# Chapter 182-539 WAC
# HIV/AIDS RELATED SERVICES

**Last Update:** 8/13/15

**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 people who are not eligible for the medicaid agency's Washington apple health 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:

(a) A person must be:

(i) Diagnosed with AIDS as defined in WAC 246-100-011;

(ii) A resident of the state of Washington;

(iii) Responsible for all or part of the health insurance premium payment (without the agency's help);

(b) A person must not:

(i) Be eligible for one of the agency's other medical programs;

(ii) Have personal income that exceeds three hundred seventy percent of the federal poverty level; and

(iii) Have personal assets, after exemptions, exceeding fifteen thousand dollars, except for:

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

(B) A vehicle used as personal transportation.

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

(a) Cooperate with the agency's contractor;

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

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

(4) People diagnosed with AIDS who are eligible for an agency medical program may ask the agency to pay their health insurance premiums under a separate process. The client's community services office (CSO) can assist the client with this process.

(5) When a person is eligible for the AIDS health insurance premium payment program, eligibility ceases only when the person:

(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 because the legislature terminated the funding for this program.

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

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-17-054, § 182-539-0200, filed 8/13/15, effective 9/13/15. 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 people living with HIV/AIDS.** The medicaid agency provides HIV/AIDS case management to assist people infected with HIV to: Live as independently as possible; maintain and improve health; reduce behaviors that put the person and others at risk; and gain access to needed medical, social, and educational services.

(1) To be eligible for agency-reimbursed HIV/AIDS case management services, a 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 under WAC 182-539-0350(2).

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

(3) HIV/AIDS case management agencies who serve Washington apple health clients must be approved by HIV client services, DOH.

(4) HIV/AIDS case management providers must:

(a) Notify HIV positive people 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 form to release and obtain information. The provider must have a valid authorization on file for the months that case management services are billed to the agency (see RCW 70.02.030). The fee referenced in RCW 70.02.030 is included in the agency's payment to providers. Clients must not be charged for services or documents related to covered services.

(c) Maintain enough contact to ensure effective, ongoing services under subsection (5) of this section. The agency requires a minimum of one contact per month between the HIV/AIDS case manager and the client. However, contact frequency must be enough to ensure the individual service plan (ISP) is implemented and maintained.

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

(a) Providers must start a comprehensive assessment within two working days of the client's referral to HIV/AIDS case management services.

(b) Providers must complete the assessment before billing for ongoing case management services.

(c) If the assessment does not meet requirements under this subsection, the provider must document the reason or reasons for failure to do so.

(d) The assessment must include the following elements as reported by the client:

(i) Demographic information (for example, age, gender, education, family composition, housing);

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

(iii) HIV diagnosis (both the documented diagnosis from the assessment and historical diagnosis information);

(iv) Psychological, social, and 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 (for example, family, friends, and spiritual support);

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

(x) Self-reported behaviors that could lead to HIV transmission or re-infection (for example, drug or alcohol use).

(e) Providers must develop, monitor, and revise the client's 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 agency-reimbursed HIV/AIDS case management services; and

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

(A) In the case record narrative; or

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

(f) Providers must maintain ongoing narrative records and must document case management services provided in each month the provider bills the agency. 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.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-17-054, § 182-539-0300, filed 8/13/15, effective 9/13/15. 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 medicaid agency pays HIV/AIDS case management providers for the following three services:

(a) Comprehensive assessment. The assessment must cover the areas outlined in WAC 182-539-0300 (1) and (5).

(i) The agency pays for 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) If a comprehensive assessment is completed during a month the client is medicaid eligible and ongoing case management has been provided, the agency pays for the assessment and the monthly case management charge (either full-month or partial-month).

(b) HIV/AIDS case management, full-month. Providers may request the full-month payment for any month when the requirements of WAC 182-539-0300 have been met and the case manager has an individual service plan (ISP) in place for twenty or more days in that month. The agency pays 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 payment for any month when the requirements of WAC 182-539-0300 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 agency may pay two different case management providers for services to a client who changes from one provider to a new provider during that month.

(2) The agency limits payments to HIV/AIDS case managers when a client becomes stabilized and no longer needs an ISP with active service elements. The agency limits payment for monitoring to ninety days after the last active service element of the ISP is completed. To bill the agency for a maximum of ninety days of monitoring, a provider must:

(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 agency reinstates payment for ongoing case management if a client shifts from monitoring status to active case management status due to documented need or needs. Providers must meet the requirements in WAC 182-539-0300 when a client is reinstated to active case management.

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