WSR 22-23-009
EXPEDITED RULES
HEALTH CARE AUTHORITY
[Filed November 3, 2022, 7:45 a.m.]

Title of Rule and Other Identifying Information: WAC 182-500-0050 Washington apple health definitions—I and 182-502-0002 Eligible provider types.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The agency is amending these rules with housekeeping changes to modernize language.

Reasons Supporting Proposal: These housekeeping fixes are required to align the definition of "residential habilitation center" with the definition written in RCW 71A.10.020(11); update "chemical dependency professional" to "substance use disorder professional" as written in chapter 18.205 RCW and chapter 246-811 WAC; and update "detoxification" to "withdrawal management" with certification done by the department of health as written in chapter 246-341 WAC.

Statutory Authority for Adoption: RCW 71A.10.020(11), 41.05.021, 41.05.160; chapter 18.205 RCW.

Statute Being Implemented: RCW 71A.10.020(11), 41.05.021, 41.05.160; chapter 18.205 RCW.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Health care authority, governmental.

Name of Agency Personnel Responsible for Drafting: Valerie Freudenstein, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-1344; Implementation and Enforcement: Melissa Kundur, P.O. Box 45502, Olympia, WA 98504-5502, 360-725-5297.

This notice meets the following criteria to use the expedited adoption process for these rules:

Corrects typographical errors, makes address or name changes, or clarifies language of a rule without changing its effect.

NOTICE

THIS RULE IS BEING PROPOSED UNDER AN EXPEDITED RULE-MAKING PROCESS THAT WILL ELIMINATE THE NEED FOR THE AGENCY TO HOLD PUBLIC HEARINGS, PREPARE A SMALL BUSINESS ECONOMIC IMPACT STATEMENT, OR PROVIDE RESPONSES TO THE CRITERIA FOR A SIGNIFICANT LEGISLATIVE RULE. IF YOU OBJECT TO THIS USE OF THE EXPEDITED RULE-MAKING PROCESS, YOU MUST EXPRESS YOUR OBJECTIONS IN WRITING AND THEY MUST BE SENT TO Rules Coordinator, Health Care Authority, P.O. Box 42716, Olympia, WA 98504-2716, phone 360-725-1306, email arc@hca.wa.gov, AND RECEIVED BY January 24, 2023.

November 3, 2022
Wendy Barcus
Rules Coordinator

OTS-4186.1

AMENDATORY SECTION (Amending WSR 22-07-105, filed 3/23/22, effective 4/23/22)

WAC 182-500-0050 Washington apple health definitions—I. "Ineligible spouse" see "spouse" in WAC 182-500-0100.

"Institution" means an entity that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more people unrelated to the proprietor. Eligibility for a Washington apple health program may vary depending upon the type of institution in which an individual resides. For the purposes of apple health programs, "institution" includes all the following:

(1) **"Institution for mental diseases (IMD)"** - A hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of people with mental diseases, including medical attention, nursing care and related services. An IMD may include inpatient substance use disorder (SUD) facilities of more than 16 beds which provide residential treatment for SUD.

(2) **"Intermediate care facility for individuals with intellectual disabilities (ICF/IID)"** - An institution or distinct part of an institution that is:

(a) Defined in 42 C.F.R. 440.150;

(b) Certified to provide ICF/IID services under 42 C.F.R. 483, Subpart I; and

(c) Primarily for the diagnosis, treatment, or rehabilitation for people with intellectual disabilities or a related condition.

(3) **"Medical institution"** - An entity that is organized to provide medical care, including nursing and convalescent care. The terms "medical facility" and "medical institution" are sometimes used interchangeably throughout Title 182 WAC.

(a) To meet the definition of medical institution, the entity must:

(i) Be licensed as a medical institution under state law;

(ii) Provide medical care, with the necessary professional personnel, equipment, and facilities to manage the health needs of the patient on a continuing basis under acceptable standards; and

(iii) Include adequate physician and nursing care.

(b) Medical institutions include:

(i) "Hospice care center" - An entity licensed by the department of health (DOH) to provide hospice services. Hospice care centers must be medicare-certified, and approved by the agency or the agency's designee to be considered a medical institution.

(ii) "Hospital" - Defined in WAC 182-500-0045.

(iii) "Nursing facility (NF)" - An entity certified to provide skilled nursing care and long-term care services to medicaid recipients under Social Security Act Sec. 1919(a), 42 U.S.C. Sec. 1396r. Nursing facilities that may become certified include nursing homes licensed under chapter 18.51 RCW, and nursing facility units within hospitals licensed by DOH under chapter 70.41 RCW. This includes the nursing facility section of a state veteran's facility.

(iv) "Psychiatric hospital" - An institution, or a psychiatric unit located in a hospital, licensed as a hospital under applicable Washington state laws and rules, that is primarily engaged to provide psychiatric services for the diagnosis and treatment of mentally ill people under the supervision of a physician.

(v) "Psychiatric residential treatment facility (PRTF)" - A non-hospital residential treatment center licensed by DOH, and certified by the agency or the agency's designee to provide psychiatric inpatient services to medicaid-eligible people age 21 and younger. A PRTF must be accredited by the Joint Commission on Accreditation of Health care Organizations (JCAHO) or any other accrediting organization with comparable standards recognized by Washington state. A PRTF must meet the requirements in 42 C.F.R. 483, Subpart G, regarding the use of restraint and seclusion.

(vi) "Residential habilitation center (RHC)" - ((~~A residence operated by the state under chapter 71A.20 RCW that serves people who have exceptional care and treatment needs due to their developmental disabilities by providing residential care designed to develop individual capacities to their optimum. RHCs provide residential care and may be certified to provide ICF/MR services and nursing facility services.~~)) A state-operated facility for persons with developmental disabilities governed by chapter 71A.20 RCW.

(c) Medical institutions do not include entities licensed by the agency or the agency's designee as adult family homes (AFHs) and boarding homes. AFHs and boarding homes include assisted living facilities, adult residential centers, enhanced adult residential centers, and developmental disability group homes.

(4) **"Public institution"** means an entity that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

(a) Public institutions include:

(i) Correctional facility - An entity such as a state prison, or city, county, or tribal jail, or juvenile rehabilitation or juvenile detention facility.

(ii) Eastern and Western State mental hospitals. (Medicaid coverage for these institutions is limited to people age 21 and younger, and people age 65 and older.)

(iii) Certain facilities administered by Washington state's department of veteran's affairs (see (b) of this subsection for facilities that are not considered public institutions).

(b) Public institutions do not include intermediate care facilities, entities that meet the definition of medical institution (such as Harborview Medical Center and University of Washington Medical Center), or facilities in Retsil, Orting, and Spokane that are administered by the department of veteran's affairs and licensed as nursing facilities.

"Institution for mental diseases (IMD)" see "institution" in this section.

"Institutional review board" – A board or committee responsible for reviewing research protocols and determining whether:

(1) Risks to subjects are minimized;

(2) Risks to subjects are reasonable in relation to anticipated benefits, if any, to subjects, and the importance of the knowledge that may reasonably be expected to result;

(3) Selection of subjects is equitable;

(4) Informed consent will be sought from each prospective subject or the subject's legally authorized representative;

(5) Informed consent will be appropriately documented;

(6) When appropriate, the research plan makes adequate provision for monitoring the data collected to ensure the safety of subjects;

(7) When appropriate, there are adequate provisions to protect the privacy of subjects and to maintain the confidentiality of data; and

(8) When some or all of the subjects are likely to be vulnerable to coercion or undue influence, such as children, prisoners, pregnant people, mentally disabled persons, or economically or educationally disadvantaged persons, additional safeguards have been included in the study to protect the rights and welfare of these subjects.

"Institutionalized spouse" see "spouse" in WAC 182-500-0100.

"Intermediate care facility for individuals with intellectual disabilities (ICF/IID)" see "institution" in this section.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 22-07-105, § 182-500-0050, filed 3/23/22, effective 4/23/22; WSR 21-19-141, § 182-500-0050, filed 9/22/21, effective 10/23/21; WSR 17-12-017, § 182-500-0050, filed 5/30/17, effective 6/30/17; WSR 15-17-013, § 182-500-0050, filed 8/7/15, effective 9/7/15. WSR 11-14-075, recodified as § 182-500-0050, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 2011 1st sp.s. c 15. WSR 11-14-053, § 388-500-0050, filed 6/29/11, effective 7/30/11.]

OTS-4187.1

AMENDATORY SECTION (Amending WSR 22-15-115, filed 7/20/22, effective 8/20/22)

WAC 182-502-0002 Eligible provider types. The following health care professionals, health care entities, suppliers or contractors of service may request enrollment with the Washington state health care authority (medicaid agency) to provide covered health care services to eligible clients. For the purposes of this chapter, health care services include treatment, equipment, related supplies, and drugs.

(1) Professionals:

(a) Advanced registered nurse practitioners;

(b) Anesthesiologists;

(c) Applied behavior analysis (ABA) professionals, as provided in WAC 182-531A-0800:

(i) Licensed behavior analyst;

(ii) Licensed assistant behavior analyst; and

(iii) Certified behavior technician.

(d) Audiologists;

(e) ((~~Chemical dependency~~)) Substance use disorder professionals:

(i) Mental health ((~~care~~)) providers; and

(ii) Peer counselors.

(f) Chiropractors;

(g) Dentists;

(h) Dental health aide therapists, as provided in chapter 70.350 RCW;

(i) Dental hygienists;

(j) Denturists;

(k) Dietitians or nutritionists;

(l) Hearing aid fitters/dispensers;

(m) Marriage and family therapists;

(n) Mental health counselors;
(o) Mental health care providers;
(p) Midwives;
(q) Naturopathic physicians;
(r) Nurse anesthetist;
(s) Occularists;
(t) Occupational therapists;
(u) Ophthalmologists;
(v) Opticians;
(w) Optometrists;
(x) Orthodontists;
(y) Orthotist;
(z) Osteopathic physicians;
(aa) Osteopathic physician assistants;
(bb) Peer counselors;
(cc) Podiatric physicians;
(dd) Pharmacists;
(ee) Physicians;
(ff) Physician assistants;
(gg) Physical therapists;
(hh) Prosthetist;
(ii) Psychiatrists;
(jj) Psychologists;
(kk) Radiologists;
(ll) Registered nurse delegators;
(mm) Registered nurse first assistants;
(nn) Respiratory therapists;
(oo) Social workers; and
(pp) Speech/language pathologists.

(2) Agencies, centers and facilities:
(a) Adult day health centers;
(b) Ambulance services (ground and air);
(c) Ambulatory surgery centers (medicare-certified);
(d) Birthing centers (licensed by the department of health);
(e) Cardiac diagnostic centers;
(f) Case management agencies;
(g) ((~~Chemical dependency~~)) Substance use disorder treatment facilities certified by the department of ((~~social and health services (DSHS) division of behavioral health and recovery (DBHR), and contracted through either:~~

~~(i) A county under chapter 388-810 WAC; or~~

~~(ii) DBHR to provide chemical dependency treatment services.~~

~~(h) Centers for the detoxification of acute alcohol or other drug intoxication conditions (certified by DBHR)~~)) health (DOH);
(h) Withdrawal management treatment facilities certified by DOH;
(i) Community AIDS services alternative agencies;
(j) Community mental health centers;
(k) Diagnostic centers;
(l) Early and periodic screening, diagnosis, and treatment (EPSDT) clinics;
(m) Family planning clinics;
(n) Federally qualified health centers (designated by the federal department of health and human services);
(o) Genetic counseling agencies;
(p) Health departments;
(q) Health maintenance organization (HMO)/managed care organization (MCO);

(r) HIV/AIDS case management;
(s) Home health agencies;
(t) Hospice agencies;
(u) Hospitals;
(v) Indian health service facilities/tribal 638 facilities;
(w) Tribal or urban Indian clinics;
(x) Inpatient psychiatric facilities;
(y) Intermediate care facilities for individuals with intellectual disabilities (ICF-IID);
(z) Kidney centers;
(aa) Laboratories (CLIA certified);
(bb) Maternity support services agencies; maternity case managers; infant case management, first steps providers;
(cc) Neuromuscular and neurodevelopmental centers;
(dd) Nurse services/delegation;
(ee) Nursing facilities (approved by the DSHS aging and long-term support administration);
(ff) Pathology laboratories;
(gg) Pharmacies;
(hh) Private duty nursing agencies;
(ii) Radiology - Stand-alone clinics;
(jj) Rural health clinics (medicare-certified);
(kk) School districts and educational service districts;
(ll) Sleep study centers; and
(mm) Washington state school districts and educational service districts.
(3) Suppliers of:
(a) Blood, blood products, and related services;
(b) Durable and nondurable medical equipment and supplies;
(c) Complex rehabilitation technologies;
(d) Infusion therapy equipment and supplies;
(e) Prosthetics/orthotics;
(f) Hearing aids; and
(g) Respiratory care, equipment, and supplies.
(4) Contractors:
(a) Transportation brokers;
(b) Spoken language interpreter services agencies;
(c) Independent sign language interpreters; and
(d) Eyeglass and contact lens providers.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 22-15-115, § 182-502-0002, filed 7/20/22, effective 8/20/22; WSR 22-07-105, § 182-502-0002, filed 3/23/22, effective 4/23/22. Statutory Authority: RCW 41.05.021, 41.05.160 and 2019 c 415 § 211(49). WSR 19-20-046, § 182-502-0002, filed 9/25/19, effective 10/26/19. Statutory Authority: RCW 41.05.021, 2013 c 178, and 2013 2nd sp.s. c 4. WSR 14-06-054, § 182-502-0002, filed 2/27/14, effective 3/30/14. WSR 11-14-075, recodified as § 182-502-0002, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.080, and 74.09.290. WSR 11-11-017, § 388-502-0002, filed 5/9/11, effective 6/9/11.]

WSR 22-23-033
EXPEDITED RULES
DEPARTMENT OF
SOCIAL AND HEALTH SERVICES
(Economic Services Administration)
[Filed November 7, 2022, 4:40 p.m.]

Title of Rule and Other Identifying Information: The department is proposing to repeal WAC 388-437-0015 Good cause extension of Social Security number (SSN) requirement for basic food applicants during COVID-19.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: This rule is being repealed as the related federal COVID-19 flexibility waiver expired on September 30, 2022. SSN good cause rules are found in WAC 388-476-0005 and based on federal rule.

Reasons Supporting Proposal: See purpose above.

Statutory Authority for Adoption: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 74.08.090.

Statute Being Implemented: 7 C.F.R. 273.2 (f)(1)(v).

Rule is necessary because of federal law, [no information provided by agency].

Name of Proponent: Department of social and health services (DSHS), governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Joyce Hensen, P.O. Box 45470, Olympia, WA 98504-5470, 425-999-5162.

This notice meets the following criteria to use the expedited repeal process for these rules:

The rule is no longer necessary because of changed circumstances.

Explanation of the Reason the Agency Believes the Expedited Rule-Making Process is Appropriate: Expedited repeal of this rule is appropriate due to the changed circumstance of the related federal COVID-19 flexibility waiver expiring on September 30, 2022.

NOTICE

THIS RULE IS BEING PROPOSED UNDER AN EXPEDITED RULE-MAKING PROCESS THAT WILL ELIMINATE THE NEED FOR THE AGENCY TO HOLD PUBLIC HEARINGS, PREPARE A SMALL BUSINESS ECONOMIC IMPACT STATEMENT, OR PROVIDE RESPONSES TO THE CRITERIA FOR A SIGNIFICANT LEGISLATIVE RULE. IF YOU OBJECT TO THIS USE OF THE EXPEDITED RULE-MAKING PROCESS, YOU MUST EXPRESS YOUR OBJECTIONS IN WRITING AND THEY MUST BE SENT TO Rules Coordinator, DSHS, Rules and Policies Assistance Unit, P.O. Box 45850, Olympia, WA 98504, phone 360-664-6185, email DSHSRPAURulesCoordinator@dshs.wa.gov, AND RECEIVED BY January 24, 2023.

November 7, 2022
Katherine I. Vasquez
Rules Coordinator

SHS-4952.1

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 388-437-0015	Good cause extension of Social Security number (SSN) requirement for basic food applicants during COVID-19.

WSR 22-23-082
EXPEDITED RULES
HEALTH CARE AUTHORITY
[Filed November 14, 2022, 10:21 a.m.]

Title of Rule and Other Identifying Information: WAC 182-507-0125 State-funded long-term care services, 182-513-1105 Personal needs allowance (PNA) and room and board standards in a medical institution and alternate living facility (ALF), 182-513-1215 Community first choice (CFC)—Eligibility, 182-513-1220 Community first choice (CFC)—Spousal impoverishment protections for noninstitutional Washington apple health clients, 182-513-1225 Medicaid personal care (MPC), 182-513-1240 The hospice program, 182-513-1350 Defining the resource standard and determining resource eligibility for SSI-related long-term care (LTC) services, 182-513-1355 Allocating resources to a community spouse when determining resource eligibility for SSI-related long-term care services, 182-513-1380 Determining a client's financial participation in the cost of care for long-term care in a medical institution, 182-513-1385 Determining the community spouse monthly maintenance needs allowance and dependent allowance in post-eligibility treatment of income for long-term care (LTC) programs, 182-513-1660 Medicaid alternative care (MAC) and tailored supports for older adults (TSOA)—Spousal impoverishment, 182-514-0230 Purpose, 182-515-1506 Home and community based (HCB) waiver services authorized by home and community services (HCS)—General eligibility, 182-515-1507 Home and community based (HCB) waiver services authorized by home and community services (HCS)—Financial eligibility if a client is eligible for an SSI-related noninstitutional categorically needy (CN) medicaid program, 182-515-1508 Home and community based (HCB) waiver services authorized by home and community services (HCS)—Financial eligibility using SSI-related institutional rules, 182-515-1509 Home and community based (HCB) waiver services authorized by home and community services (HCS)—Client financial responsibility, 182-515-1511 Home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA)—General eligibility, 182-515-1512 Home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA)—Financial eligibility if a client is eligible for a noninstitutional SSI-related categorically needy (CN) program, 182-515-1513 Home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA)—Financial eligibility using SSI-related institutional rules, 182-515-1514 Home and community based (HCB) services authorized by the developmental disabilities administration (DDA)—Client financial responsibility, and 182-517-0100 Federal medicare savings programs.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Correct a website address.

Reasons Supporting Proposal: In each of the rules listed above, the agency is replacing an incorrect website address with the correct address for the Washington apple health income and resource standards. The correct address is https://www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

Statutory Authority for Adoption: RCW 41.05.021, 41.06.160.

Statute Being Implemented: RCW 41.05.021, 41.06.160.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Health care authority, governmental.

Name of Agency Personnel Responsible for Drafting: Brian Jensen, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-0815; Implementation and Enforcement: Paige Lewis, P.O. Box 42722, Olympia, WA 98504-2722, 360-725-0757.

This notice meets the following criteria to use the expedited adoption process for these rules:

Corrects typographical errors, makes address or name changes, or clarifies language of a rule without changing its effect.

Explanation of the Reason the Agency Believes the Expedited Rule-Making Process is Appropriate: The expedited rule-making process is appropriate because the proposed rules correct typographical errors.

NOTICE

THIS RULE IS BEING PROPOSED UNDER AN EXPEDITED RULE-MAKING PROCESS THAT WILL ELIMINATE THE NEED FOR THE AGENCY TO HOLD PUBLIC HEARINGS, PREPARE A SMALL BUSINESS ECONOMIC IMPACT STATEMENT, OR PROVIDE RESPONSES TO THE CRITERIA FOR A SIGNIFICANT LEGISLATIVE RULE. IF YOU OBJECT TO THIS USE OF THE EXPEDITED RULE-MAKING PROCESS, YOU MUST EXPRESS YOUR OBJECTIONS IN WRITING AND THEY MUST BE SENT TO Rules Coordinator, Health Care Authority, P.O. Box 42716, Olympia, WA 98504-2716, phone 360-725-1306, fax 360-586-9272, email arc@hca.wa.gov, AND RECEIVED BY January 24, 2023.

November 11, 2022
Wendy Barcus
Rules Coordinator

OTS-4178.1

AMENDATORY SECTION (Amending WSR 17-03-116, filed 1/17/17, effective 2/17/17)

WAC 182-507-0125 State-funded long-term care services. (1) **Caseload limits.**

(a) The state-funded long-term care services program is subject to caseload limits determined by legislative funding.

(b) The aging and long-term support administration (ALTSA) must preauthorize state-funded long-term care service before payments begin.

(c) ALTSA cannot authorize a service, under chapter 388-106 WAC, if doing so would exceed statutory caseload limits.

(2) **Location of services.** State-funded long-term care services may be provided in:

(a) The person's own home, defined in WAC 388-106-0010;

(b) An adult family home, defined in WAC 182-513-1100;

(c) An assisted living facility, defined in WAC 182-513-1100;

(d) An enhanced adult residential care facility, defined in WAC 182-513-1100;

(e) An adult residential care facility, defined in WAC 182-513-1100; or

(f) A nursing facility, defined in WAC 182-500-0050, but only if nursing facility care is necessary to sustain life.

(3) **Client eligibility.** To be eligible for the state-funded long-term care services program, a person must meet all of the following conditions:

(a) General eligibility requirements for medical programs under WAC 182-503-0505, except (c) and (d) of this subsection;

(b) Be age ((~~nineteen~~)) 19 or older;

(c) Reside in one of the locations under subsection (2) of this section;

(d) Attain institutional status under WAC 182-513-1320;

(e) Meet the functional eligibility requirements under WAC 388-106-0355 for nursing facility level of care;

(f) Not have a penalty period due to a transfer of assets under WAC 182-513-1363;

(g) Not have equity interest in a primary residence more than the amount under WAC 182-513-1350; and

(h) Meet the requirements under chapter 182-516 WAC for annuities owned by the person or the person's spouse.

(4) **General limitations.**

(a) If a person entered Washington only to obtain medical care, the person is ineligible for state-funded long-term care services.

(b) The certification period for state-funded long-term care services may not exceed ((~~twelve~~)) 12 months.

(c) People who qualify for state-funded long-term care services receive categorically needy (CN) medical coverage under WAC 182-501-0060.

(5) **Supplemental security income (SSI)-related program limitations.**

(a) A person who is related to the SSI program under WAC 182-512-0050 (1), (2), and (3) must meet the financial requirements under WAC 182-513-1315 to be eligible for state-funded long-term care services.

(b) An SSI-related person who is not eligible for the state-funded long-term care services program under CN rules may qualify under medically needy (MN) rules under WAC 182-513-1395.

(c) The agency determines how much an SSI-related person is required to pay toward the cost of care, using:

(i) WAC 182-513-1380, if the person resides in a nursing facility.

(ii) WAC 182-515-1505 or 182-515-1510, if the person resides in one of the locations listed in subsection (2)(a) through (e) of this section.

(6) **Modified adjusted gross income (MAGI)-based program limitations.**

(a) A person who is related to the MAGI-based program may be eligible for state-funded long-term care services under this section and chapter 182-514 WAC if the person resides in a nursing facility.

(b) A MAGI-related person is not eligible for residential or in-home care state-funded long-term care services unless the person also meets the SSI-related eligibility criteria under subsection (5)(a) of this section.

(c) A MAGI-based person does not pay toward the cost of care in a nursing facility.

(7) Current resource, income, PNA, and room and board standards are found at ((~~http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/standards-ltc~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R § 155. WSR 17-03-116, § 182-507-0125, filed 1/17/17, effective 2/17/17. WSR 12-13-056, recodified as § 182-507-0125, filed 6/15/12, effective 7/1/12. Statutory Authority: 2011 c 5, RCW 74.04.057, 74.08.090, and 74.09.510. WSR 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. WSR 10-19-085, § 388-438-0125, filed 9/17/10, effective 10/18/10.]

OTS-4179.1

AMENDATORY SECTION (Amending WSR 22-08-104, filed 4/6/22, effective 5/7/22)

WAC 182-513-1105 Personal needs allowance (PNA) and room and board standards in a medical institution and alternate living facility (ALF). (1) This section describes the personal needs allowance (PNA), which is an amount set aside from a client's income that is intended for personal needs, and the room and board standard.

(2) The PNA in a state veteran's nursing facility:

(a) Is indicated on the chart described in subsection (8) of this section as "All other PNA Med Inst.", for a veteran without a spouse or dependent children receiving a needs-based veteran's pension in excess of $90;

(b) Is indicated on the chart described in subsection (8) of this section as "All other PNA Med Inst.", for a veteran's surviving spouse with no dependent children receiving a needs-based veteran's pension in excess of $90; or

(c) Is $160 for a client who does not receive a needs-based veteran's pension.

(3) The PNA in a medical institution for clients receiving aged, blind, or disabled (ABD) cash assistance or temporary assistance for needy families (TANF) cash assistance is the client's personal and incidental (CPI) cash payment, as described in WAC 388-478-0006, based on residing in a medical institution, which is $41.62.

(4) The PNA in an alternate living facility (ALF) for clients receiving ABD cash assistance or TANF cash assistance is the CPI, as described in WAC 388-478-0006, based on residing in an ALF that is not an adult family home, which is $38.84.

(5) The PNA for clients not described in subsections (2), (3), and (4) of this section, who reside in a medical institution or in an ALF, is indicated on the chart described in subsection (8) of this section as "All other PNA Med Inst." and "HCS & DDA Waivers, CFC & MPC PNA in ALF."

(6) Effective January 1, 2018, and each year thereafter, the amount of the PNA in subsection (5) of this section may be adjusted by the percentage of the cost-of-living adjustment (COLA) for old-age, survivors, and disability social security benefits as published by the federal Social Security Administration. This adjustment is subject to state legislative funding.

(7) The room and board standard in an ALF used by home and community services (HCS) and the developmental disabilities administration (DDA) is based on the federal benefit rate (FBR) minus the current PNA as described under subsection (5) of this section.

(8) The current PNA and room and board standards used in long-term services and supports are published under the institutional standards on the Washington apple health (medicaid) income and resource standards chart located at ((~~www.hca.wa.gov/health-care-services-supports/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 22-08-104, § 182-513-1105, filed 4/6/22, effective 5/7/22. Statutory Authority: RCW 41.05.021, 41.05.160, and 74.09.340. WSR 21-02-086, § 182-513-1105, filed 1/6/21, effective 2/6/21. Statutory Authority: RCW 41.05.021, 41.05.160, 2018 c 137, 2018 c 299 §§ 204 (2)(p) and 207(13), and 2018 c 299. WSR 18-20-047, § 182-513-1105, filed 9/26/18, effective 1/1/19. Statutory Authority: RCW 41.05.021, 41.05.160, 2017 c 270. WSR 17-23-039, § 182-513-1105, filed 11/8/17, effective 1/1/18.]

AMENDATORY SECTION (Amending WSR 21-10-051, filed 4/29/21, effective 5/30/21)

WAC 182-513-1215 Community first choice (CFC)—Eligibility. (1) A client who is determined functionally eligible for community first choice (CFC) services under WAC 388-106-0270 through 388-106-0295 is financially eligible to receive CFC services if the client is:

(a) Eligible for a noninstitutional Washington apple health (medicaid) program which provides categorically needy (CN) or alternative benefits plan (ABP) scope of care;

(b) Through September 30, 2023, a spousal impoverishment protections institutional (SIPI) spouse under WAC 182-513-1220; or

(c) Determined eligible for a home and community based (HCB) waiver program under chapter 182-515 WAC.

(2) A client whose only coverage is through one of the following programs is not eligible for CFC:

(a) Medically needy program under WAC 182-519-0100;

(b) Premium-based children's program under WAC 182-505-0215;

(c) Medicare savings programs under WAC 182-517-0300;

(d) Family planning program under WAC 182-505-0115;

(e) Take charge program under WAC 182-532-0720;

(f) Medical care services program under WAC 182-508-0005;

(g) Pregnant minor program under WAC 182-505-0117;

(h) Alien emergency medical program under WAC 182-507-0110 through 182-507-0120;

(i) State-funded long-term care (LTC) for noncitizens program under WAC 182-507-0125; or

(j) Kidney disease program under chapter 182-540 WAC.

(3) Transfer of asset penalties under WAC 182-513-1363 do not apply to CFC applicants, unless the client is applying for long-term services and supports (LTSS) that are available only through one of the HCB waivers under chapter 182-515 WAC.

(4) Home equity limits under WAC 182-513-1350 do apply.

(5) Post-eligibility treatment of income rules do not apply if the client is eligible under subsection (1)(a) or (b) of this section.

(6) Clients eligible under subsection (1)(a) or (b) of this section, who reside in an alternate living facility (ALF):

(a) Keep a personal needs allowance (PNA) under WAC 182-513-1105; and

(b) Pay up to the room and board standard under WAC 182-513-1105 except when CN eligibility is based on the rules under WAC 182-513-1205.

(7) A client who receives CFC services under the health care for workers with disabilities (HWD) program under chapter 182-511 WAC must pay the HWD premium in addition to room and board under WAC 182-513-1105, if residing in an ALF.

(8) Post-eligibility treatment of income rules do apply if a client is eligible under subsection (1)(c) of this section.

(9) A client may have to pay third-party resources as defined under WAC 182-513-1100 in addition to the room and board and participation.

(10) PNA, MNIL, and room and board standards are found at ((~~www.hca.wa.gov/health-care-services-supports/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

[Statutory Authority: RCW 41.05.021, 41.05.160 and Consolidated Appropriations Act of 2021, H.R. 133, Division CC, Title II, Sec. 204 (b)(1)(A) and Sec. 205. WSR 21-10-051, § 182-513-1215, filed 4/29/21, effective 5/30/21. Statutory Authority: RCW 41.05.021, 41.05.160 and P.L. 111–148, Title II, § 2404. WSR 18-06-031, § 182-513-1215, filed 2/28/18, effective 3/31/18. Statutory Authority: RCW 41.05.021, 41.05.160, 2017 c 270. WSR 17-23-039, § 182-513-1215, filed 11/8/17, effective 1/1/18. Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1215, filed 1/17/17, effective 2/17/17.]

AMENDATORY SECTION (Amending WSR 21-10-051, filed 4/29/21, effective 5/30/21)

WAC 182-513-1220 Community first choice (CFC)—Spousal impoverishment protections for noninstitutional Washington apple health clients. (1) This section is effective through September 30, 2023.

(2) The agency or its designee determines eligibility for community first choice (CFC) using spousal impoverishment protections under this section, when an applicant:

(a) Is married to, or marries, a person not in a medical institution;

(b) Meets institutional level of care and eligibility for CFC services under WAC 388-106-0270 through 388-106-0295;

(c) Is ineligible for a noninstitutional categorically needy (CN) SSI-related program:

(i) Due to spousal deeming rules under WAC 182-512-0920, or due to exceeding the resource limit in WAC 182-512-0010, or both; or

(ii) In an ALF due to combined spousal resources exceeding the resource limit in WAC 182-512-0010; and

(d) Meets the aged, blindness, or disability criteria under WAC 182-512-0050.

(3) The agency or its designee determines countable income using the SSI-related income rules under chapter 182-512 WAC but uses only the applicant's or recipient's separate income and not the income of the applicant's or recipient's spouse.

(4) The agency or its designee determines countable resources using the SSI-related resource rules under chapter 182-512 WAC, except pension funds owned by the spousal impoverishment protections community (SIPC) spouse are not excluded as described under WAC 182-512-0550:

(a) For the applicant or recipient, the resource standard is $2000.

(b) Before determining countable resources used to establish eligibility for the applicant, the agency allocates the state spousal resource standard to the SIPC spouse.

(c) The resources of the SIPC spouse are unavailable to the spousal impoverishment protections institutionalized (SIPI) spouse the month after eligibility for CFC services is established unless subsection (9) of this section applies.

(5) The SIPI spouse has until the end of the month of the first regularly scheduled eligibility review to transfer countable resources in excess of $2000 to the SIPC spouse.

(6) A redetermination of the couple's resources under subsection (4) of this section is required if:

(a) The SIPI spouse has a break in CFC services of at least ((~~thirty~~)) 30 consecutive days;

(b) The SIPI spouse's countable resources exceed the standard under subsection (4)(a) of this section; or

(c) The SIPI spouse does not transfer the amount under subsection (5) of this section to the SIPC spouse by the end of the month of the first regularly scheduled eligibility review.

(7) If the applicant lives at home and the applicant's separate countable income is at or below the SSI categorically needy income level (CNIL) and the applicant is resource eligible, the applicant is a SIPI spouse and is financially eligible for noninstitutional CN coverage and CFC services.

(8) If the applicant lives in an ALF, has separate countable income at or below the standard under WAC 182-513-1205(2), and is resource eligible, the applicant is a SIPI spouse and is financially eligible for noninstitutional CN coverage and CFC services.

(9) If the applicant is employed and has separate countable income at or below the standard under WAC 182-511-1060, the applicant is a SIPI spouse and is financially eligible for noninstitutional CN coverage and CFC services.

(10) Once a person no longer receives CFC services for ((~~thirty~~)) 30 consecutive days, the agency redetermines eligibility without using spousal impoverishment protection, under WAC 182-504-0125.

(11) If the applicant's separate countable income is above the standards under subsections (7), (8), and (9) of this section, the applicant is not eligible for CFC services under this section.

(12) The spousal impoverishment protections under this section expire on September 30, 2023.

(13) Standards are found at ((~~www.hca.wa.gov/health-care-services-supports/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

[Statutory Authority: RCW 41.05.021, 41.05.160 and Consolidated Appropriations Act of 2021, H.R. 133, Division CC, Title II, Sec. 204 (b)(1)(A) and Sec. 205. WSR 21-10-051, § 182-513-1220, filed 4/29/21, effective 5/30/21. Statutory Authority: RCW 41.05.021, 41.05.160 and P.L. 111-148, Title II, § 2404. WSR 18-06-031, § 182-513-1220, filed 2/28/18, effective 3/31/18. Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1220, filed 1/17/17, effective 2/17/17.]

AMENDATORY SECTION (Amending WSR 17-23-039, filed 11/8/17, effective 1/1/18)

WAC 182-513-1225 Medicaid personal care (MPC). (1) Medicaid personal care (MPC) is a state-plan benefit available to a client who is determined:

(a) Functionally eligible for MPC services under WAC 388-106-0200 through 388-106-0235; and

(b) Financially eligible for a noninstitutional categorically needy (CN) or alternative benefits plan (ABP) Washington apple health (medicaid) program.

(2) MPC services may be provided to a client residing at home, in a department-contracted adult family home (AFH), or in a licensed assisted living facility that is contracted with the department to provide adult residential care services.

(3) A client who resides in an alternate living facility (ALF) listed in subsection (2) of this section:

(a) Keeps a personal needs allowance (PNA) under WAC 182-513-1105; and

(b) Pays room and board up to the room and board standard under WAC 182-513-1105, unless CN eligibility is determined using rules under WAC 182-513-1205.

(4) A client who receives MPC services under the health care for workers with disabilities (HWD) program under chapter 182-511 WAC must pay the HWD premium in addition to room and board under WAC 182-513-1105, if residing in an ALF.

(5) A client may have to pay third-party resources as defined under WAC 182-513-1100 in addition to room and board.

(6) Current PNA and room and board standards are found at ((~~www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2017 c 270. WSR 17-23-039, § 182-513-1225, filed 11/8/17, effective 1/1/18. Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1225, filed 1/17/17, effective 2/17/17.]

AMENDATORY SECTION (Amending WSR 17-03-116, filed 1/17/17, effective 2/17/17)

WAC 182-513-1240 The hospice program. (1) General information.

(a) The hospice program provides palliative care to people who elect to receive hospice services and are certified as terminally ill by their physician.

(b) Program rules governing election of hospice services are under chapter 182-551 WAC.

(c) A person may revoke an election to receive hospice services at any time by signing a revocation statement.

(d) Transfer of asset rules under WAC 182-513-1363 do not apply to the hospice program in any setting, regardless of which apple health program the person is eligible to receive.

(2) When hospice is a covered service.

(a) A person who receives coverage under a categorically needy (CN), medically needy (MN), or alternative benefits plan (ABP) program is eligible for hospice services as part of the program specific benefit package.

(b) A person who receives coverage under the alien emergency medical (AEM) program under WAC 182-507-0110 may be eligible for payment for hospice services if preapproved by the agency.

(c) A person who receives coverage under the medical care services (MCS) program is not eligible for coverage of hospice services.

(3) When HCB waiver rules are used to determine eligibility for hospice.

(a) A person who is not otherwise eligible for a CN, MN, or ABP noninstitutional program who does not reside in a medical institution, may be eligible for CN coverage under the hospice program by using home and community based (HCB) waiver rules under WAC 182-515-1505 to determine financial eligibility.

(b) When HCB waiver rules are used, the following exceptions apply:

(i) A person on the hospice program may reside in a medical institution, including a hospice care center, ((~~thirty~~)) 30 days or longer and remain eligible for hospice services; and

(ii) A person residing at home on the hospice program who has available income over the special income limit (SIL), defined under WAC 182-513-1100, is not eligible for CN coverage. If available income is over the SIL, the agency or its designee determines eligibility for medically needy coverage under WAC 182-519-0100.

(c) When HCB waiver rules are used, a person may be required to pay income and third-party resources (TPR) as defined under WAC 182-513-1100 toward the cost of hospice services. The cost of care calculation is described under WAC 182-515-1509.

(d) When a person already receives HCB waiver services and elects hospice, the person must pay any required cost of care towards the HCB waiver service provider first.

(4) Eligibility for hospice services in a medical institution:

(a) A person who elects to receive hospice services, resides in a medical institution for ((~~thirty~~)) 30 days or longer, and has income:

(i) Equal to or less than the SIL is income eligible for CN coverage. Eligibility for institutional hospice is determined under WAC 182-513-1315; or

(ii) Over the SIL may be eligible for MN coverage under WAC 182-513-1245.

(b) A person eligible for hospice services in a medical institution may have to pay toward the cost of nursing facility or hospice care center services. The cost of care calculation is under WAC 182-513-1380.

(5) Changes in coverage. The agency or its designee redetermines a person's eligibility under WAC 182-504-0125 if the person:

(a) Revokes the election of hospice services and is eligible for coverage using HCB waiver rules only, described in subsection (3) of this section; or

(b) Loses CN, MN, or ABP eligibility.

(6) Personal needs allowance and income and resource standards for hospice and home and community based (HCB) waiver programs are found at ((~~http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1240, filed 1/17/17, effective 2/17/17.]

AMENDATORY SECTION (Amending WSR 22-13-058, filed 6/8/22, effective 7/9/22)

WAC 182-513-1350 Defining the resource standard and determining resource eligibility for SSI-related long-term care (LTC) services.

(1) General information.

(a) This section describes how the agency or the agency's designee defines the resource standard and countable or excluded resources when determining a person's eligibility for SSI-related long-term care (LTC) services.

(b) "Resource standard" means the maximum amount of resources a person can have and still be resource eligible for program benefits.

(c) For a person not SSI-related, the agency applies program specific resource rules to determine eligibility.

(2) Resource standards.

(a) The resource standard for the following people is $2000:

(i) A single person; or

(ii) An institutionalized spouse.

(b) The resource standard for a legally married couple is $3000, unless subsection (3)(b)(ii) of this section applies.

(c) The resource standard for a person with a qualified long-term care partnership policy under WAC 182-513-1400 may be higher based on the dollar amount paid out by a partnership policy.

(d) Determining the amount of resources that can be allocated to the community spouse when determining resource eligibility is under WAC 182-513-1355.

(3) Availability of resources.

(a) General. The agency or the agency's designee applies the following rules when determining available resources for LTC services:

(i) WAC 182-512-0300 SSI-related medical—Resources eligibility;

(ii) WAC 182-512-0250 SSI-related medical—Ownership and availability of resources; and

(iii) WAC 182-512-0260 SSI-related medical—How to count a sponsor's resources.

(b) Married couples.

(i) When both spouses apply for LTC services, the resources of both spouses are available to each other through the month in which the spouses stopped living together.

(ii) When both spouses are institutionalized, the agency or the agency's designee determines the eligibility of each spouse as a single person the month following the month of separation.

(iii) If the agency or the agency's designee has already established eligibility and authorized services for one spouse, and the community spouse needs LTC services in the same month, but after eligibility has been established and services authorized for the institutionalized spouse, then the agency applies the standard under subsection (2)(a) of this section to each spouse. If doing this would make one of the spouses ineligible, then the agency applies subsection (2)(b) of this section for the couple.

(iv) The resources of the community spouse are unavailable to the institutionalized spouse the month after eligibility for LTC services is established, unless (v) or (vi) of this subsection applies.

(v) When a single institutionalized individual marries, the agency or the agency's designee redetermines eligibility applying the resource and income rules for a legally married couple.

(vi) A redetermination of the couple's resources under this section is required if:

(A) The institutionalized spouse has a break of at least 30 consecutive days in a period of institutional status;

(B) The institutionalized spouse's countable resources exceed the standard under subsection (2)(a) of this section, and WAC 182-513-1355 (2)(b) applies; or

(C) The institutionalized spouse does not transfer the amount, under WAC 182-513-1355 (3) or (5), to the community spouse by either:

(I) The end of the month of the first regularly scheduled eligibility review; or

(II) A reasonable amount of time necessary to obtain a court order for the support of the community spouse.

(4) Countable resources.

(a) The agency or the agency's designee determines countable resources using the following sections:

(i) WAC 182-512-0200 SSI-related medical—Definition of resources.

(ii) WAC 182-512-0250 SSI-related medical—Ownership and availability of resources.

(iii) WAC 182-512-0260 SSI-related medical—How to count a sponsor's resources.

(iv) WAC 182-512-0300 SSI-related medical—Resources eligibility.

(v) WAC 182-512-0350 SSI-related medical—Property and contracts excluded as resources;

(vi) WAC 182-512-0400 SSI-related medical—Vehicles excluded as resources;

(vii) WAC 182-512-0450 SSI-related medical—Life insurance excluded as a resource; and

(viii) WAC 182-512-0500 SSI-related medical—Burial funds, contracts and spaces excluded as resources.

(ix) Chapter 182-516 WAC, Trusts, annuities, life estates, and promissory notes—Effect on medical programs.

(b) The agency or the agency's designee determines excluded resources based on federal law and WAC 182-512-0550, except:

(i) For institutional and HCB waiver programs, pension funds owned by a nonapplying spouse are counted toward the resource standard.

(ii) For long-term services and supports (LTSS), based on the need for either nursing facility level of care or intermediate care facility for the intellectually disabled level of care, one home is excluded only if it meets the home equity limits of subsection (8) of this section. See WAC 182-512-0350 (1)(b).

(c) The agency or the agency's designee adds together the countable resources of both spouses if subsections (3)(b)(i) and (iv) apply, but not if subsection (3)(b)(ii) or (iii) apply. For a person with a community spouse, see WAC 182-513-1355.

(5) Excess resources.

(a) For LTC programs, a person may reduce excess resources by deducting incurred medical expenses under subsection (6) of this section;

(b) The amount of excess resources is limited to the following amounts:

(i) For LTC services provided under the categorically needy (CN) program:

(A) In a medical institution, excess resources and available income must be under the state medicaid rate based on the number of days the person spent in the medical institution in the month.

(B) For HCB waiver eligibility, incurred medical expenses must reduce resources within allowable resource standards. The cost of care for the HCB waiver services cannot be allowed as a projected expense.

(ii) For LTC services provided under the medically needy (MN) program, see:

(A) WAC 182-513-1395 for LTC programs; and

(B) WAC 182-513-1245 for hospice.

(c) Excess resources not otherwise applied to medical expenses will be applied to the projected cost of care for services in a medical institution under WAC 182-513-1380.

(6) Allowable medical expenses.

(a) The following incurred medical expenses may be used to reduce excess resources:

(i) Premiums, deductibles, coinsurance, or copayment charges for health insurance and medicare;

(ii) Medically necessary care defined under WAC 182-500-0070, but not covered under the state's medicaid plan. Information regarding covered services is under chapter 182-501 WAC;

(iii) Medically necessary care defined under WAC 182-500-0070 incurred prior to medicaid eligibility. Expenses for nursing facility care are reduced at the state rate for the specific facility that provided the services.

(b) To be allowed, the medical expense must:

(i) Have been incurred no more than three months before the month of the medicaid application;

(ii) Not be subject to third-party payment or reimbursement;

(iii) Not have been used to satisfy a previous spenddown liability;

(iv) Not have been previously used to reduce excess resources;

(v) Not have been used to reduce participation;

(vi) Not have been incurred during a transfer of asset penalty under WAC 182-513-1363; and

(vii) Be an amount for which the person remains liable.

(7) Nonallowable expenses. The following expenses are not allowed to reduce excess resources:

(a) Unpaid adult family home (AFH) or assisted living facility expenses incurred prior to medicaid eligibility;

(b) Personal care cost in excess of approved hours determined by the CARE assessment under chapter 388-106 WAC; and

(c) Expenses excluded by federal law.

(8) Excess home equity.

(a) A person with an equity interest in a primary residence in excess of the home equity limit is ineligible for long-term services and supports (LTSS) that are based on the need for either nursing facility level of care or intermediate care facility for the intellectually disabled level of care, unless one of the following persons lawfully resides in the home:

(i) That person's spouse; or

(ii) That person's dependent child under age 21, blind child, or disabled child.

(b) The home equity provision applies to all applications for LTSS received on or after May 1, 2006.

(c) The excess home equity limit is the federal maximum allowed. On January 1st of each year, this standard may change by the percentage in the consumer price index for all consumers (CPI-U). The current maximum home equity limit is posted by the Centers for Medicare and Medicaid Services. (See subsection (9) of this section for institutional resource standards.)

(d) A person who is denied or terminated LTC services due to excess home equity may apply for an undue hardship waiver under WAC 182-513-1367.

(9) Institutional resource standards are found at ((~~https://www.hca.wa.gov/health-care-services-supports/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 22-13-058, § 182-513-1350, filed 6/8/22, effective 7/9/22; WSR 17-18-023, § 182-513-1350, filed 8/28/17, effective 9/28/17. Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1350, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as § 182-513-1350, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, section 6014 of the Deficit Reduction Act of 2005 (DRA), and 2010 1st sp.s. c 37 § 209(1). WSR 12-21-091, § 388-513-1350, filed 10/22/12, effective 11/22/12. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, and 74.09.575. WSR 09-12-058, § 388-513-1350, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.530. WSR 08-13-072, § 388-513-1350, filed 6/16/08, effective 7/17/08. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.575, 74.09.500, and 74.09.530. WSR 07-19-128, § 388-513-1350, filed 9/19/07, effective 10/20/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.09.575, 2005 Federal Deficit Reduction Act (DRA) P.L. 109-171, and Section 1924 of the Social Security Act (42 U.S.C. 1396r-5). WSR 07-01-073, § 388-513-1350, filed 12/18/06, effective 1/18/07. Statutory Authority: RCW 74.04.050, 74.04.057,

74.08.090, 74.09.500, 42 U.S.C. 9902(2). WSR 05-07-033, § 388-513-1350, filed 3/9/05, effective 4/9/05. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.575; 2003 1st sp.s. c 28, and section 1924 of the Social Security Act (42 U.S.C. 1396R-5). WSR 04-04-072, § 388-513-1350, filed 2/2/04, effective 3/4/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500 and Section 1924 (42 U.S.C. 1396R-5). WSR 01-18-055, § 388-513-1350, filed 8/30/01, effective 9/30/01. Statutory Authority: RCW 11.92.180, 43.20B.460, 48.85.020, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, 74.[09.]575, 74.09.585; 20 C.F.R. 416.1110-1112, 1123 and 1160; 42 C.F.R. 435.403 (j)(2) and 1005; and Sections 17, 1915(c), and 1924 (42 U.S.C. 1396) of the Social Security Act. WSR 00-01-051, § 388-513-1350, filed 12/8/99, effective 1/8/00. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 99-06-045, § 388-513-1350, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.09.575 and Section 1924 (42 U.S.C. 1396r-5). WSR 98-11-033, § 388-513-1350, filed 5/14/98, effective 6/14/98. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090 and 74.09.575. WSR 97-09-112, § 388-513-1350, filed 4/23/97, effective 5/24/97. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 95-44. WSR 96-09-033 (Order 3963), § 388-513-1350, filed 4/10/96, effective 5/11/96. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 94-49, notice of increase in SSI level. WSR 95-05-022 (Order 3832), § 388-513-1350, filed 2/8/95, effective 3/11/95. Statutory Authority: RCW 74.08.090. WSR 94-23-129 (Order 3808), § 388-513-1350, filed 11/23/94, effective 12/24/94; WSR 94-10-065 (Order 3732), § 388-513-1350, filed 5/3/94, effective 6/3/94. Formerly parts of WAC 388-95-337 and 388-95-340.]

AMENDATORY SECTION (Amending WSR 17-03-116, filed 1/17/17, effective 2/17/17)

WAC 182-513-1355 Allocating resources to a community spouse when determining resource eligibility for SSI-related long-term care services. (1) The agency or its designee uses this section to calculate the resource allocation from the institutionalized spouse to the community spouse for the determination of the institutionalized spouse's resource eligibility under WAC 182-513-1350 (2)(a)(ii).

(2) If the institutionalized spouse's most recent continuous period of institutionalization (MRCPI) began:

(a) Before October 1, 1989, the agency adds together one-half the total amount of countable resources, as determined under WAC 182-513-1350(4), held in the name of:

(i) The institutionalized spouse; and

(ii) Both spouses.

(b) On or after October 1, 1989, the agency or its designee adds together the total amount of countable resources, as determined under WAC 182-513-1350(4), held in the name of:

(i) Either spouse; and

(ii) Both spouses.

(3) If subsection (2)(b) of this section applies, the agency or its designee determines the amount of resources allocated to the community spouse, before determining the amount of countable resources used to establish eligibility for the institutionalized spouse under WAC 182-513-1350:

(a) If the institutionalized spouse's MRCPI began on or after October 1, 1989, and before August 1, 2003, the agency or its designee allocates the federal spousal resource maximum;

(b) If the institutionalized spouse's MRCPI began on or after August 1, 2003, the agency or its designee allocates the greater of:

(i) A spousal share equal to one-half of the couple's combined countable resources, up to the federal spousal resource maximum; or

(ii) The state spousal resource standard.

(4) Countable resources under subsection (3)(b) of this section determined as of the first day of the month in which MRCPI began.

(5) The agency or its designee uses a community spouse evaluation to determine the amount of the spousal share under subsection (3)(b)(i) of this section.

(6) The agency or its designee completes a community spouse resource evaluation:

(a) Upon request by the institutionalized spouse, or the institutionalized spouse's community spouse;

(b) At any time between the date that the MRCPI began and the date that eligibility for long-term care (LTC) is determined; and

(c) Upon receipt of any verification required to establish the amount of the couple's resources in the month of MRCPI.

(7) The community spouse resource evaluation can be completed prior to an application for LTC or as part of the LTC application if:

(a) The beginning of the MRCPI was prior to the month of application; and

(b) The spousal share exceeds the state spousal resource standard.

(8) The amount of allocated resources under subsection (3) of this section can be increased, but only if:

(a) A court has entered an order against the institutionalized spouse for the support of the community spouse or a dependent of either spouse; or

(b) A final order is entered under chapter 182-526 WAC, ruling that the institutionalized spouse or community spouse established that the income generated by the resources allocated under subsection (3) of this section is insufficient to raise the community spouse's income to the monthly maintenance needs allowance (MMNA) determined under WAC 182-513-1385, but only after the application of the income-first rule under 42 U.S.C. 1396r-5 (d)(6).

(9) If a final order establishes that the conditions identified in subsection (8)(b) of this section have been met, then an amount of allocated resources under subsection (3) of this section will be substituted by an amount adequate to provide such an MMNA.

(10) The institutionalized spouse has until the end of the month of the first regularly scheduled eligibility review to transfer countable resources in excess of $2000 to the community spouse.

(11) Standards in this section are found at ((~~http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1355, filed 1/17/17, effective 2/17/17.]

AMENDATORY SECTION (Amending WSR 21-09-092, filed 4/21/21, effective 5/22/21)

WAC 182-513-1380 Determining a client's financial participation in the cost of care for long-term care in a medical institution. This rule describes how the agency or the agency's designee allocates income and excess resources when determining participation in the cost of care in a medical institution.

(1) The agency or the agency's designee defines which income and resources must be used in this process under WAC 182-513-1315.

(2) The agency or the agency's designee allocates nonexcluded income in the following order, and the combined total of (a), (b), (c), and (d) of this subsection cannot exceed the effective one-person medically needy income level (MNIL):

(a) A personal needs allowance (PNA) under WAC 182-513-1105.

(b) Mandatory federal, state, or local income taxes owed by the client.

(c) Wages for a client who:

(i) Is related to the supplemental security income (SSI) program under WAC 182-512-0050(1); and

(ii) Receives the wages as part of an agency-approved or department-approved training or rehabilitative program designed to prepare the client for a less restrictive placement. When determining this deduction, employment expenses are not deducted.

(d) Guardianship fees and administrative costs, including any attorney fees paid by the guardian, as allowed under chapter 388-79A WAC.

(3) The agency or the agency's designee allocates nonexcluded income after deducting amounts under subsection (2) of this section in the following order:

(a) Current or back child support garnished or withheld from income according to a child support order in the month of the garnishment if it is:

(i) For the current month;

(ii) For the time period covered by the PNA; and

(iii) Not counted as the dependent member's income when determining the dependent allocation amount under WAC 182-513-1385.

(b) A monthly maintenance needs allowance for the community spouse as determined using the calculation under WAC 182-513-1385. If the community spouse is also receiving long-term care services, the allocation is limited to an amount that brings the community spouse's income up to the PNA.

(c) A dependent allowance for each dependent of the institutionalized client or the client's spouse, as determined using the calculation under WAC 182-513-1385.

(d) Medical expenses incurred by the institutionalized individual and not used to reduce excess resources. Allowable medical expenses and reducing excess resources are described in WAC 182-513-1350.

(e) Maintenance of the home of a single institutionalized client or institutionalized couple:

(i) Up to ((~~one hundred~~)) 100 percent of the one-person federal poverty level per month;

(ii) Limited to a six-month period;

(iii) When a physician has certified that the client or couple is likely to return to the home within the six-month period; and

(iv) When social services staff documents the need for the income deduction.

(4) A client may have to pay third-party resources as defined under WAC 182-513-1100 in addition to the participation.

(5) A client is responsible to pay only up to the state rate for the cost of care. If long-term care insurance pays a portion of the state rate cost of care, a client pays only the difference up to the state rate cost of care.

(6) When a client lives in multiple living arrangements in a month, the agency allows the highest PNA available based on all the living arrangements and services the client has in a month.

(7) Standards under this section for long-term care are found at ((~~https://www.hca.wa.gov/health-care-services-supports/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 21-09-092, § 182-513-1380, filed 4/21/21, effective 5/22/21; WSR 20-08-082, § 182-513-1380, filed 3/27/20, effective 4/27/20. Statutory Authority: RCW 41.05.021, 41.05.160, 2017 c 270. WSR 17-23-039, § 182-513-1380, filed 11/8/17, effective 1/1/18. Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1380, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as WAC 182-513-1380, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, section 6014 of the Deficit Reduction Act of 2005 (DRA), and 2010 1st sp.s. c 37 § 209(1). WSR 12-21-091, § 388-513-1380, filed 10/22/12, effective 11/22/12. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, and Deficit Reduction Act of 2005, 42 C.F.R. Section 435. WSR 09-07-037, § 388-513-1380, filed 3/10/09, effective 4/10/09. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.530. WSR 08-13-072, § 388-513-1380, filed 6/16/08, effective 7/17/08. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, and 2006 c 372. WSR 07-19-126, § 388-513-1380, filed 9/19/07, effective 10/20/07; WSR 07-01-072, § 388-513-1380, filed 12/18/06, effective 1/18/07. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530 and 2005 c 518 § 207 and Sec. 1924 Social Security Act (42 U.S.C. 1396r-5). WSR 06-07-144, § 388-513-1380, filed 3/21/06, effective 4/21/06. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 42 U.S.C. 9902(2). WSR 05-07-033, § 388-513-1380, filed 3/9/05, effective 4/9/05. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.575; 2003 1st sp.s. c 28, and section 1924 of the Social Security Act (42 U.S.C. 1396R-5). WSR 04-04-072, § 388-513-1380, filed 2/2/04, effective 3/4/04. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500 and Section 1924 (42 U.S.C. 1396R-5). WSR 01-18-055, § 388-513-1380, filed 8/30/01, effective 9/30/01. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and Section 1924(g) of the Social Security Act. WSR 00-17-058, § 388-513-1380, filed 8/9/00, effective 9/9/00. Statutory Authority: RCW 72.36.160, 74.04.050, 74.04.057, 74.08.090, 74.09.500 and Section 1924(g) of the Social Security Act, Section 4715 of the BBA of 1997 (Public Law 105-33, HR 2015). WSR 99-11-017, § 388-513-1380, filed 5/10/99, effective 6/10/99. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 43.20B.460, 11.92.180, and Section 1924 (42 U.S.C. 396r-5). WSR 98-08-077, § 388-513-1380, filed 3/31/98, effective 4/1/98. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and Social Security

Act, Federal Register, March 10, 1997, pgs. 10856 - 10859, 42 U.S.C. 1396 (a)(l)(m). WSR 97-16-008, § 388-513-1380, filed 7/24/97, effective 7/24/97. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 95-44. WSR 96-09-033 (Order 3963), § 388-513-1380, filed 4/10/96, effective 5/11/96. Statutory Authority: RCW 74.08.090. WSR 95-11-045 (Order 3848), § 388-513-1380, filed 5/10/95, effective 6/10/95. Statutory Authority: RCW 74.08.090 and Title XIX State Agency Letter 94-49, notice of increase in SSI level. WSR 95-05-022 (Order 3832), § 388-513-1380, filed 2/8/95, effective 3/11/95. Statutory Authority: RCW 74.08.090. WSR 94-10-065 (Order 3732), § 388-513-1380, filed 5/3/94, effective 6/3/94. Formerly WAC 388-95-360.]

AMENDATORY SECTION (Amending WSR 17-03-116, filed 1/17/17, effective 2/17/17)

WAC 182-513-1385 Determining the community spouse monthly maintenance needs allowance and dependent allowance in post-eligibility treatment of income for long-term care (LTC) programs. (1) This section describes how to calculate the monthly maintenance needs allowance (MMNA) in post-eligibility treatment of income for long-term care (LTC) programs for a community spouse or dependent of the institutionalized individual.

(2) The community spouse MMNA standards are found at ((~~http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/standards-ltc~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources, unless a greater amount is calculated under subsection (5) of this section. The MMNA standards may change each January and July based on the consumer price index.

(3) The community spouse MMNA is allowed only to the extent that the institutionalized spouse's income is made available to the community spouse, and is calculated as follows:

(a) The minimum MMNA as calculated in subsection (4)(a) of this section plus excess shelter expenses as calculated in subsection (4)(b) of this section;

(i) The total under (a) of this subsection cannot be less than the minimum MMNA; and

(ii) If the total under subsection (4)(a) of this section exceeds the maximum MMNA, the maximum MMNA is the result under subsection (4)(a) of this section; and

(b) The total under subsection (4)(a) of this section is reduced by the community spouse's gross income. The result is the MMNA.

(4) The minimum MMNA and excess shelter expense values are calculated as follows:

(a) The minimum MMNA is ((~~one hundred fifty~~)) 150 percent of the two-person federal poverty level (FPL); and

(b) If excess shelter expenses are less than zero, the result is zero. Excess shelter expenses are calculated as follows:

(i) Add:

(A) Mortgage or rent, which includes space rent for mobile homes;

(B) Real property taxes;

(C) Homeowner's insurance;

(D) Required maintenance fees for a condominium, cooperative, or homeowner's association that are recorded in a covenant; and

(E) The food assistance standard utility allowance (SUA) under WAC 388-450-0195 minus the cost of any utilities that are included in (b)(i)(D) of this subsection.

(ii) Subtract the standard shelter allocation from the total in (b)(i) of this subsection. The standard shelter allocation is ((~~thirty~~)) 30 percent of ((~~one hundred fifty~~)) 150 percent of the two-person FPL. The result is the value of excess shelter expenses.

(5) The amount allocated to the community spouse may be greater than the amount determined in subsection (3) of this section, but only if:

(a) A court order has been entered against the institutionalized spouse approving a higher MMNA for the support of the community spouse; or

(b) A final order has been entered after an administrative hearing has been held under chapter 182-526 WAC ruling the institutionalized spouse or the community spouse established the community spouse needs income, above the level otherwise provided by the MMNA, due to exceptional circumstances causing significant financial duress.

(6) If a final order establishes that the conditions identified in subsection (5)(b) of this section have been met, then an amount of allocated resources under subsection (3) of this section will be substituted by an amount adequate to provide such an MMNA.

(7) The agency or its designee determines the dependent allowance for dependents of the institutionalized individual or the institutionalized individual's spouse. The amount the agency allows depends on whether the dependent resides with the community spouse.

(a) For each dependent who resides with the community spouse:

(i) Subtract the dependent's income from ((~~one hundred fifty~~)) 150 percent of the two-person FPL;

(ii) Divide the amount determined in (a)(i) of this subsection by three;

(iii) The result is the dependent allowance for that dependent.

(b) For each dependent who does not reside with the community spouse:

(i) The agency determines the effective MNIL standard based on the number of dependent family members in the home;

(ii) Subtracts each dependent's separate income;

(iii) The result is the dependent allowance for the dependents.

(c) Child support received from a noncustodial parent is the child's income.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1385, filed 1/17/17, effective 2/17/17.]

AMENDATORY SECTION (Amending WSR 21-10-051, filed 4/29/21, effective 5/30/21)

WAC 182-513-1660 Medicaid alternative care (MAC) and tailored supports for older adults (TSOA)—Spousal impoverishment. (1) The medicaid agency or the agency's designee determines financial eligibility for medicaid alternative care (MAC) or tailored supports for older adults (TSOA) using spousal impoverishment protections under this section, when an applicant or recipient:

(a) Is married to, or marries, a person who is not in a medical institution; and

(b) Is ineligible for a noninstitutional categorically needy (CN) SSI-related program or the TSOA program due to:

(i) Spousal deeming rules under WAC 182-512-0920 for MAC;

(ii) Exceeding the resource limit in WAC 182-512-0010 for MAC, or the limit under WAC 182-513-1640 for TSOA; or

(iii) Both (b)(i) and (ii) of this subsection.

(2) When a resource test applies, the agency or the agency's designee determines countable resources using the SSI-related resource rules under chapter 182-512 WAC, except pension funds owned by the spousal impoverishment protections community (SIPC) spouse are not excluded as described under WAC 182-512-0550:

(a) Resource standards:

(i) For MAC, the resource standard is $2,000; or

(ii) For TSOA, the resource standard is $53,100.

(b) Before determining countable resources used to establish eligibility for the applicant, the agency or the agency's designee allocates the state spousal resource standard to the SIPC spouse.

(c) The resources of the SIPC spouse are unavailable to the spousal impoverishment protections institutionalized (SIPI) spouse the month after eligibility for MAC or TSOA services is established.

(3) The SIPI spouse has until the end of the month of the first regularly scheduled eligibility review to transfer countable resources in excess of $2,000 (for MAC) or $53,100 (for TSOA) to the SIPC spouse.

(4) Income eligibility:

(a) For MAC:

(i) The agency or the agency's designee determines countable income using the SSI-related income rules under chapter 182-512 WAC, but uses only the applicant or recipient's income;

(ii) If the applicant's or recipient's countable income is at or below the SSI categorically needy income level (CNIL), the applicant or recipient is considered a SIPI spouse and is income eligible for noninstitutional CN coverage and MAC services;

(iii) If the applicant is employed and the applicant's countable income is at or below the standard under WAC 182-511-1060, the applicant is considered a SIPI spouse and is income eligible for noninstitutional CN coverage under the health care for workers with disabilities (HWD) program and MAC services.

(b) For TSOA, see WAC 182-513-1635.

(5) Once a person no longer receives MAC services, eligibility is redetermined without using spousal impoverishment protections under WAC 182-504-0125.

(6) If the applicant's separate countable income is above the standards described in subsection (4) of this section, the applicant is not income eligible for MAC or TSOA services.

(7) The spousal impoverishment protections described in this section are time-limited and expire on September 30, 2023.

(8) Standards described in this chapter are located at ((~~www.hca.wa.gov/health-care-services-supports/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

[Statutory Authority: RCW 41.05.021, 41.05.160 and Consolidated Appropriations Act of 2021, H.R. 133, Division CC, Title II, Sec. 204

(b)(1)(A) and Sec. 205. WSR 21-10-051, § 182-513-1660, filed 4/29/21, effective 5/30/21. Statutory Authority: RCW 41.05.021, 41.05.160, 2016 1st sp.s. c 36 § 213 (1)(e), section 1115 of the Social Security Act, and 42 C.F.R. §§ 431.400 through 431.428. WSR 17-12-019, § 182-513-1660, filed 5/30/17, effective 7/1/17.]

OTS-4176.1

AMENDATORY SECTION (Amending WSR 16-04-087, filed 1/29/16, effective 2/29/16)

WAC 182-514-0230 Purpose. (1) This chapter describes eligibility requirements for the Washington apple health (WAH) modified adjusted gross income (MAGI)-based long-term care program (LTC) for children and adults who have been admitted to an institution as defined in WAC 182-500-0050 for at least ((~~thirty~~)) 30 days. The rules are stated in the following sections:

(a) WAC 182-514-0240 General eligibility;

(b) WAC 182-514-0245 Resource eligibility;

(c) WAC 182-514-0250 Program for adults age ((~~nineteen~~)) 19 and older;

(d) WAC 182-514-0260 Program for children under age ((~~nineteen~~)) 19;

(e) WAC 182-514-0263 Non-SSI-related institutional medically needy coverage for pregnant women and people age ((~~twenty~~)) 20 and younger.

(f) WAC 182-514-0270 Involuntary commitment to Eastern or Western State Hospital.

(2) A noninstitutional WAH program recipient does not need to submit a new application for LTC coverage if admitted to an institution under this section. Admission to an institution constitutes a change of circumstances. Eligibility is based on institutional status under WAC 182-513-1320.

(3) In this chapter, "medicaid agency" or "agency" means the Washington state health care authority and includes the agency's designee. See chapter 182-500 WAC for additional definitions.

(4) Income standards used in this chapter are listed at ((~~http://www.hca.wa.gov/medicaid/eligibility/pages/standards.aspx~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 16-04-087, § 182-514-0230, filed 1/29/16, effective 2/29/16. Statutory Authority: RCW 41.05.021 and Patient Protection and Affordable Care Act (P.L. 111-148), 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 14-06-068, § 182-514-0230, filed 2/28/14, effective 3/31/14. WSR 12-02-034, recodified as § 182-514-0230, filed 12/29/11, effective 1/1/12. Statutory Authority: RCW 74.04.055, 74.04.057, 74.08.090, 74.09.530, and 42 C.F.R. 441.151. WSR 09-06-029, § 388-505-0230, filed 2/24/09, effective 3/27/09.]

OTS-4175.1

AMENDATORY SECTION (Amending WSR 17-03-116, filed 1/17/17, effective 2/17/17)

WAC 182-515-1506 Home and community based (HCB) waiver services authorized by home and community services (HCS)—General eligibility. (1) To be eligible for home and community based (HCB) waiver services a person must:

(a) Meet the program and age requirements for the specific program:

(i) Community options program entry system (COPES), under WAC 388-106-0310;

(ii) Residential support waiver (RSW), under WAC 388-106-0310; or

(iii) New Freedom, under WAC 388-106-0338.

(b) Meet the disability criteria for the supplemental security income (SSI) program under WAC 182-512-0050;

(c) Require the level of care provided in a nursing facility under WAC 388-106-0355;

(d) Reside in a medical institution as defined in WAC 182-500-0050, or be likely to be placed in one within the next ((~~thirty~~)) 30 days without HCB waiver services provided under one of the programs listed in (a) of this subsection;

(e) Attain institutional status under WAC 182-513-1320;

(f) Assessed for HCB waiver services, be approved for a plan of care, and receiving an HCB waiver service under (a) of this subsection;

(g) Be able to live at home with community support services and choose to remain at home, or live in a department-contracted alternate living facility under WAC 182-513-1100.

(2) A person is not eligible for home and community based (HCB) waiver services if the person:

(a) Is subject to a penalty period of ineligibility for the transfer of an asset under WAC 182-513-1363; or

(b) Has a home with equity in excess of the requirements under WAC 182-513-1350.

(3) See WAC 182-513-1315 for rules used to determine countable resources, income, and eligibility standards for long-term care (LTC) services.

(4) Current income and resource standards are found at ((~~http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R § 155. WSR 17-03-116, § 182-515-1506, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as WAC 182-515-1506, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, section 6014 of the Deficit Reduction Act of 2005 (DRA), and 2010 1st sp.s. c 37 § 209(1). WSR 12-21-091, § 388-515-1506, filed 10/22/12, effective 11/22/12. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.530 and Washington state 2007-09 operating budget

(SHB 1128). WSR 08-22-052, § 388-515-1506, filed 11/3/08, effective 12/4/08.]

AMENDATORY SECTION (Amending WSR 17-23-039, filed 11/8/17, effective 1/1/18)

WAC 182-515-1507 Home and community based (HCB) waiver services authorized by home and community services (HCS)—Financial eligibility if a client is eligible for an SSI-related noninstitutional categorically needy (CN) medicaid program. (1) A client is financially eligible for home and community based (HCB) waiver services if the client:

(a) Is receiving coverage under one of the following categorically needy (CN) medicaid programs:

(i) SSI program under WAC 182-510-0001. This includes SSI clients under Section 1619(b) of the Social Security Act;

(ii) SSI-related noninstitutional CN program under chapter 182-512 WAC; or

(iii) Health care for workers with disabilities program (HWD) under chapter 182-511 WAC.

(b) Does not have a penalty period of ineligibility for the transfer of an asset under WAC 182-513-1363; and

(c) Does not own a home with equity in excess of the requirements under WAC 182-513-1350.

(2) A client eligible under this section does not pay toward the cost of care, but must pay room and board if living in an alternate living facility (ALF) under WAC 182-513-1100.

(3) A client eligible under this section who lives in a department-contracted ALF described under WAC 182-513-1100:

(a) Keeps a personal needs allowance (PNA) under WAC 182-513-1105; and

(b) Pays towards room and board under WAC 182-513-1105.

(4) A client who is eligible under the HWD program must pay the HWD premium under WAC 182-511-1250, in addition to room and board, if residing in an ALF.

(5) Current resource, income, PNA, and room and board standards are found at ((~~www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2017 c 270. WSR 17-23-039, § 182-515-1507, filed 11/8/17, effective 1/1/18. Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R § 155. WSR 17-03-116, § 182-515-1507, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as WAC 182-515-1507, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, section 6014 of the Deficit Reduction Act of 2005 (DRA), and 2010 1st sp.s. c 37 § 209(1). WSR 12-21-091, § 388-515-1507, filed 10/22/12, effective 11/22/12. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, and section 1915(c) of the Social Security Act. WSR 09-14-043, § 388-515-1507, filed 6/24/09, effective 7/25/09. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and

74.09.530 and Washington state 2007-09 operating budget (SHB 1128). WSR 08-22-052, § 388-515-1507, filed 11/3/08, effective 12/4/08.]

AMENDATORY SECTION (Amending WSR 17-03-116, filed 1/17/17, effective 2/17/17)

WAC 182-515-1508 Home and community based (HCB) waiver services authorized by home and community services (HCS)—Financial eligibility using SSI-related institutional rules. (1) If a person is not eligible for a categorically needy (CN) program under WAC 182-515-1507, the agency determines eligibility for home and community based (HCB) waiver services authorized by home and community services (HCS) using institutional medicaid rules. This section explains how a person may qualify using institutional rules.

(2) A person must meet:

(a) General eligibility requirements under WAC 182-513-1315 and 182-515-1506;

(b) The resource requirements under WAC 182-513-1350;

(c) The following income requirements:

(i) Available income must be at or below the special income level (SIL), defined under WAC 182-513-1100; or

(ii) If available income is above the SIL, net available income is no greater than the effective one-person medically needy income level (MNIL). Net income is calculated by reducing available income by:

(A) Medically needy (MN) disregards found under WAC 182-513-1345;

(B) The average monthly nursing facility state rate;

(C) Health insurance premiums, other than medicare; and

(D) Outstanding medical bills, prorated monthly over a ((~~twelve-month~~)) 12-month certification period, that meet the requirements of WAC 182-513-1350.

(3) The agency determines available income and income exclusions under WAC 182-513-1325, 182-513-1330, and 182-513-1340.

(4) A person eligible under this section is responsible to pay toward the cost of care and room and board, as described under WAC 182-515-1509.

(5) Current resource, income standards, and the average state nursing facility rate for long-term care are found at ((~~http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R § 155. WSR 17-03-116, § 182-515-1508, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as WAC 182-515-1508, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, section 6014 of the Deficit Reduction Act of 2005 (DRA), and 2010 1st sp.s. c 37 § 209(1). WSR 12-21-091, § 388-515-1508, filed 10/22/12, effective 11/22/12. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.530 and Washington state 2007-09 operating budget (SHB 1128). WSR 08-22-052, § 388-515-1508, filed 11/3/08, effective 12/4/08.]

AMENDATORY SECTION (Amending WSR 22-16-040, filed 7/27/22, effective 8/27/22)

WAC 182-515-1509 Home and community based (HCB) waiver services authorized by home and community services (HCS)—Client financial responsibility. (1) A client eligible for home and community based (HCB) waiver services authorized by home and community services (HCS) under WAC 182-515-1508 must pay toward the cost of care and room and board under this section.

(a) Post-eligibility treatment of income, participation, and participate are all terms that refer to a client's responsibility towards cost of care.

(b) Room and board is a term that refers to a client's responsibility toward food and shelter in an alternate living facility (ALF).

(2) The agency determines how much a client must pay toward the cost of care for HCB waiver services authorized by HCS when living in their own home:

(a) A single client who lives in their own home (as defined in WAC 388-106-0010) keeps a personal needs allowance (PNA) of up to 300% of the federal benefit rate (FBR) for the supplemental security income (SSI) cash grant program and must pay the remaining available income toward cost of care after allowable deductions described in subsection (4) of this section. The Washington apple health income and resource standards chart identifies 300% of the FBR as the medical special income level (SIL).

(b) A married client who lives with the client's spouse in their own home (as defined in WAC 388-106-0010) keeps a PNA of up to the effective one-person medically needy income level (MNIL) and pays the remainder of the client's available income toward cost of care after allowable deductions under subsection (4) of this section.

(c) A married client who lives in their own home and apart from the client's spouse keeps a PNA of up to the SIL but must pay the remaining available income toward cost of care after allowable deductions under subsection (4) of this section.

(d) A married couple living in their own home where each client receives HCB waiver services is each allowed to keep a PNA of up to the SIL but must pay remaining available income toward cost of care after allowable deductions under subsection (4) of this section.

(e) A married couple living in their own home where each client receives HCB waiver services, one spouse authorized by the developmental disabilities administration (DDA) and the other authorized by HCS, is allowed the following:

(i) The client authorized by DDA pays toward the cost of care under WAC 182-515-1512 or 182-515-1514; and

(ii) The client authorized by HCS retains the SIL and pays the remainder of the available income toward cost of care after allowable deductions under subsection (4) of this section.

(3) The agency determines how much a client must pay toward the cost of care for HCB waiver services authorized by HCS and room and board when living in a department contracted alternate living facility (ALF) defined under WAC 182-513-1100. A client:

(a) Keeps a PNA of under WAC 182-513-1105;

(b) Pays room and board up to the room and board standard under WAC 182-513-1105; and

(c) Pays the remainder of available income toward the cost of care after allowable deductions under subsection (4) of this section.

(4) If income remains after the PNA and room and board liability under subsection (2) or (3) of this section, the remaining available income must be paid toward the cost of care after it is reduced by deductions in the following order:

(a) An earned income deduction of the first $65 plus one-half of the remaining earned income;

(b) Guardianship fees and administrative costs including any attorney fees paid by the guardian only as allowed under chapter 388-79A WAC;

(c) Current or back child support garnished or withheld from the client's income according to a child support order in the month of the garnishment if it is for the current month. If the agency allows this as a deduction from income, the agency does not count it as the child's income when determining the family allocation amount in WAC 182-513-1385;

(d) A monthly maintenance-needs allowance for the community spouse as determined under WAC 182-513-1385. If the community spouse is also receiving long-term care services, the allocation is limited to an amount that brings the community spouse's income to the community spouse's PNA, as calculated under WAC 182-513-1385;

(e) A monthly maintenance-needs allowance for each dependent of the institutionalized client, or the client's spouse, as calculated under WAC 182-513-1385;

(f) Incurred medical expenses which have not been used to reduce excess resources. Allowable medical expenses are under WAC 182-513-1350.

(5) The total of the following deductions cannot exceed the special income level (SIL) defined under WAC 182-513-1100:

(a) The PNA allowed in subsection (2) or (3) of this section, including room and board;

(b) The earned income deduction in subsection (4)(a) of this section; and

(c) The guardianship fees and administrative costs in subsection (4)(b) of this section.

(6) A client may have to pay third-party resources defined under WAC 182-513-1100 in addition to the room and board and participation.

(7) A client must pay the client's provider the sum of the room and board amount, and the cost of care after all allowable deductions, and any third-party resources defined under WAC 182-513-1100.

(8) A client on HCB waiver services does not pay more than the state rate for cost of care.

(9) When a client lives in multiple living arrangements in a month, the agency allows the highest PNA available based on all the living arrangements and services the client has received in a month.

(10) Standards described in this section are found at ((~~www.hca.wa.gov/health-care-services-supports/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

[Statutory Authority: RCW 41.05.021, 41.05.160, and 2022 c 164. WSR 22-16-040, § 182-515-1509, filed 7/27/22, effective 8/27/22. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 20-08-082, § 182-515-1509, filed 3/27/20, effective 4/27/20. Statutory Authority: RCW 41.05.021, 41.05.160, 2017 c 270. WSR 17-23-039, § 182-515-1509, filed 11/8/17, effective 1/1/18. Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R § 155. WSR

17-03-116, § 182-515-1509, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as WAC 182-515-1509, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, section 6014 of the Deficit Reduction Act of 2005 (DRA), and 2010 1st sp.s. c 37 § 209(1). WSR 12-21-091, § 388-515-1509, filed 10/22/12, effective 11/22/12. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 74.09.530 and Washington state 2007-09 operating budget (SHB 1128). WSR 08-22-052, § 388-515-1509, filed 11/3/08, effective 12/4/08.]

AMENDATORY SECTION (Amending WSR 17-03-116, filed 1/17/17, effective 2/17/17)

WAC 182-515-1511 Home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA)—General eligibility. (1) To be eligible for home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA), a person must:

(a) Meet specific program requirements under chapter 388-845 WAC;

(b) Be an eligible client of the DDA;

(c) Meet the disability criteria for the supplemental security income (SSI) program under WAC 182-512-0050;

(d) Need the level of care provided in an intermediate care facility for the intellectually disabled (ICF/ID);

(e) Have attained institutional status under WAC 182-513-1320;

(f) Be able to reside in the community and choose to do so as an alternative to living in an ICF/ID;

(g) Be assessed for HCB waiver services, be approved for a plan of care, and receive HCB waiver services under (a) of this subsection, and:

(i) Be able to live at home with HCB waiver services; or

(ii) Live in a department-contracted facility with HCB waiver services, such as:

(A) A group home;

(B) A group training home;

(C) A child foster home, group home, or staffed residential facility;

(D) An adult family home (AFH); or

(E) An adult residential care (ARC) facility.

(iii) Live in the person's own home with supported living services from a certified residential provider; or

(iv) Live in the home of a contracted companion home provider.

(2) A person is not eligible for home and community based (HCB) waiver services if the person:

(a) Is subject to a penalty period of ineligibility for the transfer of an asset under WAC 182-513-1363; or

(b) Has a home with equity in excess of the requirements under WAC 182-513-1350.

(3) See WAC 182-513-1315 for rules used to determine countable resources, income, and eligibility standards for long-term care (LTC) services.

(4) Current income and resource standard charts are found at ((~~http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources~~)) www.hca.wa.gov/

free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R § 155. WSR 17-03-116, § 182-515-1511, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as WAC 182-515-1511, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, section 6014 of the Deficit Reduction Act of 2005 (DRA), and 2010 1st sp.s. c 37 § 209(1). WSR 12-21-091, § 388-515-1511, filed 10/22/12, effective 11/22/12. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, and Washington state 2007-09 operating budget (SHB 1128). WSR 08-11-083, § 388-515-1511, filed 5/20/08, effective 6/20/08.]

AMENDATORY SECTION (Amending WSR 17-23-039, filed 11/8/17, effective 1/1/18)

WAC 182-515-1512 Home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA)—Financial eligibility if a client is eligible for a noninstitutional SSI-related categorically needy (CN) program. (1) A client is financially eligible for home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA) if:

(a) The client is receiving coverage under one of the following categorically needy (CN) medicaid programs:

(i) Supplemental security income (SSI) program under WAC 182-510-0001. This includes SSI clients under 1619(b) status; or

(ii) Health care for workers with disabilities (HWD) under chapter 182-511 WAC; or

(iii) SSI-related noninstitutional (CN) program under chapter 182-512 WAC; or

(iv) The foster care program under WAC 182-505-0211 and the client meets disability requirements under WAC 182-512-0050.

(b) The client does not have a penalty period of ineligibility for the transfer of an asset as under WAC 182-513-1363; and

(c) The client does not own a home with equity in excess of the requirements under WAC 182-513-1350.

(2) A client eligible under this section does not pay toward the cost of care, but must pay room and board if living in an alternate living facility (ALF) under WAC 182-513-1100.

(3) A client eligible under this section who lives in a department-contracted ALF described under WAC 182-513-1100:

(a) Keeps a personal needs allowance (PNA) under WAC 182-513-1105; and

(b) Pays towards room and board up to the room and board standard under WAC 182-513-1105.

(4) A client who is eligible under the HWD program must pay the HWD premium under WAC 182-511-1250, in addition to room and board if residing in an ALF.

(5) Current resource, income, PNA and room and board standards are found at ((~~www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources~~)) www.hca.wa.gov/

free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2017 c 270. WSR 17-23-039, § 182-515-1512, filed 11/8/17, effective 1/1/18. Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R § 155. WSR 17-03-116, § 182-515-1512, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as WAC 182-515-1512, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, section 6014 of the Deficit Reduction Act of 2005 (DRA), and 2010 1st sp.s. c 37 § 209(1). WSR 12-21-091, § 388-515-1512, filed 10/22/12, effective 11/22/12. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.575, 74.09.500, 74.09.530. WSR 08-24-069, § 388-515-1512, filed 12/1/08, effective 1/1/09. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, and Washington state 2007-09 operating budget (SHB 1128). WSR 08-11-083, § 388-515-1512, filed 5/20/08, effective 6/20/08.]

AMENDATORY SECTION (Amending WSR 17-03-116, filed 1/17/17, effective 2/17/17)

WAC 182-515-1513 Home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA)—Financial eligibility using SSI-related institutional rules. (1) If a person is not eligible for a categorically needy (CN) program under WAC 182-515-1512, the agency determines eligibility for home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA) using institutional medicaid rules. This section explains how a person may qualify using institutional rules.

(2) A person must meet:

(a) General eligibility requirements under WAC 182-513-1315 and 182-515-1511;

(b) Resource requirements under WAC 182-513-1350; and

(c) Have available income at or below the special income level (SIL) defined under WAC 182-513-1100.

(3) The agency determines available income and income exclusions according to WAC 182-513-1325, 182-513-1330, and 182-513-1340.

(4) A person eligible under this section is responsible to pay income toward the cost of care and room and board, as described under WAC 182-515-1514.

(5) Current resource, income standards are found at ((~~http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R § 155. WSR 17-03-116, § 182-515-1513, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as § 182-515-1513, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, section 6014 of the Deficit Reduction Act of 2005 (DRA), and 2010 1st sp.s. c 37 §

209(1). WSR 12-21-091, § 388-515-1513, filed 10/22/12, effective 11/22/12. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, and Washington state 2007-09 operating budget (SHB 1128). WSR 08-11-083, § 388-515-1513, filed 5/20/08, effective 6/20/08.]

AMENDATORY SECTION (Amending WSR 20-08-082, filed 3/27/20, effective 4/27/20)

WAC 182-515-1514 Home and community based (HCB) services authorized by the developmental disabilities administration (DDA)—Client financial responsibility. (1) A client eligible for home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA) under WAC 182-515-1513 must pay toward the cost of care and room and board under this section.

(a) Post-eligibility treatment of income, participation, and participate are all terms that refer to a client's responsibility towards cost of care.

(b) Room and board is a term that refers to a client's responsibility toward food and shelter in an alternate living facility (ALF).

(2) The agency determines how much a client must pay toward the cost of care for home and community based (HCB) waiver services authorized by the DDA when the client is living at home, as follows:

(a) A single client who lives at home (as defined in WAC 388-106-0010) keeps a personal needs allowance (PNA) of up to the special income level (SIL) defined under WAC 182-513-1100.

(b) A single client who lives at home on the roads to community living program authorized by DDA keeps a PNA up to the SIL but must pay any remaining available income toward cost of care after allowable deductions described in subsection (4) of this section.

(c) A married client who lives with the client's spouse at home (as defined in WAC 388-106-0010) keeps a PNA of up to the SIL but must pay any remaining available income toward cost of care after allowable deductions under subsection (4) of this section.

(d) A married couple living at home where each client receives HCB waiver services, one authorized by DDA and the other authorized by home and community services (HCS) is allowed the following:

(i) The client authorized by DDA keeps a PNA of up to the SIL but must pay any remaining available income toward the client's cost of care after allowable deductions in subsection (4) of this section; and

(ii) The client authorized by HCS pays toward the cost of care under WAC 182-515-1507 or 182-515-1509.

(3) The agency determines how much a client must pay toward the cost of care for HCB wavier services authorized by DDA and room and board when the client is living in a department-contracted ALF defined under WAC 182-513-1100. A client:

(a) Keeps a PNA under WAC 182-513-1105;

(b) Pays room and board up to the room and board standard under WAC 182-513-1105; and

(c) Pays the remainder of available income toward the cost of care after allowable deductions under subsection (4) of this section.

(4) If income remains after the PNA and room and board liability under subsection (2) or (3) of this section, the remaining available

income must be paid toward the cost of care after it is reduced by allowable deductions in the following order:

(a) An earned income deduction of the first $65, plus one-half of the remaining earned income;

(b) Guardianship fees and administrative costs including any attorney fees paid by the guardian only as allowed under chapter 388-79A WAC;

(c) Current or back child support garnished or withheld from the client's income according to a child support order in the month of the garnishment if it is for the current month. If the agency allows this as a deduction from income, the agency does not count it as the child's income when determining the family allocation amount in WAC 182-513-1385;

(d) A monthly maintenance-needs allowance for the community spouse under WAC 182-513-1385. If the community spouse is on long-term care services, the allocation is limited to an amount that brings the community spouse's income to the community spouse's PNA;

(e) A monthly maintenance-needs allowance for each dependent of the institutionalized client, or the client's spouse, as calculated under WAC 182-513-1385; and

(f) Incurred medical expenses which have not been used to reduce excess resources. Allowable medical expenses are under WAC 182-513-1350.

(5) The total of the following deductions cannot exceed the SIL defined under WAC 182-513-1100:

(a) The PNA described in subsection (2) or (3) of this section, including room and board;

(b) The earned income deduction in subsection (4)(a) of this section; and

(c) The guardianship fees and administrative costs in subsection (4)(b) of this section.

(6) A client may have to pay third-party resources defined under WAC 182-513-1100 in addition to the room and board and participation.

(7) A client must pay the client's provider the sum of the room and board amount, the cost of care after all allowable deductions, and any third-party resources defined under WAC 182-513-1100.

(8) A client on HCB waiver services does not pay more than the state rate for cost of care.

(9) When a client lives in multiple living arrangements in a month, the agency allows the highest PNA available based on all the living arrangements and services the client has received in a month.

(10) Standards described in this section are found at ((~~www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 20-08-082, § 182-515-1514, filed 3/27/20, effective 4/27/20. Statutory Authority: RCW 41.05.021, 41.05.160, 2017 c 270. WSR 17-23-039, § 182-515-1514, filed 11/8/17, effective 1/1/18. Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R § 155. WSR 17-03-116, § 182-515-1514, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as § 182-515-1514, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, section 6014 of the Deficit Reduction Act of 2005 (DRA), and 2010 1st sp.s. c 37 § 209(1). WSR 12-21-091, §

388-515-1514, filed 10/22/12, effective 11/22/12. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.575, 74.09.500, 74.09.530. WSR 08-24-069, § 388-515-1514, filed 12/1/08, effective 1/1/09. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, and Washington state 2007-09 operating budget (SHB 1128). WSR 08-11-083, § 388-515-1514, filed 5/20/08, effective 6/20/08.]

OTS-4212.1

AMENDATORY SECTION (Amending WSR 22-21-043, filed 10/11/22, effective 1/1/23)

WAC 182-517-0100 Federal medicare savings programs. (1) Available programs. The medicaid agency offers eligible clients the following medicare savings programs (MSPs):

(a) The qualified medicare beneficiary (QMB) program;

(b) The specified low-income medicare beneficiary (SLMB) program;

(c) The qualified individual (QI-1) program; and

(d) The qualified disabled and working individuals (QDWI) program.

(2) Eligibility requirements.

(a) To be eligible for an MSP, a client must:

(i) Be entitled to medicare Part A; and

(ii) Meet the general eligibility requirements under WAC 182-503-0505.

(b) To be eligible for QDWI, a client must be under age 65.

(c) Income limits.

(i) Income limits for all MSPs are found at ((~~https://www.hca.wa.gov/health-care-services-and-supports/program-administration/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

(ii) If a client's countable income is less than or equal to 100 percent of the federal poverty level (FPL), the client is income eligible for the QMB program.

(iii) If a client's countable income is over 100 percent of the FPL, but does not exceed 120 percent of the FPL, the client is income eligible for the SLMB program.

(iv) If a client's countable income is over 120 percent of the FPL, but does not exceed 135 percent of the FPL, the client is income eligible for the QI-1 program.

(v) If a client's countable income is over 135 percent of the FPL, but does not exceed 200 percent of the FPL, the client is income eligible for the QDWI program if the client is employed and meets disability requirements described in WAC 182-512-0050.

(d) The federal MSPs do not require a resource test.

(3) MSP income eligibility determinations.

(a) The agency has two methods for determining if a client is eligible for an MSP:

(i) The agency first determines if the client is eligible based on SSI-rated methodologies under chapter 182-512 WAC. Under this method, the agency calculates the household's net countable income and compares the result to the one-person standard. However, if the spou-

se's income is deemed to the client, or if both spouses are applying, the household's net countable income is compared to the two-person standard.

(ii) If the client is not eligible under the methodology described in (a)(i) of this subsection, the agency compares the same countable income, as determined under (a)(i) of this subsection, to the appropriate FPL standard based on family size. The number of individuals that count for family size include:

(A) The client;

(B) The client's spouse who lives with the client;

(C) The client's dependents who live with the client;

(D) The spouse's dependents who live with the spouse, if the spouse lives with the client; and

(E) Any unborn children of the client, or of the spouse if the spouse lives with the client.

(b) Under both eligibility determinations, the agency follows the rules for SSI-related people under chapter 182-512 WAC for determining:

(i) Countable income;

(ii) Availability of income;

(iii) Allowable income deductions and exclusions; and

(iv) Deemed income from and allocated income to a nonapplying spouse and dependents.

(c) The agency uses the eligibility determination that provides the client with the highest level of coverage.

(i) If the MSP applicant is eligible for QMB coverage under (a)(i) of this subsection, the agency approves the coverage.

(ii) If the MSP applicant is not eligible for QMB coverage, the agency determines if the applicant is eligible under (a)(ii) of this subsection.

(iii) If neither eligibility determination results in QMB coverage, the agency uses the same process to determine if the client is eligible under any other MSP.

(d) When calculating income under this section:

(i) The agency subtracts client participation from a long-term care client's countable income under WAC 182-513-1380, 182-515-1509, or 182-515-1514.

(ii) The agency counts the annual Social Security cost-of-living increase beginning April 1st each year.

(4) Covered costs.

(a) The QMB program pays:

(i) Medicare Part A and Part B premiums using the start date in WAC 182-504-0025; and

(ii) Medicare coinsurance, copayments, and deductibles for Part A, Part B, and Part C, subject to the limitations in WAC 182-502-0110.

(b) If the client is eligible for both SLMB and another medicaid program:

(i) The SLMB program pays the Part B premiums using the start date in WAC 182-504-0025; and

(ii) The medicaid program pays medicare coinsurance, copayments, and deductibles for Part A, Part B, and Part C subject to the limitations in WAC 182-502-0110.

(c) If the client is only eligible for SLMB, the SLMB program covers medicare Part B premiums using the start date in WAC 182-504-0025.

(d) The QI-1 program pays medicare Part B premiums using the start date in WAC 182-504-0025 until the agency's federal funding al-

lotment is spent. The agency resumes QI-1 benefit payments the beginning of the next calendar year.

(e) The QDWI program covers medicare Part A premiums using the start date in WAC 182-504-0025.

(5) MSP eligibility. Medicaid eligibility may affect MSP eligibility:

(a) QMB and SLMB clients may receive medicaid and still be eligible to receive QMB or SLMB benefits.

(b) QI-1 and QDWI clients who begin receiving medicaid are no longer eligible for QI-1 or QDWI benefits, but may be eligible for the state-funded medicare buy-in program under WAC 182-517-0300.

(6) Right to request administrative hearing. A person who disagrees with agency action under this section may request an administrative hearing under chapter 182-526 WAC.

[Statutory Authority: RCW 41.05.021, 41.05.160, and 2022 c 297 § 211(79). WSR 22-21-043, § 182-517-0100, filed 10/11/22, effective 1/1/23. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 19-12-085, § 182-517-0100, filed 6/4/19, effective 7/15/19; WSR 16-13-157, § 182-517-0100, filed 6/22/16, effective 7/23/16. WSR 11-23-091, recodified as § 182-517-0100, filed 11/17/11, effective 11/21/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500 and 42 U.S.C. 9902(2). WSR 06-16-026, § 388-478-0085, filed 7/24/06, effective 8/24/06; WSR 05-17-157, § 388-478-0085, filed 8/22/05, effective 9/22/05. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 42 U.S.C. 9902(2). WSR 04-17-076, § 388-478-0085, filed 8/13/04, effective 9/13/04. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530, and Section 673(2) (42 U.S.C. 9902(2)). WSR 01-18-056, § 388-478-0085, filed 8/30/01, effective 9/30/01; WSR 00-17-085, § 388-478-0085, filed 8/14/00, effective 9/14/00; WSR 99-19-005, § 388-478-0085, filed 9/3/99, effective 10/4/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. WSR 98-16-044, § 388-478-0085, filed 7/31/98, effective 9/1/98. Formerly WAC 388-517-1715, 388-517-1730, 388-517-1750 and 388-517-1770.]

WSR 22-23-083
EXPEDITED RULES
HEALTH CARE AUTHORITY
[Filed November 14, 2022, 10:22 a.m.]

Title of Rule and Other Identifying Information: WAC 182-513-1445 Designating a protected asset and required proof.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Correct a website address.

Reasons Supporting Proposal: The agency is amending the rule to correct the website address at which individuals will learn how to determine the value of a life estate. The correct address is https://www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/determining-value-life-estates.

Statutory Authority for Adoption: RCW 41.05.021, 41.06.160.

Statute Being Implemented: RCW 41.05.021, 41.06.160.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Health care authority, governmental.

Name of Agency Personnel Responsible for Drafting: Brian Jensen, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-0815; Implementation and Enforcement: Paige Lewis, P.O. Box 42722, Olympia, WA 98504-2722, 360-725-0757.

This notice meets the following criteria to use the expedited adoption process for these rules:

Corrects typographical errors, makes address or name changes, or clarifies language of a rule without changing its effect.

Explanation of the Reason the Agency Believes the Expedited Rule-Making Process is Appropriate: The expedited rule-making process is appropriate because the proposed rule corrects a typographical error.

NOTICE

THIS RULE IS BEING PROPOSED UNDER AN EXPEDITED RULE-MAKING PROCESS THAT WILL ELIMINATE THE NEED FOR THE AGENCY TO HOLD PUBLIC HEARINGS, PREPARE A SMALL BUSINESS ECONOMIC IMPACT STATEMENT, OR PROVIDE RESPONSES TO THE CRITERIA FOR A SIGNIFICANT LEGISLATIVE RULE. IF YOU OBJECT TO THIS USE OF THE EXPEDITED RULE-MAKING PROCESS, YOU MUST EXPRESS YOUR OBJECTIONS IN WRITING AND THEY MUST BE SENT TO Rules Coordinator, Health Care Authority, P.O. Box 42716, Olympia, WA 98504-2716, phone 360-725-1306, fax 360-586-9272, email arc@hca.wa.gov, AND RECEIVED BY January 24, 2023.

November 14, 2022
Wendy Barcus
Rules Coordinator

OTS-4177.1

AMENDATORY SECTION (Amending WSR 17-03-116, filed 1/17/17, effective 2/17/17)

WAC 182-513-1445 Designating a protected asset and required proof. (1) Complete a department of social and health services (DSHS) 10-438 long-term care partnership (LTCP) asset designation form list-

ing assets and the full fair market value that are earmarked as protected at the time of initial application for long-term services and supports under medicaid.

(a) The full fair market value (FMV) of real property or interests in real property will be based on the current assessed value for property tax purposes for real property. A professional appraisal by a licensed appraiser can establish the current value if the assessed value is disputed.

(b) The value of a life estate in real property is determined using the life estate tables found at ((~~http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/determining-value-life-estates~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/determining-value-life-estates.

(c) If you own an asset with others, you can designate the value of your pro rata equity share.

(d) If the dollar amount of the benefits paid under a LTCP policy is greater than the fair market value of all assets protected at the time of the application for long-term care medicaid, you may designate additional assets for protection under this section. The DSHS LTCP asset designation form must be submitted with the updated assets indicated along with proof of the current value of designated assets.

(e) The value of your assets protected for you under your LTC partnership policy do not carry over to your spouse should the spouse need medicaid LTC services during or after your lifetime. If your surviving spouse has an LTC partnership policy the spouse may designate assets based on the dollar amount paid under the spouse's own policy.

(f) Assets designated as protected under this subsection will not be subject to transfer penalties under WAC 182-513-1363.

(2) Proof of the current fair market value of all protected assets is required at the initial application and each annual review.

(3) Submit current verification from the issuer of the LTCP policy of the current dollar value paid toward LTC benefits. This verification is required at application and each annual eligibility review.

(4) Any person or the personal representative of the person's estate who asserts that an asset is protected has the initial burden of:

(a) Documenting and proving by convincing evidence that the asset or source of funds for the asset in question was designated as protected;

(b) Demonstrating the value of the asset and the proceeds of the asset beginning from the time period the LTC partnership has paid out benefits to the present; and

(c) Documenting that the asset or proceeds of the asset remained protected at all times.

[Statutory Authority: RCW 41.05.021, 41.05.160, P.L. 111-148, 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 17-03-116, § 182-513-1445, filed 1/17/17, effective 2/17/17. WSR 13-01-017, recodified as § 182-513-1445, filed 12/7/12, effective 1/1/13. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, section 6014 of the Deficit Reduction Act of 2005, WAC 284-83-140, 284-83-400, 284-83-405, 284-83-410, 284-83-415, 284-83-420, and chapter 48.83 RCW. WSR 11-23-106, § 388-513-1445, filed 11/18/11, effective 12/19/11.]

WSR 22-23-084
EXPEDITED RULES
HEALTH CARE AUTHORITY
[Filed November 14, 2022, 10:24 a.m.]

Title of Rule and Other Identifying Information: WAC 182-501-0215 Wraparound with intensive services (WISe) and 182-502-0022 Provider preventable conditions (PPCs)——Payment policy.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Correct a website address.

Reasons Supporting Proposal: The agency is amending WAC 182-501-0215 to correct the wraparound with intensive services (WISe) website address. The correct address is https://www.hca.wa.gov/billers-providers-partners/program-information-providers/wraparound-intensive-services-wise. The agency is amending WAC 182-502-0022 to correct the agency's forms and publications website address. The correct address is https://www.hca.wa.gov/billers-providers-partners/forms-and-publications.

Statutory Authority for Adoption: RCW 41.05.021, 41.06.160.

Statute Being Implemented: RCW 41.05.021, 41.06.160.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Health care authority, governmental.

Name of Agency Personnel Responsible for Drafting, Implementation, and Enforcement: Brian Jensen, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-0815.

This notice meets the following criteria to use the expedited adoption process for these rules:

Corrects typographical errors, makes address or name changes, or clarifies language of a rule without changing its effect.

Explanation of the Reason the Agency Believes the Expedited Rule-Making Process is Appropriate: The expedited rule-making process is appropriate because the proposed rules only correct typographical errors.

NOTICE

THIS RULE IS BEING PROPOSED UNDER AN EXPEDITED RULE-MAKING PROCESS THAT WILL ELIMINATE THE NEED FOR THE AGENCY TO HOLD PUBLIC HEARINGS, PREPARE A SMALL BUSINESS ECONOMIC IMPACT STATEMENT, OR PROVIDE RESPONSES TO THE CRITERIA FOR A SIGNIFICANT LEGISLATIVE RULE. IF YOU OBJECT TO THIS USE OF THE EXPEDITED RULE-MAKING PROCESS, YOU MUST EXPRESS YOUR OBJECTIONS IN WRITING AND THEY MUST BE SENT TO Rules Coordinator, Health Care Authority, P.O. Box 42716, Olympia, WA 98504-2716, phone 360-725-1306, fax 360-586-9272, email arc@hca.wa.gov, AND RECEIVED BY January 24, 2023.

November 14, 2022
Wendy Barcus
Rules Coordinator

OTS-4172.1

AMENDATORY SECTION (Amending WSR 22-08-013, filed 3/24/22, effective 4/24/22)

WAC 182-501-0215 Wraparound with intensive services (WISe). (1) Wraparound with intensive services (WISe) is a service delivery model that provides comprehensive behavioral health covered services and support to:

(a) Clients age 20 or younger with complex behavioral health needs who are eligible for coverage under WAC 182-505-0210; and

(b) Their families.

(2) The authority, the managed care organizations, and the WISe provider agencies must use, continue to use, and substantially comply with the WISe quality plan (WISe QP) for the delivery of WISe. The purpose of the WISe QP is to:

(a) Provide a framework for quality management goals, objectives, processes, tools, and resources to measure the implementation and success of the WISe service delivery model; and

(b) Guide production, dissemination, and use of measures used to inform and improve WISe service delivery.

(3) The WISe QP, as may be amended from time to time, is incorporated by reference and is available online at ((~~https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/wraparound-intensive-services-wise~~)) www.hca.wa.gov/billers-providers-partners/program-information-providers/wraparound-intensive-services-wise.

[Statutory Authority: RCW 41.05.021, 41.05.160, and Thurston County Superior Court in A.G.C. v. Washington State Health Care Authority, no. 21-2-00479-34. WSR 22-08-013, § 182-501-0215, filed 3/24/22, effective 4/24/22. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 20-15-026, § 182-501-0215, filed 7/7/20, effective 8/7/20.]

OTS-4173.1

AMENDATORY SECTION (Amending WSR 19-08-037, filed 3/28/19, effective 4/28/19)

WAC 182-502-0022 Provider preventable conditions (PPCs)—Payment policy. (1) This section establishes the agency's payment policy for services provided to medicaid clients on a fee-for-service basis or to a client enrolled in a managed care organization (defined in WAC 182-538-050) by health care professionals and inpatient hospitals that result in provider preventable conditions (PPCs).

(2) The rules in this section apply to:

(a) All health care professionals who bill the agency directly; and

(b) Inpatient hospitals.

(3) Definitions. The following definitions and those found in chapter 182-500 WAC apply to this section:

(a) **Agency** - See WAC 182-500-0010.

(b) **Health care-acquired conditions (HCAC)** - A condition occurring in any inpatient hospital setting (identified as a hospital ac-

quired condition by medicare other than deep vein thrombosis/pulmonary embolism as related to a total knee replacement or hip replacement surgery in pediatric and obstetric patients.) Medicare's list of hospital acquired conditions is also available at((÷)) http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Hospital-Acquired_Conditions.html.

(c) **Other provider preventable conditions (OPPC)** - The list of serious reportable events in health care as identified by the department of health in WAC 246-302-030 and published by the National Quality Forum.

(d) **Present on admission (POA) indicator** - A status code the hospital uses on an inpatient claim that indicates if a condition was present at the time the order for inpatient admission occurs.

(e) **Provider preventable condition (PPC)** - An umbrella term for hospital and nonhospital acquired conditions identified by the agency for nonpayment to ensure the high quality of medicaid services. PPCs include two distinct categories: Health care-acquired conditions (HCACs) and other provider-preventable conditions (OPPCs).

(4) **Health care-acquired condition (HCAC)** - The agency will deny or recover payment to health care professionals and inpatient hospitals for care related only to the treatment of the consequences of a HCAC.

(a) HCAC conditions include:

(i) Foreign object retained after surgery;

(ii) Air embolism;

(iii) Blood incompatibility;

(iv) Stage III and IV pressure ulcers;

(v) Falls and trauma:

(A) Fractures;

(B) Dislocations;

(C) Intracranial injuries;

(D) Crushing injuries;

(E) Burns;

(F) Other injuries.

(vi) Manifestations of poor glycemic control:

(A) Diabetic ketoacidosis;

(B) Nonketotic hyperosmolar coma;

(C) Hypoglycemic coma;

(D) Secondary diabetes with ketoacidosis;

(E) Secondary diabetes with hyperosmolarity.

(vii) Catheter-associated urinary tract infection (UTI);

(viii) Vascular catheter-associated infection;

(ix) Surgical site infection, mediastinitis, following coronary artery bypass graft (CABG);

(x) Surgical site infection following bariatric surgery for obesity:

(A) Laparoscopic gastric bypass;

(B) Gastroenterostomy; or

(C) Laparoscopic gastric restrictive surgery.

(xi) Surgical site infection following certain orthopedic procedures:

(A) Spine;

(B) Neck;

(C) Shoulder;

(D) Elbow.

(xii) Surgical site infection following cardiac implantable electronic device (CIED).

(xiii) Deep vein thrombosis/pulmonary embolism (DVT/PE) following certain orthopedic procedures:

(A) Total knee replacement; or

(B) Hip replacement.

(xiv) Latrogenic pneumothorax with venous catheterization.

(b) Hospitals must include the present on admission (POA) indicator when submitting inpatient claims for payment. The POA indicator is to be used according to the official coding guidelines for coding and reporting and the CMS guidelines. The POA indicator may prompt a review, by the agency or the agency's designee, of inpatient hospital claims with an HCAC diagnosis code when appropriate according to the CMS guidelines. The agency will identify professional claims using the information provided on the hospital claims.

(c) HCACs are based on current medicare inpatient prospective payment system rules with the inclusion of POA indicators. Health care professionals and inpatient hospitals must report HCACs on claims submitted to the agency for consideration of payment.

(5) **Other provider preventable condition (OPPC)** - The agency will deny or recoup payment to health care professionals and inpatient hospitals for care related only to the treatment of consequences of an OPPC when the condition:

(a) Could have reasonably been prevented through the application of nationally recognized evidence based guidelines;

(b) Is within the control of the hospital;

(c) Occurred during an inpatient hospital admission;

(d) Has a negative consequence for the beneficiary;

(e) Is auditable; and

(f) Is included on the list of serious reportable events in health care as identified by the department of health in WAC 246-302-030 effective on the date the incident occurred. The list of serious reportable events in health care, as of the publishing of this rule, includes:

(i) Surgical or invasive procedure events:

(A) Surgical or other invasive procedure performed on the wrong site;

(B) Surgical or other invasive procedure performed on the wrong patient;

(C) Wrong surgical or other invasive procedure performed on a patient;

(D) Unintended retention of a foreign object in a patient after surgery or other invasive procedure;

(E) Intraoperative or immediately postoperative/postprocedure death in an ASA Class 1 patient.

(ii) Product or device events:

(A) Patient death or serious injury associated with the use of contaminated drugs, devices, or biologics provided by the hospital;

(B) Patient death or serious injury associated with the use or function of a device in patient care, in which the device is used or functions other than as intended;

(C) Patient death or serious injury associated with intravascular air embolism that occurs while being cared for in a hospital.

(iii) Patient protection events:

(A) Discharge or release of a patient/resident of any age, who is unable to make decisions, to other than an authorized person;

(B) Patient death or serious injury associated with patient elopement;

(C) Patient suicide, attempted suicide, or self-harm that results in serious injury, while being cared for in a hospital.

(iv) Care management events:

(A) Patient death or serious injury associated with a medication error (e.g., errors involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparation, or wrong route of administration);

(B) Patient death or serious injury associated with unsafe administration of blood products;

(C) Maternal death or serious injury associated with labor or delivery in a low-risk pregnancy while being cared for in a hospital;

(D) Death or serious injury of a neonate associated with labor or delivery in a low-risk pregnancy;

(E) Patient death or serious injury associated with a fall while being cared for in a hospital;

(F) Any stage 3, stage 4, or unstageable pressure ulcers acquired after admission/presentation to a hospital (not present on admission);

(G) Patient death or serious injury resulting from the irretrievable loss of an irreplaceable biological specimen;

(H) Patient death or serious injury resulting from failure to follow-up or communicate laboratory, pathology, or radiology test results.

(v) Environmental events:

(A) Patient death or serious injury associated with an electric shock in the course of a patient care process in a hospital;

(B) Any incident in which systems designated for oxygen or other gas to be delivered to a patient contains no gas, the wrong gas, or is contaminated by toxic substances;

(C) Patient death or serious injury associated with a burn incurred from any source in the course of a patient care process in a hospital;

(D) Patient death or serious injury associated with the use of physical restraints or bedrails while being cared for in a hospital.

(vi) Radiologic events: Death or serious injury of a patient associated with the introduction of a metallic object into the magnetic resonance imaging (MRI) area.

(vii) Potential criminal event:

(A) Any instance of care ordered by or provided by someone impersonating a physician, nurse, pharmacist, or other licensed health care provider;

(B) Abduction of a patient of any age;

(C) Sexual abuse/assault on a patient within or on the grounds of a health care setting;

(D) Death or serious injury of a patient resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a health care setting.

(6) Reporting PPCs.

(a) The agency requires inpatient hospitals to report PPCs (as appropriate according to (d) and (e) of this subsection) to the agency by using designated present on admission (POA) indicator codes and appropriate HCPCs modifiers that are associated:

(i) With claims for medical assistance payment; or

(ii) With courses of treatment furnished to clients for which medical assistance payment would otherwise be available.

(b) Health care professionals and inpatient hospitals must report PPCs associated with medicaid clients to the agency even if the provider does not intend to bill the agency.

(c) Use of the appropriate POA indicator codes informs the agency of the following:

(i) A condition was present at the time of inpatient hospital admission or at the time the client was first seen by the health care professional or hospital; or

(ii) A condition occurred during admission or encounter with a health care professional either inpatient or outpatient.

(d) Hospitals must notify the agency of an OPPC associated with an established medicaid client within ((~~forty-five~~)) 45 calendar days of the confirmed OPPC in accordance with RCW 70.56.020. If the client's medicaid eligibility status is not known or established at the time the OPPC is confirmed, the agency allows hospitals ((~~thirty~~)) 30 days to notify the agency once the client's eligibility is established or known.

(i) Notification must be in writing, addressed to the agency's office of program integrity, and include the OPPC, date of service, client identifier, and the claim number if the facility submits a claim to the agency.

(ii) Hospitals must complete the appropriate portion of the HCA 12-200 form to notify the agency of the OPPC. Agency forms are available for download at((÷)) https://www.hca.wa.gov/billers-providers-partners/forms-and-publications.

(e) Health care professionals or designees responsible for or may have been associated with the occurrence of a PPC involving a medicaid client must notify the agency within ((~~forty-five~~)) 45 calendar days of the confirmed PPC in accordance with chapter 70.56 RCW. Notifications must be in writing, addressed to the agency's chief medical officer, and include the PPC, date of service, and client identifier. Providers must complete the appropriate portion of the HCA 12-200 form to notify the agency of the PPC. Agency forms are available for download at((~~: http://www.hca.wa.gov/medicaid/forms/Pages/index.aspx~~)) www.hca.wa.gov/billers-providers-partners/forms-and-publications.

(f) Failure to report, code, bill or claim PPCs according to the requirements in this section will result in loss or denial of payments.

(7) Identifying PPCs. The agency may identify PPCs as follows:

(a) Through the department of health (DOH); or

(b) Through the agency's program integrity efforts, including:

(i) The agency's claims payment system;

(ii) Retrospective hospital utilization review process (see WAC 182-550-1700);

(iii) The agency's provider payment review process (see WAC 182-502-0230);

(iv) The agency's provider audit process (see chapter 182-502A WAC); and

(v) A provider or client complaint.

(8) Payment adjustment for PPCs. The agency or its designee conducts a review of the PPC prior to reducing or denying payment.

(a) The agency does not reduce, recoup, or deny payment to a provider for a PPC when the condition:

(i) Existed prior to the initiation of treatment for that client by that provider. Documentation must be kept in the client's clinical record to clearly support that the PPC existed prior to initiation of treatment; or

(ii) Is directly attributable to a comorbid condition(s).

(b) The agency reduces payment to a provider when the following applies:

(i) The identified PPC would otherwise result in an increase in payment; and

(ii) The portion of the professional services payment directly related to the PPC, or treatment of the PPC, can be reasonably isolated for nonpayment.

(c) The agency does not make additional payments for services on claims for covered health care services that are attributable to HCACs and/or are coded with POA indicator codes "N" or "U."

(d) Medicare crossover claims. The agency applies the following rules for these claims:

(i) If medicare denies payment for a claim at a higher rate for the increased costs of care under its PPC policies:

(A) The agency limits payment to the maximum allowed by medicare;

(B) The agency does not pay for care considered nonallowable by medicare; and

(C) The client cannot be held liable for payment.

(ii) If medicare denies payment for a claim under its national coverage determination agency from Section 1862 (a)(1)(A) of the Social Security Act (42 U.S.C. 1395) for an adverse health event:

(A) The agency does not pay the claim, any medicare deductible or any coinsurance related to the inpatient hospital and health care professional services; and

(B) The client cannot be held liable for payment.

(9) The agency will calculate its reduction, denial or recoupment of payment based on the facts of each OPPC or HCAC. Any overpayment applies only to the health care professional or hospital where the OPPC or HCAC occurred and does not apply to care provided by other health care professionals and inpatient hospitals, should the client subsequently be transferred or admitted to another hospital for needed care.

(10) Medicaid clients are not liable for payment of an item or service related to an OPPC or HCAC or the treatment of consequences of an OPPC or HCAC that would have been otherwise payable by the agency, and must not be billed for any item or service related to a PPC.

(11) Provider dispute process for PPCs.

(a) A health care professional or inpatient hospital may dispute the agency's reduction, denial or recoupment of payment related to a PPC as described in chapter 182-502A WAC.

(b) The disputing health care professional or inpatient hospital must provide the agency with the following information:

(i) The health care professional or inpatient hospital's assessment of the PPC; and

(ii) A complete copy of the client's medical record and all associated billing records, to include itemized statement or explanation of charges.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 19-08-037, § 182-502-0022, filed 3/28/19, effective 4/28/19. Statutory Authority: RCW 41.05.021. WSR 13-19-038, § 182-502-0022, filed 9/11/13, effective 10/12/13. Statutory Authority: 42 C.F.R. § 447.26. WSR 13-11-051, § 182-502-0022, filed 5/14/13, effective 7/1/13.]

WSR 22-23-106
EXPEDITED RULES
HEALTH CARE AUTHORITY
[Filed November 16, 2022, 11:34 a.m.]

Title of Rule and Other Identifying Information: WAC 182-550-1100 Hospital care—General, 182-550-1200 Restrictions on hospital coverage, 182-550-3000 Payment method, 182-550-3850 Budget neutrality adjustment and measurement, and 182-550-4300 Hospitals and units exempt from the DRG payment method.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The health care authority (HCA) is changing the name of the chemical-using pregnant (CUP) women program to substance-using pregnant people (SUPP) program. Due to this name change, HCA is fixing all references to the old program name in the above-mentioned rules.

Reasons Supporting Proposal: To make a name change.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Statute Being Implemented: RCW 41.05.021, 41.05.160.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Jason Crabbe, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-9563; Implementation and Enforcement: Melissa Craig, P.O. Box 45500, Olympia, WA 98504-5500, 360-725-0938.

Agency Comments or Recommendations, if any, as to Statutory Language, Implementation, Enforcement, and Fiscal Matters: Not applicable.

This notice meets the following criteria to use the expedited adoption process for these rules:

Corrects typographical errors, makes address or name changes, or clarifies language of a rule without changing its effect.

Explanation of the Reason the Agency Believes the Expedited Rule-Making Process is Appropriate: This rule making is for correction purposes only as allowed by RCW 34.05.353 (1)(c).

NOTICE

THIS RULE IS BEING PROPOSED UNDER AN EXPEDITED RULE-MAKING PROCESS THAT WILL ELIMINATE THE NEED FOR THE AGENCY TO HOLD PUBLIC HEARINGS, PREPARE A SMALL BUSINESS ECONOMIC IMPACT STATEMENT, OR PROVIDE RESPONSES TO THE CRITERIA FOR A SIGNIFICANT LEGISLATIVE RULE. IF YOU OBJECT TO THIS USE OF THE EXPEDITED RULE-MAKING PROCESS, YOU MUST EXPRESS YOUR OBJECTIONS IN WRITING AND THEY MUST BE SENT TO Rules Coordinator, HCA, P.O. Box 42716, Olympia, WA 98504-2716, phone 360-725-1306, fax 360-586-9272, email arc@hca.wa.gov, AND RECEIVED BY January 24, 2023.

November 16, 2022
Wendy Barcus
Rules Coordinator

OTS-4213.2

AMENDATORY SECTION (Amending WSR 21-15-128, filed 7/21/21, effective 8/21/21)

WAC 182-550-1100 Hospital care—General. (1) The medicaid agency:

(a) Pays for an eligible Washington apple health client's admission to a hospital only when the client's attending physician orders admission and when the admission and treatment provided:

(i) Are covered under WAC 182-501-0050, 182-501-0060 and 182-501-0065;

(ii) Are medically necessary as defined in WAC 182-500-0070;

(iii) Are determined according to WAC 182-501-0165 when prior authorization is required;

(iv) Are authorized when required under this chapter; and

(v) Meet applicable state and federal requirements.

(b) For hospital admissions, defines "attending physician" as the client's primary care provider, or the primary provider of care to the client at the time of admission.

(2) Medical record documentation of hospital services must meet the requirements in WAC 182-502-0020.

(3) The agency:

(a) Pays for a hospital covered service provided to an eligible apple health client enrolled in an agency-contracted managed care organization (MCO) plan, under the fee-for-service program if the service is excluded from the MCO's capitation contract with the agency and meets prior authorization requirements. (See WAC 182-550-2600 for inpatient psychiatric services.)

(b) Does not pay for nonemergency services provided to an apple health client from a nonparticipating hospital in a selective contracting area (SCA) unless exclusions in WAC 182-550-4700 apply. The agency's selective contracting program and selective contracting payment limitations end for hospital claims with dates of admission before July 1, 2007.

(4) The agency pays up to ((~~twenty-six~~)) 26 days of inpatient hospital care for hospital-based withdrawal management, medical stabilization, and drug treatment for chemical dependent pregnant clients eligible under the ((~~chemical-using pregnant (CUP) women~~)) substance-using pregnant people (SUPP) program.

See WAC 182-533-0701 through 182-533-0730.

(5) The agency pays for inpatient hospital withdrawal management of acute alcohol or other drug intoxication when the services are provided to an eligible client:

(a) In a withdrawal management unit in a hospital that has a withdrawal management provider agreement with the agency to perform these services and the services are approved by the division of behavioral health and recovery (DBHR) within the health care authority (HCA); or

(b) In an acute hospital and all the following criteria are met:

(i) The hospital does not have a withdrawal management specific provider agreement with DBHR;

(ii) The hospital provides the care in a medical unit;

(iii) Nonhospital-based withdrawal management is not medically appropriate for the client;

(iv) The client does not require medically necessary inpatient psychiatric care and it is determined that an approval from the agency or the agency's designee as an inpatient stay is not indicated;

(v) The client's stay qualifies as an inpatient stay;

(vi) The client is not participating in the agency's ((~~chemical-using pregnant (CUP) women~~)) substance-using pregnant people (SUPP) program; and

(vii) The client's principal diagnosis meets the agency's medical inpatient withdrawal management criteria listed in the agency's published billing instructions.

(6) The agency covers medically necessary dental-related services provided to an eligible client in a hospital-based dental clinic when the services:

(a) Are provided under chapter 182-535 WAC; and

(b) Are billed on the American Dental Association (ADA) or health care financing administration (HCFA) claim form.

(7) The agency pays a hospital for covered dental-related services, including oral and maxillofacial surgeries, that are provided in the hospital's operating room, when:

(a) The covered dental-related services are medically necessary and provided under chapter 182-535 WAC;

(b) The covered dental-related services are billed on a UB claim form; and

(c) At least one of the following is true:

(i) The dental-related service(s) is provided to an eligible apple health client on an emergency basis;

(ii) The client is eligible under the division of developmental disability program;

(iii) The client is age eight or younger; or

(iv) The dental service is prior authorized by the agency.

(8) For inpatient voluntary or involuntary psychiatric admissions, see WAC 182-550-2600.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 21-15-128, § 182-550-1100, filed 7/21/21, effective 8/21/21. Statutory Authority: RCW 41.05.021, 41.05.160, 2014 c 225. WSR 16-06-053, § 182-550-1100, filed 2/24/16, effective 4/1/16. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-18-065, § 182-550-1100, filed 8/27/15, effective 9/27/15. WSR 11-14-075, recodified as § 182-550-1100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-053, § 388-550-1100, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. WSR 01-16-142, § 388-550-1100, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090. WSR 01-02-075, § 388-550-1100, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-1100, filed 12/18/97, effective 1/18/98.]

AMENDATORY SECTION (Amending WSR 14-16-019, filed 7/24/14, effective 8/24/14)

WAC 182-550-1200 Restrictions on hospital coverage. A hospital covered service provided to a person eligible under a Washington apple health (WAH) program that is paid by the agency's fee-for-services payment system must be within the scope of the person's WAH program. Coverage restriction includes, but is not limited to the following:

(1) Persons enrolled with the agency's managed care organization (MCO) plans are subject to the respective plan's policies and procedures for coverage of hospital services;

(2) Persons covered by primary care case management are subject to the persons' primary care physicians' approval for hospital services;

(3) For emergency care exemptions for persons described in subsections (1) and (2) of this section, see WAC 182-538-100;

(4) Health care services provided by a hospital located out-of-state are:

(a) Not covered for persons eligible under the medical care services (MCS) program. However, persons eligible for MCS are covered for that program's scope of care in bordering city and critical border hospitals.

(b) Covered for:

(i) Emergency care for eligible medicaid and CHIP persons without prior authorization, based on the medical necessity and utilization review standards and limits established by the agency.

(ii) Nonemergency out-of-state care for medicaid and CHIP persons when prior authorized by the agency based on the medical necessity and utilization review standards and limits.

(iii) Hospitals in bordering cities and critical border hospitals, based on the same client eligibility criteria and authorization policies as for instate hospitals. See WAC 182-501-0175 for a list of bordering cities.

(c) Covered for out-of-state voluntary inpatient psychiatric hospital services for eligible medicaid and CHIP clients based on authorization by a division of behavioral health and recovery (DBHR) designee.

(5) See WAC 182-550-1100 for hospital services for ((~~chemical-using pregnant (CUP) women~~)) substance-using pregnant people (SUPP) program clients;

(6) All psychiatric inpatient hospital admissions, length of stay extensions, and transfers must be prior authorized by a DBHR designee. See WAC 182-550-2600;

(7) For persons eligible for both medicare and medicaid (dual eligibles), the agency pays deductibles and coinsurance, unless the person has exhausted his or her medicare Part A benefits. If medicare benefits are exhausted, the agency pays for hospitalization for such persons subject to agency rules. See also chapter 182-502 WAC;

(8) The agency does not pay for covered inpatient hospital services for a WAH client:

(a) Who is discharged from a hospital by a physician because the person no longer meets medical necessity for acute inpatient level of care; and

(b) Who chooses to stay in the hospital beyond the period of medical necessity.

(9) If the hospital's utilization review committee determines the person's stay is beyond the period of medical necessity, as described in subsection (8) of this section, the hospital must:

(a) Inform the person in a written notice that the agency is not responsible for payment (42 C.F.R. 456);

(b) Comply with the requirements in WAC 182-502-0160 in order to bill the person for the service(s); and

(c) Send a copy of the written notice in (a) of this subsection to the agency.

(10) Other coverage restrictions, as determined by the agency.

[Statutory Authority: RCW 41.05.021, 41.05.160, Public Law 111-148, 42 C.F.R. § 431, 435, and 457, and 45 C.F.R. § 155. WSR 14-16-019, § 182-550-1200, filed 7/24/14, effective 8/24/14. WSR 11-14-075, recodified as § 182-550-1200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 07-14-018, § 388-550-1200, filed 6/22/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 42 U.S.C. 1395 x(v), 42 C.F.R. 447.271, 447.11303, and 447.2652. WSR 99-06-046, § 388-550-1200, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-1200, filed 12/18/97, effective 1/18/98.]

AMENDATORY SECTION (Amending WSR 21-15-128, filed 7/21/21, effective 8/21/21)

WAC 182-550-3000 Payment method. (1) The medicaid agency uses the diagnosis-related group (DRG) payment method to pay for covered inpatient hospital services, except as specified in WAC 182-550-4300 and 182-550-4400.

(2) The agency assigns a DRG code to each claim for an inpatient hospital stay using 3M™ software (AP-DRG or APR-DRG) or other software currently in use by the agency. That DRG code determines the method used to pay claims for prospective payment system (PPS) hospitals. For the purpose of this section, PPS hospitals include all in-state and border area hospitals, except both of the following:

(a) Critical access hospitals (CAH), which the agency pays per WAC 182-550-2598; and

(b) Military hospitals, which the agency pays using the following payment methods depending on the revenue code billed by the hospital:

(i) Ratio of costs-to-charges (RCC); and

(ii) Military subsistence per diem.

(3) For each DRG code, the agency establishes an average length of stay (ALOS). The agency may use the DRG ALOS as part of its authorization process and payment methods as specified in this chapter.

(4) An inpatient claim payment includes all hospital covered services provided to a client during days the client is eligible. This includes, but is not limited to:

(a) The inpatient hospital stay;

(b) Outpatient hospital services, including preadmission, emergency department, and observation services related to an inpatient hospital stay and provided within one calendar day of a client's inpatient hospital stay. These outpatient services must be billed on the inpatient hospital claim;

(c) Any hospital covered service for which the admitting hospital sends the client to another facility or provider during the client's inpatient hospital stay, and the client returns as an inpatient to the admitting hospital.

(5) The agency's claim payment for an inpatient stay is determined by the payment method. The agency pays hospitals for inpatient hospital covered services provided to clients using the following methods:

Payment Method	General Description of Payment Formula	WAC Reference
DRG (Diagnostic Related Group)	DRG specific relative weight times hospital specific DRG rate times maximum service adjustor	182-550-3000
Per Diem	Hospital-specific daily rate for the service (psych, rehab, withdrawal management, or ((~~CUP~~)) SUPP) times covered allowable days	182-550-2600 and 182-550-3381
Fixed Per Diem for Long Term Acute Care (LTAC)	Fixed LTAC rate per day times allowed days plus ratio of cost to charges times allowable covered ancillaries not included in the daily rate	182-550-2595 and 182-550-2596
Ratio of Costs-to-Charges (RCC)	RCC times billed covered allowable charges	182-550-4500
Cost Settlement with Ratio of Costs-to-Charges	RCC times billed covered allowable charges (subject to hold harmless and other settlement provisions of the Certified Public Expenditure program)	182-550-4650 and 182-550-4670
Cost Settlement with Weighted Costs-to-Charges (WCC)	WCC times billed covered allowable charges subject to Critical Access Hospital settlement provisions	182-550-2598
Military	Depending on the revenue code billed by the hospital: • RCC times billed covered allowable charges; and • Military subsistence per diem.	182-550-4300
Administrative Day	Standard administrative day rate times days authorized by the agency combined with RCC times ancillary charges that are allowable and covered for administrative days	182-550-3381

(6) For claims paid using the DRG method, the payment may not exceed the billed amount.

(7) The agency may adjust the initial allowable calculated for a claim when one or more of the following occur:

(a) A claim qualifies as a high outlier (see WAC 182-550-3700);

(b) A claim is paid by the DRG method and a client transfers from one acute care hospital or distinct unit per WAC 182-550-3600;

(c) A client is not eligible for a Washington apple health program on one or more days of the hospital stay;

(d) A client has third-party liability coverage at the time of admission to the hospital or distinct unit;

(e) A client is eligible for Part B medicare, the hospital submitted a timely claim to medicare for payment, and medicare has made a payment for the Part B hospital charges;

(f) A client is discharged from an inpatient hospital stay and, within ((~~fourteen~~)) 14 calendar days, is readmitted as an inpatient to the same hospital or an affiliated hospital. The agency or the agency's designee performs a retrospective utilization review (see WAC 182-550-1700) on the initial admission and all readmissions to determine which inpatient hospital stays qualify for payment. The review may determine:

(i) If both admissions qualify for separate reimbursement;

(ii) If both admissions must be combined to be reimbursed as one payment; or

(iii) Which inpatient hospital stay qualifies for individual payment.

(g) A readmission is due to a complication arising from a previous admission (e.g., provider preventable condition described in WAC 182-502-0022). The agency or the agency's designee performs a retrospective utilization review to determine if both admissions are appropriate and qualify for individual payments; or

(h) The agency identifies an enhanced payment due to a provider preventable condition, hospital-acquired condition, serious reportable event, or a condition not present on admission.

(8) In response to direction from the legislature, the agency may change any one or more payment methods outlined in chapter 182-550 WAC for the purpose of achieving the legislature's targeted expenditure levels. The legislative direction may take the form of express language in the Biennial Appropriations Act or may be reflected in the level of funding appropriated to the agency in the Biennial Appropriations Act. In response to this legislative direction, the agency may calculate an adjustment factor (known as an "inpatient adjustment factor") to apply to inpatient hospital rates.

(a) The inpatient adjustment factor is a specific multiplier calculated by the agency and applied to existing inpatient hospital rates to meet targeted expenditure levels as directed by the legislature.

(b) The agency will apply the inpatient adjustment factor when the agency determines that its expenditures on inpatient hospital rates will exceed the legislature's targeted expenditure levels.

(c) The agency will apply any such inpatient adjustment factor to each affected rate.

(9) The agency does not pay for a client's day of absence from the hospital.

(10) The agency pays an interim billed hospital claim for covered inpatient hospital services provided to an eligible client only when the interim billed claim meets the criteria in WAC 182-550-2900.

(11) The agency applies to the allowable for each claim all applicable adjustments for client responsibility, any third-party liability, medicare payments, and any other adjustments as determined by the agency.

(12) The agency pays hospitals in designated bordering cities for allowed covered services as described under WAC 182-550-3900.

(13) The agency pays out-of-state hospitals for allowed covered services as described under WAC 182-550-4000.

(14) The agency's annual aggregate payments for inpatient hospital services, including payments to state-operated hospitals, will not exceed the estimated amounts that the agency would have paid using medicare payment principles.

(15) When hospital ownership changes, the agency's payment to the hospital will not exceed the amount allowed under 42 U.S.C. Section 1395x (v)(1)(O).

(16) Hospitals participating in the apple health program must annually submit to the agency:

(a) A copy of the hospital's CMS medicare cost report (Form 2552 version currently in use by the agency) that is the official "as filed" cost report submitted to the medicare fiscal intermediary; and

(b) A disproportionate share hospital (DSH) application if the hospital wants to be considered for DSH payments. See WAC 182-550-4900 for the requirements for a hospital to qualify for a DSH payment.

(17) Reports referred to in subsection (16) of this section must be completed according to:

(a) Medicare's cost reporting requirements;
(b) The provisions of this chapter; and
(c) Instructions issued by the agency.

(18) The agency requires hospitals to follow generally accepted accounting principles.

(19) Participating hospitals must permit the agency to conduct periodic audits of their financial records, statistical records, and any other records as determined by the agency.

(20) The agency limits payment for private room accommodations to the semiprivate room rate. Room charges must not exceed the hospital's usual and customary charges to the general public as required by 42 C.F.R. Sec. 447.271.

(21) For psychiatric hospitals and psychiatric hospital units, when a claim groups to a DRG code that pays by the DRG method, the agency may manually price the claim at the hospital's psychiatric per diem rate.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 21-15-128, § 182-550-3000, filed 7/21/21, effective 8/21/21; WSR 19-04-004, § 182-550-3000, filed 1/23/19, effective 3/1/19; WSR 18-11-074, § 182-550-3000, filed 5/16/18, effective 7/1/18; WSR 15-24-096, § 182-550-3000, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-12-047, § 182-550-3000, filed 5/29/14, effective 7/1/14. WSR 11-14-075, recodified as § 182-550-3000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 2009-11 Omnibus Operating Budget (ESHB 1244). WSR 09-12-063, § 388-550-3000, filed 5/28/09, effective 7/1/09. Statutory Authority: RCW 74.08.090 and 74.09.500. WSR 07-14-055, § 388-550-3000, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.04.050, 74.08.090. WSR 05-11-077, § 388-550-3000, filed 5/17/05, effective 6/17/05. Statutory Authority: RCW 74.08.090, 42 U.S.C. 1395 x(v), 42 C.F.R. 447.271, 447.11303, and 447.2652. WSR 99-06-046, § 388-550-3000, filed 2/26/99, effective 3/29/99. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-3000, filed 12/18/97, effective 1/18/98.]

AMENDATORY SECTION (Amending WSR 14-14-049, filed 6/25/14, effective 7/26/14)

WAC 182-550-3850 Budget neutrality adjustment and measurement. (1) The medicaid agency measures the effectiveness of budget neutral rebasing by applying a budget neutrality adjustment factor to the base payment rates for both inpatient and outpatient hospitals as needed to maintain aggregate payments under rebased payment systems.

(a) The agency performs budget-neutrality adjustments and measurement by prospectively adjusting conversion factors and rates to offset unintentional aggregate payment system decreases or increases. The agency publishes conversion factors and rates which reflect any required budget neutrality adjustment.

(b) The following rates and factors are not adjusted by the BNAF:
(i) Inpatient per diem;
(ii) Ratio of costs-to-charges (RCC);
(iii) Critical access hospital (CAH) weighted costs-to-charges (WCC);

(iv) Inpatient pain management and rehabilitation (PM&R);

(v) Per-case rates;

(vi) Administrative day rates;

(vii) Long-term acute care (LTAC);

(viii) ((~~Chemical-using pregnant women (CUP)~~)) Substance-using pregnant people (SUPP);

(ix) Outlier parameters;

(x) Outpatient services paid at the resource-based relative value scale (RBRVS) fee;

(xi) Outpatient corneal transplants; and

(xii) Diabetic education.

(2) The agency measures budget neutrality on an ongoing basis after rebased system implementation as follows:

(a) The agency gathers inpatient and outpatient claims and encounter data from the rebased system implementation date to the end of the measurement period.

(i) The first measurement period is the initial six months following rebased payment system implementation.

(ii) Additional measurement periods occur no more frequently than quarterly thereafter.

(iii) The agency performs a final measurement period for data received through June 30, 2016.

(b) The agency sums the aggregate payment amounts separately for inpatient and outpatient services. The agency will make the following adjustments to the base data:

(i) The agency removes any reductions due to third-party liability (TPL), client responsibility, and client spenddown from the payment summary;

(ii) The agency removes any increase awarded by RCW 74.09.611(2) from inpatient services;

(iii) The agency includes any outpatient service lines which are bundled under the enhanced ambulatory patient group (EAPG) system, but would be otherwise payable under the ambulatory payment classification (APC) system; and

(iv) Other adjustments as necessary.

(c) The agency processes all claims and encounters using the rates, factors, and policies which were in effect on June 30, 2014, with the following exceptions:

(i) The agency uses the RCC effective on the date of service;

(ii) The agency uses the most recent RBRVS values for any outpatient service paid using the RBRVS; and

(iii) The agency updates APC relative weights to reflect the most recent relative weights supplied by CMS;

(iv) The agency adjusts the outpatient budget target adjuster (BTA) to offset the inflation factor applied to OPPS in the CMS OPPS final rule; and

(v) The agency may include other adjustments as necessary to ensure accurate payment determination.

(d) The agency aggregates payment amounts calculated under (c) of this subsection separately for inpatient and outpatient services.

(3) The agency will modify the conversion factors and rates to reflect aggregate changes in the overall payment system as follows:

(a) If the amount calculated in subsection (2)(b) of this section is between ((~~ninety-nine~~)) 99 percent and ((~~one hundred one~~)) 101 percent of the amount calculated in subsection (2)(d) of this section, no adjustment will be made to the conversion factors and rates currently in effect;

(b) If the amount calculated in subsection (2)(b) of this section is greater than ((~~one hundred one~~)) 101 percent of the amount calculated in subsection (2)(d) of this section, the conversion factors and rates will be adjusted to reach a target expenditure of ((~~one hundred one~~)) 101 percent from the rebased payment system implementation date to the end of the subsequent six-month period;

(c) If the amount calculated in subsection (2)(b) of this section is less than ((~~ninety-nine~~)) 99 percent of the amount calculated in subsection (2)(d) of this section, the conversion factors and rates will be adjusted to reach a target expenditure decrease of ((~~ninety-nine~~)) 99 percent from the rebased payment system implementation date to the end of the subsequent six-month period.

(4) The agency applies adjustments to the BNAF to rates prospectively at the beginning of the calendar quarter following the measurement.

[Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-14-049, § 182-550-3850, filed 6/25/14, effective 7/26/14.]

AMENDATORY SECTION (Amending WSR 22-03-007, filed 1/6/22, effective 2/6/22)

WAC 182-550-4300 Hospitals and units exempt from the DRG payment method. (1) Except when otherwise specified, inpatient services provided by hospitals and units that are exempt from the diagnosis-related group (DRG) payment method are paid under the ratio of costs-to-charges (RCC) payment method described in WAC 182-550-4500, the per diem payment method described in WAC 182-550-3000, the per case rate payment method described in WAC 182-550-3000, or other payment methods identified in this chapter (e.g., long term acute care (LTAC), certified public expenditure (CPE), critical access hospital (CAH), etc.). Inpatient services provided by hospitals and units are exempt from the DRG payment method only if they qualify for payment methods specifically mentioned in other sections of this chapter or in this section.

(2) The agency exempts the following hospitals, units, and services from the DRG payment method for inpatient services provided to clients eligible for Washington apple health:

(a) Hospitals participating in the agency's certified public expenditure (CPE) payment program (see WAC 182-550-4650);

(b) Hospitals participating in the agency's critical access hospital program (see WAC 182-550-2598);

(c) Rehabilitation services. All rehabilitation services are paid through the per diem payment method except as indicated in (a), (b), and (d) of this subsection (see WAC 182-550-3000);

(d) Military hospitals when no other specific arrangements have been made with the agency. The agency, or the military hospital, may elect or arrange for one of the following payment methods in lieu of the RCC payment method:

(i) Per diem payment method; or

(ii) DRG payment method; and

(e) Psychiatric services. All psychiatric services are paid through the per diem payment method except as indicated in (a), (b), and (d) of this subsection (see WAC 182-550-3000). An agency designee that arranges to directly pay a hospital and/or a designated distinct

psychiatric unit of a hospital may use the agency's payment methods or contract with the hospital to pay using different methods.

(3) Inpatient psychiatric services, Involuntary Treatment Act services, and withdrawal management services provided in out-of-state hospitals are not covered or paid by the agency or the agency's designee. The agency does not cover or pay for other hospital services provided to clients eligible for those services in the following programs, when the services are provided in out-of-state hospitals that are not in designated bordering cities:

(a) Medical care services; and

(b) Other state-administered programs.

(4) The agency has established an average length of stay (ALOS) for each DRG classification and publishes it on the agency's website. The agency uses the DRG ALOS as a benchmark to authorize and pay inpatient hospital stays exempt from the DRG payment method. When an inpatient hospital stay exceeds the agency's DRG ALOS benchmark or prior authorized LOS:

(a) For a psychiatric inpatient stay, the hospital must obtain approval for additional days beyond the prior authorized days from the agency or the agency's designee who prior authorized the admission. See WAC 182-550-2600;

(b) For an acute physical medicine and rehabilitation (PM&R) or a long term acute care (LTAC) stay, the hospital must obtain approval for additional days beyond the prior authorized days from the agency unit that prior authorized the admission. See WAC 182-550-2561 and 182-550-2590;

(c) For an inpatient hospital stay for withdrawal management for a ((~~chemical using pregnant (CUP) client~~)) substance-using pregnant people (SUPP) program client, see WAC 182-550-1100;

(d) For other medical inpatient stays for withdrawal management, see WAC 182-550-1100;

(e) For an inpatient stay in a certified public expenditure (CPE) hospital, see WAC 182-550-4690; and

(f) For an inpatient hospital stay not identified in (a) through (e) of this subsection, the agency may perform retrospective utilization review to determine if the LOS was medically necessary and at the appropriate level of care.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 22-03-007, § 182-550-4300, filed 1/6/22, effective 2/6/22; WSR 21-15-128, § 182-550-4300, filed 7/21/21, effective 8/21/21. Statutory Authority: RCW 41.05.021 and chapter 74.60 RCW. WSR 14-12-047, § 182-550-4300, filed 5/29/14, effective 7/1/14. WSR 11-14-075, recodified as § 182-550-4300, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.500 and 2005 c 518. WSR 07-14-051, § 388-550-4300, filed 6/28/07, effective 8/1/07. Statutory Authority: RCW 74.08.090, 74.09.500. WSR 06-08-046, § 388-550-4300, filed 3/30/06, effective 4/30/06. Statutory Authority: RCW 74.04.050, 74.08.090. WSR 05-12-132, § 388-550-4300, filed 6/1/05, effective 7/1/05. Statutory Authority: RCW 74.08.090 and 42 U.S.C. 1395x(v), 42 C.F.R. 447.271, .11303, and .2652. WSR 01-16-142, § 388-550-4300, filed 7/31/01, effective 8/31/01. Statutory Authority: RCW 74.08.090, 74.09.730, 74.04.050, 70.01.010, 74.09.200, [74.09.]500, [74.09.]530 and 43.20B.020. WSR 98-01-124, § 388-550-4300, filed 12/18/97, effective 1/18/98.]