Substance abuse services; and
- (t) Smoking cessation services.

(8) The services listed in subsection (7) of this section are not within the scope of service categories for this program. The exception to rule process is not available.

(9) Providers must not bill the department for visits or services that do not meet the qualifying criteria described in this section.

[Statutory Authority: RCW 74.04.050, 74.08.090, and 2009 c 564 §§ 1109, 201, 209, 10-19-085, § 388-438-0120, filed 9/17/10, effective 10/18/10.]

**WAC 388-438-0125 State-funded long-term care services program.** (1) The state-funded long-term care services program is subject to caseload limits determined by legislative funding. Services cannot be authorized for eligible persons prior to a determination by the aging and disability services administration (ADSA) that caseload limits will not be exceeded as a result of the authorization.

(2) Long-term care services are defined in this section as services provided in one of the following settings:

- (a) In a person's own home, as described in WAC 388-106-0010;
- (b) Nursing facility, as defined in WAC 388-97-0001;
- (c) Adult family home, as defined in RCW 70.128.010;
- (d) Assisted living facility, as described in WAC 388-513-1301;
- (e) Enhanced adult residential care facility, as described in WAC 388-513-1301;
- (f) Adult residential care facility, as described in WAC 388-513-1301.

(3) Long-term care services will be provided in one of the facilities listed in subsection (2)(b) through (f) of this section unless nursing facility care is required to sustain life.

(4) To be eligible for the state-funded long-term care services program described in this section, an adult nineteen years of age or older must meet all of the following conditions:

- (a) Meet the general eligibility requirements for medical programs described in WAC 388-503-0505 (2) and (3)(a),(b), (e), and(f);
- (b) Reside in one of the settings described in subsection (2) of this section;
- (c) Attain institutional status as described in WAC 388-513-1320;
- (d) Meet the functional eligibility described in WAC 388-106-0355 for nursing facility level of care;
- (e) Not have a penalty period due to a transfer of assets as described in WAC 388-513-1363, 388-513-1364, 388-513-1365, and 388-513-1366;
- (f) Not have equity interest in a primary residence more than the amount described in WAC 388-513-1350 (7)(a)(ii); and
- (g) Any annuities owned by the adult or spouse must meet the requirements described in chapter 388-561 WAC.

(5) An adult who is related to the supplemental security income (SSI) program as described in WAC 388-475-0050 (1), (2), and (3) must meet the financial requirements described in WAC 388-513-1325, 388-513-1330, and 388-513-1350.

(6) An adult who does not meet the SSI-related criteria in subsection (2) of this section may be eligible under the family institutional medical program rules described in WAC 388-505-0250 or 388-505-0255.

(7) An adult who is not eligible for the state-funded long-term care services program under categorically needy (CN) rules may qualify under medically needy (MN) rules described in:

- (a) WAC 388-513-1395 for adults related to SSI; or
- (b) WAC 388-505-0255 for adults related to family institutional medical.

(8) All adults qualifying for the state-funded long-term care services program will receive CN scope of medical coverage described in WAC 388-501-0060.

(9) The department determines how much an individual is required to pay toward the cost of care using the following rules:

- (a) For an SSI-related individual residing in a nursing home, see rules described in WAC 388-513-1380.

(b) For an SSI-related individual residing in one of the other settings described in subsection (2) of this section, see rules described in WAC 388-515-1505.

(c) For an individual eligible under the family institutional program, see WAC 388-505-0265.

(10) A person is not eligible for state-funded long-term care services if that person entered the state specifically to obtain medical care.

(11) A person eligible for the state-funded long-term care services program is certified for a twelve month period.

[Statutory Authority: 2011 c 5, RCW 74.04.057, 74.08.090, and 74.09.510. 11-19-070, § 388-438-0125, filed 9/15/11, effective 10/16/11. Statutory Authority: RCW 74.04.050, 74.08.090, and 2009 c 564 §§ 1109, 201, 209. 10-19-085, § 388-438-0125, filed 9/17/10, effective 10/18/10.]