



EXPEDITED RULE MAKING

CR-105 (June 2024) (Implements RCW 34.05.353)

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Agency: Health Care Authority

Title of rule and other identifying information: (describe subject)

182-502-0120, Payment for health care services provided outside the state of Washington

182-503-0090, Washington apple health—Exceptions to rule

182-503-0120, Washington apple health—Equal access services

182-508-0200, Civil transition program (CTP)—Overview

182-513-1100, Definitions related to long-term services and supports (LTSS)

182-513-1105, Personal needs allowance (PNA) and room and board standards in a medical institution and alternate living facility (ALF)

182-513-1235, Roads to community living (RCL)

182-513-1316, General eligibility requirements for long-term care (LTC) programs

182-513-1318, Income and resource criteria for home and community based (HCB) waiver programs and hospice

182-515-1509, Home and community based (HCB) waiver services authorized by home and community services (HCS)—Client financial responsibility

182-515-1510, Home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA)

182-515-1511, Home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA)—General eligibility

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

182-515-1513, Home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA)—Financial eligibility using SSI-related institutional rules

182-515-1514, Home and community based (HCB) services authorized by the developmental disabilities administration (DDA)—Client financial responsibility

182-527-2730, Definitions

182-527-2740, Estate recovery—Age-related limitations

182-527-2742, Estate recovery—Service-related limitations

182-530-7350, Reimbursement—Unit dose drug delivery systems

182-531A-0600, Applied behavior analysis (ABA)—Stage two: Functional assessment and treatment plan development

182-535-1082, Covered—Preventive services

182-535-1084, Dental-related services—Covered—Restorative services

182-535-1088, Dental-related services—Covered—Periodontic services

182-535-1098, Covered—Adjunctive general services

182-535-1099, Dental-related services for clients of the developmental disabilities administration of the department of social and health services

182-551-3100, Private duty nursing for clients age seventeen and younger—Client eligibility

182-551-3200, Private duty nursing for clients age seventeen and younger—Provider requirements

182-551-3300, Private duty nursing for clients age seventeen and younger—Application requirements

182-551-3400, Private duty nursing for clients age seventeen and younger—Authorization

182-559-200, Eligible providers

Purpose of the proposal and its anticipated effects, including any changes in existing rules: Change state agency unit names

Reasons supporting proposal: The agency is amending its rules because of a reorganization within the Washington State Department of Social and Health Services. References in Title 182 WAC to the aging and long-term support administration (ALISA) are being changed to the home and community living administration (HCLA). References to the developmental disabilities administration (DDA) are being changed to the developmental disabilities community services (DDCS) division.

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Statute being implemented: RCW 41.05.021, 41.05.160

Is rule necessary because of a:

Federal Law?	☐ Yes	☒ No
Federal Court Decision?	☐ Yes	☒ No
State Court Decision?	☐ Yes	☒ No

If yes, CITATION:

Name of proponent: (person or organization) Health Care Authority

☐ Private
☐ Public
☒ Governmental

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting:	Brian Jensen	PO Box 42716, Olympia, WA 98504-2716	360-725-0815
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Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters: None

Expedited Adoption - Which of the following criteria was used by the agency to file this notice:

- ☐ Relates only to internal governmental operations that are not subject to violation by a person;
- ☐ Adopts or incorporates by reference without material change federal statutes or regulations, Washington state statutes, rules of other Washington state agencies, shoreline master programs other than those programs governing shorelines of statewide significance, or, as referenced by Washington state law, national consensus codes that generally establish industry standards, if the material adopted or incorporated regulates the same subject matter and conduct as the adopting or incorporating rule;
- ☒ Corrects typographical errors, make address or name changes, or clarify language of a rule without changing its effect;
- ☐ Content is explicitly and specifically dictated by statute;
- ☐ Have been the subject of negotiated rule making, pilot rule making, or some other process that involved substantial participation by interested parties before the development of the proposed rule; or
- ☐ Is being amended after a review under RCW 34.05.328.

Expedited Repeal - Which of the following criteria was used by the agency to file notice:

- ☐ The statute on which the rule is based has been repealed and has not been replaced by another statute providing statutory authority for the rule;
- ☐ The statute on which the rule is based has been declared unconstitutional by a court with jurisdiction, there is a final judgment, and no statute has been enacted to replace the unconstitutional statute;
- ☐ The rule is no longer necessary because of changed circumstances; or
- ☐ Other rules of the agency or of another agency govern the same activity as the rule, making the rule redundant.

Explanation of the reason the agency believes the expedited rule-making process is appropriate pursuant to RCW 34.05.353(4): The proposed rule amendments are for the purpose of changing the names of units of a state agency.

NOTICE

THIS RULE IS BEING PROPOSED UNDER AN EXPEDITED RULE-MAKING PROCESS THAT WILL ELIMINATE THE NEED FOR THE AGENCY TO HOLD PUBLIC HEARINGS, PREPARE A SMALL BUSINESS ECONOMIC IMPACT STATEMENT, OR PROVIDE RESPONSES TO THE CRITERIA FOR A SIGNIFICANT LEGISLATIVE RULE. IF YOU OBJECT TO THIS USE OF THE EXPEDITED RULE-MAKING PROCESS, YOU MUST EXPRESS YOUR OBJECTIONS IN WRITING AND THEY MUST BE SENT TO

Name: Wendy Barcus, HCA Rules Coordinator

Agency: Health Care Authority

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Other:

BEGINNING (date/time) August 27, 2025, 8:00 a.m. **AND RECEIVED BY** (date/time) November 3, 2025, 11:59 p.m.

Date: August 26, 2025

Name: Wendy Barcus

Title: HCA Rules Coordinator

Signature:



WAC 182-502-0120 Payment for health care services provided outside the state of Washington. (1) The medicaid agency pays for health care services provided outside the state of Washington only when the service meets the provisions described in WAC 182-501-0180, 182-501-0182, 182-501-0184, and specific program WAC.

(2) With the exception of hospital services and nursing facilities, the agency pays the provider of service in designated bordering cities as if the care was provided within the state of Washington (see WAC 182-501-0175).

(3) With the exception of designated bordering cities, the agency does not pay for health care services provided to clients in medical care services (MCS) programs outside the state of Washington.

(4) With the exception of hospital services (see subsection (5) of this section), the agency pays for health care services provided outside the state of Washington at the lower of:

(a) The billed amount; or

(b) The rate established by the Washington apple health programs.

(5) The agency pays for hospital services provided in designated bordering cities and outside the state of Washington under WAC 182-550-3900, 182-550-4000, 182-550-4800, and 182-550-6700.

(6) The agency pays nursing facilities located outside the state of Washington when approved by the ~~((aging and long-term support administration (ALTSA)))~~ home and community living administration (HCLA) at the lower of the billed amount or the adjusted statewide average reimbursement rate for in-state nursing facility care, only in the following limited circumstances:

(a) Emergency situations; or

(b) When the client intends to return to Washington state and the out-of-state stay is for:

(i) Thirty days or less; or

(ii) More than ~~((thirty))~~ 30 days if approved by ~~((ALTSA))~~ HCLA.

(7) To receive payment from the agency, an out-of-state provider must:

(a) Have a signed agreement with the agency;

(b) Meet the functionally equivalent licensing requirements of the state or province in which care is rendered;

(c) Meet the conditions in WAC 182-502-0100 and 182-502-0150;

(d) Satisfy all medicaid conditions of participation;

(e) Accept the agency's payment as payment in full according to 42 C.F.R. 447.15; and

(f) If a Canadian provider, bill at the U.S. exchange rate in effect when the service was provided.

(8) For covered services for eligible clients, the agency reimburses other approved out-of-state providers at the lower of:

(a) The billed amount; or

(b) The rate paid by the Washington state Title XIX medicaid program.

AMENDATORY SECTION (Amending WSR 21-04-076, filed 1/29/21, effective 3/1/21)

WAC 182-503-0090 Washington apple health—Exceptions to rule.

(1) A client or client's representative may request an exception to a Washington apple health financial eligibility rule in Title 182 WAC. The request for an exception to rule (ETR) may be submitted orally or in writing. The request must:

(a) Be received within ~~((ninety))~~ 90 calendar days of the agency action with which the client disagrees or wants waived;

(b) Identify the rule for which an exception is being requested;

(c) State what the client is requesting; and

(d) Describe how the request meets subsection (2) of this section.

(2) The agency director or designee has the discretion to grant an ETR if they determine that the client's circumstances satisfy the conditions below:

(a) The exception would not contradict a specific provision of federal or state law; and

(b) The client's situation differs from the majority; and

(c) It is in the interest of the overall economy and the client's welfare, and:

(i) It increases opportunity for the client to function effectively; or

(ii) The client has an impairment or limitation that significantly interferes with the usual procedures required to determine eligibility and payment.

(3) A client does not have a right to an administrative hearing on ETR decisions under chapter 182-526 WAC.

(4) A client is mailed a decision in writing within ~~((ten))~~ 10 calendar days when agency staff:

(a) Approve or deny an ETR request; or

(b) Request more information.

(5) If the ETR is approved, the notice includes information on what is approved and for what time frame.

(6) The agency designates staff at the ~~((aging and long-term support administration (AL TSA) and the developmental disabilities administration (DDA)))~~ home and community living administration (HCLA) to process all ETRs specifically relating to long-term services and supports programs described in Title 182 WAC.

(7) This section does not apply to requests that the agency pay for noncovered medical or dental services or related equipment. WAC 182-501-0160 applies to such requests.

AMENDATORY SECTION (Amending WSR 14-06-068, filed 2/28/14, effective 3/31/14)

WAC 182-503-0120 Washington apple health—Equal access services.

(1) When you have a mental, neurological, cognitive, physical or sensory impairment, or limitation that prevents you from receiving health care coverage, we provide services to help you apply for, maintain, and understand the health care coverage options available and eligi-

bility decisions we make. These services are called equal access (EA) services.

(2) We provide EA services on an ongoing basis to ensure that you are able to maintain health care coverage and access to services we provide. EA services include, but are not limited to:

- (a) Helping you to:
 - (i) Apply for or renew coverage;
 - (ii) Complete and submit forms;
 - (iii) Give us information to determine or continue your eligibility;
 - (iv) Ask for continued coverage;
 - (v) Ask for reinstated (restarted) coverage after your coverage ends; and
 - (vi) Ask for and participate in a hearing.

(b) Giving you additional time, when needed, for you to give us information before we reduce or end your health care coverage;

(c) Explaining our decision to change, reduce, end, or deny your health care coverage;

(d) Working with your authorized representative, if you have one, and giving that person copies of notices and letters we send you; and

(e) Providing you the services of a sign language interpreter/transliterator who is certified by the Registry of Interpreters for the Deaf at the appropriate level of certification.

(i) These services may include in-person sign language interpreter services, relay interpreter services, and video interpreter services, as well as other services; we decide which services to offer you based on your communication needs and preferences.

(ii) We offer these services as a reasonable accommodation, free of charge, if you are deaf, hard-of-hearing, or a deaf-blind person who uses sign language to communicate.

(f) Not taking adverse action in your case, or automatically reinstating your coverage for up to three months after the adverse action was taken, if we determine that your impairment or limitation was the cause of your failure to follow through on something you need to do to get or keep your Washington apple health coverage, such as:

- (i) Applying for or renewing coverage;
- (ii) Completing and submitting forms;
- (iii) Giving us information to determine or continue your eligibility;

(iv) Asking for continued or reinstated coverage; or

(v) Asking for and participating in a hearing.

(3) We inform you of your right to EA services listed in subsection (2) of this section:

(a) On printed applications and notices, including the printed rights and responsibilities form;

(b) In the Washington healthplanfinder website, including the electronic rights and responsibilities form; and

(c) During contact with us.

(4) We provide you the EA services listed in subsection (2) of this section if you ask for EA services, you are receiving services through the ((aging and long-term support)) home and community living administration, or we determine that you would benefit from EA services. We determine you would benefit from EA services if you:

(a) Appear to have or claim to have any impairment or limitation described in subsection (1) of this section;

(b) Have a developmental disability;

(c) Are disabled by alcohol or drug addiction;

- (d) Are unable to read or write in any language;
 - (e) Appear to have limitations in your ability to communicate, understand, remember, process information, exercise judgment and make decisions, perform routine tasks, or relate appropriately with others (whether or not you have a disability) that may prevent you from understanding the nature of EA services or affect your ability to access our programs; or
 - (f) Are a minor not residing with your parents.
- (5) If we determine that you are eligible for EA services, we develop and document an EA plan appropriate to your needs. The plan may be updated or changed at any time based on your request or a change in your needs.
- (6) You may at any time refuse the EA services offered to you.
- (7) We reinstate your coverage when:
- (a) We end coverage because we were unable to determine if you continue to qualify; and
 - (b) You provide proof that you are still qualified for coverage within ((~~twenty~~)) 20 calendar days from when we ended your coverage. We restore your coverage retroactive to the first of the month so there is no break in your coverage.
- (8) If you believe that we have discriminated against you on the basis of a disability or another protected status, the person may file a complaint with the U.S. Department of Health and Human Services at <http://www.hhs.gov/ocr/civilrights/complaints> or Region Manager, Office for Civil Rights, U.S. Department of Health and Human Services, 2201 Sixth Ave. - M/S: RX-11, Seattle, WA 98121-1831 (voice phone 800-368-1019, fax 206-615-2297, TDD 800-537-7697).

WAC 182-508-0200 Civil transition program (CTP)—Overview. (1)

The civil transition program (CTP) is a state-funded, fee-for-service program that requires the department of social and health services (department) to provide wraparound services and supports in community-based settings, which may include residential supports, to persons who have been found not competent to stand trial due to an intellectual or developmental disability, dementia, or traumatic brain injury. This apple health program is for persons who are not eligible for any other federal or state-funded medical coverage.

(2) **Definitions.** The following definitions and those found in chapter 388-106 WAC apply to this section unless otherwise stated.

"**Participation**" has the same meaning given in WAC 182-513-1100.

"**Room and board**" has the same meaning given in WAC 182-513-1100.

"**Wraparound services**" means coordination of services between the individual and service providers.

(3) **General eligibility.** Effective December 1, 2023, a person is eligible for the CTP when the person:

(a) Has been referred to the home and community services (HCS) division or the developmental disabilities ~~((administration—(DDA)))~~ community services (DDCS) division by the behavioral health and habilitation administration and found not competent to stand trial due to dementia, traumatic brain injury, or an intellectual or developmental disability as described in WAC 388-106-2005;

(b) Applies for apple health coverage as described in WAC 182-503-0005; and

(c) Is not eligible for other federal or state-funded medical coverage.

(4) HCS long-term services and supports (LTSS) for persons 18 years and older are governed by chapter 388-106 WAC when LTSS services are authorized by the department.

(5) ~~((DDA))~~ DDCS services are governed by chapter 388-825 WAC.

(6) **Client participation.**

(a) A person who is not otherwise eligible for a noninstitutional medical program must have client participation and room and board. Home and community-based services waiver eligibility and cost of care calculations are under:

(i) WAC 182-515-1508 and 182-515-1509 for HCS services; and

(ii) WAC 182-515-1513 and 182-515-1514 for ~~((DDA))~~ DDCS services.

(b) Changes in income or deductions may affect the amount a person pays toward LTSS including room and board in an alternate living facility based on chapter 182-515 WAC.

(7) **Effective dates.**

(a) Eligibility for the CTP begins on the date the person:

(i) Does not meet financial or functional eligibility for LTSS that is covered under another apple health coverage group; or

(ii) Meets the criteria described in WAC 388-106-2000 through 388-106-2040.

(b) Eligibility for the CTP ends the earlier of:

(i) When the person moves out-of-state;

(ii) When the person dies;

(iii) The date the person becomes eligible for federal or state-funded medical coverage;

(iv) Six months after the start date of the first CTP-eligible service; or

(v) When CTP services end.

(c) CTP effective dates are subject to WAC 182-504-0120 and 388-106-2030.

(8) **Administrative hearings.** A person who disagrees with an agency or the agency's designee action under this section may request an administrative hearing under chapter 182-526 WAC.

WAC 182-513-1100 Definitions related to long-term services and supports (LTSS). This section defines the meaning of certain terms used in chapters 182-513 and 182-515 WAC. Within these chapters, institutional, home and community-based services (HCBS) waiver, program of all-inclusive care for the elderly (PACE), and hospice in a medical institution are referred to collectively as long-term care (LTC). Long-term services and supports (LTSS) is a broader definition which includes institutional, HCBS waiver, and other services such as medic-aid personal care (MPC), community first choice (CFC), PACE, and hospice in the community.

- See chapter 182-516 WAC for definitions related to trusts, annuities, life estates, and promissory notes.

- See chapter 388-106 WAC for long-term care services definitions.

- See WAC 182-513-1405 for long-term care partnership definitions.

- See chapter 182-500 WAC for additional apple health eligibility definitions.

"Adequate consideration" means that the fair market value (FMV) of the property or services received, in exchange for transferred property, approximates the FMV of the property transferred.

"Administrative costs" or "costs" means necessary costs paid by the guardian or conservator including attorney fees.

~~((**"Aging and long-term support administration (ALISA)"** means the administration within the Washington state department of social and health services (DSHS).))~~

"Alternate living facility (ALF)" is not an institution under WAC 182-500-0050; it is one of the following community residential facilities:

- (a) Adult family home (AFH) licensed under chapter 70.128 RCW.

- (b) Adult residential care facility (ARC) licensed under chapter 18.20 RCW.

- (c) Assisted living facility (AL) licensed under chapter 18.20 RCW.

- (d) Behavioral health adult residential treatment facility (RTF) licensed under chapter 246-337 WAC.

- (e) Intensive behavioral health treatment facility (IBHTF) is an RTF licensed under chapter 246-337 WAC.

- (f) Developmental disabilities ~~((administration (DDA)))~~ community services (DDCS) group home (GH) licensed as an adult family home under chapter 70.128 RCW or an assisted living facility under chapter 18.20 RCW.

- (g) Enhanced adult residential care facility (EARC) licensed as an assisted living facility under chapter 18.20 RCW.

- (h) Enhanced service facility (ESF) licensed under chapter 70.97 RCW.

- (i) Facility for children and youth 20 years of age and younger where a state-operated living alternative program, as defined under chapter 71A.10 RCW, is operated.

- (j) Group care facility for medically complex children licensed under chapter 74.15 RCW.

- (k) Staffed residential facility licensed under chapter 74.15 RCW.

"Assets" means all income and resources of a person and of the person's spouse, including any income or resources which that person or that person's spouse would otherwise currently be entitled to but does not receive because of action:

(a) By that person or that person's spouse;

(b) By another person, including a court or administrative body, with legal authority to act in place of or on behalf of the person or the person's spouse; or

(c) By any other person, including any court or administrative body, acting at the direction or upon the request of the person or the person's spouse.

"Authorization date" means the date payment begins for long-term services and supports (LTSS) under WAC 388-106-0045.

"Clothing and personal incidentals (CPI)" means the cash payment (under WAC 388-478-0090, 388-478-0006, and 388-478-0033) issued by the department for clothing and personal items for people living in an ALF or medical institution.

"Community first choice (CFC)" means a medicaid state plan home and community-based service developed under the authority of section 1915(k) of the Social Security Act under chapter 388-106 WAC.

"Community options program entry system (COPES)" means a medicaid home and community-based services (HCBS) waiver program developed under the authority of section 1915(c) of the Social Security Act under chapter 388-106 WAC.

"Community spouse (CS)" means the spouse of an institutionalized spouse.

"Community spouse resource allocation (CSRA)" means the resource amount that may be transferred without penalty from:

(a) The institutionalized spouse (IS) to the community spouse (CS); or

(b) The spousal impoverishment protections institutionalized (SIPI) spouse to the spousal impoverishment protections community (SIPC) spouse.

"Community spouse resource evaluation" means the calculation of the total value of the resources owned by a married couple on the first day of the first month of the institutionalized spouse's most recent continuous period of institutionalization.

"Comprehensive assessment reporting evaluation (CARE) assessment" means the evaluation process defined under chapter 388-106 WAC used by a department designated social services worker or a case manager to determine a person's need for long-term services and supports (LTSS).

"Conservator" has the same meaning given in RCW 11.130.010.

"Conservatorship" means the process outlined in chapter 11.130 RCW for appointing a conservator and a conservator's carrying out of any duties pursuant to an order entered under RCW 11.130.360 through 11.130.575.

"Conservatorship fees" or "fees" means necessary fees charged by a conservator for services rendered on behalf of a client.

"Continuing care contract" means a contract to provide a person, for the duration of that person's life or for a term in excess of one year, shelter along with nursing, medical, health-related, or personal care services, which is conditioned upon the transfer of property, the payment of an entrance fee to the provider of such services, or the payment of periodic charges for the care and services involved.

"Continuing care retirement community" means an entity which provides shelter and services under continuing care contracts with its

members and which sponsors or includes a health care facility or a health service.

"Dependent" means a minor child, or one of the following who meets the definition of a tax dependent under WAC 182-500-0105: Adult child, parent, or sibling.

"Developmental disabilities ((administration—(DDA))) community services (DDCS)" means ((an administration)) a division within the Washington state department of social and health services (DSHS).

"Developmental disabilities ((administration—(DDA))) community services (DDCS) home and community-based services (HCBS) waiver" means a medicaid HCBS waiver program developed under the authority of section 1915(c) of the Social Security Act under chapter 388-845 WAC authorized by ((DDA)) DDCS. There are five ((DDA)) DDCS HCBS waivers:

- (a) Basic Plus;
- (b) Core;
- (c) Community protection;
- (d) Children's intensive in-home behavioral support (CIIBS); and
- (e) Individual and family services (IFS).

"Equity" means the fair market value of real or personal property less any encumbrances (mortgages, liens, or judgments) on the property.

"Fair market value (FMV)" means the price an asset may reasonably be expected to sell for on the open market in an agreement, made by two parties freely and independently of each other, in pursuit of their own self-interest, without pressure or duress, and without some special relationship (arm's length transaction), at the time of transfer or assignment.

"Guardian" has the same meaning given in RCW 11.130.010.

"Guardianship" means the process outlined in chapter 11.130 RCW for appointing a guardian and a guardian's carrying out of any duties pursuant to an order entered under RCW 11.130.265 through 11.130.355.

"Guardianship fees" or "fees" means necessary fees charged by a guardian for services rendered on behalf of a client.

"Home and community living administration (HCLA)" means the administration within the Washington state department of social and health services.

"Home and community-based services (HCBS) waiver programs authorized by home and community services (HCS)" means medicaid HCBS waiver programs developed under the authority of Section 1915(c) of the Social Security Act under chapter 388-106 WAC authorized by HCS. There are three HCS HCBS waivers: Community options program entry system (COPES), new freedom consumer directed services (New Freedom), and residential support waiver (RSW).

"Home and community-based services (HCBS)" means LTSS provided in the home or a residential setting to persons assessed by the department.

"Institutional services" means services paid for by Washington apple health, and provided:

- (a) In a medical institution;
- (b) Through an HCBS waiver; or
- (c) Through programs based on HCBS waiver rules for post-eligibility treatment of income under chapter 182-515 WAC.

"Institutionalized individual" means a person who has attained institutional status under WAC 182-513-1320.

"Institutionalized spouse" means a person who, regardless of legal or physical separation:

- (a) Has attained institutional status under WAC 182-513-1320; and

(b) Is legally married to a person who is not in a medical institution.

"Life care community" see continuing care community.

"Likely to reside" means the agency or its designee reasonably expects a person will remain in a medical institution for 30 consecutive days. Once made, the determination stands, even if the person does not actually remain in the facility for that length of time.

"Long-term care services" see "Institutional services."

"Long-term services and supports (LTSS)" includes institutional and noninstitutional services authorized by the department.

"Medicaid alternative care (MAC)" is a Washington apple health benefit authorized under Section 1115 of the Social Security Act. It enables the medicaid agency and the agency's designees to deliver an array of person-centered long-term services and supports (LTSS) to unpaid caregivers caring for a medicaid-eligible person who meets nursing facility level of care under WAC 388-106-0355 and 182-513-1605.

"Medicaid personal care (MPC)" means a medicaid state plan home and community-based service under chapter 388-106 WAC.

"Most recent continuous period of institutionalization (MRCPI)" means the current period an institutionalized spouse has maintained uninterrupted institutional status when the request for a community spouse resource evaluation is made. Institutional status is determined under WAC 182-513-1320.

"Noninstitutional medicaid" means any apple health program not based on HCBS waiver rules under chapter 182-515 WAC, or rules based on a person residing in an institution for 30 days or more under chapter 182-513 WAC.

"Nursing facility level of care (NFLOC)" is described in WAC 388-106-0355.

"Participation" means the amount a person must pay each month toward the cost of long-term care services received each month; it is the amount remaining after the post-eligibility process under WAC 182-513-1380, 182-515-1509, or 182-515-1514. Participation is not room and board.

"Penalty period" or **"period of ineligibility"** means the period of time during which a person is not eligible to receive services that are subject to transfer of asset penalties.

"Personal needs allowance (PNA)" means an amount set aside from a person's income that is intended for personal needs. The amount a person is allowed to keep as a PNA depends on whether the person lives in a medical institution, ALF, or at home.

"Presumptive eligibility (PE)" for long-term services and supports is described in WAC 182-513-1110.

"Program of all-inclusive care for the elderly (PACE)" provides long-term services and supports (LTSS), medical, mental health, and substance use disorder (SUD) treatment through a department-contracted managed care plan using a personalized plan of care for each enrollee.

"Roads to community living (RCL)" is a demonstration project authorized under Section 6071 of the Deficit Reduction Act of 2005 (P.L. 109-171) and extended through the Patient Protection and Affordable Care Act (P.L. 111-148).

"Room and board" means the amount a person must pay each month for food, shelter, and household maintenance requirements when that person resides in an ALF. Room and board is not participation.

"Short stay" means residing in a medical institution for a period of 29 days or fewer.

"Significant financial duress" means, but is not limited to, threatened loss of, or financial burden from, basic shelter, food, or medically necessary health care. It means that a member of a couple has established to the satisfaction of a hearing officer that the community spouse needs income above the level permitted by the community spouse maintenance standard to provide for medical, remedial, or other support needs of the community spouse to permit the community spouse to remain in the community.

"Special income level (SIL)" means the monthly income standard that is 300 percent of the supplemental security income (SSI) federal benefit rate.

"Spousal impoverishment protections" means the financial provisions within Section 1924 of the Social Security Act that protect income and assets of the community spouse through income and resource allocation. The allocation process is used to discourage the impoverishment of a spouse due to the other spouse's need for LTSS. This includes services provided in a medical institution, HCBS waivers authorized under 1915(c) of the Social Security Act, and through September 30, 2027, services authorized under 1115 and 1915(k) of the Social Security Act.

"Spousal impoverishment protections community (SIPC) spouse" means the spouse of a SIPI spouse.

"Spousal impoverishment protections institutionalized (SIPI) spouse" means a legally married person who qualifies for the noninstitutional categorically needy (CN) Washington apple health SSI-related program only because of the spousal impoverishment protections under WAC 182-513-1220.

"State spousal resource standard" means the minimum CSRA standard for a CS or SIPC spouse.

"Tailored supports for older adults (TSOA)" is a federally funded program approved under Section 1115 of the Social Security Act. It enables the medicaid agency and the agency's designees to deliver person-centered long-term services and supports (LTSS).

"Third-party resource (TPR)" means funds paid to or on behalf of a person by a third party, where the purpose of the funds is for payment of activities of daily living, medical services, or personal care. The agency does not pay for these services if there is a third-party resource available.

"Transfer" means, in the context of long-term care eligibility, the changing of ownership or title of an asset, such as income, real property, or personal property, by one of the following:

- (a) An intentional act that changes ownership or title; or
- (b) A failure to act that results in a change of ownership or title.

"Uncompensated value" means the fair market value (FMV) of an asset on the date of transfer, minus the FMV of the consideration the person receives in exchange for the asset.

"Undue hardship" means a person is not able to meet shelter, food, clothing, or health needs. A person may apply for an undue hardship waiver based on criteria under WAC 182-513-1367.

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

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

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

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

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

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

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

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

(6) Effective January 1, 2024, and each year thereafter, the amount of the PNA in subsection (5) of this section will be adjusted by the percentage of the cost-of-living adjustment (COLA) for old-age, survivors, and disability social security benefits as published by the federal Social Security Administration, per RCW 74.09.340.

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

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

WAC 182-513-1235 Roads to community living (RCL). (1) Roads to community living (RCL) is a demonstration project authorized under Section 6071 of the Deficit Reduction Act of 2005 (P.L. 109-171) and extended through the Patient Protection and Affordable Care Act (P.L. 111-148).

(2) Program rules governing functional eligibility for RCL are described in WAC 388-106-0250 through 388-106-0265. RCL services are authorized by the department.

(3) A person must have a stay of at least ~~((sixty))~~ 60 consecutive days in a qualified institutional setting such as a hospital, nursing home, or residential habilitation center, to be eligible for RCL. The ~~((sixty))~~ 60-day count excludes days paid solely by medicare, must include at least one day of medicaid paid inpatient services immediately prior to discharge, and the person must be eligible to receive any categorically needy (CN), medically needy (MN), or alternate benefit plan (ABP) medicaid program on the day of discharge. In addition to meeting the ~~((sixty))~~ 60-day criteria, a person who is being discharged from a state psychiatric hospital must be under age ~~((twenty-two))~~ 22 or over age ~~((sixty-four))~~ 64.

(4) Once a person is discharged to home or to a residential setting under RCL, the person remains continuously eligible for medical coverage for ~~((three hundred sixty-five))~~ 365 days unless the person:

- (a) Returns to an institution for ~~((thirty))~~ 30 days or longer;
- (b) Is incarcerated in a public jail or prison;
- (c) No longer wants RCL services;
- (d) Moves out-of-state; or
- (e) Dies.

(5) Changes in income or resources during the continuous eligibility period do not affect eligibility for RCL services. Changes in income or deductions may affect the amount a person must pay toward the cost of care.

(6) A person approved for RCL is not subject to transfer of asset provisions under WAC 182-513-1363 during the continuous eligibility period, but transfer penalties may apply if the person needs HCB waiver or institutional services once the continuous eligibility period has ended.

(7) A person who is not otherwise eligible for a noninstitutional medical program must have eligibility determined using the same rules used to determine eligibility for HCB waivers. If HCB rules are used to establish eligibility, the person must pay participation toward the cost of RCL services. HCB waiver eligibility and cost of care calculations are under:

(a) WAC 182-515-1508 and 182-515-1509 for home and community services (HCS); and

(b) WAC 182-515-1513 and 182-515-1514 for ~~((development disabilities administration (DDA) services))~~ developmental disabilities community services (DDCS).

(8) At the end of the continuous eligibility period, the agency or its designee redetermines a person's eligibility for other programs under WAC 182-504-0125.

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

WAC 182-513-1316 General eligibility requirements for long-term care (LTC) programs. (1) To be eligible for long-term care (LTC) services, a person must:

(a) Meet the general eligibility requirements for medical programs under WAC 182-503-0505, except:

(i) An adult age (~~nineteen~~) 19 or older must meet citizenship and immigration status requirements under WAC 182-503-0535 (2)(a) or (b);

(ii) A person under age (~~nineteen~~) 19 must meet citizenship and immigration status requirements under WAC 182-503-0535 (2)(a), (b), (c), or (d); and

(iii) If a person does not meet the requirements in (a)(i) or (ii) of this subsection, the person is not eligible for medicaid and must have eligibility determined under WAC 182-513-1319.

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

(c) Meet the functional eligibility under:

(i) Chapter 388-106 WAC for a home and community services (HCS) home and community based (HCB) waiver or nursing facility coverage; or

(ii) Chapter 388-828 WAC for developmental disabilities (~~administration (DDA)~~) community services (DDCS) HCB waiver or institutional services; and

(d) Meet either:

(i) SSI-related criteria under WAC 182-512-0050; or

(ii) MAGI-based criteria under WAC 182-503-0510(2), if residing in a medical institution. A person who is eligible for MAGI-based coverage is not subject to the provisions under subsection (2) of this section.

(2) A supplemental security income (SSI) recipient or a person meeting SSI-related criteria who needs LTC services must also:

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

(b) Not have equity interest in a primary residence greater than the home equity standard under WAC 182-513-1350; and

(c) Disclose to the agency or its designee any interest the applicant or spouse has in an annuity, which must meet annuity requirements under chapter 182-516 WAC.

(3) A person who receives SSI must submit a signed health care coverage application form attesting to the provisions under subsection (2) of this section. A signed and completed eligibility review for LTC benefits can be accepted for people receiving SSI who are applying for long-term care services.

(4) To be eligible for HCB waiver services, a person must also meet the program requirements under:

(a) WAC 182-515-1505 through 182-515-1509 for HCS HCB waivers; or

(b) WAC 182-515-1510 through 182-515-1514 for (~~DDA~~) DDCS HCB waivers.

WAC 182-513-1318 Income and resource criteria for home and community based (HCB) waiver programs and hospice. (1) This section provides an overview of the income and resource eligibility rules for a person to be eligible for a categorically needy (CN) home and community based (HCB) waiver program under chapter 182-515 WAC or the hospice program under WAC 182-513-1240 and 182-513-1245.

(2) To determine income eligibility for an SSI-related long-term care (LTC) HCB waiver, the agency or its designee:

(a) Determines income available under WAC 182-513-1325 and 182-513-1330;

(b) Excludes income under WAC 182-513-1340;

(c) Compares remaining gross nonexcluded income to:

(i) The special income level (SIL) defined under WAC 182-513-1100; or

(ii) For HCB service programs authorized by the ~~((aging and long-term supports administration (ALTSA)))~~ home and community living administration (HCLA), a higher standard is determined following the rules under WAC 182-515-1508 if a client's income is above the SIL but net income is below the medically needy income level (MNIL).

(3) A person who receives MAGI-based coverage is not eligible for HCB waiver services unless found eligible based on program rules in chapter 182-515 WAC.

(4) To be resource eligible under the HCB waiver program, the person must:

(a) Meet the resource eligibility requirements and standards under WAC 182-513-1350;

(b) Not be in a period of ineligibility due to a transfer of asset penalty under WAC 182-513-1363;

(c) Disclose to the state any interest the person or that person's spouse has in an annuity and meet the annuity requirements under chapter 182-516 WAC.

(5) The agency or its designee determines a person's responsibility to pay toward the cost of care for LTC services as follows:

(a) For people receiving HCS HCB waiver services, see WAC 182-515-1509;

(b) For people receiving ~~((DDA))~~ DDCS HCB waiver services, see WAC 182-515-1514.

(6) To be eligible for the CN hospice program, see WAC 182-513-1240.

(7) To be eligible for the MN hospice program in a medical institution, see WAC 182-513-1245.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WAC 182-515-1510 Home and community based (HCB) waiver services authorized by ((the)) developmental disabilities ((administration-~~DDA~~)) community services (DDCS). This chapter describes the general and financial eligibility requirements for categorically needy (CN) home and community based (HCB) waivers authorized by ((the)) developmental disabilities ((administration-~~DDA~~)) community services (DDCS). The definitions in WAC 182-513-1100 and chapter 182-500 WAC apply throughout this chapter.

(1) The ((~~DDA~~)) DDCS waiver programs are:

(a) Basic Plus;

(b) Core;

(c) Community protection;

(d) Children's intensive in-home behavioral support (CIIBS); and

(e) Individual and family services (IFS).

(2) WAC 182-515-1511 describes the general eligibility requirements for HCB waiver services authorized by ((~~DDA~~)) DDCS.

(3) WAC 182-515-1512 describes the financial requirements for eligibility for HCB waiver services authorized by ((~~DDA~~)) DDCS if a person is eligible for a noninstitutional SSI-related CN program.

(4) WAC 182-515-1513 describes the financial eligibility requirements for HCB waiver services authorized by ((~~DDA~~)) DDCS when a person is not eligible for an SSI-related noninstitutional CN program under WAC 182-515-1512.

(5) WAC 182-515-1514 describes the rules used to determine a person's responsibility in the cost of care and room and board for HCB waiver services authorized by ((~~DDA~~)) DDCS if the person is eligible under WAC 182-515-1512.

AMENDATORY SECTION (Amending WSR 23-04-034, filed 1/25/23, effective 2/25/23)

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

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

(b) Be an eligible client of ((~~the-~~DDA~~~~)) DDCS;

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

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

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

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

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

(i) Be able to live at home with HCB waiver services; or
(ii) Live in a department-contracted facility with HCB waiver services, such as:
(A) A group home;
(B) A group training home;
(C) A child foster home, group home, or staffed residential facility;
(D) An adult family home (AFH); or
(E) An adult residential care (ARC) facility.
(iii) Live in the person's own home with supported living services from a certified residential provider; or
(iv) Live in the home of a contracted companion home provider.
(2) A person is not eligible for home and community based (HCB) waiver services if the person:
(a) Is subject to a penalty period of ineligibility for the transfer of an asset under WAC 182-513-1363; or
(b) Has a home with equity in excess of the requirements under WAC 182-513-1350.
(3) See WAC 182-513-1315 for rules used to determine countable resources, income, and eligibility standards for long-term care (LTC) services.
(4) Current income and resource standard charts are found at www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

AMENDATORY SECTION (Amending WSR 23-04-034, filed 1/25/23, effective 2/25/23)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

AMENDATORY SECTION (Amending WSR 23-04-034, filed 1/25/23, effective 2/25/23)

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

(2) A person must meet:

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

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

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

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

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

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

AMENDATORY SECTION (Amending WSR 25-04-040, filed 1/29/25, effective 3/1/25)

WAC 182-515-1514 Home and community based (HCB) services authorized by ~~((the))~~ developmental disabilities ~~((administration (DDA)))~~ community services (DDCS)—Client financial responsibility. (1) A client eligible for home and community based (HCB) waiver services authorized by ~~((the))~~ developmental disabilities ~~((administration~~

~~((DDA))~~) community services (DDCS) under WAC 182-515-1513 must pay toward the cost of care and room and board under this section.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

WAC 182-527-2730 Definitions. The following definitions apply to this chapter:

"Contract health service delivery area (CHSDA)" means the geographic area within which contract health services will be made available by the Indian health service to members of an identified Indian community who reside in the area as identified in 42 C.F.R. Secs. 136.21(d) and 136.22.

"Estate" means all property and any other assets that pass upon the client's death under the client's will or by intestate succession under chapter 11.04 or 11.62 RCW. The value of the estate will be reduced by any valid liability against the client's property when the client died. An estate also includes:

(1) For a client who died after June 30, 1995, and before July 27, 1997, nonprobate assets as defined by RCW 11.02.005, except property passing through a community property agreement; or

(2) For a client who died after July 26, 1997, and before September 14, 2006, nonprobate assets as defined by RCW 11.02.005.

(3) For a client who died on or after September 14, 2006, nonprobate assets as defined by RCW 11.02.005 and any life estate interest held by the client immediately before death.

"Heir" means a person entitled to inherit a deceased client's property under a valid will accepted by the court, or a person entitled to inherit under the Washington state intestacy statute, RCW 11.04.015.

"Life estate" means an ownership interest in a property only during the lifetime of the person owning the life estate.

"Lis pendens" means a notice filed in public records warning that title to certain real property is in litigation and the outcome of the litigation may affect the title.

"Long-term care services (LTC)" means, for the purposes of this chapter only, the services administered directly or through contract by the department of social and health services (DSHS) for clients of the home and community services division of DSHS and the developmental disabilities ((administration)) community services division of DSHS including, but not limited to, nursing facility care and home and community services.

"Property" means everything a person owns, whether in whole or in part.

(1) **"Personal property"** means any movable or intangible thing a person owns, whether in whole or in part;

(2) **"Real property"** means land and anything growing on, attached to, or built on it, excluding anything that may be removed without injury to the land;

(3) **"Trust property"** means any type of property held in trust for the benefit of another.

"Qualified long-term care insurance partnership" means an agreement between the Centers for Medicare and Medicaid services (CMS) and the Washington state insurance commission which allows for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of a person who is a beneficiary under a long-term care insurance policy that has been determined by the Washington state insurance commission to meet the requirements of section 1917 (b)(1)(C)(iii) of the act.

"Recover" or "recovery" means the agency or the agency's designee's receipt of funds to satisfy the client's debt.

AMENDATORY SECTION (Amending WSR 16-05-054, filed 2/12/16, effective 3/14/16)

WAC 182-527-2740 Estate recovery—Age-related limitations. For the purposes of this section, the term "agency" includes the agency's designee.

(1) **Liability for medicaid services.**

(a) Beginning July 26, 1987, a client's estate is liable for medicaid services subject to recovery that were provided on or after the client's ~~((sixty-fifth))~~ 65th birthday.

(b) Beginning July 1, 1994, a client's estate is liable for medicaid services subject to recovery that were provided on or after the client's ~~((fifty-fifth))~~ 55th birthday.

(2) **Liability for state-only-funded long-term care services.**

(a) A client's estate is liable for all state-only-funded long-term care services provided by the home and community services division of the department of social and health services (DSHS) on or after July 1, 1995.

(b) A client's estate is liable for all state-only-funded long-term care services provided by the developmental disabilities ~~((administration))~~ community services division of DSHS on or after June 1, 2004.

AMENDATORY SECTION (Amending WSR 24-12-011, filed 5/23/24, effective 6/23/24)

WAC 182-527-2742 Estate recovery—Service-related limitations. For the purposes of this section, the term "agency" includes the agency's designee.

The agency's payment for the following services is subject to recovery:

(1) State-only funded services, except:

(a) Adult protective services;

(b) Offender reentry community safety program services;

(c) Supplemental security payments (SSP) authorized by ~~((the))~~ developmental disabilities ~~((administration—(DDA)))~~ community services (DDCS);

(d) Volunteer chore services; and

(e) Guardianship and conservatorship assistance program services.

(2) For dates of service on and after January 1, 2014:

(a) Basic plus waiver services;

(b) Community first choice (CFC) services;

(c) Community option program entry system (COPES) services;

(d) Community protection waiver services;

(e) Core waiver services;

(f) Hospice services;

(g) Intermediate care facility for individuals with intellectual disabilities services provided in either a private community setting or in a rural health clinic;

(h) Individual and family services;

(i) Medicaid personal care services;

(j) New Freedom consumer directed services;

(k) Nursing facility services;

(l) Personal care services funded under Title XIX or XXI;

(m) Private duty nursing administered by the ~~((aging and long-term support administration (ALTSA) or the DDA))~~ home and community living administration (HCLA);

(n) Residential habilitation center services;

(o) Residential support waiver services;

(p) Roads to community living demonstration project services;

(q) The portion of the managed care premium used to pay for ~~((ALTSA))~~ HCLA-authorized long-term care services under the program of all-inclusive care for the elderly (PACE); and

(r) The hospital and prescription drug services provided to a client while the client was receiving services listed in this subsection.

(3) For dates of service beginning January 1, 2010, through December 31, 2013:

(a) Medicaid services;

(b) Premium payments to managed care organizations (MCOs); and

(c) The client's proportional share of the state's monthly contribution to the Centers for Medicare and Medicaid Services to defray the costs for outpatient prescription drug coverage provided to a person who is eligible for medicare Part D and medicaid.

(4) For dates of service beginning June 1, 2004, through December 31, 2009:

(a) Medicaid services;

(b) Medicare premiums for people also receiving medicaid;

(c) Medicare savings programs (MSPs) services for people also receiving medicaid; and

(d) Premium payments to MCOs.

(5) For dates of service beginning July 1, 1995, through May 31, 2004:

(a) Adult day health services;

(b) Home and community-based services;

(c) Medicaid personal care services;

(d) Nursing facility services;

(e) Private duty nursing services; and

(f) The hospital and prescription drug services provided to a client while the client was receiving services listed in this subsection.

(6) For dates of service beginning July 1, 1994, through June 30, 1995:

(a) Home and community-based services;

(b) Nursing facility services; and

(c) The hospital and prescription drug services provided to a client while the client was receiving services listed in this subsection.

(7) For dates of service beginning July 26, 1987, through June 30, 1994: Medicaid services.

(8) For dates of service through December 31, 2009. If a client was eligible for the MSP, but not otherwise medicaid eligible, the

client's estate is liable only for any sum paid to cover medicare premiums and cost-sharing benefits.

(9) For dates of service beginning January 1, 2010. If a client was eligible for medicaid and the MSP, the client's estate is not liable for any sum paid to cover medical assistance cost-sharing benefits.

(10) For dates of service beginning July 1, 2017, long-term services and supports authorized under the medicaid transformation project are exempt from estate recovery. Exempted services include those provided under:

(a) Medicaid alternative care under WAC 182-513-1600;

(b) Tailored supports for older adults under WAC 182-513-1610;

(c) Supportive housing under WAC 388-106-1700 through 388-106-1765; or

(d) Supported employment under WAC 388-106-1800 through 388-106-1865.

WAC 182-530-7350 Reimbursement—Unit dose drug delivery systems.

(1) The medicaid agency pays for unit dose drug delivery systems only for clients residing in nursing facilities, except as provided in subsections (7) and (8) of this section.

(2) Unit dose delivery systems may be either true or modified unit dose.

(3) The agency pays pharmacies that provide unit dose delivery services the agency's highest allowable dispensing fee for each unit dose prescription dispensed to clients in nursing facilities. The agency reimburses ingredient costs for drugs under unit dose systems as described in WAC 182-530-7000.

(4) The agency pays a pharmacy that dispenses drugs in bulk containers or multidose forms to clients in nursing facilities the regular dispensing fee applicable to the pharmacy's total annual prescription volume tier. Drugs the agency considers not deliverable in unit dose form include, but are not limited to, liquids, creams, ointments, ophthalmic and otic solutions. The agency reimburses ingredient costs as described in WAC 182-530-7000.

(5) The agency pays a pharmacy that dispenses drugs prepackaged by the manufacturer in unit dose form to clients in nursing facilities the regular dispensing fee applicable under WAC 182-530-7050. The agency reimburses ingredient costs for drugs prepackaged by the manufacturer in unit dose form as described in WAC 182-530-7000.

(6) The agency limits its coverage and payment for manufacturer-designated unit dose packaging to the following conditions:

(a) The drug is a single source drug and a multidose package for the drug is not available;

(b) The drug is a multiple source drug but there is no other multidose package available among the drug's generic equivalents; or

(c) The manufacturer-designated unit dose package is the most cost-effective package available or it is the least costly alternative form of the drug.

(7) The agency reimburses a pharmacy provider for manufacturer-designated unit dose drugs dispensed to clients not residing in nursing facilities only when such drugs:

(a) Are available in the marketplace only in manufacturer-designated unit dose packaging; and

(b) Would otherwise be covered as an outpatient drug. The unit dose dispensing fee does not apply in such cases. The agency pays the pharmacy the dispensing fee applicable to the pharmacy's total annual prescription volume tier.

(8) The agency may pay for unit dose delivery systems for clients of ~~((the))~~ developmental disabilities ~~((administration (DDA)))~~ community services residing in approved community living arrangements.

WAC 182-531A-0600 Applied behavior analysis (ABA)—Stage two: Functional assessment and treatment plan development. (1) If the center of excellence (COE) provider has prescribed applied behavior analysis (ABA) services, the client may begin stage two - ABA assessment, functional analysis, and ABA therapy treatment plan development.

(2) Prior authorization must be obtained from the agency prior to implementing the ABA therapy treatment plan. The prior authorization request must be received no more than 60 days from the date of the assessment and ABA therapy treatment plan. See WAC 182-501-0165 for agency authorization requirements.

(3) The client or the client's legal guardian selects the ABA provider and the setting in which services will be rendered. ABA services may be rendered in one of the following settings:

(a) Day services program, which mean an agency-approved, outpatient facility or clinic-based program that:

(i) Employs or contracts with a lead behavior analysis therapist (LBAT), therapy assistant, speech therapist, and if clinically indicated, an occupational therapist, physical therapist, psychologist, medical provider, and dietitian;

(ii) Provides multidisciplinary services in a short-term day treatment program setting;

(iii) Delivers comprehensive intensive services;

(iv) Embeds early, intensive behavioral interventions in a developmentally appropriate context;

(v) Provides an individualized developmentally appropriate ABA therapy treatment plan for each client; and

(vi) Includes family support and training.

(b) Community-based program, which means a program that provides services in a natural setting, such as a school, home, workplace, office, or clinic. A community-based program:

(i) May be used after discharge from a day services program (see subsection (3)(a) of this section);

(ii) Provides a developmentally appropriate ABA therapy treatment plan for each client;

(iii) Provides ABA services in the home (wherever the client resides), office, clinic, or community setting, as required to accomplish the goals in the ABA therapy treatment plan. Examples of community settings are: A park, restaurant, child care, early childhood education, school, or place of employment and must be included in the ABA therapy treatment plan with services being provided by the enrolled LBAT or therapy assistant approved to provide services via authorization;

(iv) Requires recertification of medical necessity through continued authorization; and

(v) Includes family or caregiver education, support, and training.

(4) An assessment, as described in this chapter, must be conducted and an ABA therapy treatment plan developed by an LBAT in the setting chosen by the client or the client's legal guardian. The ABA therapy treatment plan must follow the agency's ABA therapy treatment plan report template and:

- (a) Be signed by the LBAT responsible for the plan development and oversight;
- (b) Be applicable to the services to be rendered over the next six months, based on the LBAT's judgment, and correlate with the COE provider's current diagnostic evaluation (see WAC 182-531A-0500(2));
- (c) Address each behavior, skill deficit, and symptom that prevents the client from adequately participating in home, school, employment, community activities, or that presents a safety risk to the client or others;
- (d) Be individualized;
- (e) Be client-centered, family-focused, community-based, culturally competent, and minimally intrusive;
- (f) Take into account all school or other community resources available to the client, confirm that the requested services are not redundant or in conflict with, but are in coordination with, other services already being provided or otherwise available, and coordinate services (e.g., from school and special education, from early intervention programs and early intervention providers or from ((the)) developmental disabilities ((administration)) community services) with other interventions and treatments (e.g., speech therapy, occupational therapy, physical therapy, family counseling, and medication management);
- (g) Focus on family engagement and training;
- (h) Identify and describe in detail the targeted behaviors and symptoms;
- (i) Include objective, baseline measurement levels for each target behavior/symptom in terms of frequency, intensity, and duration, including use of curriculum-based measures, single-case studies, or other generally accepted assessment tools;
- (j) Include a comprehensive description of treatment interventions, or type of treatment interventions, and techniques specific to each of the targeted behaviors/symptoms, (e.g., discrete trial training, reinforcement, picture exchange, communication systems) including documentation of the number of service hours, in terms of frequency and duration, for each intervention;
- (k) Establish treatment goals and objective measures of progress for each intervention specified to be accomplished in the authorized treatment period;
- (l) Incorporate strategies for promoting the learning of skills that improve targeted behaviors within settings as listed in this chapter;
- (m) Integrate family education, goals, training, support services, and modeling and coaching family/client interaction;
- (n) Incorporate strategies for coordinating treatment with school-based education and vocational programs, behavioral health treatment, habilitative supports, and community-based early intervention programs, and plan for transition through a continuum of treatments, services, and settings; and
- (o) Include measurable discharge criteria and a discharge plan.

WAC 182-535-1082 Covered—Preventive services. Clients described in WAC 182-535-1060 are eligible for the dental-related preventive services listed in this section, subject to coverage limitations and client-age requirements identified for a specific service.

(1) **Prophylaxis.** The medicaid agency covers prophylaxis as follows. Prophylaxis:

(a) Includes scaling and polishing procedures to remove coronal plaque, calculus, and stains when performed on tooth structures and implants.

(b) Is limited to once every:

(i) Six months for clients:

(A) Age 18 and younger; or

(B) Of any age residing in an alternate living facility or nursing facility;

(ii) Twelve months for clients age 19 and older.

(c) Is reimbursed according to (b) of this subsection when the service is performed:

(i) At least six months after periodontal scaling and root planing, or periodontal maintenance services, for clients:

(A) Age 13 through 18; or

(B) Of any age residing in an alternate living facility or nursing facility; or

(ii) At least 12 months after periodontal scaling and root planing, periodontal maintenance services, for clients age 19 and older.

(d) Is not reimbursed separately when performed on the same date of service as periodontal scaling and root planing, periodontal maintenance, gingivectomy, gingivoplasty, or scaling in the presence of generalized moderate or severe gingival inflammation.

(e) Is covered for clients of the developmental disabilities ((administration)) community services division of the department of social and health services (DSHS) according to (a), (c), and (d) of this subsection and WAC 182-535-1099.

(2) **Topical fluoride treatment.** The agency covers the following per client, per provider or clinic:

(a) Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, three times within a 12-month period with a minimum of 110 days between applications for clients:

(i) Age six and younger;

(ii) During orthodontic treatment.

(b) Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, two times within a 12-month period with a minimum of 170 days between applications for clients:

(i) From age seven through 18; or

(ii) Of any age residing in alternate living facilities or nursing facilities.

(c) Fluoride rinse, foam or gel, fluoride varnish, including disposable trays, for clients age 19 and older, once within a 12-month period.

(d) Additional topical fluoride applications only on a case-by-case basis and when prior authorized.

(e) Topical fluoride treatment for clients of the developmental disabilities ((~~administration~~)) community services division of DSHS according to WAC 182-535-1099.

(3) **Silver diamine fluoride.**

(a) The agency covers silver diamine fluoride as follows:

(i) When used for stopping the progression of caries or as a topical preventive agent;

(ii) Allowed two times per client per tooth in a 12-month period; and

(iii) Cannot be billed with interim therapeutic restoration on the same tooth when arresting caries or as a preventive agent.

(b) The dental provider or office must have a signed informed consent form on file for each client receiving a silver diamine fluoride application. The form must include the following:

(i) Benefits and risks of silver diamine fluoride application;

(ii) Alternatives to silver diamine fluoride application; and

(iii) A color photograph example that demonstrates the post-procedure blackening of a tooth with silver diamine fluoride application.

(4) **Oral hygiene instruction.** Includes instruction for home care such as tooth brushing technique, flossing, and use of oral hygiene aids. Oral hygiene instruction is included as part of the global fee for prophylaxis for clients age nine and older. The agency covers individualized oral hygiene instruction for clients age eight and younger when all of the following criteria are met:

(a) Only once per client every six months within a 12-month period.

(b) Only when not performed on the same date of service as prophylaxis or within six months from a prophylaxis by the same provider or clinic.

(c) Only when provided by a licensed dentist or a licensed dental hygienist and the instruction is provided in a setting other than a dental office or clinic.

(5) **Tobacco/nicotine cessation counseling for the control and prevention of oral disease.** The agency covers tobacco/nicotine cessation counseling for pregnant individuals only. See WAC 182-531-1720.

(6) **Sealants.** The agency covers:

(a) Sealants for clients age 20 and younger and clients any age of the developmental disabilities ((~~administration~~)) community services division of DSHS.

(b) Sealants once per tooth:

(i) In a three-year period for clients age 20 and younger; and

(ii) In a two-year period for clients any age of the developmental disabilities ((~~administration~~)) community services division of DSHS according to WAC 182-535-1099.

(c) Sealants only when used on the occlusal surfaces of:

(i) Permanent teeth two, three, 14, 15, 18, 19, 30, and 31; and

(ii) Primary teeth A, B, I, J, K, L, S, and T.

(d) Sealants on noncarious teeth or teeth with incipient caries.

(e) Sealants only when placed on a tooth with no preexisting occlusal restoration, or any occlusal restoration placed on the same day.

(f) Sealants are included in the agency's payment for occlusal restoration placed on the same day.

(g) Additional sealants not described in this subsection on a case-by-case basis and when prior authorized.

(7) **Space maintenance.** The agency covers:

(a) One fixed unilateral space maintainer per quadrant or one fixed bilateral space maintainer per arch, including recementation, for missing primary molars A, B, I, J, K, L, S, and T, when:

(i) Evidence of pending permanent tooth eruption exists; and
(ii) The service is not provided during approved orthodontic treatment.

(b) Replacement space maintainers on a case-by-case basis when authorized.

(c) The removal of fixed space maintainers when removed by a different provider.

(i) Space maintainer removal is allowed once per appliance.

(ii) Reimbursement for space maintainer removal is included in the payment to the original provider that placed the space maintainer.

AMENDATORY SECTION (Amending WSR 21-14-055, filed 7/1/21, effective 8/1/21)

WAC 182-535-1084 Dental-related services—Covered—Restorative services. Clients described in WAC 182-535-1060 are eligible for the dental-related restorative services listed in this section, subject to coverage limitations, restrictions, and client age requirements identified for a specific service.

(1) **Amalgam, resin, and glass ionomer restorations for primary and permanent teeth.** The medicaid agency considers:

(a) Tooth preparation, acid etching, all adhesives (including bonding agents), liners and bases, indirect and direct pulp capping, polishing, and curing as part of the restoration.

(b) Occlusal adjustment of either the restored tooth or the opposing tooth or teeth as part of the restoration.

(c) Restorations placed within six months of a crown preparation by the same provider or clinic to be included in the payment for the crown.

(2) **Limitations for all restorations.** The agency:

(a) Considers multiple restoration involving the proximal and occlusal surfaces of the same tooth as a multisurface restoration, and limits reimbursement to a single multisurface restoration.

(b) Considers multiple restorative resins, flowable composite resins, resin-based composites, or glass ionomer restorations for the occlusal, buccal, lingual, mesial, and distal fissures and grooves on the same tooth as a one-surface restoration.

(c) Considers multiple restorations of fissures and grooves of the occlusal surface of the same tooth as a one-surface restoration.

(d) Considers resin-based composite restorations of teeth where the decay does not penetrate the dentinoenamel junction (DEJ) to be sealants. (See WAC 182-535-1082 for sealant coverage.)

(e) Covers only one buccal and one lingual surface per tooth. The agency reimburses buccal or lingual restorations, regardless of size or extension, as a one-surface restoration.

(f) Does not cover preventative restorations.

(g) Covers replacement restorations between six and ~~((twenty-four))~~ 24 months of original placement, with approved prior authorization, if the restoration is cracked or broken. The client's record

must include X-rays or documentation supporting the medical necessity for the replacement restoration.

(h) Replacement of a cracked or broken restoration within a six-month period by the same provider is considered part of the global payment of the initial restoration and will not pay separately.

(3) **Additional limitations for restorations on permanent teeth.** The agency covers:

(a) Two occlusal restorations for the upper molars on teeth one, two, three, (~~fourteen, fifteen, and sixteen~~) 14, 15, and 16 if, the restorations are anatomically separated by sound tooth structure.

(b) A maximum of five surfaces per tooth for permanent posterior teeth, except for upper molars. The agency allows a maximum of six surfaces per tooth for teeth one, two, three, (~~fourteen, fifteen, and sixteen~~) 14, 15, and 16.

(c) A maximum of six surfaces per tooth for resin-based composite restorations for permanent anterior teeth.

(4) **Crowns.** The agency:

(a) Covers the following indirect crowns once every five years, per tooth, for permanent anterior teeth for clients age (~~fifteen through twenty~~) 15 through 20 when the crowns meet prior authorization criteria in WAC 182-535-1220 and the provider follows the prior authorization requirements in (c) of this subsection:

(i) Porcelain/ceramic crowns to include all porcelains, glasses, glass-ceramic, and porcelain fused to metal crowns; and

(ii) Resin crowns and resin metal crowns to include any resin-based composite, fiber, or ceramic reinforced polymer compound.

(b) Considers the following to be included in the payment for a crown:

(i) Tooth and soft tissue preparation;

(ii) Amalgam and resin-based composite restoration, or any other restorative material placed within six months of the crown preparation. Exception: The agency covers a one-surface restoration on an endodontically treated tooth, or a core buildup or cast post and core;

(iii) Temporaries including, but not limited to, temporary restoration, temporary crown, provisional crown, temporary prefabricated stainless steel crown, ion crown, or acrylic crown;

(iv) Packing cord placement and removal;

(v) Diagnostic or final impressions;

(vi) Crown seating (placement), including cementing and insulating bases;

(vii) Occlusal adjustment of crown or opposing tooth or teeth; and

(viii) Local anesthesia.

(c) Requires the provider to submit the following with each prior authorization request:

(i) Radiographs to assess all remaining teeth;

(ii) Documentation and identification of all missing teeth;

(iii) Caries diagnosis and treatment plan for all remaining teeth, including a caries control plan for clients with rampant caries;

(iv) Pre- and post-endodontic treatment radiographs for requests on endodontically treated teeth; and

(v) Documentation supporting a five-year prognosis that the client will retain the tooth or crown if the tooth is crowned.

(d) Requires a provider to bill for a crown only after delivery and seating of the crown, not at the impression date.

(5) **Other restorative services.** The agency covers the following restorative services:

(a) All recementations of permanent indirect crowns.

(b) Prefabricated stainless steel crowns, including stainless steel crowns with resin window, resin-based composite crowns (direct), prefabricated esthetic coated stainless steel crowns, and prefabricated resin crowns for primary anterior teeth once every three years only for clients age ~~((twenty))~~ 20 and younger.

(c) Prefabricated stainless steel crowns, including stainless steel crowns with resin window, resin-based composite crowns (direct), prefabricated esthetic coated stainless steel crowns, and prefabricated resin crowns, for primary posterior teeth once every three years without prior authorization for clients ages zero through ~~((twelve))~~ 12 and with prior authorization for clients age ~~((thirteen through twenty))~~ 13 through 20 if:

(i) The tooth had a pulpotomy; or

(ii) Evidence of Class II caries with rampant decay; or

(iii) Evidence of extensive caries; or

(iv) Treatment of decay requires sedation or general anesthesia.

(d) Prefabricated stainless steel crowns, including stainless steel crowns with resin window, and prefabricated resin crowns, for permanent posterior teeth excluding one, ~~((sixteen, seventeen, and thirty-two))~~ 16, 17, and 32 once every three years, for clients age ~~((twenty))~~ 20 and younger, without prior authorization.

(e) Prefabricated stainless steel crowns, for permanent posterior teeth, excluding one, ~~((sixteen, seventeen, and thirty-two))~~ 16, 17, and 32 for clients age ~~((twenty-one))~~ 21 and older in lieu of a restoration requiring three or more surfaces.

(f) Prefabricated stainless steel crowns for clients of the developmental disabilities ~~((administration))~~ community services division of the department of social and health services (DSHS) without prior authorization in accordance with WAC 182-535-1099.

(g) Core buildup, including pins, only on permanent teeth, only for clients age ~~((twenty))~~ 20 and younger, and only allowed in conjunction with crowns and when prior authorized. For indirect crowns, prior authorization must be obtained from the agency at the same time as the crown. Providers must submit pre- and post-endodontic treatment radiographs to the agency with the authorization request for endodontically treated teeth.

(h) Cast post and core or prefabricated post and core, only on permanent teeth, only for clients age ~~((twenty))~~ 20 and younger, and only when in conjunction with a crown and when prior authorized.

AMENDATORY SECTION (Amending WSR 23-20-129, filed 10/4/23, effective 1/1/24)

WAC 182-535-1088 Dental-related services—Covered—Periodontic services. Clients described in WAC 182-535-1060 are eligible to receive the dental-related periodontic services listed in this section, subject to coverage limitations, restrictions, and client-age requirements identified for a specified service.

(1) **Surgical periodontal services.** The medicaid agency covers the following surgical periodontal services, including all postoperative care:

(a) Gingivectomy/gingivoplasty (does not include distal wedge procedures on erupting molars) only on a case-by-case basis and when prior authorized and only for clients age 20 and younger; and

(b) Gingivectomy/gingivoplasty (does not include distal wedge procedures on erupting molars) for clients of the developmental disabilities ((~~administration~~)) community services division of the department of social and health services (DSHS) according to WAC 182-535-1099.

(2) **Nonsurgical periodontal services.** The agency:

(a) Covers periodontal scaling and root planing for clients age 13 through 18, once per quadrant per client, in a two-year period on a case-by-case basis, when prior authorized, and only when:

(i) The client has radiographic evidence of periodontal disease;

(ii) The client's record includes supporting documentation for the medical necessity, including complete periodontal charting done within the past 12 months from the date of the prior authorization request and a definitive diagnosis of periodontal disease;

(iii) The client's clinical condition meets current published periodontal guidelines; and

(iv) Performed at least two years from the date of completion of periodontal scaling and root planing or surgical periodontal treatment, or at least 12 calendar months from the completion of periodontal maintenance.

(b) Covers periodontal scaling and root planing once per quadrant per client in a two-year period for clients age 19 and older. Criteria in (a)(i) through (iv) of this subsection must be met.

(c) Considers ultrasonic scaling, gross scaling, or gross debridement to be included in the procedure and not a substitution for periodontal scaling and root planing.

(d) Covers periodontal scaling and root planing only when the services are not performed on the same date of service as prophylaxis, periodontal maintenance, gingivectomy, or gingivoplasty.

(e) Covers periodontal scaling and root planing for clients of the developmental disabilities ((~~administration~~)) community services division of DSHS according to WAC 182-535-1099.

(f) Covers periodontal scaling and root planing, one time per quadrant in a 12-month period for clients residing in an alternate living facility or nursing facility.

(3) **Other periodontal services.** The agency:

(a) Covers periodontal maintenance for clients age 13 through 18 once per client in a 12-month period on a case-by-case basis, when prior authorized, and only when:

(i) The client has radiographic evidence of periodontal disease;

(ii) The client's record includes supporting documentation for the medical necessity, including complete periodontal charting done within the past 12 months with location of the gingival margin and clinical attachment loss and a definitive diagnosis of periodontal disease;

(iii) The client's clinical condition meets current published periodontal guidelines; and

(iv) The client has had periodontal scaling and root planing but not within 12 months of the date of completion of periodontal scaling and root planing, or surgical periodontal treatment.

(b) Covers periodontal maintenance once per client in a 12-month period for clients age 19 and older. Criteria in (a)(i) through (iv) of this subsection must be met.

(c) Covers periodontal maintenance only if performed at least 12 calendar months after receiving prophylaxis, periodontal scaling and root planing, gingivectomy, or gingivoplasty.

(d) Covers periodontal maintenance for clients of the developmental disabilities ((~~administration~~)) community services division of DSHS according to WAC 182-535-1099.

(e) Covers periodontal maintenance for clients residing in an alternate living facility or nursing facility:

(i) Periodontal maintenance (four quadrants) substitutes for an eligible periodontal scaling or root planing once every six months.

(ii) Periodontal maintenance allowed six months after scaling or root planing.

(f) Covers periodontal maintenance for clients 21 and older with a diagnosis of diabetes:

(i) Periodontal maintenance allowed once every three months. Criteria in (a)(i) through (iii) of this subsection must be met.

(ii) Periodontal maintenance allowed three months after scaling or root planing.

(g) Covers full-mouth scaling in the presence of generalized moderate or severe gingival inflammation and only:

(i) For clients age 19 and older once in a 12-month period after an oral evaluation; and

(ii) For clients age 13 through 18 once in a 12-month period after an oral evaluation and when prior authorized.

AMENDATORY SECTION (Amending WSR 23-08-080, filed 4/5/23, effective 5/6/23)

WAC 182-535-1098 Covered—Adjunctive general services. Clients described in WAC 182-535-1060 are eligible to receive the adjunctive general services listed in this section, subject to coverage limitations, restrictions, and client-age requirements identified for a specific service.

(1) **Adjunctive general services.** The medicaid agency:

(a) Covers palliative (emergency) treatment, not to include pupal debridement (see WAC 182-535-1086 (2)(b)), for treatment of dental pain, limited to once per day, per client, as follows:

(i) The treatment must occur during limited evaluation appointments;

(ii) A comprehensive description of the diagnosis and services provided must be documented in the client's record; and

(iii) Appropriate radiographs must be in the client's record supporting the medical necessity of the treatment.

(b) Covers local anesthesia and regional blocks as part of the global fee for any procedure being provided to clients.

(c) Covers office-based deep sedation/general anesthesia services:

(i) For all eligible clients age eight and younger and clients any age of the developmental disabilities ((~~administration~~)) community services division of the department of social and health services

(DSHS). Documentation supporting the medical necessity of the anesthesia service must be in the client's record.

(ii) For clients age nine through 20 on a case-by-case basis and when prior authorized, except for oral surgery services. For oral surgery services listed in WAC 182-535-1094 (1)(f) through (1) and clients with cleft palate diagnoses, the agency does not require prior authorization for deep sedation/general anesthesia services.

(iii) For clients age 21 and older when prior authorized. The agency considers these services for only those clients:

(A) With medical conditions such as tremors, seizures, or asthma;

(B) Whose records contain documentation of tried and failed treatment under local anesthesia or other less costly sedation alternatives due to behavioral health conditions; or

(C) With other conditions for which general anesthesia is medically necessary, as defined in WAC 182-500-0070.

(d) Covers office-based intravenous moderate (conscious) sedation/analgesia:

(i) For any dental service for clients age 20 and younger, and for clients any age of the developmental disabilities (~~administration~~) community services division of DSHS. Documentation supporting the medical necessity of the service must be in the client's record.

(ii) For clients age 21 and older when prior authorized. The agency considers these services for only those clients:

(A) With medical conditions such as tremors, seizures, or asthma;

(B) Whose records contain documentation of tried and failed treatment under local anesthesia, or other less costly sedation alternatives due to behavioral health conditions; or

(C) With other conditions for which general anesthesia or conscious sedation is medically necessary, as defined in WAC 182-500-0070.

(e) Covers office-based nonintravenous conscious sedation:

(i) For any dental service for clients age 20 and younger, and for clients any age of the developmental disabilities (~~administration~~) community services division of DSHS. Documentation supporting the medical necessity of the service must be in the client's record.

(ii) For clients age 21 and older, only when prior authorized.

(f) Requires providers to bill anesthesia services using the current dental terminology (CDT) codes listed in the agency's current published billing instructions.

(g) Requires providers to have a current anesthesia permit on file with the agency.

(h) Covers administration of nitrous oxide once per day, per client per provider.

(i) Requires providers of oral or parenteral conscious sedation, deep sedation, or general anesthesia to meet:

(i) The prevailing standard of care;

(ii) The provider's professional organizational guidelines;

(iii) The requirements in chapter 246-817 WAC; and

(iv) Relevant department of health (DOH) medical, dental, or nursing anesthesia regulations.

(j) Pays for dental anesthesia services according to WAC 182-535-1350.

(k) Covers professional consultation/diagnostic services as follows:

(i) A dentist or a physician other than the practitioner providing treatment must provide the services; and

(ii) A client must be referred by the agency for the services to be covered.

(2) **Professional visits.** The agency covers:

(a) Up to two house/extended care facility calls (visits) per facility, per provider. The agency limits payment to two facilities per day, per provider.

(b) One hospital visit, including emergency care, per day, per provider, per client, and not in combination with a surgical code unless the decision for surgery is a result of the visit.

(c) Emergency office visits after regularly scheduled hours. The agency limits payment to one emergency visit per day, per client, per provider.

(3) **Drugs and medicaments (pharmaceuticals).**

(a) The agency covers oral sedation medications only when prescribed and the prescription is filled at a pharmacy. The agency does not cover oral sedation medications that are dispensed in the provider's office for home use.

(b) The agency covers therapeutic parenteral drugs as follows:

(i) Includes antibiotics, steroids, anti-inflammatory drugs, or other therapeutic medications. This does not include sedative, anesthetic, or reversal agents.

(ii) Only one single-drug injection or one multiple-drug injection per date of service.

(c) For clients age 20 and younger, the agency covers other drugs and medicaments dispensed in the provider's office for home use. This includes, but is not limited to, oral antibiotics and oral analgesics. The agency does not cover the time spent writing prescriptions.

(d) For clients enrolled in an agency-contracted managed care organization (MCO), the client's MCO pays for dental prescriptions.

(4) **Miscellaneous services.** The agency covers:

(a) Behavior management provided by a dental provider or clinic. The agency does not cover assistance with managing a client's behavior provided by a dental provider or staff member delivering the client's dental treatment.

(i) Documentation supporting the need for behavior management must be in the client's record and including the following:

(A) A description of the behavior to be managed;

(B) The behavior management technique used; and

(C) The identity of the additional professional staff used to provide the behavior management.

(ii) Clients, who meet one of the following criteria and whose documented behavior requires the assistance of one additional professional staff employed by the dental provider or clinic to protect the client and the professional staff from injury while treatment is rendered, may receive behavior management:

(A) Clients age eight and younger;

(B) Clients age nine through 20, only on a case-by-case basis and when prior authorized;

(C) Clients any age of the developmental disabilities (~~administration~~) community services division of DSHS;

(D) Clients diagnosed with autism;

(E) Clients who reside in an alternate living facility (ALF) as defined in WAC 182-513-1301, or in a nursing facility as defined in WAC 182-500-0075.

(iii) Behavior management can be performed in the following settings:

(A) Clinics (including independent clinics, tribal health clinics, federally qualified health centers, rural health clinics, and public health clinics);

(B) Offices;

(C) Homes (including private homes and group homes); and

(D) Facilities (including nursing facilities and alternate living facilities).

(b) Treatment of post-surgical complications (e.g., dry socket). Documentation supporting the medical necessity of the service must be in the client's record.

(c) Occlusal guards when medically necessary and prior authorized. (Refer to WAC 182-535-1094(4) for occlusal orthotic device coverage and coverage limitations.) The agency covers:

(i) An occlusal guard only for clients age 12 through 20 when the client has permanent dentition; and

(ii) An occlusal guard only as a laboratory processed full arch appliance.

(5) Nonclinical procedures.

(a) The agency covers teledentistry according to the department of health, health systems quality assurance office of health professions, current guidelines, appropriate use of teledentistry, and as follows (see WAC 182-531-1730 for coverage limitations not listed in this section):

(i) Synchronous teledentistry at the distant site for clients of all ages; and

(ii) Asynchronous teledentistry at the distant site for clients of all ages.

(b) The client's record must include the following supporting documentation regarding teledentistry:

(i) Service provided via teledentistry;

(ii) Location of the client;

(iii) Location of the provider; and

(iv) Names and credentials of all persons involved in the teledentistry visit and their role in providing the service at both the originating and distant sites.

AMENDATORY SECTION (Amending WSR 21-14-055, filed 7/1/21, effective 8/1/21)

WAC 182-535-1099 Dental-related services for clients of the developmental disabilities ((administration)) community services division of the department of social and health services. Subject to coverage limitations and restrictions identified for a specific service, the medicaid agency pays for the additional dental-related services listed in this section that are provided to clients of the developmental disabilities ((administration)) community services division of the department of social and health services (DSHS), regardless of age.

(1) **Preventive services.** The agency covers:

(a) Periodic oral evaluations once every four months per client, per provider.

(b) Prophylaxis once every four months.

(c) Periodontal maintenance once every six months (see subsection

(3) of this section for limitations on periodontal scaling and root planing).

- (d) Topical fluoride varnish, rinse, foam or gel, once every four months, per client, per provider or clinic.
- (e) Sealants (see WAC 182-535-1082 for sealant coverage):
- (i) Only when used on the occlusal surfaces of:
- (A) Primary teeth A, B, I, J, K, L, S, and T; or
- (B) Permanent teeth two, three, four, five, (~~twelve, thirteen, fourteen, fifteen, eighteen, nineteen, twenty, twenty one, twenty eight, twenty nine, thirty, and thirty one~~) 12, 13, 14, 15, 18, 19, 20, 21, 28, 29, 30, and 31.
- (ii) Once per tooth in a two-year period.
- (2) **Other restorative services.** The agency covers:
- (a) All recementations of permanent indirect crowns.
- (b) Prefabricated stainless steel crowns, including stainless steel crowns with resin window, resin-based composite crowns (direct), prefabricated esthetic coated stainless steel crowns, and prefabricated resin crowns for primary anterior teeth once every two years only for clients age (~~twenty~~) 20 and younger without prior authorization.
- (c) Prefabricated stainless steel crowns, including stainless steel crowns with resin window, resin-based composite crowns (direct), prefabricated esthetic coated stainless steel crowns, and prefabricated resin crowns for primary posterior teeth once every two years for clients age (~~twenty~~) 20 and younger without prior authorization if:
- (i) Decay involves three or more surfaces for a primary first molar;
- (ii) Decay involves four or more surfaces for a primary second molar; or
- (iii) The tooth had a pulpotomy.
- (d) Prefabricated stainless steel crowns, including stainless steel crowns with resin window, and prefabricated resin crowns for permanent posterior teeth excluding one, (~~sixteen, seventeen, and thirty two~~) 16, 17, and 32 once every two years without prior authorization for any age.
- (3) **Periodontic services.**
- (a) **Surgical periodontal services.** The agency covers:
- (i) Gingivectomy/gingivoplasty once every three years. Documentation supporting the medical necessity of the service must be in the client's record (e.g., drug induced gingival hyperplasia).
- (ii) Gingivectomy/gingivoplasty with periodontal scaling and root planing or periodontal maintenance when the services are performed:
- (A) In a hospital or ambulatory surgical center; or
- (B) For clients under conscious sedation, deep sedation, or general anesthesia.
- (b) **Nonsurgical periodontal services.** The agency covers:
- (i) Periodontal scaling and root planing, one time per quadrant in a (~~twelve~~) 12-month period.
- (ii) Periodontal maintenance (four quadrants) substitutes for an eligible periodontal scaling or root planing, twice in a (~~twelve~~) 12-month period.
- (iii) Periodontal maintenance allowed six months after scaling or root planing.
- (iv) Full-mouth or quadrant debridement allowed once in a (~~twelve~~) 12-month period.
- (v) Full-mouth scaling in the presence of generalized moderate or severe gingival inflammation allowed once in a (~~twelve~~) 12-month period.
- (4) **Adjunctive general services.** The agency covers:

(a) Oral parenteral conscious sedation, deep sedation, or general anesthesia for any dental services performed in a dental office or clinic. Documentation supporting the medical necessity must be in the client's record.

(b) Sedation services according to WAC 182-535-1098 (1)(c) and (e).

(5) **Nonemergency dental services.** The agency covers nonemergency dental services performed in a hospital or an ambulatory surgical center for services listed as covered in WAC 182-535-1082, 182-535-1084, 182-535-1086, 182-535-1088, and 182-535-1094. Documentation supporting the medical necessity of the service must be included in the client's record.

(6) **Miscellaneous services - Behavior management.** The agency covers behavior management according to WAC 182-535-1098.

WAC 182-551-3100 Private duty nursing for clients age ((seventeen)) 17 and younger—Client eligibility. (1) To be eligible for private duty nursing under the medically intensive children's program (MICP), clients must:

- (a) Be age ((seventeen)) 17 or younger;
- (b) Meet financial eligibility under subsection (2) of this section;
- (c) Meet medical eligibility under subsection (3) of this section;
- (d) Have informal support by a person who has been trained to provide designated skilled nursing care and is able to perform the care as required;

(e) Have prior authorization from the department of social and health services/developmental disabilities ((administration—(DSHS/DDA))) community services (DSHS/DDCS); and

(f) Have exhausted all other funding sources for private duty nursing, according to RCW 74.09.185, prior to accessing these services through the medically intensive children's program (MICP).

(2) To be financially eligible for private duty nursing, clients must meet medicaid eligibility requirements under the categorically needy program, the medically needy program, or alternative benefits plan program (see WAC 182-501-0060).

(3) To be medically eligible for private duty nursing under fee-for-service, clients must be assessed by a DSHS/((DDA)) DDCS nursing care consultant and determined medically eligible for MICP.

(4) Clients must meet the following criteria to be medically eligible for MICP:

(a) Require four or more continuous hours of active skilled nursing care with consecutive tasks at a level that:

(i) Cannot be delegated at the time of the initial assessment; and

(ii) Can be provided safely outside of a hospital in a less restrictive setting.

(b) Require two or more tasks of complex skilled nursing care such as:

(i) System assessments, including multistep approaches of systems (e.g., respiratory assessment, airway assessment, vital signs, nutritional and hydration assessment, complex gastrointestinal assessment and management, seizure management requiring intervention, or level of consciousness);

(ii) Administration of treatment for complex respiratory issues related to technological dependence requiring multistep approaches on a day-to-day basis (e.g., ventilator tracheostomy);

(iii) Assessment of complex respiratory issues and interventions with use of oximetry, titration of oxygen, ventilator settings, humidification systems, fluid balance, or any other cardiopulmonary critical indicators based on medical necessity;

(iv) Skilled nursing interventions of intravenous/parenteral administration of multiple medications and nutritional substances on a continuing or intermittent basis with frequent interventions; or

(v) Skilled nursing interventions of enteral nutrition and medications requiring multistep approaches daily.

AMENDATORY SECTION (Amending WSR 18-15-010, filed 7/6/18, effective 9/1/18)

WAC 182-551-3200 Private duty nursing for clients age ((seven-teen)) 17 and younger—Provider requirements. Providers qualified to deliver private duty nursing under the medically intensive children's program must have the following:

- (1) An in-home services license with the state of Washington to provide private duty nursing;
- (2) A contract with the department of social and health services/developmental disabilities ((~~administration~~—(DSHS/DDA))) community services (DSHS/DDCS) to provide private duty nursing; and
- (3) A signed core provider agreement with the medicaid agency.

AMENDATORY SECTION (Amending WSR 18-15-010, filed 7/6/18, effective 9/1/18)

WAC 182-551-3300 Private duty nursing for clients age ((seven-teen)) 17 and younger—Application requirements. Clients requesting private duty nursing through fee-for-service must submit a complete signed medically intensive children's program (MICP) application (DSHS form 15-398). The MICP application must include the following:

- (1) DSHS 14-012 consent form;
- (2) DSHS 14-151 request for ((DDA)) DDCS eligibility determination form for clients not already determined ((DDA)) DDCS eligible;
- (3) DSHS 03-387 notice of practices for client medical information;
- (4) Appropriate and current medical documentation including medical plan of treatment or plan of care (WAC 246-335-080) with the client's age, medical history, diagnoses, and the parent/guardian contact information including address and phone number;
- (5) A list of current treatments or treatment records;
- (6) Information about ventilator, bilevel positive airway pressure (BiPAP), or continuous positive airway pressure (CPAP) hours per day or frequency of use;
- (7) History and physical from current hospital admission, recent discharge summary, or recent primary physician exam;
- (8) A recent interim summary, discharge summary, or clinical summary;
- (9) Recent nursing charting within the past five to seven days of hospitalization or in-home nursing documentation;
- (10) Current nursing care plan that may include copies of current daily nursing notes that describe nursing care activities;
- (11) An emergency medical plan that includes strategies to address loss of power and environmental disasters such as methods to maintain life-saving medical equipment supporting the client. The plan may include notification of electric and gas companies and the local fire department;
- (12) A psycho-social history/summary with the following information, as available:
 - (a) Family arrangement and current situation;
 - (b) Available personal support systems; and

(c) Presence of other stresses within and upon the family.

(13) Statement that the home care plan is safe for the child and is agreed to by the child's parent or legal guardian;

(14) Information about other family supports such as medicaid, school hours, or hours paid by a third-party insurance or trust; and

(15) For a client with third-party insurance or a managed care organization (MCO), a denial letter from the third-party insurance or MCO that states the private duty nursing will not be covered.

AMENDATORY SECTION (Amending WSR 18-15-010, filed 7/6/18, effective 9/1/18)

WAC 182-551-3400 Private duty nursing for clients age ((seven-teen)) 17 and younger—Authorization. (1) Private duty nursing when provided through fee-for-service requires prior authorization from the department of social and health services/developmental disabilities ((administration (DSHS/DDA))) community services (DSHS/DDCS).

(2) DSHS/((DDA)) DDCS authorizes requests for private duty nursing on a case-by-case basis when:

(a) The application requirements under WAC 182-551-3300 are met; and

(b) The nursing care consultant determines the services to be medically necessary, as defined in WAC 182-500-0070 and according to the process in WAC 182-501-0165.

(3) DSHS/((DDA)) DDCS authorizes only the number of private duty nursing hours that are medically necessary.

(a) Services are limited to ((sixteen)) 16 hours of private duty nursing per day.

(b) DSHS/((DDA)) DDCS may adjust the number of authorized hours when the client's condition or situation changes.

(c) Additional hours beyond ((sixteen)) 16 per day are subject to review as a limitation extension under WAC 182-501-0169.

(4) Private duty nursing provided to the client in excess of the authorized hours may be the financial responsibility of the client, the client's family, or the client's guardian. Providers must follow the provisions of WAC 182-502-0160.

AMENDATORY SECTION (Amending WSR 21-23-052, filed 11/10/21, effective 12/11/21)

WAC 182-559-200 Eligible providers. (1) Providers of community support services and supported employment services under this authority must be:

(a) Health care professionals, entities, or contractors as defined by WAC 182-502-0002;

(b) Agencies, centers, or facilities as defined by WAC 182-502-0002;

(c) Health home providers as described in WAC 182-557-0050;

(d) Behavioral health providers licensed and certified according to chapter 246-809 WAC; or

(e) Housing, employment, social service, or related agencies with demonstrated experience and ability to provide community support services, supported employment, or equivalent services.

(i) Community support services experience may be demonstrated by:

(A) Two years' experience in the coordination of supportive housing or in the coordination of independent living services in a social service setting under qualified supervision; or

(B) Certification in supportive housing services (WAC 246-341-0722).

(ii) Supported employment experience may be demonstrated by one or more of the following:

(A) Accredited by the commission on accreditation of rehabilitation facilities (CARF) in employment services;

(B) Certified in employment services (WAC 246-341-0720 or 246-341-0722); or

(C) All staff that will be performing supported employment services meet one of the following criteria:

(I) Be a certified employment support professional (CESP) by the employment support professional certification council (ESPCC);

(II) Be a certified rehabilitation counselor (CRC) by the commission of rehabilitation counselor certification (CRCC);

(III) Have a bachelor's degree or higher in human or social services from an accredited college or university and at least two years of demonstrated experience providing supported employment or similar services; or

(IV) Have four or more years of demonstrated experience providing supported employment or similar services.

(2) Providers of community support services or supported employment services must:

(a) Obtain a core provider agreement in accordance with WAC 182-502-0005;

(b) Enroll with the medicaid agency as a nonbilling provider in accordance with WAC 182-502-0006; or

(c) Be qualified to bill for (~~aging and long-term support~~) home and community living administration services to provide community support services or supported employment services.