Chapter 182-539 WAC
HIV/AIDS RELATED SERVICES

WAC

WAC 182-539-0200 AIDS—Health insurance premium payment program. (1) The purpose of the AIDS health insurance premium payment program is to help individuals who are not eligible for the department's medical programs and who are diagnosed with AIDS, pay their health insurance premiums.

(2) To be eligible for the AIDS health insurance premium payment program, individuals must:

(a) Be diagnosed with AIDS as defined in WAC 246-100-011;

(b) Be a resident of the state of Washington;

(c) Be responsible for all, or part of, the health insurance premium payment (without the department's help);

(d) Not be eligible for one of the department's other medical programs;

(e) Not have personal income that exceeds three hundred seventy percent of the federal poverty level; and

(f) Not have personal assets, after exemptions, exceeding fifteen thousand dollars. The following personal assets are exempt from the personal assets calculation:

(i) A home used as the person's primary residence; and

(ii) A vehicle used as personal transportation.

(3) The department may contract with a not-for-profit community agency to administer the AIDS health insurance premium payment program. The department or its contractor determines an individual's initial eligibility and redetermines eligibility on a periodic basis. To be eligible, individuals must:

(a) Cooperate with the department's contractor;

(b) Cooperate with eligibility determination and redetermination process; and

(c) Initially meet and continue to meet the eligibility criteria in subsection (2) of this section.

(4) Individuals, diagnosed with AIDS, who are eligible for one of the department's medical programs may ask the department to pay their health insurance premiums under a separate process. The client's community services office (CSO) is able to assist the client with this process.

(5) Once an individual is eligible to participate in the AIDS health insurance premium payment program, eligibility would cease only when one of the following occurs. The individual:

(a) Is deceased;

(b) Voluntarily quits the program;

(c) No longer meets the requirements of subsection (2) of this section; or

(d) Has benefits terminated due to the legislature's termination of the funding for this program.

(6) The department sets a reasonable payment limit for health insurance premiums. The department sets its limit by tracking the charges billed to the department for department clients who have AIDS. The department does not pay health insurance premiums that exceed fifty percent of the average of charges billed to the department for its clients with AIDS.

[WSR 11-14-075, recodified as § 182-539-0200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-539-0200, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.757. WSR 00-14-070, § 388-539-0200, filed 7/5/00, effective 8/5/00.]

WAC 182-539-0300 Case management for persons living with HIV/AIDS. The department provides HIV/AIDS case management to assist persons infected with HIV to: Live as independently as possible; maintain and improve health; reduce behaviors that put the client and others at risk; and gain access to needed medical, social, and educational services.

(1) To be eligible for department reimbursed HIV/AIDS case management services, the person must:

(a) Have a current medical diagnosis of HIV or AIDS;

(b) Be eligible for Title XIX (medicaid) coverage under either the categorically needy program (CNP) or the medically needy program (MNP); and

(c) Require:

(i) Assistance to obtain and effectively use necessary medical, social, and educational services; or

(ii) Ninety days of continued monitoring as provided in WAC 388-539-0350(2).

(2) The department has an interagency agreement with the Washington state department of health (DOH) to administer the HIV/AIDS case management program for the department's Title XIX (medicaid) clients.

(3) HIV/AIDS case management agencies who serve the department's clients must be approved to perform these services by HIV client services, DOH.

(4) HIV/AIDS case management providers must:

(a) Notify HIV positive persons of their statewide choice of available HIV/AIDS case management providers and document that notification in the client's record. This notification requirement does not obligate HIV/AIDS case management providers to accept all clients who request their services.

(b) Have a current client-signed authorization to release/obtain information form. The provider must have a valid authorization on file for the months that case management services are billed to the department (see RCW 70.02.030). The fee referenced in RCW 70.02.030 is included in the department's reimbursement to providers. The department's clients may not be charged for services or documents related to covered services.

(c) Maintain sufficient contact to ensure the effectiveness of ongoing services per subsection (5) of this section. The department requires a minimum of one contact per

month between the HIV/AIDS case manager and the client. However, contact frequency must be sufficient to ensure implementation and ongoing maintenance of the individual service plan (ISP).

(5) HIV/AIDS case management providers must document services as follows:

(a) Providers must initiate a comprehensive assessment within two working days of the client's referral to HIV/AIDS case management services. Providers must complete the assessment before billing for ongoing case management services. If the assessment does not meet these requirements, the provider must document the reason(s) for failure to do so. The assessment must include the following elements as reported by the client:

(i) Demographic information (e.g., age, gender, education, family composition, housing.);

(ii) Physical status, the identity of the client's primary care provider, and current information on the client's medications/treatments;

(iii) HIV diagnosis (both the documented diagnosis at the time of assessment and historical diagnosis information);

(iv) Psychological/social/cognitive functioning and mental health history;

(v) Ability to perform daily activities;

(vi) Financial and employment status;

(vii) Medical benefits and insurance coverage;

(viii) Informal support systems (e.g., family, friends and spiritual support);

(ix) Legal status, durable power of attorney, and any self-reported criminal history; and

(x) Self-reported behaviors which could lead to HIV transmission or re-infection (e.g., drug/alcohol use).

(b) Providers must develop, monitor, and revise the client's individual service plan (ISP). The ISP identifies and documents the client's unmet needs and the resources needed to assist in meeting the client's needs. The case manager and the client must develop the ISP within two days of the comprehensive assessment or the provider must document the reason this is not possible. An ISP must be:

(i) Signed by the client, documenting that the client is voluntarily requesting and receiving the department reimbursed HIV/AIDS case management services; and

(ii) Reviewed monthly by the case manager through in-person or telephone contact with the client. Both the review and any changes must be noted by the case manager:

(A) In the case record narrative; or

(B) By entering notations in, initialing and dating the ISP.

(c) Maintained ongoing narrative records - These records must document case management services provided in each month for which the provider bills the department. Records must:

(i) Be entered in chronological order and signed by the case manager;

(ii) Document the reason for the case manager's interaction with the client; and

(iii) Describe the plans in place or to be developed to meet unmet client needs.

[WSR 11-14-075, recodified as § 182-539-0300, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090. WSR 10-19-057, § 388-539-0300, filed 9/14/10, effective 10/15/10. Statutory Authority: RCW 74.08.090, 74.09.755, 74.09.800, 42 U.S.C. Section 1915(g). WSR 00-23-070, § 388-539-0300, filed 11/16/00, effective 12/17/00.]

WAC 182-539-0350 HIV/AIDS case management reimbursement information. (1) The department reimburses HIV/AIDS case management providers for the following three services:

(a) Comprehensive assessment—The assessment must cover the areas outlined in WAC 388-539-0300 (1) and (5).

(i) The department reimburses only one comprehensive assessment unless the client's situation changes as follows:

(A) There is a fifty percent change in need from the initial assessment; or

(B) The client transfers to a new case management provider.

(ii) The department reimburses for a comprehensive assessment in addition to a monthly charge for case management (either full-month or partial-month) if the assessment is completed during a month the client is medicaid eligible and the ongoing case management has been provided.

(b) HIV/AIDS case management, full-month—Providers may request the full-month reimbursement for any month in which the criteria in WAC 388-539-0300 have been met and the case manager has an individual service plan (ISP) in place for twenty or more days in that month. The department reimburses only one full-month case management fee per client in any one month.

(c) HIV/AIDS case management, partial-month—Providers may request the partial-month reimbursement for any month in which the criteria in WAC 388-539-0300 have been met and the case manager has an ISP in place for fewer than twenty days in that month. Using the partial-month reimbursement, the department may reimburse two different case management providers for services to a client who changes from one provider to a new provider during that month.

(2) The department limits reimbursement to HIV/AIDS case managers when a client becomes stabilized and no longer needs an ISP with active service elements. The department limits reimbursement for monitoring to ninety days past the time the last active service element of the ISP is completed. Case management providers who are monitoring a stabilized client must meet all of the following criteria in order to bill the department for up to ninety days of monitoring:

(a) Document the client's history of recurring need;

(b) Assess the client for possible future instability; and

(c) Provide monthly monitoring contacts.

(3) The department reinstates reimbursement for ongoing case management if a client shifts from monitoring status to active case management status due to documented need(s). Providers must meet the requirements in WAC 388-539-0300 when a client is reinstated to active case management.

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