RCW 74.09.520 Medical assistance—Care and services included—Funding limitations. (1) The term "medical assistance" may include the following care and services subject to rules adopted by the authority or department: (a) Inpatient hospital services; (b) outpatient hospital services; (c) other laboratory and X-ray services; (d) nursing facility services; (e) physicians' services, which shall include prescribed medication and instruction on birth control devices; (f) medical care, or any other type of remedial care as may be established by the secretary or director; (g) home health care services; (h) private duty nursing services; (i) dental services; (j) physical and occupational therapy and related services; (k) prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist, whichever the individual may select; (l) personal care services, as provided in this section; (m) hospice services; (n) other diagnostic, screening, preventive, and rehabilitative services; and (o) like services when furnished to a child by a school district in a manner consistent with the requirements of this chapter. For the purposes of this section, neither the authority nor the department may cut off any prescription medications, oxygen supplies, respiratory services, or other life-sustaining medical services or supplies.

"Medical assistance," notwithstanding any other provision of law, shall not include routine foot care, or dental services delivered by any health care provider, that are not mandated by Title XIX of the social security act unless there is a specific appropriation for these services.

(2) The department shall adopt, amend, or rescind such administrative rules as are necessary to ensure that Title XIX personal care services are provided to eligible persons in conformance with federal regulations.

(a) These administrative rules shall include financial eligibility indexed according to the requirements of the social security act providing for medicaid eligibility.

(b) The rules shall require clients be assessed as having a medical condition requiring assistance with personal care tasks. Plans of care for clients requiring health-related consultation for assessment and service planning may be reviewed by a nurse.

(c) The department shall determine by rule which clients have a health-related assessment or service planning need requiring registered nurse consultation or review. This definition may include clients that meet indicators or protocols for review, consultation, or visit.

(3) The department shall design and implement a means to assess the level of functional disability of persons eligible for personal care services under this section. The personal care services benefit shall be provided to the extent funding is available according to the assessed level of functional disability. Any reductions in services made necessary for funding reasons should be accomplished in a manner that assures that priority for maintaining services is given to persons with the greatest need as determined by the assessment of functional disability.

(4) Effective July 1, 1989, the authority shall offer hospice services in accordance with available funds.

(5) For Title XIX personal care services administered by the department, the department shall contract with area agencies on aging

or may contract with a federally recognized Indian tribe under RCW 74.39A.090(3):

(a) To provide case management services to individuals receiving Title XIX personal care services in their own home; and

(b) To reassess and reauthorize Title XIX personal care services or other home and community services as defined in RCW 74.39A.009 in home or in other settings for individuals consistent with the intent of this section:

(i) Who have been initially authorized by the department to receive Title XIX personal care services or other home and community services as defined in RCW 74.39A.009; and

(ii) Who, at the time of reassessment and reauthorization, are receiving such services in their own home.

(6) In the event that an area agency on aging or federally recognized Indian tribe is unwilling to enter into or satisfactorily fulfill a contract or an individual consumer's need for case management services will be met through an alternative delivery system, the department is authorized to:

(a) Obtain the services through competitive bid; and

(b) Provide the services directly until a qualified contractor can be found.

(7) Subject to the availability of amounts appropriated for this specific purpose, the authority may offer medicare part D prescription drug copayment coverage to full benefit dual eligible beneficiaries.

(8) Effective January 1, 2016, the authority shall require universal screening and provider payment for autism and developmental delays as recommended by the bright futures guidelines of the American academy of pediatrics, as they existed on August 27, 2015. This requirement is subject to the availability of funds.

(9) Subject to the availability of amounts appropriated for this specific purpose, effective January 1, 2018, the authority shall require provider payment for annual depression screening for youth ages twelve through eighteen as recommended by the bright futures guidelines of the American academy of pediatrics, as they existed on January 1, 2017. Providers may include, but are not limited to, primary care providers, public health nurses, and other providers in a clinical setting. This requirement is subject to the availability of funds appropriated for this specific purpose.

(10) Subject to the availability of amounts appropriated for this specific purpose, effective January 1, 2018, the authority shall require provider payment for maternal depression screening for mothers of children ages birth to six months. This requirement is subject to the availability of funds appropriated for this specific purpose.

(11) Subject to the availability of amounts appropriated for this specific purpose, the authority shall:

(a) Allow otherwise eligible reimbursement for the following related to mental health assessment and diagnosis of children from birth through five years of age:

(i) Up to five sessions for purposes of intake and assessment, if necessary;

(ii) Assessments in home or community settings, including reimbursement for provider travel; and

(b) Require providers to use the current version of the DC:0-5 diagnostic classification system for mental health assessment and diagnosis of children from birth through five years of age.

(12) Effective January 1, 2024, the authority shall require coverage for noninvasive preventive colorectal cancer screening tests

assigned either a grade of A or grade of B by the United States preventive services task force and shall require coverage for colonoscopies performed as a result of a positive result from such a test.

(13)(a) The authority shall require or provide payment to the hospital for any day of a hospital stay in which an adult or child patient enrolled in medical assistance, including home and community services or with a medicaid managed care organization, under this chapter:

(i) Does not meet the criteria for acute inpatient level of care as defined by the authority;

(ii) Meets the criteria for discharge, as defined by the authority or department, to any appropriate placement including, but not limited to:

(A) A nursing home licensed under chapter 18.51 RCW;

(B) An assisted living facility licensed under chapter 18.20 RCW;

(C) An adult family home licensed under chapter 70.128 RCW; or

(D) A setting in which residential services are provided or funded by the developmental disabilities administration of the department, including supported living as defined in RCW 71A.10.020; and

(iii) Is not discharged from the hospital because placement in the appropriate location described in (a)(ii) of this subsection is not available.

(b) The authority shall adopt rules identifying which services are included in the payment described in (a) of this subsection and which services may be billed separately, including specific revenue codes or services required on the inpatient claim.

(c) Allowable medically necessary services performed during a stay described in (a) of this subsection shall be billed by and paid to the hospital separately. Such services may include but are not limited to hemodialysis, laboratory charges, and x-rays.

(d) Pharmacy services and pharmaceuticals shall be billed by and paid to the hospital separately.

(e) The requirements of this subsection do not alter requirements for billing or payment for inpatient care.

(f) The authority shall adopt, amend, or rescind such administrative rules as necessary to facilitate calculation and payment of the amounts described in this subsection, including for clients of medicaid managed care organizations.

(g) The authority shall adopt rules requiring medicaid managed care organizations to establish specific and uniform administrative and review processes for payment under this subsection.

(h) For patients meeting the criteria in (a)(ii)(A) of this subsection, hospitals must utilize swing beds or skilled nursing beds to the extent the services are available within their facility and the associated reimbursement methodology prior to the billing under the methodology in (a) of this subsection, if the hospital determines that such swing bed or skilled nursing bed placement is appropriate for the patient's care needs, the patient is appropriate for the existing patient mix, and appropriate staffing is available. [2023 c 315 § 1; 2023 c 299 § 1; 2022 c 255 § 4; 2021 c 126 § 2; 2017 c 202 § 4; 2015 1st sp.s. c 8 § 2; 2011 1st sp.s. c 15 § 27; 2007 c 3 § 1; 2004 c 141 § 2; 2003 c 279 § 1; 1998 c 245 § 145; 1995 1st sp.s. c 18 § 39; 1994 c 21 § 4. Prior: 1993 c 149 § 10; 1993 c 57 § 1; 1991 sp.s. c 8 § 9; prior: 1991 c 233 § 1; 1991 c 119 § 1; prior: 1990 c 33 § 594; 1990 c 25 § 1; prior: 1989 c 427 § 10; 1989 c 400 § 3; 1985 c 5 § 3; 1982 1st

ex.s. c 19 § 4; 1981 1st ex.s. c 6 § 21; 1981 c 8 § 20; 1979 c 141 § 344; 1969 ex.s. c 173 § 11; 1967 ex.s. c 30 § 5.]

Reviser's note: This section was amended by 2023 c 299 § 1 and by 2023 c 315 § 1, each without reference to the other. Both amendments are incorporated in the publication of this section under RCW 1.12.025(2). For rule of construction, see RCW 1.12.025(1).

Findings—Intent—2017 c 202: See note following RCW 74.09.495.

Findings—2015 1st sp.s. c 8: "(1) The bright futures guidelines issued by the American academy of pediatrics outline recommended well-child visit schedules and universal screening of children for autism and developmental delays. Private health plans established after March 2010 are required to comply with the bright futures guidelines as the standard for preventive services. The federal law does not require medicaid programs to follow the guidelines; however, thirty states completely cover the bright futures guidelines, six states cover all but one well-child screen, and six additional states cover all but developmental and autism screens as part of their medicaid programs.

(2) The 2012 Washington state legislature directed the Washington state institute for public policy to assess the costs and benefits of implementing the guidelines. The research indicates that fewer than half of children with developmental delays are identified before starting school and roughly half of children with autism spectrum disorder are diagnosed only after entering school, by which time significant delays may have occurred and opportunities for treatment may have been missed. Adopting the universal screening guidelines improves early diagnosis and enables early intervention with appropriate therapies and services. The annual cost to society for caring for children with autism or developmental delays can be significant, including cost of services, special education, informal care, and lost productivity. Early intervention and access to appropriate therapies mitigate long-term societal costs and improve the health and opportunity for the child.

(3) The more adverse experiences a child has, such as the burden of family economic hardship and social bias, the greater the likelihood of developmental delays and later health problems. Over forty-six percent of Washington's children have medicaid apple health for kids and have a much greater likelihood of reporting poor to very poor health compared to children who have commercial insurance. Disparities also exist in the diagnosis and initiation of treatment services for children of color. Research shows that children of color are diagnosed later and begin receiving early intervention services later. This health equity gap can be addressed by identifying and supporting children early through universal screening.

(4) Primary care providers currently see ninety-nine percent of children between birth and three years of age and are uniquely situated to access nearly all children with universal screening." [2015 1st sp.s. c 8 § 1.]

Effective date—Findings—Intent—Report—Agency transfer—References to head of health care authority—Draft legislation—2011 1st sp.s. c 15: See notes following RCW 74.09.010.

Conflict with federal requirements—Severability—Effective date—1995 1st sp.s. c 18: See notes following RCW 74.39A.030.

Conflict with federal requirements—Effective date—1994 c 21: See notes following RCW 43.20B.080.

Conflict with federal requirements—Severability—Effective dates —1993 c 149: See notes following RCW 28A.150.390.

Effective date—1991 sp.s. c 8: See note following RCW 18.51.050.

Purpose—Statutory references—Severability—1990 c 33: See RCW 28A.900.100 through 28A.900.102.

Intent—1989 c 400: See note following RCW 28A.150.390.

Effective date—1982 1st ex.s. c 19: See note following RCW 74.09.035.

Effective date—Severability—1981 1st ex.s. c 6: See notes following RCW 74.04.005.

Legislative confirmation of effect of 1994 c 21: RCW 43.20B.090.