Chapter 388-105 WAC

MEDICAID RATES FOR CONTRACTED HOME AND COMMUNITY RESIDENTIAL CARE SERVICES

WAC

388-105-0005 The daily medicaid payment rates for clients assessed using the comprehensive assessment reporting evaluation (CARE) tool and that reside in adult family homes (AFH) and assisted living facilities contracted to provide assisted living (AL), adult residential care (ARC), and enhanced adult residential care (EARC) services.

388-105-0035 Requirements for a capital add-on rate for licensed boarding homes contracted to provide assisted living (AL) services.

388-105-0045 Bed or unit hold—Medicaid resident discharged for a hospital or nursing home stay from an adult family home (AFH) or a boarding home contracted to provide adult residential care (ARC), enhanced adult residential care (EARC), or assisted living services (AL).

388-105-0050 Supplementation—General requirements.

388-105-0055 Supplementation—Unit or bedroom.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

388-105-0010 What are care levels? [Statutory Authority: Chapter 74.39A RCW. WSR 01-14-056, § 388-105-0010, filed 6/29/01, effective 7/30/01.] Repealed by WSR 06-07-013, filed 3/3/06, effective 4/3/06. Statutory Authority: Chapter 74.39A RCW.

388-105-0015 How does the department determine whether the medicaid resident needs assistance in completing ADLs and/or has unmet care needs? [Statutory Authority: Chapter 74.39A RCW. WSR 01-14-056, § 388-105-0015, filed 6/29/01, effective 7/30/01.] Repealed by WSR 06-07-013, filed 3/3/06, effective 4/3/06. Statutory Authority: Chapter 74.39A RCW.

388-105-0020 How does the department determine at which care level the medicaid resident will be placed? [Statutory Authority: Chapter 74.39A RCW. WSR 01-14-056, § 388-105-0020, filed 6/29/01, effective 7/30/01.] Repealed by WSR 06-07-013, filed 3/3/06, effective 4/3/06. Statutory Authority: Chapter 74.39A RCW.

388-105-0025 How many ADL values and unmet care need points correspond to the four care levels? [Statutory Authority: Chapter 74.39A RCW. WSR 01-14-056, § 388-105-0025, filed 6/29/01, effective 7/30/01.] Repealed by WSR 06-07-013, filed 3/3/06, effective 4/3/06. Statutory Authority: Chapter 74.39A RCW.

388-105-0030 What are the daily medicaid payment rates for contracted assisted living facilities (AL) not receiving a capital rate add-on? [Statutory Authority: RCW 74.39A.030, 2003 c 231. WSR 04-09-092, § 388-105-0030, filed 4/20/04, effective 5/21/04. Statutory Authority: 2002 c 371. WSR 02-22-058, § 388-105-0030, filed 10/31/02, effective 12/1/02.] Repealed by WSR 06-07-013, filed 3/3/06, effective 4/3/06. Statutory Authority: Chapter 74.39A RCW.

388-105-0040 What are the daily capital add-on rates for assisted living facilities (AL) and the AL daily payment rates with a capital add-on rate? [Statutory Authority: RCW 74.39A.030, 2003 c 231. WSR 04-09-092, § 388-105-0040, filed 4/20/04, effective 5/21/04. Statutory Authority: 2002 c 371. WSR 02-22-058, § 388-105-0040, filed 10/31/02, effective 12/1/02.] Repealed by WSR 06-07-013, filed 3/3/06, effective 4/3/06. Statutory Authority: Chapter 74.39A RCW.

WAC 388-105-0005 The daily medicaid payment rates for clients assessed using the comprehensive assessment reporting evaluation (CARE) tool and that reside in adult family homes (AFH) and assisted living facilities contracted to provide assisted living (AL), adult residential care (ARC), and enhanced adult residential care (EARC) services. For contracted AFH and assisted living facilities contracted to provide AL, ARC, and EARC services, the department pays the following daily rates for care of a medicaid resident:

COMMUNITY RESIDENTIAL DAILY RATES FOR CLIENTS ASSESSED USING CARE

KING COUNTY

CARE CLASSIFICATION	AL Without Capital Add-on	AL With Capital Add-on	ARC	EARC	AFH
A Low	$65.58	$71.00	$46.51	$46.51	$47.45
A Med	$70.97	$76.39	$52.71	$52.71	$53.70
A High	$79.58	$85.00	$57.85	$57.85	$59.96
B Low	$65.58	$71.00	$46.51	$46.51	$47.68
B Med	$73.13	$78.55	$58.92	$58.92	$60.25
B Med-High	$82.76	$88.18	$62.62	$62.62	$64.48
B High	$87.10	$92.52	$71.52	$71.52	$73.57
C Low	$70.97	$76.39	$52.71	$52.71	$53.70
C Med	$79.58	$85.00	$66.05	$66.05	$68.28
C Med-High	$98.96	$104.38	$87.89	$87.89	$89.12

COMMUNITY RESIDENTIAL DAILY RATES FOR CLIENTS ASSESSED USING CARE

KING COUNTY

CARE CLASSIFICATION	AL Without Capital Add-on	AL With Capital Add-on	ARC	EARC	AFH
C High	$99.94	$105.36	$88.73	$88.73	$90.35
D Low	$73.13	$78.55	$71.09	$71.09	$69.58
D Med	$81.20	$86.62	$82.29	$82.29	$84.93
D Med-High	$104.87	$110.29	$104.52	$104.52	$101.98
D High	$112.97	$118.39	$112.97	$112.97	$115.96
E Med	$136.43	$141.85	$136.43	$136.43	$139.90
E High	$159.89	$165.31	$159.89	$159.89	$163.85

COMMUNITY RESIDENTIAL DAILY RATES FOR CLIENTS ASSESSED USING CARE

METROPOLITAN COUNTIES*

CARE CLASSIFICATION	AL Without Capital Add-on	AL With Capital Add-on	ARC	EARC	AFH
A Low	$60.19	$65.11	$46.51	$46.51	$47.45
A Med	$63.43	$68.35	$50.64	$50.64	$51.61
A High	$77.43	$82.35	$55.18	$55.18	$56.82
B Low	$60.19	$65.11	$46.51	$46.51	$47.68
B Med	$68.80	$73.72	$55.82	$55.82	$57.10
B Med-High	$77.88	$82.80	$59.33	$59.33	$61.16
B High	$84.95	$89.87	$69.51	$69.51	$71.52
C Low	$63.43	$68.35	$50.85	$50.85	$51.99
C Med	$77.43	$82.35	$65.21	$65.21	$66.64
C Med-High	$95.71	$100.63	$81.69	$81.69	$82.88
C High	$96.67	$101.59	$86.87	$86.87	$87.87
D Low	$68.80	$73.72	$70.12	$70.12	$68.07
D Med	$79.00	$83.92	$80.65	$80.65	$82.67
D Med-High	$101.44	$106.36	$101.95	$101.95	$98.90
D High	$109.88	$114.80	$109.88	$109.88	$112.22
E Med	$132.21	$137.13	$132.21	$132.21	$135.01
E High	$154.54	$159.46	$154.54	$154.54	$157.80

*Benton, Clark, Franklin, Island, Kitsap, Pierce, Snohomish, Spokane, Thurston, Whatcom, and Yakima counties.

COMMUNITY RESIDENTIAL DAILY RATES FOR CLIENTS ASSESSED USING CARE

NONMETROPOLITAN COUNTIES**

CARE CLASSIFICATION	AL Without Capital Add-on	AL With Capital Add-on	ARC	EARC	AFH
A Low	$59.13	$64.37	$46.51	$46.51	$47.45
A Med	$63.43	$68.67	$49.62	$49.62	$50.58
A High	$77.43	$82.67	$54.30	$54.30	$55.79

COMMUNITY RESIDENTIAL DAILY RATES FOR CLIENTS ASSESSED USING CARE

NONMETROPOLITAN COUNTIES**

CARE CLASSIFICATION	AL Without Capital Add-on	AL With Capital Add-on	ARC	EARC	AFH
B Low	$59.13	$64.37	$46.51	$46.51	$47.68
B Med	$68.80	$74.04	$54.79	$54.79	$56.06
B Med-High	$77.88	$83.12	$58.22	$58.22	$59.98
B High	$84.95	$90.19	$65.77	$65.77	$67.70
C Low	$63.43	$68.67	$49.62	$49.62	$50.58
C Med	$77.43	$82.67	$61.66	$61.66	$64.13
C Med-High	$95.71	$100.95	$78.58	$78.58	$79.76
C High	$96.67	$101.91	$82.13	$82.13	$83.16
D Low	$68.80	$74.04	$66.30	$66.30	$64.43
D Med	$79.00	$84.24	$76.26	$76.26	$78.23
D Med-High	$101.44	$106.68	$96.38	$96.38	$93.58
D High	$103.88	$109.12	$103.88	$103.88	$106.16
E Med	$124.99	$130.23	$124.99	$124.99	$127.70
E High	$146.10	$151.34	$146.10	$146.10	$149.25

** Nonmetropolitan counties: Adams, Asotin, Chelan, Clallam, Columbia, Cowlitz, Douglas, Ferry, Garfield, Grant, Grays Harbor, Jefferson, Kittitas, Klickitat, Lewis, Lincoln, Mason, Okanogan, Pacific, Pend Orielle, San Juan, Skagit, Skamania, Stevens, Wahkiakum, Walla Walla and Whitman.

[Statutory Authority: RCW 74.39A.030 (3)(a). WSR 13-03-093, § 388-105-0005, filed 1/15/13, effective 2/15/13. Statutory Authority: RCW 74.34 RCW based on 2011 1st sp.s. c 7. WSR 12-02-050, § 388-105-0005, filed 12/30/11, effective 1/30/12. Statutory Authority: RCW 74.39A.030(3) and 2010 c 37 § 206 (19)(a). WSR 10-21-035, § 388-105-0005, filed 10/12/10, effective 10/29/10. Statutory Authority: RCW 74.39A.030(3), 18.20.290, and 2009 c 564 § 206(4). WSR 09-20-011, § 388-105-0005, filed 9/25/09, effective 10/26/09. Statutory Authority: RCW 74.39A.030 (3)(a). WSR 09-11-053, § 388-105-0005, filed 5/13/09, effective 6/13/09. Statutory Authority: Chapter 74.39A RCW, RCW 18.20.290, 2006 c 372, 260, and 64. WSR 06-19-017, § 388-105-0005, filed 9/8/06, effective 10/9/06. Statutory Authority: Chapter 74.39A RCW. WSR 06-07-013, § 388-105-0005, filed 3/3/06, effective 4/3/06. Statutory Authority: RCW 74.39A.030, 2003 c 231. WSR 04-09-092, § 388-105-0005, filed 4/20/04, effective 5/21/04. Statutory Authority: 2002 c 371. WSR 02-22-058, § 388-105-0005, filed 10/31/02, effective 12/1/02. Statutory Authority: 2001 c 7 § 206. WSR 01-21-077, § 388-105-0005, filed 10/18/01, effective 11/18/01. Statutory Authority: Chapter 74.39A RCW. WSR 01-14-056, § 388-105-0005, filed 6/29/01, effective 7/30/01.]

WAC 388-105-0035 Requirements for a capital add-on rate for licensed boarding homes contracted to provide assisted living (AL) services. (1) To the extent funds are appropriated to pay a capital add-on rate to AL contractors, beginning July 1, 2006 and every July 1 thereafter, the department will pay a capital add-on rate to AL contractors that have a medicaid occupancy percentage that equals or exceeds sixty percent as determined in accordance with subsection (2) and (3) of this section. The department will pay the capital add-on rate to those AL contractors meeting the sixty percent medicaid occupancy percentage for a full fiscal year i.e., July 1 through June 30.

(2) The department will determine an AL contractor's medicaid occupancy percentage by dividing its medicaid resident days from the last six months of the calendar year preceding the applicable July 1 rate effective date by the product of the weighted average for all its licensed boarding home beds irrespective of use times the calendar days (one hundred eighty-four) for the same six-month period.

(3) For the purposes of this section, medicaid resident days include those clients enrolled in medicaid managed long-term care programs, including but not limited to the program for all inclusive care (PACE) and medicaid/medicare integration project (MMIP).

[Statutory Authority: Chapter 74.39A RCW, RCW 18.20.290, 2006 c 372, 260, and 64. WSR 06-19-017, § 388-105-0035, filed 9/8/06, effective 10/9/06. Statutory Authority: Chapter 74.39A RCW. WSR 06-07-012, § 388-105-0035, filed 3/3/06, effective 4/3/06. Statutory Authority: 2002 c 371. WSR 02-22-058, § 388-105-0035, filed 10/31/02, effective 12/1/02.]

WAC 388-105-0045 Bed or unit hold—Medicaid resident discharged for a hospital or nursing home stay from an adult family home (AFH) or a boarding home contracted to provide adult residential care (ARC), enhanced adult residential care (EARC), or assisted living services (AL). (1) When an AFH, ARC, EARC, or AL contracts to provide services under chapter 74.39A RCW, the AFH, ARC, EARC, and AL contractor must hold a medicaid eligible resident's bed or unit when:

(a) Short-term care is needed in a nursing home or hospital;

(b) The resident is likely to return to the AFH, ARC, EARC, or AL; and

(c) Payment is made under subsection (3) of this section.

(2)(a) When the department pays the contractor to hold the medicaid resident's bed or unit during the resident's short-term nursing home or hospital stay, the contractor must hold the bed or unit for up to twenty days. If during the twenty day bed hold period, a department case manager determines that the medicaid resident's hospital or nursing home stay is not short term and the medicaid resident is unlikely to return to the AFH, ARC, EARC or AL facility, the department will cease paying for the bed hold the day the case manager notifies the contractor of his/her decision.

(b) A medicaid resident's discharge from an AFH, ARC, EARC, or an AL facility for a short term stay in a nursing home or hospital must be longer than twenty-four hours before subsection (3) of WAC 388-105-0045 applies.

(c) When a medicaid resident on bed hold leave returns to an AFH, ARC, EARC, or an AL facility but remains less than twenty-four hours, the bed hold leave on which the resident returned applies after the resident's discharge. A new bed hold leave will begin only when the returned resident has resided in the facility for more than twenty-four hours before the resident's next discharge.

(d) When an AFH, ARC, EARC, or AL facility discharges a resident to a nursing home or hospital and the resident is out of the facility for more than twenty-four hours, then by using e-mail, fax or telephone, the facility must notify the department of the resident's discharge within twenty-four hours after the initial twenty-four hours has passed. When the end of the initial twenty-four hours falls on a weekend or state holiday, then the facility must notify the department of the discharge within twenty-four hours after the weekend or holiday.

(3) The department will compensate the contractor for holding the bed or unit for the:

(a) First through seventh day at seventy percent of the medicaid daily rate paid for care of the resident before the hospital or nursing home stay; and

(b) Eighth through the twentieth day, at eleven dollars a day.

(4) The AFH, ARC, EARC, or AL facility may seek third-party payment to hold a bed or unit for twenty-one days or longer. The third-party payment shall not exceed the medicaid daily rate paid to the facility for the resident. If third-party payment is not available and the returning medicaid resident continues to meet the admission criteria under chapter 388-71 and/or 388-106 WAC, then the medicaid resident may return to the first available and appropriate bed or unit.

(5) The department's social worker or case manager determines whether the:

(a) Stay in a nursing home or hospital will be short-term; and

(b) Resident is likely to return to the AFH, ARC, EARC, or AL facility.

(6) When the resident's stay in the hospital or nursing home exceeds twenty days or the department's social worker or case manager determines that the medicaid resident's stay in the nursing home or hospital is not short-term and the resident is unlikely to return to the AFH, ARC, EARC, or AL facility, then only subsection (4) of this section applies to any private contractual arrangements that the contractor may make with a third party in regard to the discharged resident's unit or bed.

[Statutory Authority: RCW 74.39A.030(3), 18.20.290, and 2009 c 564 § 206(4). WSR 09-20-011, § 388-105-0045, filed 9/25/09, effective 10/26/09. Statutory Authority: RCW 74.39A.030 (3)(a). WSR 09-11-053, § 388-105-0045, filed 5/13/09, effective 6/13/09. Statutory Authority: Chapter 74.39A RCW, RCW 18.20.290, 2006 c 372, 260, and 64. WSR 06-19-017, § 388-105-0045, filed 9/8/06, effective 10/9/06. Statutory Authority: Chapter 74.39A RCW. WSR 06-07-013, § 388-105-0045, filed 3/3/06, effective 4/3/06. Statutory Authority: RCW 74.39A.030, 2003 c 231. WSR 04-09-092, § 388-105-0045, filed 4/20/04, effective 5/21/04.]

WAC 388-105-0050 Supplementation—General requirements. (1) Supplementation of the medicaid daily payment rate is an additional payment requested from a medicaid recipient or a third-party payer by an adult family home (AFH) contractor or a licensed boarding home contractor with a contract to provide adult residential care (ARC), enhanced adult residential care (EARC), or assisted living (AL) services.

(2) The AFH, ARC, EARC, or AL contractor may not request supplemental payment of a medicaid recipient's daily rate for services or items that are covered in the daily rate, and the contractor is required to provide:

(a) Under licensing chapters 388-76 or [388-]78A WAC and chapter 388-110 WAC; and/or

(b) In accordance with his or her contract with the department.

(3) Before a contractor may request supplemental payments, the contractor must have a supplemental payment policy that has been given to all applicants for admittance and current residents. In the policy, the contractor must inform the applicant for admittance or current resident that:

(a) The department medicaid payment plus any client participation assigned by the department is payment in full for the services, items, activities, room and board required by the resident's negotiated service plan per chapter 388-78A WAC or the negotiated care plan per chapter 388-76 WAC and its contract with the department; and

(b) Additional payments requested by the contractor are for services, items, activities, room and board not covered by the medicaid per diem rate.

(4) For services, items and activities, the supplementation policy must comply with RCW 70.129.030(4).

(5) For units or bedrooms for which the contractor may request supplemental payments, the contractor must include in the supplemental payment policy the:

(a) Units and/or bedrooms for which the contractor may request supplementation;

(b) Action the contractor will take when a private pay resident converts to medicaid and the resident or a third party is unwilling or unable to pay a supplemental payment in order for the resident to remain in his or her unit or bedroom. When the only units or bedrooms available are those for which the contractor charges a supplemental payment, the contractor's policy may require the medicaid resident to move from the facility. However, the contractor must give the medicaid resident thirty days notice before requiring the medicaid resident to move.

(6) For the medicaid resident for whom the contractor receives supplemental payments, the contractor must indicate in the resident's record the:

(a) Unit or bedroom for which the contractor is receiving a supplemental payment;

(b) Services, items, or activities for which the contractor is receiving supplemental payments;

(c) Who is making the supplemental payments;

(d) Amount of the supplemental payments; and

(e) Private pay charge for the unit or bedroom for which the contractor is receiving a supplemental payment.

(7) When the contractor receives supplemental payment for a unit or bedroom, the contractor must notify the medicaid resident's case manager of the supplemental payment.

[Statutory Authority: RCW 74.39A.901. WSR 07-04-042, § 388-105-0050, filed 1/30/07, effective 3/2/07.]

WAC 388-105-0055 Supplementation—Unit or bedroom. When the AFH, ARC, EARC, or AL contractor only has one type of unit or all private bedrooms, the contractor may not request supplementation from the medicaid applicant/resident or a third party, unless the unit or private bedroom has an amenity that some or all of the other units or private bedrooms lack e.g., a bathroom in private bedroom, a view unit, etc.

[Statutory Authority: RCW 74.39A.901. WSR 07-04-042, § 388-105-0055, filed 1/30/07, effective 3/2/07.]