



RULE-MAKING ORDER

CR-103P (May 2009)
(Implements RCW 34.05.360)

Agency: Health Care Authority, Washington Apple Health

Permanent Rule Only

Effective date of rule:

Permanent Rules

- 31 days after filing.
- Other (specify) _____ (If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?

- Yes
 - No
- If Yes, explain:

Purpose: The agency is making housekeeping changes to correct agency names, update rule numbers and make other clarifications.

Citation of existing rules affected by this order:

Repealed:
 Amended: 182-539-0020, -0300, -0350
 Suspended:

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 15-12-011 on May 21, 2015.
 Describe any changes other than editing from proposed to adopted version: None

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name: _____ phone () _____
 Address: _____ fax () _____
 e-mail _____

Date adopted: August 13, 2015

NAME (TYPE OR PRINT)
Wendy Barcus

SIGNATURE

TITLE
HCA Rules Coordinator

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
 STATE OF WASHINGTON
 FILED
DATE: August 13, 2015
TIME: 3:41 PM
WSR 15-17-054

**Note: If any category is left blank, it will be calculated as zero.
No descriptive text.**

**Count by whole WAC sections only, from the WAC number through the history note.
A section may be counted in more than one category.**

The number of sections adopted in order to comply with:

Federal statute:	New	_____	Amended	_____	Repealed	_____
Federal rules or standards:	New	_____	Amended	_____	Repealed	_____
Recently enacted state statutes:	New	_____	Amended	_____	Repealed	_____

The number of sections adopted at the request of a nongovernmental entity:

New	_____	Amended	_____	Repealed	_____
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The number of sections adopted in the agency's own initiative:

New	_____	Amended	_____	Repealed	_____
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The number of sections adopted in order to clarify, streamline, or reform agency procedures:

New	_____	Amended	<u>3</u>	Repealed	_____
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The number of sections adopted using:

Negotiated rule making:	New	_____	Amended	_____	Repealed	_____
Pilot rule making:	New	_____	Amended	_____	Repealed	_____
Other alternative rule making:	New	_____	Amended	<u>3</u>	Repealed	_____

WAC 182-539-0200 AIDS—Health insurance premium payment program.

(1) The purpose of the AIDS health insurance premium payment program is to help ~~((individuals))~~ people who are not eligible for the ~~((department's))~~ medicaid agency's Washington apple health medical programs and who are diagnosed with AIDS~~((τ))~~ pay their health insurance premiums.

(2) To be eligible for the AIDS health insurance premium payment program~~((τ individuals must))~~:

(a) ~~((Be))~~ A person must be:

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

~~((b))~~ Be ~~((ii))~~ A resident of the state of Washington;

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

~~((d))~~ Not ~~((b))~~ A person must not:

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

~~((e))~~ Not ~~((ii))~~ Have personal income that exceeds three hundred seventy percent of the federal poverty level; and

~~((f))~~ Not ~~((iii))~~ Have personal assets, after exemptions, exceeding fifteen thousand dollars~~((τ. The following personal assets are exempt from the personal assets calculation))~~, except for:

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

~~((ii))~~ (B) A vehicle used as personal transportation.

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

(a) Cooperate with the ~~((department's))~~ agency's contractor;

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

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

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

(5) ~~((Once an individual))~~ When a person is eligible ~~((to participate in))~~ for the AIDS health insurance premium payment program, eligibility ~~((would))~~ ceases only when ~~((one of the following occurs. The individual))~~ the person:

(a) Is deceased;

(b) Voluntarily quits the program;

(c) No longer meets the requirements of subsection (2) of this section; or

(d) Has benefits terminated ~~((due to))~~ because the ~~((legislature's termination of))~~ legislature terminated the funding for this program.

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

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

WAC 182-539-0300 Case management for ~~((persons))~~ people living with HIV/AIDS. The ~~((department))~~ medicaid agency provides HIV/AIDS case management to assist ~~((persons))~~ people infected with HIV to: Live as independently as possible; maintain and improve health; reduce behaviors that put the ~~((client))~~ person and others at risk; and gain access to needed medical, social, and educational services.

(1) To be eligible for ~~((department))~~ agency-reimbursed HIV/AIDS case management services, ~~((the))~~ a person must:

(a) Have a current medical diagnosis of HIV or AIDS;

(b) Be eligible for Title XIX (medicaid) coverage under either the categorically needy program (CNP) or the medically needy program (MNP); and

(c) Require:

(i) Assistance to obtain and effectively use necessary medical, social, and educational services; or

(ii) Ninety days of continued monitoring ~~((as provided in WAC 388-539-0350(2)))~~ under WAC 182-539-0350(2).

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

(3) HIV/AIDS case management agencies who serve ~~((the department's))~~ Washington apple health clients must be approved ~~((to perform these services))~~ by HIV client services, DOH.

(4) HIV/AIDS case management providers must:

(a) Notify HIV positive ~~((persons))~~ people of their statewide choice of available HIV/AIDS case management providers and document that notification in the client's record. This notification requirement does not obligate HIV/AIDS case management providers to accept all clients who request their services.

(b) Have a current, client-signed authorization form to release ~~((+))~~ and obtain information ~~((form))~~. The provider must have a valid authorization on file for the months that case management services are billed to the ~~((department))~~ agency (see RCW 70.02.030). The fee referenced in RCW 70.02.030 is included in the ~~((department's reimbursement))~~ agency's payment to providers. ~~((The department's))~~ Clients ~~((may))~~ must not be charged for services or documents related to covered services.

(c) Maintain ~~((sufficient))~~ enough contact to ensure ~~((the effectiveness of))~~ effective, ongoing services ~~((per))~~ under subsection (5) of this section. The ~~((department))~~ agency requires a minimum of one contact per month between the HIV/AIDS case manager and the client. However, contact frequency must be ~~((sufficient))~~ enough to ensure

~~((implementation and ongoing maintenance of))~~ the individual service plan (ISP) is implemented and maintained.

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

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

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

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

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

(i) Demographic information ~~((e.g.))~~ for example, age, gender, education, family composition, housing ~~((r))~~;

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

(iii) HIV diagnosis (both the documented diagnosis ~~((at))~~ from the ~~((time of))~~ assessment and historical diagnosis information);

(iv) Psychological ~~((social/cognitive))~~, social, and cognitive functioning and mental health history;

(v) Ability to perform daily activities;

(vi) Financial and employment status;

(vii) Medical benefits and insurance coverage;

(viii) Informal support systems ~~((e.g.))~~ for example, family, friends, and spiritual support);

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

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

~~((b))~~ (e) Providers must develop, monitor, and revise the client's ~~((individual service plan (r)))~~ ISP ~~((r))~~. The ISP identifies and documents the client's unmet needs and the resources needed to assist in meeting the client's needs. The case manager and the client must develop the ISP within two days of the comprehensive assessment, or the provider must document the reason this is not possible. An ISP must be:

(i) Signed by the client, documenting that the client is voluntarily requesting and receiving the ~~((department))~~ agency-reimbursed HIV/AIDS case management services; and

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

(A) In the case record narrative; or

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

~~((e-Maintained))~~ (f) Providers must maintain ongoing narrative records ~~((These records))~~ and must document case management services provided in each month ~~((for which))~~ the provider bills the ~~((department))~~ agency. Records must:

(i) Be entered in chronological order and signed by the case manager;

(ii) Document the reason for the case manager's interaction with the client; and

(iii) Describe the plans in place or to be developed to meet unmet client needs.

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

WAC 182-539-0350 HIV/AIDS case management reimbursement information. (1) The ~~((department reimburses))~~ medicaid agency pays HIV/AIDS case management providers for the following three services:

(a) Comprehensive assessment~~((--))~~. The assessment must cover the areas outlined in WAC ~~((388-539-0300))~~ 182-539-0300 (1) and (5).

(i) The ~~((department reimburses))~~ agency pays for only one comprehensive assessment unless the client's situation changes as follows:

(A) There is a fifty percent change in need from the initial assessment; or

(B) The client transfers to a new case management provider.

(ii) ~~((The department reimburses for a comprehensive assessment in addition to a monthly charge for case management (either full-month or partial-month) if the))~~ If a comprehensive assessment is completed during a month the client is medicaid eligible and ((the)) ongoing case management has been provided, the agency pays for the assessment and the monthly case management charge (either full-month or partial-month).

(b) HIV/AIDS case management, full-month~~((--))~~. Providers may request the full-month ~~((reimbursement))~~ payment for any month ~~((in which))~~ when the ~~((criteria in WAC 388-539-0300))~~ requirements of WAC 182-539-0300 have been met and the case manager has an individual service plan (ISP) in place for twenty or more days in that month. The ~~((department reimburses))~~ agency pays only one full-month case management fee per client in any one month.

(c) HIV/AIDS case management, partial-month~~((--))~~. Providers may request the partial-month ~~((reimbursement))~~ payment for any month ~~((in which the criteria in WAC 388-539-0300))~~ when the requirements of WAC 182-539-0300 have been met and the case manager has an ISP in place for fewer than twenty days in that month. Using the partial-month reimbursement, the ~~((department may reimburse))~~ agency may pay two different case management providers for services to a client who changes from one provider to a new provider during that month.

(2) The ~~((department))~~ agency limits ((reimbursement)) payments to HIV/AIDS case managers when a client becomes stabilized and no longer needs an ISP with active service elements. The ~~((department))~~ agency limits ((reimbursement)) payment for monitoring to ninety days ~~((past the time))~~ after the last active service element of the ISP is completed. ~~((Case management providers who are monitoring a stabilized client must meet all of the following criteria in order to bill the department for up))~~ To bill the agency for a maximum of ninety days of monitoring, a provider must:

(a) Document the client's history of recurring need;

(b) Assess the client for possible future instability; and

(c) Provide monthly monitoring contacts.

(3) The ~~((department))~~ agency reinstates ((reimbursement)) payment for ongoing case management if a client shifts from monitoring

status to active case management status due to documented need(~~(s)~~)
or needs. Providers must meet the requirements in WAC (~~(388-539-0300)~~)
182-539-0300 when a client is reinstated to active case management.