RULE-MAKING ORDER
PERMANENT RULE ONLY

CR-103P (December 2017)
(Implements RCW 34.05.360)

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STATE OF WASHINGTON
FILED

DATE: July 25, 2025
TIME: 9:14 AM

WSR 25-16-015

Agency: Health Care Authority

Effective date of rule:

Permanent Rules

☐ 31 days after filing.

☒ Other (specify) September 1, 2025 **(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 has revised the hospice rules to align with current policy and to identify rules that are applicable to managed care. The rules:

- Define and clarify the role of health care representatives
- Clarify hospice notice requirements
- Update the requirements to become a Medicaid-approved hospice care center
- Add the Alternative Benefit Plan (ABP) as a qualifier to receive pediatric palliative care case management/coordination services
- Update the process for noncovered services recommended based on the Early Periodic, Screening, Diagnosis, and Treatment (EPSDT) program
- Make housekeeping changes throughout the chapter

Citation of rules affected by this order:

New: 182-551-1315

Repealed:

Amended: 182-551-1000, 182-551-1010, 182-551-1200, 182-551-1210, 182-551-1300, 182-551-1305, 182-551-1310, 182-551-1320, 182-551-1330, 182-551-1340, 182-551-1350, 182-551-1360, 182-551-1370, 182-551-1400, 182-551-1500, 182-551-1510, 182-551-1520, 182-551-1530, 182-551-1810, 182-551-1820, 182-551-1830, 182-551-1840, 182-551-1860,

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 25-12-037 on May 28, 2025 (date).

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: N/A

Address:

Phone:

Fax:

TTY:

Email:

Web site:

Other:

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Federal statute:	New		Amended		Repealed	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	

The number of sections adopted on the agency's own initiative:

	New		Amended		Repealed	

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

	New	1	Amended	23	Repealed	

The number of sections adopted using:

Negotiated rule making:	New		Amended		Repealed	
Pilot rule making:	New		Amended		Repealed	
Other alternative rule making:	New	1	Amended	23	Repealed	

Date Adopted: July 25, 2025	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

AMENDATORY SECTION (Amending WSR 12-09-079, filed 4/17/12, effective 5/18/12)

WAC 182-551-1000 Hospice program—General. (1) The medicaid agency's hospice program is a ((~~twenty-four~~)) 24 hour a day program that allows a terminally ill client to choose physical, pastoral/spiritual, and psychosocial comfort care and a focus on quality of life. A hospice interdisciplinary team communicates with the client's nonhospice care providers to ensure the client's needs are met through the hospice plan of care. Hospitalization is used only for acute symptom management.

(2) A client, a physician, or an authorized health care representative ((~~under RCW 7.70.065~~)) may initiate hospice care. ((~~The client's physician must certify the client as terminally ill and appropriate for hospice care.~~))

(3) Hospice care is provided in a client's temporary or permanent place of residence.

(4) Hospice care ends when:

(a) The client or an authorized health care representative ((~~under RCW 7.70.065~~)) revokes the hospice care;

(b) The hospice agency discharges the client;

(c) The client's physician determines hospice care is no longer appropriate; or

(d) The client dies.

(5) Hospice care includes the provision of emotional and spiritual comfort and bereavement support to the client's family member(s).

(6) Medicaid agency-approved hospice agencies must meet the general requirements in chapter 182-502 WAC, Administration of medical programs—Providers.

(7) A client enrolled in a medicaid agency-contracted managed care organization (MCO) must receive all hospice services, including facility room and board, directly through that MCO.

(8) The MCO is responsible for arranging and providing all hospice services for an MCO client consistent with the rules in this chapter.

AMENDATORY SECTION (Amending WSR 12-09-079, filed 4/17/12, effective 5/18/12)

WAC 182-551-1010 Hospice program—Definitions. The following definitions and abbreviations and those found in ((~~WAC 182-500-0005~~)) chapter 182-500 WAC, Medical definitions, apply to this subchapter.

"Authorized health care representative" - ((~~An individual who has been authorized~~)) A person who has authority under RCW 7.70.065 to provide informed consent to terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill individual who ((~~is mentally or physically incapacitated. See RCW 7.70.065~~)) lacks capacity.

"Biologicals" - Medicinal preparations including serum, vaccine autotoxins, and biotechnological drugs made from living organisms and their products.

"Brief period" - Six days or less within a ((~~thirty~~)) 30 consecutive-day period.

"Community services office (CSO)" - An office of the department of social and health services (DSHS) that administers social and health services at the community level.

"Concurrent care" - Medically necessary services delivered at the same time as hospice services, providing a blend of curative and palliative services to clients ((~~twenty~~)) 20 years of age and younger who are enrolled in hospice. See WAC 182-551-1860.

"Curative care" - Treatment aimed at achieving a disease-free state.

"Discharge" - A hospice agency ends hospice care for a client.

"Election period" - The time, ((~~ninety or sixty~~)) 90 or 60 calendar days, that the client is certified as eligible for and chooses to receive hospice care.

"Family" - ((~~An individual or individuals~~)) A person or people who are important to((~~, and designated in writing by,~~)) the client and need not be relatives((~~, or who are legally authorized to represent the client~~)).

"Home and community services (HCS) office" - A department of social and health services (DSHS) ((~~aging and disability services~~)) home and community living administration ((~~(ADSA)~~)) office that manages the state's comprehensive long-term care system which provides in-home, residential, and nursing home services to clients with functional disabilities.

"Hospice agency" - A person or entity administering or providing hospice services directly or through a contract arrangement to ((~~individuals~~)) people in places of temporary or permanent residence under the direction of an interdisciplinary team composed of at least a nurse, social worker, physician, spiritual counselor, and volunteer. (Note: For the purposes of this subchapter, requirements for hospice agencies also apply to hospice care centers.)

"Hospice aide" - ((~~An individual~~)) A person registered or certified as a nursing assistant under chapter 18.88A RCW who, under the direction and supervision of a registered nurse, physical therapist, occupational therapist, or speech therapist, assists in the delivery of nursing or therapy related activities, or both, to patients of a hospice agency((~~,~~)) or hospice care center.

"Hospice aide services" - Services provided by hospice aides employed by an in-home services agency licensed to provide hospice or hospice care center services under the supervision of a registered nurse, physical therapist, occupational therapist, or speech therapist. Such care may include ambulation and exercise, medication assistance level 1 and level 2, reporting changes in client's conditions and needs, completing appropriate records, ((~~and~~)) personal care or homemaker services, and other nonmedical tasks, as defined in this section.

"Hospice care center" - A homelike noninstitutional facility where hospice services are provided((~~, and~~)) that meets the requirements for operation under RCW 70.127.280 and applicable rules.

"Hospice services" - Symptom and pain management provided to a terminally ill ((~~individual~~)) person, and emotional, spiritual, and bereavement support for the ((~~individual~~)) person and ((~~individual's~~)) their family in a place of temporary or permanent residence.

"Interdisciplinary team" - The group of ((~~individuals~~)) people involved in client care providing hospice services or hospice care

center services including, at a minimum, a physician, registered nurse, social worker, spiritual counselor, and volunteer.

"Palliative" - Medical treatment designed to reduce pain or increase comfort, rather than cure.

"Plan of care (POC)" - A written document based on assessment of client needs that identifies services to meet these needs.

"Related condition(s)" - Any health condition(s) that manifests secondary to or exacerbates symptoms associated with the progression of the condition and/or disease, the treatment being received, or the process of dying. (Examples of related conditions: Medication management of nausea and vomiting secondary to pain medication; skin breakdown prevention/treatment due to peripheral edema.)

"Residence" - A client's home or place of living.

"Revoke" or **"revocation"** - The choice to stop receiving hospice care.

"Terminally ill" - The client has a life expectancy of six months or less, assuming the client's disease process runs its natural course.

"((~~Twenty-four~~)) 24-hour day" - A day beginning and ending at midnight.

AMENDATORY SECTION (Amending WSR 14-07-042, filed 3/12/14, effective 4/12/14)

WAC 182-551-1200 Client eligibility for hospice care. (1) Subject to the requirements and limitations in this chapter and other medicaid agency rules, a person who elects to receive hospice care must be eligible for:

(a) One of the Washington apple health programs listed in the table in WAC 182-501-0060 with hospice as a covered benefit; or ((~~be eligible for~~))

(b) The alien emergency medical (AEM) program (see WAC 182-507-0110)((~~, subject to the restrictions and limitations in this chapter and other WAC~~)).

(2) ((~~A hospice agency is responsible to verify a person's eligibility with the person or the person's department of social and health services (DSHS) home and community services (HCS) office or community services office (CSO).~~

~~(3) A person enrolled in one of the medicaid agency's managed care organizations (MCO) must receive all hospice services, including facility room and board, directly through that MCO. The MCO is responsible for arranging and providing all hospice services for an MCO client.~~

~~(4)~~)) A ((~~person~~)) client who is ((~~also~~)) eligible for ((~~medicare~~)) hospice under medicare part A is not eligible for hospice care through the medicaid agency's hospice program.

(3) The medicaid agency ((~~does~~)) pays hospice nursing facility room and board ((~~for these persons~~)) if the ((~~person~~)) client is:

(a) Admitted to a nursing facility or hospice care center (HCC); and ((~~is~~))

(b) Not receiving general inpatient care or inpatient respite care. See also WAC 182-551-1530.

((~~(5)~~)) (4) A ((~~person~~)) client who meets the requirements in this section is eligible to receive hospice care through the medicaid

agency's hospice program when all ((~~of~~)) the following ((~~is~~)) requirements are met:

(a) The ((~~person's~~)) client's physician certifies the ((~~person~~)) client has a life expectancy of six months or less((~~.~~)), which is supported by medical records, including documentation that the person's condition is declining;

(b) The ((~~person~~)) client or an authorized health care representative on the client's behalf elects to receive hospice care and agrees to the conditions of the "election statement" as described in WAC 182-551-1310((~~.~~));

(c) The client's hospice agency ((~~serving the person~~)) must:

(i) ((~~Notifies~~)) Notify the medicaid agency's hospice program within five ((~~working~~)) business days of the ((~~admission of all persons, including~~)) client's admission. The hospice agency must give notice for clients with the following types of eligibility:

(A) Medicaid-only ((~~persons~~));

(B) Medicaid-medicare dual eligible ((~~persons~~));

(C) Medicaid ((~~persons~~)) with third-party insurance; and

(D) Medicaid-medicare dual eligible ((~~persons~~)) with third-party insurance.

(ii) Meet((~~s~~)) the hospice agency requirements in WAC 182-551-1300 and 182-551-1305((~~.~~));

(d) The hospice agency provides additional information for a diagnosis when the medicaid agency requests and determines, on a case-by-case basis, the information that is needed for further review.

AMENDATORY SECTION (Amending WSR 12-09-079, filed 4/17/12, effective 5/18/12)

WAC 182-551-1210 Covered services, including core services and supplies reimbursed through the hospice daily rate. (1) The medicaid agency reimburses a hospice agency for providing covered services((~~, including core services and supplies described in this section,~~)) through the medicaid agency's hospice daily rate.

(2) Covered services include core services and supplies described in this section, subject to the ((~~conditions~~)) requirements and limitations described in this section and other WAC. See WAC 182-551-1860 for pediatric concurrent care.

((~~(2)~~)) (3) To qualify for reimbursement, covered services, including core services and supplies in the hospice daily rate, must be:

(a) Related to the client's hospice diagnosis;

(b) Identified by the client's hospice interdisciplinary team;

(c) Written in the client's plan of care (POC); and

(d) Made available to the client by the hospice agency on a ((~~twenty-four~~)) 24-hour basis.

((~~(3)~~)) (4) The hospice daily rate includes the following core services ((~~that must be either provided by hospice agency staff, or contracted through a hospice agency, if necessary, to supplement hospice staff in order to meet the needs of a client during a period of peak patient loads or under extraordinary circumstances~~)):

(a) Physician services related to ((~~the~~)) POC administration ((~~of POC~~)).

(b) Nursing care provided by:

(i) A registered nurse (RN); or

(ii) A licensed practical nurse (LPN) under the supervision of an RN.

(c) Medical social services provided by a social worker under the direction of a physician.

(d) Counseling services provided to a client and the client's family members or caregivers.

((~~(4)~~)) (5) Core services must be provided by hospice agency staff. If necessary, a contracted hospice agency may provide core services to supplement services provided by hospice staff to meet client needs:

(a) During a period of peak patient loads; or

(b) Under extraordinary circumstances.

(6) Covered services and supplies may be provided by a service organization or an individual provider when contracted through a hospice agency.

(7) To be reimbursed the hospice daily rate, a hospice agency must:

(a) ((~~Assure~~)) Ensure all contracted staff meet((~~s~~)) the regulatory qualification requirements;

(b) Have a written agreement with the service organization or ((~~individual~~)) person providing the services and supplies; and

(c) Maintain professional, financial, and administrative responsibility.

((~~(5)~~)) (8) The following covered services and supplies are included in the appropriate hospice daily rate as described in WAC 182-551-1510((~~(6)~~)), subject to the ((~~conditions~~)) requirements and limitations described in this section and other WAC:

(a) Skilled nursing care;

(b) Drugs, biologicals, and over-the-counter medications used for the relief of pain and symptom control of a client's terminal illness and related conditions;

(c) Communication with nonhospice providers about care not related to the client's terminal illness to ensure the client's plan of care needs are met and not compromised;

(d) Durable medical equipment and related supplies, prosthetics, orthotics, medical supplies, related services, or related repairs and labor charges ((~~in accordance with WAC 182-543-9100 (6)(c)~~)). See chapter 182-543 WAC. These services and equipment are paid by the hospice agency for the palliation and management of a client's terminal illness and related conditions and are included in the daily hospice rate;

(e) Hospice aide((~~, homemaker, and/or personal care~~)) services that ((~~are~~)) meet the following criteria:

(i) Ordered by a client's physician and documented in the POC((~~. (Hospice aide services are~~));

(ii) Provided through the hospice agency to meet a client's extensive needs due to the client's terminal illness((~~. These services must be~~)); and

(iii) Provided by a qualified hospice aide and are an extension of skilled nursing or therapy services. See 42 C.F.R. ((~~484.36)~~)) Part 484;

(f) Physical therapy, occupational therapy, and speech-language therapy to manage symptoms or enable a client to safely perform ADLs (activities of daily living) and basic functional skills;

(g) Medical transportation services, including ambulance (see WAC 182-546-5550 (1)((~~(d)~~)) (e));

(h) A brief period of inpatient care, for general or respite care provided in a medicare-certified hospice care center, hospital, or nursing facility; and

(i) Other services or supplies that are documented as necessary for the palliation and management of a client's terminal illness and related conditions;

((~~(6)~~)) (9) A hospice agency is responsible to determine if a nursing facility has requested authorization for medical supplies or medical equipment, including wheelchairs, for a client who becomes eligible for the hospice program.

(10) The medicaid agency does not pay separately for medical equipment or supplies that were previously authorized by the medicaid agency and delivered on or after the date the medicaid agency enrolls the client in the hospice program.

AMENDATORY SECTION (Amending WSR 16-03-035, filed 1/12/16, effective 2/12/16)

WAC 182-551-1300 Requirements for a medicaid-approved hospice agency. (1) To become ((~~a~~)) medicaid-approved ((~~hospice agency~~)), ((~~the medicaid agency requires~~)) a hospice agency ((~~to provide documentation that it is~~)) must be medicare, Title XVIII-certified by the department of health (DOH) as a hospice agency.

(2) A medicaid-approved hospice agency must, at all times, meet the requirements in chapter 182-551 WAC, subchapter I, Hospice services, and the requirements under the Title XVIII medicare program.

(3) To ensure quality of care for Washington apple health clients, the medicaid agency's clinical staff ((~~may~~)) conducts hospice agency site visits.

AMENDATORY SECTION (Amending WSR 12-09-079, filed 4/17/12, effective 5/18/12)

WAC 182-551-1305 Requirements for becoming a medicaid-approved hospice care center (HCC). (1) To ((~~apply to~~)) become a medicaid-approved hospice care center, the ((~~medicaid agency requires a~~)) hospice agency ((~~to:~~

~~(a) Be enrolled with the medicaid agency as an approved hospice agency (see WAC 182-551-1300);~~

~~(b) Submit a letter of request to:~~

~~Hospice Program Manager~~
~~P.O. Box 45506~~
~~Olympia, WA 98504-5506; and~~

~~(c) Include documentation that confirms the approved hospice agency is~~)) must be medicare-certified by the department of health (DOH) as a hospice care center and provides one or more of the following levels of hospice care (levels of care are described in WAC 182-551-1500):

((~~(i)~~)) (a) Routine home care;

((~~(ii)~~)) (b) Inpatient respite care; and

((~~(iii)~~)) (c) General inpatient care.

(2) A medicaid-approved hospice care center must at all times meet the requirements in chapter 182-551 WAC, subchapter I, Hospice services, and the requirements under the Title XVIII medicare program.

(3) A hospice agency qualifies as a medicaid-approved hospice care center when:

(a) All the requirements in this section are met; and

(b) The medicaid agency provides the hospice agency with written notification.

AMENDATORY SECTION (Amending WSR 12-09-079, filed 4/17/12, effective 5/18/12)

WAC 182-551-1310 Hospice election periods((~~,~~)) and election statements((~~, and the hospice certification process~~)). (1) Hospice coverage is available for two ((~~ninety~~)) 90-day election periods followed by an unlimited number of ((~~sixty~~)) 60-day election periods.

(2) A client or a client's authorized health care representative must sign an election statement to initiate or reinitiate an election period for hospice care.

((~~(2)~~)) (3) The election statement must be filed in the client's hospice medical record within two calendar days following the day the hospice care begins and requires all of the following:

(a) Name and address of the hospice agency that will provide the care;

(b) Documentation that the client or the client's authorized health care representative is fully informed and understands hospice care and waiver of other medicaid and/or medicare services;

(c) Effective date of the election; and

(d) Signature of the client or the client's authorized health care representative.

((~~(3) The following describes the hospice certification process:~~

~~(a) When a client elects to receive hospice care, the medicaid agency requires a hospice agency to:~~

~~(i) Obtain a signed written certification from a physician of the client's terminal illness; or~~

~~(ii) Document in the client's medical file that a verbal certification was obtained and follow up a documented verbal certification with a written certification signed by:~~

~~(A) The medical director of the hospice agency or a physician staff member of the interdisciplinary team; and~~

~~(B) The client's attending physician (if the client has one).~~

~~(iii) Place the signed written certification of the client's terminal illness in the client's medical file:~~

~~(A) Within sixty days following the day the hospice care begins; and~~

~~(B) Before billing the medicaid agency for the hospice services.~~

~~(b) For subsequent election periods, the medicaid agency requires:~~

~~(i) A hospice physician or hospice nurse practitioner to:~~

~~(A) Have a face-to-face encounter with every hospice client within thirty days prior to the one hundred eightieth-day recertification and prior to each subsequent recertification to determine continued~~

~~eligibility of the client for hospice care. The medicaid agency does not pay for face-to-face encounters to recertify a hospice client; and~~

~~(B) Attest that the face-to-face encounter took place.~~

~~(ii) The hospice agency to:~~

~~(A) Document in the client's medical file that a verbal certification was obtained and follow up a documented verbal certification with a written certification signed by the medical director of the hospice agency or a physician staff member of the hospice agency;~~

~~(B) Place the written certification of the client's terminal illness in the client's medical file before billing the medicaid agency for the hospice services; and~~

~~(C) Submit the written certification to the medicaid agency with the hospice claim related to the recertification.~~))

(4) When a client's hospice coverage ends within an election period (e.g., the client revokes hospice care), the remainder of that election period is forfeited.

(5) The client or the client's authorized health care representative may reinstate the hospice benefit at any time by providing an election statement and meeting the certification process requirements.

NEW SECTION

WAC 182-551-1315 Hospice certification process. (1) The following describes the hospice certification process:

(a) When a client or the client's authorized health care representative elects to receive hospice care, the medicaid agency requires a hospice agency to:

(i) Obtain a signed written certification from a physician of the client's terminal illness; or

(ii) Document in the client's medical file that the hospice agency obtained verbal certification, followed up with a written certification signed by:

(A) The medical director of the hospice agency or a physician staff member of the interdisciplinary team; and

(B) The client's attending physician if the client has one;

(iii) Place the signed written certification of the client's terminal illness in the client's medical file:

(A) Within 60 calendar days following the day the hospice care begins; and

(B) Before billing the medicaid agency for the hospice services.

(b) For a subsequent election period, the medicaid agency requires a hospice physician or hospice nurse practitioner to:

(i) Have a face-to-face encounter with every hospice client:

(A) Within 30 calendar days prior to the 180th-day recertification; and

(B) Prior to each subsequent recertification to determine continued eligibility of the client for hospice care; and

(ii) Attest that the face-to-face encounter took place.

(c) The hospice agency must:

(i) Document in the client's medical file that it obtained a verbal certification, followed up with a written certification signed by:

(A) The medical director of the hospice agency; or

(B) A physician staff member of the hospice agency;

(ii) Place the written certification of the client's terminal illness in the client's medical file before billing the medicaid agency for the hospice services; and

(iii) Submit the written certification to the medicaid agency with the hospice claim related to the recertification.

(2) The medicaid agency does not pay for face-to-face encounters to recertify a hospice client.

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

WAC 182-551-1320 Hospice plan of care. (1) A hospice agency must establish a written plan of care (POC) for a client that describes the hospice care to be provided. The POC must be in accordance with department of health (DOH) requirements as described in WAC ((~~246-335-085~~)) 246-335-640, and meet the requirements in this section.

(2) A registered nurse or physician must conduct an initial physical assessment of a client and develop the POC with at least one other member of the hospice interdisciplinary team.

(3) At least two other hospice interdisciplinary team members must review the POC no later than two ((~~working~~)) business days after it is developed.

(4) The POC must be reviewed and updated every two weeks by at least three members of the hospice interdisciplinary team that includes ((~~at least~~)):

(a) A registered nurse;

(b) A social worker; and

(c) One other hospice interdisciplinary team member.

AMENDATORY SECTION (Amending WSR 12-09-079, filed 4/17/12, effective 5/18/12)

WAC 182-551-1330 Hospice—Client care and responsibilities of hospice agencies. (1) A hospice agency must facilitate a client's continuity of care with nonhospice providers to ensure that medically necessary care, both related and not related to the terminal illness, is met.

This includes:

(a) Determining if the medicaid agency has approved a request for prescribed medical equipment, such as a wheelchair. If the prescribed item is not delivered to the client before the client becomes covered by a hospice agency, the medicaid agency ((~~will~~)) rescinds the approval. See WAC ((~~182-543-9100(7)~~)) 182-543-9000(17).

(b) Communicating with other medicaid programs and documenting the services a client ((~~is receiving in order~~)) receives to prevent duplication of payment and to ensure continuity of care. Other medicaid programs include, but are not limited to, programs administered by the department of social and health services ((~~aging and disability~~

~~services administration (ADSA)~~)) (DSHS) home and community living administration.

(c) Documenting each contact with nonhospice providers.

(2) When a client resides in a nursing facility, the hospice agency must:

(a) Coordinate the client's care with all providers, including pharmacies and medical vendors; and

(b) Provide the same level of hospice care the hospice agency provides to a client residing in their home.

(3) Once a client chooses hospice care, hospice agency staff must notify and inform the client of the following:

(a) By choosing hospice care from a hospice agency, the client gives up the right to:

(i) Covered medicaid hospice service and supplies received at the same time from another hospice agency; and

(ii) Any covered medicaid services and supplies received from any other provider that are necessary for the palliation and management of the terminal illness and related medical conditions.

(b) Services and supplies are not paid through the hospice daily rate if they are:

(i) Proven to be clinically unrelated to the palliation and management of the client's terminal illness and related medical conditions (see WAC 182-551-1210(3));

(ii) Not covered by the hospice daily rate;

(iii) Provided under a Title XIX medicaid program when the services are similar or duplicate the hospice care services; or

(iv) Not necessary for the palliation and management of the client's terminal illness and related medical conditions.

(4) A hospice agency must have written agreements with all contracted providers.

AMENDATORY SECTION (Amending WSR 12-09-079, filed 4/17/12, effective 5/18/12)

WAC 182-551-1340 When a client leaves hospice without notice. When a client chooses to leave hospice care or the client's authorized health care representative removes the client from hospice care and refuses hospice care without giving the hospice agency a revocation statement, as required by WAC 182-551-1360, the hospice agency must do all of the following:

(1) Within five ((~~working~~)) business days of becoming aware of the client's or the authorized health care representative's decision, inform and notify ((~~in writing~~)) the medicaid hospice program manager in writing (see WAC 182-551-1400 for further requirements);

(2) Complete a Medicaid Hospice Notification form (HCA 13-746) and forward a copy to the appropriate department of social and health services (DSHS) home and community services (HCS) office or community services office (CSO) to notify that the client is discharging from the program;

(3) Notify the client, or the client's authorized health care representative, that the client's discharge has been reported to the medicaid agency; and

(4) Document the effective date and details of the discharge in the client's hospice record.

AMENDATORY SECTION (Amending WSR 12-09-079, filed 4/17/12, effective 5/18/12)

WAC 182-551-1350 Discharges from hospice care. (1) A hospice agency may discharge a client from hospice care when the ((~~client~~)):

(a) Client is no longer certified for hospice care;

(b) Client is no longer appropriate for hospice care; or

(c) ((~~The~~)) Hospice agency's medical director determines the client is seeking treatment for the terminal illness outside the plan of care (POC).

(2) At the time of a client's discharge, a hospice agency must:

(a) Within five ((~~working~~)) business days, complete a Medicaid Hospice Notification form (HCA 13-746) and forward the form to the medicaid hospice program manager (see WAC 182-551-1400 for additional requirements), and a copy to the appropriate DSHS home and community services office (HCS) or community services office (CSO);

(b) Keep the discharge statement in the client's hospice record;

(c) Provide the client with a copy of the discharge statement; and

(d) Inform the client that the discharge statement must be:

(i) Presented with the client's current services card when obtaining medicaid-covered health care services or supplies, or both; and

(ii) Used until the medicaid agency removes the hospice restriction from the client's information available online ((~~at https://www.waproviderone.org~~)) through the ProviderOne system.

AMENDATORY SECTION (Amending WSR 12-09-079, filed 4/17/12, effective 5/18/12)

WAC 182-551-1360 Ending hospice care (revocations). (1) A client or a client's authorized health care representative may ((~~choose~~)) decide to stop hospice care at any time by signing a revocation statement.

(2) The revocation statement documents the client's ((~~choice~~)) decision to stop medicaid hospice care. The revocation statement must include all of the following:

(a) Client's signature (or the client's authorized health care representative's signature if the client is unable to sign);

(b) Date the revocation was signed; and

(c) Actual date that the client ((~~chose~~)) decided to stop receiving hospice care.

(3) The hospice agency must keep any explanation supporting any difference in the signature and revocation dates in the client's hospice records.

(4) When a client revokes hospice care, the hospice agency must:

(a) ((~~Inform and~~)) Notify in writing the medicaid agency's hospice program ((~~manager~~)), within five ((~~working~~)) business days of becoming aware of the client's decision (see WAC 182-551-1400 for additional requirements) by completing the Medicaid Hospice Notification form (HCA 13-746);

(b) Notify the appropriate department of social and health services (DSHS) home and community services (HCS) office or community

services office (CSO) of the revocation by completing and forwarding a copy of the Medicaid Hospice Notification form (HCA 13-746) to the appropriate DSHS ((~~home and community services (HCS) office or community services office (CSO)~~)) CSO;

(c) Keep the revocation statement in the client's hospice record;

(d) Provide the client with a copy of the revocation statement; and

(e) Inform the client that the revocation statement must be:

(i) Presented with the client's current services card when obtaining medicaid-covered health care services or supplies, or both; and

(ii) Used until the medicaid agency issues a new services card that identifies that the client is no longer a hospice client.

(5) After a client revokes hospice care, the remaining days within the current election period are forfeited. The client may immediately enter the next consecutive election period. The client does not have to wait for the forfeited days to pass before entering the next consecutive election period.

AMENDATORY SECTION (Amending WSR 12-09-079, filed 4/17/12, effective 5/18/12)

WAC 182-551-1370 When a hospice client dies. When a client dies, the hospice agency must:

(1) Within five ((~~working~~)) business days, ((~~inform and~~)) notify ((~~in writing~~)) the medicaid agency((~~'s hospice program manager~~)) by completing the Medicaid Hospice Notification form (HCA 13-746) to the medicaid agency; and

(2) Notify the appropriate department of social and health services (DSHS) home and community services (HCS) office or community services office (CSO) of the client's date of death by completing and forwarding a copy of the Medicaid Hospice Notification form (HCA 13-746) to the appropriate DSHS HCS office or CSO.

AMENDATORY SECTION (Amending WSR 16-03-035, filed 1/12/16, effective 2/12/16)

WAC 182-551-1400 Notification requirements for hospice agencies. (1) To be reimbursed for providing hospice services, the hospice agency must:

(a) Complete a Medicaid Hospice Notification form (HCA 13-746); and

(b) Forward the form to the medicaid agency's hospice program ((~~manager~~)) within five ((~~working~~)) business days from ((~~when~~)) the date a Washington apple health client begins ((~~the first day of~~)) hospice care, or has a change in hospice status. ((~~The hospice agency must~~))

(c) Notify the medicaid hospice program of:

((~~(a)~~)) (i) The name and address of the hospice agency;

((~~(b)~~)) (ii) The date of the client's first day of hospice care;

((~~(c)~~)) (iii) A change in the client's primary physician;

((~~(d)~~)) (iv) A client's revocation of the hospice benefit (home or institutional);

((~~(e)~~)) (v) The date a client leaves hospice without notice;

((~~(f)~~)) (vi) A client's discharge from hospice care;

((~~(g)~~)) (vii) A client who admits to a nursing facility (this does not apply to an admit for inpatient respite care or general inpatient care);

((~~(h)~~)) (viii) A client who discharges from a nursing facility (this does not apply to an admit for inpatient respite care or general inpatient care);

((~~(i)~~)) (ix) A client who is eligible for or becomes eligible for medicare or third-party liability (TPL) insurance;

((~~(j)~~)) (x) A client who dies; or

((~~(k)~~)) (xi) A client who transfers to another hospice agency. Both the former hospice agency and current hospice agency must provide the medicaid agency with:

((~~(i)~~)) (A) The client's name, the name of the former hospice agency ((~~servicing~~)) serving the client, and the effective date of the client's discharge; and

((~~(ii)~~)) (B) The name of the current hospice agency serving the client, the hospice agency's provider number, and the effective date of the client's admission.

(2) The medicaid agency does not require a hospice agency to notify the hospice program ((~~manager~~)) when a hospice client is admitted to a hospital for palliative care.

(3) When a hospice agency does not notify the medicaid agency's hospice program within five ((~~working~~)) business days of the date of the client's first day of hospice care as required in subsection (1) ((~~(c)~~)) of this section, the medicaid agency authorizes the hospice daily rate reimbursement effective the fifth ((~~working~~)) business day before the date of notification.

AMENDATORY SECTION (Amending WSR 16-03-035, filed 1/12/16, effective 2/12/16)

WAC 182-551-1500 Hospice daily rate—Four levels of hospice care. All services, supplies and equipment related to the client's terminal illness and related conditions are included in the hospice daily rate. The medicaid agency pays for only one of the following four levels of hospice care per day (see WAC 182-551-1510 for payment methods):

(1) **Routine home care.** Routine home care includes daily care administered to the client at the client's residence. The services are not restricted in length or frequency of visits, are dependent on the client's needs, and are provided to achieve palliation or management of acute symptoms.

(2) **Continuous home care.** Continuous home care includes acute skilled care provided to an unstable client during a brief period of medical crisis to maintain the client in the client's residence and is limited to:

(a) A minimum of eight hours of acute care provided during a ((~~twenty-four~~)) 24-hour day;

(b) Nursing care that must be provided by a registered or licensed practical nurse for more than half the period of care;

(c) Homemaker, hospice aide, and attendant services that may be provided as supplements to the nursing care; and

(d) In-home care only (not care in a nursing facility or a hospice care center).

(3) **Inpatient respite care.** Inpatient respite care includes room and board services provided to a client in a medicaid-approved hospice care center, nursing facility, or hospital. Respite care is intended to provide relief to the client's primary caregiver and is limited to:

(a) No more than six consecutive days; and

(b) A client not currently residing in a hospice care center, nursing facility, or hospital.

(4) **General inpatient hospice care.** General inpatient hospice care includes services administered to a client for pain control or management of acute symptoms. In addition:

(a) The services must conform to the client's written plan of care (POC).

(b) This benefit is limited to brief periods of care in medicaid agency-approved:

(i) Hospitals;

(ii) Nursing facilities; or

(iii) Hospice care centers.

(c) There must be documentation in the client's medical record to support the need for general inpatient level of hospice care.

AMENDATORY SECTION (Amending WSR 17-03-073, filed 1/11/17, effective 2/11/17)

WAC 182-551-1510 Rates methodology and payment method for hospice agencies. This section describes rates methodology and payment methods for hospice care provided to hospice clients.

(1) The medicaid agency uses the same rates methodology as medicare uses for the four levels of hospice care identified in WAC 182-551-1500.

(2) Each of the four levels of hospice care has the following three rate components:

(a) Wage component;

(b) Wage index; and

(c) Unweighted amount.

(3) To allow hospice payment rates to be adjusted for regional differences in wages, the medicaid agency bases payment rates on the core-based statistical area (CBSA) county location. CBSAs are identified in the medicaid agency's provider guides.

(4) The medicaid agency pays hospice agencies for services, ((~~(~~))not room and board((~~)~~)), at a daily rate methodology as follows:

(a) Payments for services delivered in a client's residence (routine and continuous home care) are based on the county location of the client's residence.

(b) Payments for routine home care are based on a two-tiered payment methodology.

(i) Days one through ((~~sixty~~)) 60 are paid at the base routine home care rate.

(ii) Days ((~~sixty-one~~)) 61 and after are paid at a lower routine home care rate.

(iii) If a client discharges and readmits to a hospice agency's program within ((~~sixty~~)) 60 calendar days of that discharge, the prior hospice days ((~~will~~)) continue to follow the client and count towards the client's eligible days in determining whether the hospice agency may bill at the base or lower routine home care rate.

(iv) If a client discharges from a hospice agency's program for more than ((~~sixty~~)) 60 calendar days, a readmit to the hospice agency's program ((~~will~~)) reset<u>s</u> the client's hospice days.

(c) Hospice services are eligible for an end-of-life service intensity add-on payment when the following criteria are met:

(i) The day on which the services are provided is a routine home care level of care;

(ii) The day on which the service is provided occurs during the last seven days of life, and the client is discharged deceased;

(iii) The service is provided by a registered nurse or social worker that day for at least ((~~fifteen~~)) 15 minutes and up to four hours total; and

(iv) The service is not provided by the social worker via telephone.

(d) Payments for respite and general inpatient care are based on the county location of the providing hospice agency.

(5) The medicaid agency:

(a) Pays for routine home care, continuous home care, respite care, or general inpatient care for the day of death;

(b) Does not pay room and board for the day of death; and

(c) Does not pay hospice agencies for the client's last day of hospice care when the last day is for the client's discharge, revocation, or transfer.

(6) Hospice agencies must bill the medicaid agency for their services using hospice-specific revenue codes.

(7) For hospice clients in a nursing facility:

(a) The medicaid agency pays nursing facility room and board payments at a daily rate directly to the hospice agency at ((~~ninety-five~~)) 95 percent of the nursing facility's current medicaid daily rate in effect on the date the services were provided; and

(b) The hospice agency pays the nursing facility at a daily rate no more than the nursing facility's current medicaid daily rate.

(8) The medicaid agency:

(a) Pays a hospice care center a daily rate for room and board based on the average room and board rate for all nursing facilities in effect on the date the services were provided.

(b) Does not pay hospice agencies or hospice care centers a nursing facility room and board payment for:

(i) A client's last day of hospice care (e.g., client's discharge, revocation, or transfer); or

(ii) The day of death.

(9) The daily rate for authorized out-of-state hospice services is the same as for in-state non-CBSA hospice services.

(10) The medicaid agency reduces hospice payments by two percent for providers who did not comply with the annual medicare quality data reporting program as required under 42 U.S.C. Sec. 1395f (i)(5)(A)(i). The payment reduction is effective for the fiscal reporting year in which the provider failed to submit data required for the annual medicare quality reporting program.

(a) The two percent payment reduction applies to routine home care, including the service intensity add-on, continuous home care, inpatient respite care, and general inpatient care.

(b) The two percent payment reduction does not apply to pediatric palliative care, the hospice care center daily rate, and the nursing facility room and board rate.

(c) Any provider affected by the two percent payment reduction ((~~will~~)) receives written notification.

(d) Any provider affected by the two percent payment reduction may appeal the rate reduction per WAC 182-502-0220.

(11) The client's notice of action (award) letter states the amount the client is responsible to pay each month towards the total cost of hospice care. The hospice agency receives a copy of the award letter and:

(a) Is responsible to collect the correct amount that the client is required to pay, if any; and

(b) Must show the client's monthly required payment on the hospice claim. (Hospice providers may refer to the medicaid agency's provider guides for how to bill a hospice claim.) If a client has a required payment amount that is not reflected on the claim and the medicaid agency reimburses the amount to the hospice agency, the amount is subject to recoupment by the medicaid agency.

AMENDATORY SECTION (Amending WSR 12-09-079, filed 4/17/12, effective 5/18/12)

WAC 182-551-1520 Payment method for nonhospice providers. (1) The medicaid agency pays ((~~for~~)) hospitals that provide inpatient care to clients in the hospice program for medical conditions not related to their terminal illness according to chapter 182-550 WAC, Hospital services.

(2) The medicaid agency pays providers who are attending physicians and not employed by the hospice agency((~~,~~)) the usual amount through the ((~~resource based relative value scale (RBRVS)~~)) physician-related services fee schedule:

(a) For direct physician care services provided to a hospice client;

(b) When the provided services are not related to the terminal illness; and

(c) When the client's providers, including the hospice agency, coordinate the health care provided.

(3) The department of social and health services (DSHS) ((~~aging and disability services administration (ADSA)~~)) home and community living administration pays for services provided to a client eligible under the community options program entry system (COPES) directly to the COPES provider.

(a) The client's monthly participation amount for services provided under COPES, if there is one, ((~~for services provided under COPES~~)) is paid separately to the COPES provider; and

(b) Hospice agencies must bill the medicaid agency's hospice program directly for hospice services, not the COPES program.

AMENDATORY SECTION (Amending WSR 16-03-035, filed 1/12/16, effective 2/12/16)

WAC 182-551-1530 Payment method for medicaid-medicare dual eligible clients. (1) The medicaid agency ((~~will~~)) does not pay the portion of hospice care for a client ((~~that~~)) who is covered under medicare part A. Nursing home room and board charges described in WAC 182-551-1510 that are not covered under medicare part A may be covered by the medicaid agency.

(2) The medicaid agency may pay for hospice care provided to a client:

(a) Covered by medicaid part B (medical insurance); and

(b) Not covered by medicare part A.

(3) For hospice care provided to a medicaid-medicare dual eligible client, hospice agencies are responsible to bill:

(a) Medicare before billing the medicaid agency;

(b) The medicaid agency for hospice nursing facility room and board;

(c) The medicaid agency for hospice care center room and board; and

(d) Medicare for general inpatient care or inpatient respite care.

(4) All the limitations and requirements related to hospice care described in subchapter I apply to the payments described in this section.

AMENDATORY SECTION (Amending WSR 12-09-079, filed 4/17/12, effective 5/18/12)

WAC 182-551-1810 Pediatric palliative care (PPC) case management/coordination services—Client eligibility. To receive pediatric palliative care (PPC) case management/coordination services, a person must:

(1) Be ((~~twenty~~)) 20 years of age or younger;

(2) Be a current recipient of the:

(a) Alternative benefit plan (ABP);

(b) Categorically needy program (CNP);

((~~(b)~~)) (c) Limited casualty program - Medically needy program (LCP-MNP);

((~~(c)~~)) (d) CNP - Alien emergency medical;

((~~(d)~~)) (e) LCP-MNP - Alien emergency medical; or

((~~(e)~~)) (f) Children's health insurance program ((~~(SCHIP)~~)) (CHIP); and

(3) Have a life-limiting medical condition that requires case management and coordination of medical services due to at least three of the following circumstances:

(a) An immediate medical need during a time of crisis;

(b) Coordination with family member(s) and providers required in more than one setting (i.e., school, home, and multiple medical offices or clinics);

(c) A life-limiting medical condition that impacts cognitive, social, and physical development;

(d) A medical condition with which the family is unable to cope;

(e) A family member(s) and/or caregiver who needs additional knowledge or assistance with the client's medical needs; ((~~and~~)) or

(f) Therapeutic goals focused on quality of life, comfort, and family stability.

(4) See WAC 182-551-1860 for concurrent palliative and curative care for hospice clients ((~~twenty years of~~)) age 20 and younger.

AMENDATORY SECTION (Amending WSR 12-09-079, filed 4/17/12, effective 5/18/12)

WAC 182-551-1820 Pediatric palliative care (PPC) contact—Services included and limitations to coverage. (1) The medicaid agency's pediatric palliative care (PPC) case management/coordination services ((~~cover~~)) allows, without prior authorization, up to six pediatric palliative care contacts per client, per calendar month, subject to the limitations in this section and other applicable WAC. See WAC 182-501-0169 for limitation extension requests.

(2) One pediatric palliative care contact consists of:

(a) One visit with a registered nurse, social worker, or therapist (for the purpose of this section, the medicaid agency defines therapist as a licensed physical therapist, occupational therapist, or speech/language therapist) with the client in the client's residence to address:

(i) Pain and symptom management;

(ii) Psychosocial counseling; or

(iii) Education/training.

(b) Two hours or more per month of case management or coordination services to include any combination of the following:

(i) Psychosocial counseling services ((~~(includes~~)), including grief support provided to the client, client's family member(s), or client's caregiver prior to the client's death((~~)~~));

(ii) Establishing or implementing care conferences;

(iii) Arranging, planning, coordinating, and evaluating community resources to meet the client's needs;

(iv) Visits lasting ((~~twenty~~)) 20 minutes or less (for example, visits to give injections, drop off supplies, or make appointments for other PPC-related services.); and

(v) Visits not provided in the client's home.

(3) The medicaid agency does not pay for a pediatric palliative care contact described in subsection (2) of this section when a client is receiving services from any of the following:

(a) Home health program;

(b) Hospice program;

(c) Private duty nursing (private duty nursing can subcontract with PPC to provide services)/medical intensive care;

(d) Disease case management program; or

(e) Any other medicaid program that provides similar services.

(4) The medicaid agency does not pay for a pediatric palliative care contact that includes providing counseling services to a client's family member or the client's caregiver for grief or bereavement for dates of service after a client's death.

AMENDATORY SECTION (Amending WSR 12-09-079, filed 4/17/12, effective 5/18/12)

WAC 182-551-1830 How to become a medicaid-approved pediatric palliative care (PPC) case management/coordination services provider. This section applies to medicaid-approved providers who currently do not provide pediatric palliative care (PPC) services to ((~~medical assistance~~)) medicaid clients.

(1) To apply to become a medicaid-approved provider of PPC services, a provider must:

(a) Be a medicaid-approved hospice agency (see WAC 182-551-1300 and 182-551-1305); and

(b) Submit a letter to the medicaid agency's hospice/PPC program manager requesting to become a medicaid-approved provider of PPC and include a copy of the provider's policies and position descriptions with minimum qualifications specific to pediatric palliative care.

(2) A hospice agency qualifies to provide PPC services when:

(a) All the requirements in this section are met; and

(b) The medicaid agency provides the hospice agency with written notification.

AMENDATORY SECTION (Amending WSR 12-09-079, filed 4/17/12, effective 5/18/12)

WAC 182-551-1840 Pediatric palliative care (PPC) case management/coordination services—Provider requirements. (1) An eligible provider of pediatric palliative care (PPC) case management/coordination services must ((~~do all of the following~~)):

(a) Meet the ((~~conditions~~)) requirements in WAC 182-551-1300;

(b) Confirm that a client meets the eligibility criteria in WAC 182-551-1810 prior to providing the pediatric palliative care services;

(c) Place in the client's medical record a written order for PPC from the client's physician;

(d) Determine and document in the client's medical record the medical necessity for the initial and ongoing care coordination of pediatric palliative care services;

(e) Document in the client's medical record:

(i) A palliative plan of care (POC) ((~~(a written document based on assessment of a client's individual needs that identifies services to meet those needs).~~));

(ii) The medical necessity for those services to be provided in the client's residence; and

(iii) Discharge planning.

(f) Provide medically necessary skilled interventions and psychosocial counseling services by qualified interdisciplinary hospice team members;

(g) Assign and make available a PPC case manager (nurse, social worker or therapist) to implement care coordination with community-based providers to assure clarity, effectiveness, and safety of the client's POC;

(h) Complete and fax the pediatric palliative care (PPC) referral and 5-Day Notification form (HCA 13-752) to the medicaid agency's PPC program manager within five ((~~working~~)) business days from date of occurrence of the client's:

(i) Date of enrollment in PPC.

(ii) Discharge from the hospice agency or PPC program when the client:

(A) No longer meets PPC criteria;

(B) Is able to receive all care in the community;

(C) Does not require any services for ((~~sixty~~)) 60 calendar days; or

(D) Discharges from the PPC program and enrolls in the medicaid hospice program.

(iii) Transfer to another hospice agency for pediatric palliative care services.

(iv) Death.

(i) Maintain the client's file which includes the POC, visit notes, and all of the following:

(i) The client's start of care date and dates of service;

(ii) Discipline and services provided (in-home or place of service);

(iii) Case management activity and documentation of hours of work; and

(iv) Specific documentation of the client's and/or the client's family's response to the palliative care and ((~~the client's and/or client's family's response to the~~)) its effectiveness ((~~of the palliative care (e.g~~)). For example, the client might have required acute care or hospital emergency room visits without the pediatric palliative care services((~~).~~)); and

(j) Provide, when requested by the medicaid agency's PPC program manager, a copy of the client's POC, visit notes, and any other documents listing the information identified in subsection (1)(i) of this section.

(2) If the medicaid agency determines the POC, visit notes, and/or other required information do not meet the criteria for a client's PPC eligibility or does not justify the billed amount, any payment to the provider is subject to recoupment by the medicaid agency.

AMENDATORY SECTION (Amending WSR 18-24-008, filed 11/26/18, effective 1/1/19)

WAC 182-551-1860 Concurrent care for hospice clients age ((~~twenty~~)) 20 and younger. (1) In accordance with 42 U.S.C. 1396d (o)(1)(C), a client age ((~~twenty~~)) 20 and younger may voluntarily elect hospice care without waiving any rights to services that the client is entitled to under Title XIX Medicaid and Title XXI Children's Health Insurance Program (CHIP) that are related to the treatment of the client's condition for which a diagnosis of terminal illness has been made.

(2) The related services in subsection (1) of this section and medications requested for clients age ((~~twenty~~)) 20 and younger are subject to the medicaid agency's specific program rules governing those services or medications.

(3) When a noncovered service is recommended based on the early ((~~and~~)) periodic screening, diagnosis, and treatment (EPSDT) program for a child age 20 and younger, ((~~the agency evaluates the request for medical necessity based on the definition in WAC 182-500-0070 and the process in WAC 182-501-0165~~)) providers must follow the rules in chapter 182-534 WAC.

(4) If the medicaid agency denies a request for a covered service, refer to WAC 182-502-0160, billing a client, for when a client may be responsible to pay for a covered service.