WSR 22-21-086
PERMANENT RULES
HEALTH CARE AUTHORITY

[Filed October 14, 2022, 10:01 a.m., effective November 14, 2022]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The agency is amending WAC 182-504-0005 and sections of chapter 182-500 WAC, Medical definitions, to implement requirements in RCW 74.09.830 regarding postpartum health care coverage. The amended rules will provide for retroactive postpartum coverage and define after-pregnancy coverage, continuous eligibility, and full scope coverage.

Citation of Rules Affected by this Order: Amending WAC 182-500-0010, 182-500-0020, 182-500-0035, and 182-504-0005.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Other Authority: RCW 74.09.830.

Adopted under notice filed as WSR 22-17-092 on August 18, 2022.

Changes Other than Editing from Proposed to Adopted Version:

Proposed/Adopted	WAC Subsection	Reason
WAC 182-504-0005 (2)(b)		
Proposed	(b) An individual who is applying within 12 months of their last pregnancy end date is eligible for after-pregnancy coverage in one of the three months immediately before the month of application. Eligibility continues as described in WAC 182-504-0015(4).	The agency changed "one" to "any" in the first sentence. In the second sentence the agency changed "Eligibility continues" to "Continuous eligibility begins from the earliest month the individual is found eligible" and added subsection (3) to the citation to WAC 182-504-0015. These changes clarify the intent of the rule, which is to allow an individual to qualify for continuous, full after-pregnancy coverage if they are eligible in any of the three months immediately before the application.
Adopted	(b) An individual who is applying within 12 months of their last pregnancy end date is eligible for after-pregnancy coverage in any of the three months immediately before the month of application. Continuous eligibility begins from the earliest month the individual is found eligible as described in WAC 182-504-0015 (3) and (4).	

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 4, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 4, Repealed 0.

Date Adopted: October 14, 2022.

Wendy Barcus
Rules Coordinator

OTS-3858.3

AMENDATORY SECTION (Amending WSR 16-02-122, filed 1/6/16, effective 2/6/16)

WAC 182-500-0010 Medical assistance definitions—A. "**Administrative renewal**" means the agency uses electronically available income data sources to verify and recertify a person's Washington apple health benefits for a subsequent certification period. A case is administratively renewed when the person's self-attested income is reasonably compatible (as defined in WAC 182-500-0095) with the information available to the agency from the electronic data sources and the person meets citizenship, immigration, Social Security number, and age requirements.

"**After-pregnancy coverage (APC)**" means full-scope Washington apple health (medicaid) health care coverage for people up to 12 months after the month their pregnancy ends under WAC 182-505-0115.

"**Agency**" or "**medicaid agency**" means the Washington state health care authority (HCA).

"**Agency's designee**" means any entity expressly designated by the agency to act on its behalf.

"**Allowable costs**" are the documented costs as reported after any cost adjustment, cost disallowances, reclassifications, or reclassifications to nonallowable costs which are necessary, ordinary and related to the outpatient care of medical care clients or not expressly declared nonallowable by applicable statutes or regulations. Costs are ordinary if they are of the nature and magnitude which prudent and cost-conscious management would pay.

"**Alternative benefits plan**" means the range of health care services included within the scope of service categories described in WAC 182-501-0060 available to persons eligible to receive health care coverage under the Washington apple health modified adjusted gross income (MAGI)-based adult coverage described in WAC 182-505-0250.

"**Ancillary services**" means additional services ordered by the provider to support the core treatment provided to the patient. These services may include, but are not limited to, laboratory services, radiology services, drugs, physical therapy, occupational therapy, and speech therapy.

"**Apple health for kids**" is the umbrella term for health care coverage for certain groups of children that is funded by the state and federal governments under Title XIX medicaid programs, Title XXI Children's Health Insurance Program, or solely through state funds (including the program formerly known as the children's health program). Funding for any given child depends on the program for which the child is determined to be eligible. Apple health for kids programs are included in the array of health care programs available through Washington apple health (WAH).

"**Attested income**" means a self-declared statement of a person's income made under penalty of perjury to be true. (See also "self-attested income.")

"**Authorization**" means the agency's or the agency's designee's determination that criteria are met, as one of the preconditions to the agency's or the agency's designee's decision to provide payment for a specific service or device. (See also "expedited prior authorization" and "prior authorization.")

"**Authorized representative**" is defined under WAC 182-503-0130.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 16-02-122, § 182-500-0010, filed 1/6/16, effective 2/6/16; WSR 15-15-143, § 182-500-0010, filed 7/17/15, effective 8/17/15. Statutory Authority: RCW 41.05.021, Patient Protection and Affordable Care Act (P.L. 111-148), 42 C.F.R. §§ 431, 435, 457, and 45 C.F.R. § 155. WSR 14-01-021, § 182-500-0010, filed 12/9/13, effective 1/9/14. WSR 11-14-075, recodified as § 182-500-0010, 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, § 388-500-0010, filed 6/29/11, effective 7/30/11.]

AMENDATORY SECTION (Amending WSR 19-04-095, filed 2/5/19, effective 3/8/19)

WAC 182-500-0020 Definitions—C. **"Caretaker relative"** means a relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care, and who is one of the following:

(a) The child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece.

(b) The spouse of such parent or relative (including same sex marriage or domestic partner), even after the marriage is terminated by death or divorce.

(c) Other relatives including relatives of half-blood, first cousins once removed, people of earlier generations (as shown by the prefixes of great, great-great, or great-great-great), and natural parents whose parental rights were terminated by a court order.

"Carrier" means an organization that contracts with the federal government to process claims under medicare Part B.

"Categorically needy (CN) or categorically needy program (CNP)" is the state and federally funded health care program established under Title XIX of the Social Security Act for people within medicaid-eligible categories, whose income and/or resources are at or below set standards.

"Categorically needy income level (CNIL)" is the standard used by the agency to determine eligibility under a categorically needy program.

"Categorically needy (CN) scope of care" is the range of health care services included within the scope of service categories described in WAC 182-501-0060 available to people eligible to receive benefits under a CN program. Some state-funded health care programs provide CN scope of care.

"Center of excellence" - A hospital, medical center, or other health care provider that meets or exceeds standards set by the agency for specific treatments or specialty care.

"Centers for Medicare and Medicaid Services (CMS)" - The federal agency that runs the medicare, medicaid, and children's health insurance programs, and the federally facilitated marketplace.

"Children's health program or children's health care programs" See "Apple health for kids."

"Client" means a person who is an applicant for, or recipient of, any Washington apple health program, including managed care and long-

term care. See definitions for "applicant" and "recipient" in RCW 74.09.741.

"**Community spouse.**" See "spouse" in WAC 182-500-0100.

"**Continuous eligibility**" means a person continues to receive their apple health coverage without interruption throughout their certification period regardless of changes in income, household size, immigration or citizenship status, or any other factor of eligibility other than moving out-of-state or death.

"**Core provider agreement**" is a written contract whose terms and conditions bind each provider in the fee-for-service program to applicable federal laws, state laws, and the agency's rules, provider alerts, billing guides, and other subregulatory guidance. See WAC 182-502-0005. The core provider agreement is a unilateral contract.

"**Cost-sharing**" means any expenditure required by or on behalf of an enrollee with respect to essential health benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for nonnetwork providers, and spending for noncovered services.

"**Cost-sharing reductions**" means reductions in cost-sharing for an eligible person enrolled in a silver level plan in the health benefit exchange or for a person who is an American Indian or Alaska native enrolled in a qualified health plan (QHP) in the exchange.

"**Couple.**" See "spouse" in WAC 182-500-0100.

"**Covered service**" is a health care service contained within a "service category" that is included in a Washington apple health (WAH) benefits package described in WAC 182-501-0060. For conditions of payment, see WAC 182-501-0050(5). A noncovered service is a specific health care service (for example, cosmetic surgery), contained within a service category that is included in a WAH benefits package, for which the agency or the agency's designee requires an approved exception to rule (ETR) (see WAC 182-501-0160). A noncovered service is not an excluded service (see WAC 182-501-0060).

"**Creditable coverage**" means most types of public and private health coverage, except Indian health services, that provide access to physicians, hospitals, laboratory services, and radiology services. This term applies to the coverage whether or not the coverage is equivalent to that offered under premium-based programs included in Washington apple health (WAH). Creditable coverage is described in 42 U.S.C. 300gg-3 (c)(1).

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 19-04-095, § 182-500-0020, filed 2/5/19, effective 3/8/19; WSR 17-23-040, § 182-500-0020, filed 11/8/17, effective 12/9/17; WSR 16-18-019, § 182-500-0020, filed 8/26/16, effective 9/26/16; WSR 15-17-013, § 182-500-0020, filed 8/7/15, effective 9/7/15. 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 14-16-052, § 182-500-0020, filed 7/29/14, effective 8/29/14. WSR 11-14-075, recodified as § 182-500-0020, 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, § 388-500-0020, filed 6/29/11, effective 7/30/11.]

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-500-0035 Medical assistance definitions—F. "Fee-for-service (FSS)" - The general payment method the agency or agency's designee uses to pay for covered medical services provided to clients, except those services covered under the agency's prepaid managed care programs.

"Fiscal intermediary" means an organization having an agreement with the federal government to process medicare claims under Part A.

"Full-scope coverage" means that the client is entitled to the benefits in the scope of service categories under WAC 182-501-0060.

[WSR 11-14-075, recodified as § 182-500-0035, 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, § 388-500-0035, filed 6/29/11, effective 7/30/11.]

OTS-3857.2

AMENDATORY SECTION (Amending WSR 13-14-019, filed 6/24/13, effective 7/25/13)

WAC 182-504-0005 Washington apple health—Retroactive certification period. (1) The medicaid agency approves a retroactive Washington apple health (WAH) certification period for the three months immediately before the month of application when an individual:

(a) Requests retroactive WAH on his or her application, within the certification period following the retroactive period, or before the determination of benefits and any appeal process is final;

(b) Would have been eligible for WAH for any or all of the three months if he or she had applied during the retroactive period; and

(c) The individual received covered medical services as described in WAC 182-501-0060 and 182-501-0065.

(2) When an individual is eligible only during the three-month retroactive certification period, that period is the only period of certification, except when:

(a) A pregnant ((~~woman~~)) individual is eligible in one of the three months immediately before the month of application, but no earlier than the month of conception. Eligibility continues as described in WAC 182-504-0015(3).

(b) An individual who is applying within 12 months of their last pregnancy end date is eligible for after-pregnancy coverage in any of the three months immediately before the month of application. Continuous eligibility begins from the earliest month the individual is found eligible as described in WAC 182-504-0015 (3) and (4).

(c) A child is eligible for categorically needy (CN) WAH as described in WAC 182-505-0210 (1) through (5) and (7) in at least one of the three months immediately before the month of application. Eligibility after the retroactive period continues as described in WAC 182-504-0015(11).

(3) An individual applying for the medically needy (MN) spenddown program may be eligible for a retroactive certification period as described in WAC 182-504-0020.

(4) An individual applying for a medicare savings program may be eligible for a retroactive certification period as described in WAC 182-504-0025.

[Statutory Authority: RCW 41.05.021, Patient Protection and Affordable Care Act (Public Law 111-148), 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 13-14-019, § 182-504-0005, filed 6/24/13, effective 7/25/13.]