WSR 21-13-049
PROPOSED RULES
HEALTH CARE AUTHORITY
[Filed June 11, 2021, 11:41 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 20-15-077.

Title of Rule and Other Identifying Information: WAC 182-507-0115 Alien emergency medical program and 182-507-0120 Alien medical for dialysis and cancer treatment, and treatment of life-threatening benign tumors.

Hearing Location(s): On July 27, 2021, at 10:00 a.m. In response to the coronavirus disease 2019 (COVID-19) public health emergency, the health care authority (HCA) is not providing a physical location for this hearing. This promotes social distancing and the safety of the residents of Washington state. A virtual public hearing, without a physical meeting space, will be held instead.

To attend the virtual public hearing, you must register in advance for this public hearing https://zoom.us/webinar/register/WN_wMJYBsAHTh2zJLDCJYIPhw. After registering, you will receive a confirmation email containing information about joining the public hearing.

Date of Intended Adoption: Not sooner than July 28, 2021.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by July 27, 2021.

Assistance for Persons with Disabilities: Contact Amber Lougheed, phone 360-725-1349, fax 360-586-9727, telecommunication[s] relay service 711, email amber.lougheed@hca.wa.gov, by July 16, 2021.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The agency is amending WAC 182-507-0115 to change the alien emergency medical program's scope of covered services to include testing, assessment, and treatment of conditions that pose a potential threat to public health. The agency is amending both WAC 182-507-0115 and 182-507-0120 to make housekeeping changes to rule language related to behavioral health.

Reasons Supporting Proposal: See purpose.

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: Brian Jensen, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-0815; Implementation and Enforcement: Ariel Pyrtek, P.O. Box 45534, Olympia, WA 98504-5534, 360-725-1919.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply to HCA rules unless requested by the joint administrative rules review committee or applied voluntarily.

The proposed rule does not impose more-than-minor costs on businesses. Following is a summary of the agency's analysis showing how costs were calculated. The proposed rule pertains to client program eligibility and does not impose any costs on businesses.

June 11, 2021
Wendy Barcus

OTS-2140.4

AMENDATORY SECTION (Amending WSR 12-24-038, filed 11/29/12, effective 12/30/12)

WAC 182-507-0115 Alien emergency medical program (AEM). (1) A person nineteen years of age or older who is not pregnant and meets the eligibility criteria under WAC 182-507-0110 is eligible for the alien emergency medical program's scope of covered services described in this section if the person meets ((~~(a) and (b) or (c)~~)) the requirements of (a) of this subsection, as well as the requirements of either (b), (c), or (d) of this subsection:

(a) The medicaid agency determines that the primary condition requiring treatment ((~~meets the definition of~~)) is an emergency medical condition as defined in WAC 182-500-0030, and the condition is confirmed through review of clinical records; and

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

(i) Inpatient;

(ii) Outpatient surgery;

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

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

(d) As clinically indicated, the person is receiving medically necessary diagnosis and treatment of the COVID-19 virus. The agency covers one physician visit provided in any outpatient setting, including the office or clinic setting, or via telemedicine/telehealth, to diagnose/treat and test as follows:

(i) If the test is positive, in addition to the services described in (b) of this subsection and subsection (2)(b) of this section, any medically necessary services (following applicable agency authorization requirements) to treat, including:

(A) Up to two follow-up office visits;

(B) Medications;

(C) Respiratory services and supplies; and

(D) Medical supplies.

(ii) If a test is negative, one follow-up office visit and any treatment described in (d)(i)(B) through (D) of this subsection, as a precautionary measure for an anticipated positive test result.

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

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

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

(i) Medications;

(ii) Laboratory, X-ray, and other diagnostics and the professional interpretations;

(iii) Medical equipment and supplies;

(iv) Anesthesia, surgical, and recovery services;

(v) Physician consultation, treatment, surgery, or evaluation services;

(vi) Therapy services;

(vii) Emergency medical transportation; and

(viii) Nonemergency ambulance transportation to transfer the person from a hospital to a long term acute care (LTAC) or an inpatient physical medicine and rehabilitation (PM&R) unit, if that admission is prior authorized by the agency or its designee as described in subsection (3) of this section.

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

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

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

(c) The admission is prior authorized according to LTAC and PM&R program rules (see WAC 182-550-2590 for LTAC and WAC 182-550-2561 for PM&R).

(4) The agency does not cover any services, regardless of setting, once the person is discharged from the hospital after being treated for a qualifying emergency medical condition authorized by the agency or its designee under this program. Exceptions:

(a) For inpatient hospital admissions to treat COVID-19 or complications thereof, the agency will cover up to two postdischarge follow-up visits and any medically necessary services under subsection (1)(d) of this section.

(b) Pharmacy services, drugs, devices, and drug-related supplies listed in WAC 182-530-2000, prescribed on the same day and associated with the qualifying visit or service (as described in subsection (1) of this section) will be covered for a one-time fill and retrospectively reimbursed according to pharmacy program rules.

(5) Medical necessity of inpatient psychiatric care in the hospital setting must be determined, and any admission must be authorized by the agency or the agency's ((~~inpatient mental health~~)) designee according to the requirements in WAC 182-550-2600.

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

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

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

(b) For an outpatient surgery or emergency room service the certification is only for the date of service. If the person is in the hospital overnight, the certification will be the admission date

through the discharge date. Upon release from the hospital, the person is no longer eligible for coverage.

(8) Under this program, any visit or service not meeting the criteria described in subsection (1) of this section is considered not within the scope of service categories as described in WAC 182-501-0060. This includes, but is not limited to:

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

(i) Laboratory X-ray, or other diagnostic procedures;

(ii) Physical, occupational, speech therapy, or audiology services;

(iii) Hospital clinic services; or

(iv) Emergency room visits, surgery, or hospital admissions.

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

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

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

(i) Office or clinic-based services rendered by a physician, an ARNP, or any other licensed practitioner;

(ii) Prenatal care, except labor and delivery;

(iii) Laboratory, radiology, and any other diagnostic testing;

(iv) School-based services;

(v) Personal care services;

(vi) Physical, respiratory, occupational, and speech therapy services;

(vii) Waiver services;

(viii) Nursing facility services;

(ix) Home health services;

(x) Hospice services;

(xi) Vision services;

(xii) Hearing services;

(xiii) Dental services;

(xiv) Durable and nondurable medical supplies;

(xv) Nonemergency medical transportation;

(xvi) Interpreter services; and

(xvii) Pharmacy services, except as described in subsection (4) of this section.

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

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

[Statutory Authority: RCW 41.05.021. WSR 12-24-038, § 182-507-0115, filed 11/29/12, effective 12/30/12. WSR 12-13-056, recodified as § 182-507-0115, filed 6/15/12, effective 7/1/12. Statutory Authority: RCW 74.04.050, 74.08.090, and 2009 c 564 §§ 1109, 201, 209. WSR 10-19-085, § 388-438-0115, filed 9/17/10, effective 10/18/10.]

AMENDATORY SECTION (Amending WSR 15-05-008, filed 2/5/15, effective 3/8/15)

WAC 182-507-0120 Alien medical for dialysis and cancer treatment, and treatment of life-threatening benign tumors. In addition to the provisions for emergency care described in WAC 182-507-0115, the medicaid agency also considers the conditions in this section as an emergency, as defined in WAC 182-500-0030.

(1) A person nineteen years of age or older who is not pregnant and meets the eligibility criteria under WAC 182-507-0110 may be eligible for the scope of service categories under this program if the condition requires:

(a) Surgery, chemotherapy, and/or radiation therapy to treat cancer or life-threatening benign tumors;

(b) Dialysis to treat acute renal failure or end stage renal disease (ESRD); or

(c) Antirejection medication, if the person has had an organ transplant.

(2) When related to treating the qualifying medical condition, covered services include but are not limited to:

(a) Physician and ARNP services, except when providing a service that is not within the scope of this medical program (as described in subsection (7) of this section);

(b) Inpatient and outpatient hospital care;

(c) Dialysis;

(d) Surgical procedures and care;

(e) Office or clinic based care;

(f) Pharmacy services;

(g) Laboratory, X-ray, or other diagnostic studies;

(h) Oxygen services;

(i) Respiratory and intravenous (IV) therapy;

(j) Anesthesia services;

(k) Hospice services;

(l) Home health services, limited to two visits;

(m) Durable and nondurable medical equipment;

(n) Nonemergency transportation; and

(o) Interpreter services.

(3) All hospice, home health, durable and nondurable medical equipment, oxygen and respiratory, IV therapy, and dialysis for acute renal disease services require prior authorization. Any prior authorization requirements applicable to the other services listed above must also be met according to specific program rules.

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

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

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

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

(a) Cancer screening or work-ups to detect or diagnose the presence of cancer or life-threatening benign tumors;

(b) Fistula placement while the person waits to see if dialysis will be required;

(c) Services provided by any health care professional to treat a condition not related to, or medically necessary to, treat the qualifying condition;

(d) Organ transplants, including preevaluations and post operative care;

(e) Health department services;

(f) School-based services;

(g) Personal care services;

(h) Physical, occupational, and speech therapy services;

(i) Audiology services;

(j) Neurodevelopmental services;

(k) Waiver services;

(l) Nursing facility services;

(m) Home health services, more than two visits;

(n) Vision services;

(o) Hearing services;

(p) Dental services, unless prior authorized and directly related to dialysis or cancer treatment;

(q) Mental health services;

(r) Podiatry services;

(s) Substance ((~~abuse~~)) use disorder (SUD) services; and

(t) Smoking cessation services.

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

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

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 15-05-008, § 182-507-0120, filed 2/5/15, effective 3/8/15. Statutory Authority: RCW 41.05.021. WSR 12-24-038, § 182-507-0120, filed 11/29/12, effective 12/30/12. WSR 12-13-056, recodified as § 182-507-0120, filed 6/15/12, effective 7/1/12. Statutory Authority: RCW 74.04.050, 74.08.090, and 2009 c 564 §§ 1109, 201, 209. WSR 10-19-085, § 388-438-0120, filed 9/17/10, effective 10/18/10.]