RULE-MAKING ORDER

CR-103E (July 2011)
(Implements RCW 34.05.350)

Agency: Health Care Authority, Medicaid Program

Emergency Rule Only

Effective date of rule:
Emergency Rules
☐ Immediately upon filing.
☒ Later (specify) January 1, 2014

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?
☐ Yes ☒ No If Yes, explain:

Purpose:
HCA needs to amend rules, create new rules in order to implement new federal regulations under the federal Patient Protection and Affordable Care Act. This filing is to correctly reference rules that are final January 1, 2014 in the long-term care medical rule in addition to the elimination of the presumptive disability program as an eligibility group.

Citation of existing rules affected by this order:
Repealed:
Amended: WAC 182-513-1301,182-513-1305,182-513-1315, 182-513-1325, 182-513-1330, 182-513-1340, 182-513-1345, 182-513-1350, 182-513-1363, 182-513-1364, 182-513-1365, 182-513-1366, 182-513-1367, 182-513-1380, 182-513-1395, 182-513-1400, 182-513-1405, 182-513-1415, 182-513-1425, 182-513-1430, 182-513-1450, 182-513-1455, 182-515-1500, 182-515-1506, 182-515-1507, 182-515-1508, 182-515-1509, 182-515-1510, 182-515-1511, 182-515-1512, 182-515-1513,182-515-1514,and 182-507-0125
Suspended:

Statutory authority for adoption: RCW 41.05.021; chapter 74.39 RCW

Other authority: Patient Protection and Affordable Care Act established under Public Law 111-148; and Code of Federal Regulations at 42 CFR § 431, 435, and 457, and at 45 CFR § 155. Section 1917 of the Social Security Act.

EMERGENCY RULE
Under RCW 34.05.350 the agency for good cause finds:

☒ That immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.
☒ That state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule.
☐ That in order to implement the requirements or reductions in appropriations enacted in any budget for fiscal year 2009, 2010, 2011, 2012, or 2013, which necessitates the need for the immediate adoption, amendment, or repeal of a rule, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the fiscal needs or requirements of the agency.

Reasons for this finding: Over the last year the Agency has been working diligently with client advocates and other stakeholders in crafting the new rules to implement the provisions of the Affordable Care Act, including the expansion of Medicaid. Although the permanent rulemaking process is nearing completion, the permanent rules will not be effective by the October 1, 2013 deadline due in part to the anticipated receipt of final federal rules governing this process. Hence the need for the emergency adoption of these rules, while the permanent rulemaking process is completed.

Date adopted:
December 30, 2013

NAME (TYPE OR PRINT)
Kevin M. Sullivan

SIGNATURE
Kevin M. Sullivan

TITLE
HCA Rules Coordinator

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: December 30, 2013
TIME: 4:27 PM

WSR 14-02-086

(COMPLETE REVERSE SIDE)

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

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

The number of sections adopted in order to comply with:

Federal statute:	New	4	Amended	33	Repealed	_____
Federal rules or standards:	New	_____	Amended	_____	Repealed	_____
Recently enacted state statutes:	New	_____	Amended	_____	Repealed	_____

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

New _____ Amended _____ Repealed _____

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

New _____ Amended _____ Repealed _____

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

New 4 Amended 33 Repealed _____

The number of sections adopted using:

Negotiated rule making:	New		Amended		Repealed	_____
Pilot rule making:	New	_____	Amended	_____	Repealed	_____
Other alternative rule making:	New	4	Amended	33	Repealed	_____

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1301 Definitions related to long-term care (LTC) services. This section defines the meaning of certain terms used in chapters ((~~388-513~~)) 182-513 and ((~~388-515~~)) 182-515 WAC. Within these chapters, institutional, home and community based (HCB) waiver, and hospice services are referred to collectively as LTC services. Other terms related to LTC services that also apply to other programs are found in the sections in which they are used.

Additional medical definitions that are not specific to LTC services can be found in WAC 182-500-0005 through 182-500-0110 Medical definitions.

Definitions of terms used in certain rules that regulate LTC programs are as follows:

"Adequate consideration" means the reasonable value of the goods or services received in exchange for transferred property approximates the reasonable value of the property transferred.

"Aging and disability services (ADS)" means an umbrella agency for the behavioral health and service integration administration (BHSIA), aging and long-term support administration (ALTSA) and developmental disabilities administration (DDA) within the department of social and health services (DSHS).

"Aging and long-term supports administration (ALTSA)" means an administration within aging and disability services (ADS) of the department of social and health services (DSHS) and includes:

• Home and community services (HCS) that helps low income seniors and adults with disabilities and their families get information, support and services when long-term care is needed; and

• Residential care services (RCS) that regulates nursing facilities (NF), adult family homes (AFH), assisted living facilities (AL), intermediate care facilities for individuals with intellectual disabilities (ICF-ID), and certified community residential service providers and promotes and protects the health, safety, and well-being of individuals living in licensed or certified residential settings.

"Alternate living facility (ALF)" means one of the following community residential facilities that are contracted with the department to provide certain services:

(1) Adult family home (AFH), a licensed family home that provides its residents with personal care and board and room for two to six adults unrelated to the person(s) providing the care. Licensed as an adult family home under chapter 70.128 RCW.

(2) Adult residential care facility (ARC) (formerly known as a CCF) is a licensed facility that provides its residents with shelter, food, household maintenance, personal care and supervision. Licensed as an assisted living under chapter 18.20 RCW.

(3) Adult residential rehabilitation center (ARRC) described in WAC 388-865-0235 or adult residential treatment facility (ARTF) described in WAC 388-865-0465 are licensed facilities that provides their residents with twenty-four hour residential care for impairments related to mental illness.

(4) Assisted living facility (AL), a licensed facility for aged and disabled low-income persons with functional disabilities. COPES eligible clients are often placed in assisted living. Licensed as an assisted living facility under chapter 18.20 RCW.

(5) ((~~Division of~~)) Developmental disabilities ((~~(DDD)~~)) administration (DDA) group home (GH), a licensed facility that provides its residents with twenty-four hour supervision. Depending on the size, a ((~~DDD~~)) DDA group home may be licensed as an adult family home under chapter 70.128 RCW or an assisted living facility under chapter 18.20 RCW. Group homes provide community residential instruction, supports, and services to two or more clients who are unrelated to the provider.

(6) Enhanced adult residential care facility (EARC), a licensed facility that provides its residents with those services provided in an ARC, in addition to those required because of the client's special needs. Licensed as an assisted living facility under chapter 18.20 RCW.

"Authorization date" means the date payment begins for long-term care services described in WAC 388-106-0045.

"CARE assessment" means the evaluation process defined in chapter 388-106 WAC used by a department designated social services worker or a case manager to determine the client's need for long-term care services.

"Clothing and personal incidentals (CPI)" means the cash payment issued by the department for clothing and personal items for individuals living in an ALF described in WAC ((~~388-478-0045~~)) 182-515-1500 or medical institution described in WAC ((~~388-478-0040~~)) 182-513-1300.

"Community options program entry system (COPES)" means a medicaid home and community based (HCB) waiver program described in chapter 388-106 WAC that provides an aged or disabled person assessed as needing nursing facility care with the option to remain at home or in an alternate living facility (ALF).

"Community spouse (CS)" means a person who:

(1) Does not reside in a medical institution; and

(2) Is legally married to a client who resides in a medical institution or receives services from a home and community-based (HCB) waiver program. A person is considered married if not divorced, even when physically or legally separated from his or her spouse.

"Community spouse excess shelter" means the excess shelter standard is used to calculate whether a community spouse qualifies for the community spouse maintenance allowance because of high shelter costs. The federal maximum standard that is used to calculate the amount is found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

"Community spouse income and family allocation" means:

(1) The community spouse income standard is used when there is a community spouse. It is used when determining the total allocation for the community spouse from the institutional spouse's income.

(2) The family allocation income standard is used when a dependent resides with the community spouse. This amount is deducted from an institutional spouse's payment for their cost of care to help support the dependent. The federal maximum standard that is used to calculate the amount can be found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

"Community spouse maintenance allocation" means an amount deducted from an institutional spouse's payment toward their cost of care in order for the community spouse to have enough income to pay their shelter costs. This is a combination of the community spouse income allocation and the community spouse excess shelter calculation. The

federal maximum standard that is used to calculate the amount can be found at: http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

"Community spouse resource allocation (CSRA)" means the resource amount the community spouse is allowed. A community spouse resource evaluation is completed to determine if the standard is more than the state standard up to the federal community spouse transfer maximum standard.

"Community spouse resource evaluation" means a review of the couple owned at the start of the current period of institutional status. This review may result in a resource standard for the community spouse that is higher than the state standard.

"Community spouse transfer maximum" means the federal maximum standard that is used to determine the community spouse resource allocation (CSRA). This standard is found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

"Developmental disabilities administration (DDA)" means an administration within aging and disability services (ADS) of department of social and health services (DSHS) supporting individuals with developmental disabilities.

"((~~DDD~~)) DDA waiver" means medicaid waiver programs described in chapter 388-845 WAC that provide home and community-based services as an alternative to an intermediate care facility for the intellectually disabled (ICF-ID) to persons determined eligible for services from ((~~DDD~~)) DDA.

"Dependent" means an individual who is financially dependent upon another for his well being as defined by financial responsibility regulations for the program. For the purposes of long-term care, rules allow allocation in post eligibility to a dependent. If the dependent is eighteen years or older and being claimed as a dependent for income tax purposes, a dependent allocation can be considered. This can include an adult child, a dependent parent or a dependent sibling.

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

"Exception to rule (ETR)" means a waiver by the secretary's designee to a department policy for a specific client experiencing an undue hardship because of the policy. The waiver may not be contrary to law.

"Fair market value (FMV)" means the price an asset may reasonably be expected to sell for on the open market at the time of transfer or assignment.

"Federal benefit rate (FBR)" means the basic benefit amount the Social Security administration (SSA) pays to clients who are eligible for the supplemental security income (SSI) program.

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

"Home and community based (HCB) waiver programs" means section 1915(c) of the Social Security Act enables states to request a waiver of applicable federal medicaid requirements to provide enhanced community support services to those medicaid beneficiaries who would otherwise require the level of care provided in a hospital, nursing facility or intermediate care facility for the intellectually disabled (ICF-ID).

"Initial eligibility" means part one of institutional medical eligibility for long-term care services. Once resource and general eli-

gibility is met, the gross nonexcluded income is compared to three hundred percent of the federal benefit rate (FBR) for a determination of CN or MN coverage.

"Institutional services" means services paid for by medicaid or state funds and provided in a medical institution, through a home and community based (HCB) waiver or program of all-inclusive care for the elderly (PACE).

"Institutional status" means what is described in WAC ((~~388-513-1320~~)) 182-513-1320.

"Institutionalized client" means a client who has attained institutional status as described in WAC ((~~388-513-1320~~)) 182-513-1320.

"Institutionalized spouse" means legally married person who has attained institutional status as described in chapter ((~~388-513~~)) 182-513 WAC, and receives services in a medical institution or from a home and community based waiver program described in chapters ((~~388-513~~)) 182-513 and ((~~388-515~~)) 182-515 WAC. A person is considered married if not divorced, even when physically or legally separated from his or her spouse.

"Legally married" means persons legally married to each other under provision of Washington state law. Washington recognizes other states' legal and common-law marriages. Persons are considered married if they are not divorced, even when they are physically or legally separated.

"Likely to reside" means a determination by the department that a client is reasonably expected to remain in a medical institution for thirty consecutive days. Once made, the determination stands, even if the client does not actually remain in the facility for that length of time.

"Look-back period" means the number of months prior to the month of application for LTC services that the department will consider for transfer of assets.

"Maintenance needs amount" means a monthly income amount a client keeps as a personal needs allowance or that is allocated to a spouse or dependent family member who lives in the client's home. (See community spouse maintenance allocation and community spouse income and family allocation.)

"Medicaid personal care (MPC)" means a medicaid state plan program authorized under RCW 74.09.520. Clients eligible for this program may receive personal care in their own home or in a residential facility. Financial eligibility is based on a client receiving a noninstitutional aged, blind, disabled (ABD) categorically needy (CN) medical program or receiving a modified adjusted gross income (MAGI) based medicaid program.

"Noninstitutional medical assistance" means any medical benefits or programs not authorized under chapter ((~~388-513~~)) 182-513 or ((~~388-515~~)) 182-515 WAC. The exception is WAC ((~~388-513-1305~~)) 182-513-1305 noninstitutional SSI-related clients living in an ALF.

"Participation" means the amount a client is responsible to pay each month toward the total cost of personal care they receive each month. It is the amount remaining after subtracting allowable deductions and allocations from available monthly income. Individuals receiving services in an ALF pay room and board in addition to calculated participation. Participation is the result of the post-eligibility process used in institutional and HCB waiver eligibility.

"Penalty period" means a period of time for which a client is not eligible to receive LTC services due to asset transfers.

"Personal needs allowance (PNA)" means a standard allowance for clothing and other personal needs for long-term care clients who live in a medical institution or alternate living facility, or at home.

"Short stay" means a person who has entered a medical institution but is not likely to remain institutionalized for thirty consecutive days.

"Special income level (SIL)" means the monthly income standard for the categorically needy (CN) program that is three hundred percent of the SSI federal benefit rate (FBR).

"Spousal impoverishment" means financial provisions to protect income and assets of the noninstitutional (community spouse) through income and resource allowances. The spousal allocation process is used to discourage the impoverishment of a spouse due to the need for LTC services by their husband or wife. That law and those that have extended and/or amended it are referred to as spousal impoverishment legislation. (Section 1924 of the Social Security Act.)

"State spousal resource standard" means minimum resource standard allowed for a community spouse. (See community spouse resource transfer maximum.)

"Swing bed" means a bed in a critical access hospital that is contracted to be used as either a hospital or a nursing facility bed based on the need of the individual.

"Third party resource (TPR)" means a resource where the purpose of the payment is for payment of assistance of daily living or medical services or personal care. Third party resources are described in WAC 182-501-0200. The department is considered the payer of last resort as described in WAC 182-502-0100.

"Transfer of a resource or asset" means changing ownership or title of an asset such as income, real property, or personal property by one of the following:

(1) An intentional act that changes ownership or title; or

(2) A failure to act that results in a change of ownership or title.

"Transfer date for real property or interest in real property" means:

(1) The date of transfer for real property is the day the deed is signed by the grantor if the deed is recorded; or

(2) The date of transfer for real property is the day the signed deed is delivered to the grantee.

"Transfer month" means the calendar month in which resources were legally transferred.

"Uncompensated value" means the fair market value (FMV) of an asset at the time of transfer minus the value of compensation the person receives in exchange for the asset.

"Undue hardship" means the person is not able to meet shelter, food, clothing, or health needs. Clients who are denied or terminated from LTC services due to a transfer of asset penalty or having excess home equity may apply for an undue hardship waiver based on criteria described in WAC ((~~388-513-1367~~)) 182-513-1367.

"Value of compensation received" means the consideration the purchaser pays or agrees to pay. Compensation includes:

(1) All money, real or personal property, food, shelter, or services the person receives under a legally enforceable purchase agreement whereby the person transfers the asset; and

(2) The payment or assumption of a legal debt the seller owes in exchange for the asset.

"Veterans benefits" means different types of benefits paid by the federal Department of Veterans Affairs (VA). Some may include additional allowances for:

(1) Aid and attendance for an individual needing regular help from another person with activities of daily living;

(2) "Housebound" for an individual who, when without assistance from another person, is confined to the home;

(3) Improved pension, the newest type of VA disability pension, available to veterans and their survivors whose income from other sources (including service connected disability) is below the improved pension amount;

(4) Unusual medical expenses (UME), determined by the VA based on the amount of unreimbursed medical expenses reported by the person who receives a needs-based benefit. The VA can use UME to reduce countable income to allow the person to receive a higher monthly VA payment, a one-time adjustment payment, or both;

(5) Dependent allowance veteran's payments made to, or on behalf of, spouses of veterans or children regardless of their ages or marital status. Any portion of a veteran's payment that is designated as the dependent's income is countable income to the dependent; or

(6) Special monthly compensation (SMC). Extra benefit paid to a veteran in addition to the regular disability compensation to a veteran who, as a result of military service, incurred the loss or loss of use of specific organs or extremities.

"Waiver programs/services" means programs for which the federal government authorizes exceptions to federal medicaid rules. Such programs provide to an eligible client a variety of services not normally covered under medicaid. In Washington state, home and community based (HCB) waiver programs are authorized by the ((~~division of~~)) developmental disabilities ((~~(DDD)~~)) administration (DDA), or home and community services (HCS).

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1305 Determining eligibility for SSI-related noninstitutional medical assistance in an alternate living facility (ALF). This section describes how the department defines the monthly income standard and uses it to determine eligibility for noninstitutional medical assistance for a client who lives in a department-contracted ALF. Refer to WAC ((~~388-478-0045~~)) 182-515-1500 for the personal needs allowance (PNA) amount that applies in this rule.

(1) The eligibility criteria for noninstitutional medical assistance in an ALF follows SSI-related medical rule described in chapter 182-512 WAC ((~~182-512-0050 through 182-512-0960~~)) with the exception of the higher medical standard based on the daily rate described in subsection (3) of this section.

(2) Alternate living facilities ((~~(AFH) [(ALF)]~~)) (ALF) include the following:

(a) An adult family home (AFH), a licensed family home that provides its residents with personal care and board and room for two to six adults unrelated to the person(s) providing the care. Licensed as an adult family home under chapters 70.128 RCW and 388-76 WAC;

(b) An adult residential care facility (ARC) (formally known as a CCF) is a licensed facility that provides its residents with shelter, food, household maintenance, personal care and supervision. Licensed as an assisted living facility under chapters 18.20 RCW and 388-78A WAC;

(c) An adult residential rehabilitation center (ARRC) described in WAC 388-865-0235 or adult residential treatment facility (ARTF) described in WAC 388-865-0465. These are licensed facilities that provide its residents with twenty-four hour residential care for impairments related to mental illness;

(d) Assisted living facility (AL), a licensed facility for aged and disabled low-income persons with functional disabilities. COPES eligible clients are often placed in assisted living. Licensed as an assisted living facility under chapters 18.20 RCW and 388-78A WAC;

(e) ((~~Division of~~)) Developmental disabilities ((~~(DDD)~~)) administration (DDA) group home (GH), a licensed facility that provides its residents with twenty-four hour supervision. Depending on size of a ((~~DDD~~)) DDA group home may be licensed as an adult family home under chapter 70.128 RCW or a boarding home under chapter 18.20 RCW. Group home means a residence that is licensed as either an assisted living facility or an adult family home by the department under chapters 388-78A or 388-76 WAC. Group homes provide community residential instruction, supports, and services to two or more clients who are unrelated to the provider; and

(f) Enhanced adult residential care facility (EARC), a licensed facility that provides its residents with those services provided in an ARC, in addition to those required because of the client's special needs. Licensed as an assisted living facility under chapter 18.20 RCW.

(3) The monthly income standard for noninstitutional medical assistance under the categorically needy (CN) program has two steps:

(a) The gross nonexcluded monthly income cannot exceed the special income level (SIL) which is three hundred percent of the federal benefit rate (FBR); and

(b) The countable income cannot be greater than the department contracted daily rate times thirty-one days, plus the thirty-eight dollars and eighty-four cents PNA/CPI described in WAC ((~~388-478-0045~~)) 182-513-1300.

(4) The monthly income standard for noninstitutional medical assistance under the medically needy (MN) program equals the private facility daily rate times thirty one days, plus the thirty-eight dollars and eight-four cents PNA/CPI described in WAC ((~~388-478-0045~~)) 182-513-1300. Follow MN rules described in chapter 182-519 WAC.

(5) The department approves CN noninstitutional medical assistance for a period of up to twelve months for a client who is SSI-related as described in WAC 182-512-0050, if:

(a) The client's nonexcluded resources do not exceed the standard described in WAC ((~~388-513-1350~~)) 182-513-1350(1); and

(b) The client's nonexcluded income does not exceed the CN standard described in subsection (3) of this section. SSI-related program as described in chapter 182-512 WAC.

(6) The department approves MN noninstitutional medical assistance for a period of months described in chapter 182-504 WAC for an SSI-related client, if:

(a) The client's nonexcluded resources do not exceed the standard described in WAC ((~~388-513-1350~~)) 182-513-1350(1); and

(b) The client satisfies any spenddown liability as described in chapter 182-519 WAC.

(7) ((~~The department determines eligibility for a cash grant for individuals residing in an alternate living facility using the following program rules:~~

~~(a) WAC 388-400-0005 temporary assistance for needy families (TANF);~~

~~(b) WAC 388-400-0060 aged, blind, disabled (ABD) cash benefit;~~

~~(c) WAC 388-400-0030 refugee assistance.~~

~~(8) The~~)) A client ((~~described in subsection (7)~~)) residing in an adult family home (AFH) ((~~receives~~)) receiving a grant based on a payment standard described in WAC 388-478-0033 due to an obligation to pay shelter costs to the adult family home. The client keeps a CPI/PNA in the amount of thirty-eight dollars and eighty-four cents described in WAC ((~~388-478-0045~~)) 182-515-1500 and pays the remainder of the grant to the adult family home as room and board.

((~~(9) The client described in subsection (7) residing in an ALF described in subsections (2)(b), (c), (d), (e), (f) or (g) (all nonadult family home residential settings) keeps the thirty-eight dollars and eighty-four cents CPI amount based on WAC 388-478-0045.~~

~~(10)~~)) (8) The client described in subsection (3) of this section and receiving medicaid personal care (MPC) from the department keeps sixty-two dollars and seventy-nine cents as a PNA and pays the remainder of their income to the ALF for room and board and personal care.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1315 Eligibility for long-term care (institutional, home and community based (HCB) waiver, and hospice) services. ((~~This section describes how the department determines a client's eligibility for medical for clients residing in a medical institution, on a waiver, or receiving hospice services under the categorically needy (CN) or medically needy (MN) programs. Also described are the eligibility requirements for these services under the aged, blind, or disabled (ABD) cash assistance, medical care services (MCS) and the state funded long-term care services program described in subsection (11).~~

~~(1) To be eligible for long-term care (LTC) services described in this section, a client must:~~

~~(a) Meet the general eligibility requirements for medical programs described in WAC 182-503-0505 (2) and (3)(a) through (g);~~

~~(b) Attain institutional status as described in WAC 388-513-1320;~~

~~(c) Meet functional eligibility described in chapter 388-106 WAC for home and community services (HCS) waiver and nursing facility coverage; or~~

~~(d) Meet criteria for division of developmental disabilities (DDD) assessment under chapter 388-828 WAC for DDD waiver or institutional services;~~

~~(e) Not have a penalty period of ineligibility as described in WAC 388-513-1363, 388-513-1364, or 388-513-1365;~~

~~(f) Not have equity interest in their primary residence greater than the home equity standard described in WAC 388-513-1350; and~~

~~(g) Must disclose to the state any interest the applicant or spouse has in an annuity and meet annuity requirements described in chapter 388-561 WAC:~~

~~(i) This is required for all institutional or waiver services and includes those individuals receiving supplemental security income (SSI).~~

~~(ii) A signed and completed eligibility review for long term care benefits or application for benefits form can be accepted for SSI individuals applying for long-term care services.~~

~~(2) To be eligible for institutional, waiver, or hospice services under the CN program, a client must either:~~

~~(a) Be related to the supplemental security income (SSI) program as described in WAC 182-512-0050 (1), (2) and (3) and meet the following financial requirements, by having:~~

~~(i) Gross nonexcluded income described in subsection (8)(a) that does not exceed the special income level (SIL) (three hundred percent of the federal benefit rate (FBR)); and~~

~~(ii) Countable resources described in subsection (7) that do not exceed the resource standard described in WAC 388-513-1350; or~~

~~(b) Be approved and receiving aged, blind, or disabled cash assistance described in WAC 388-400-0060 and meet citizenship requirements for federally funded medicaid described in WAC 388-424-0010; or~~

~~(c) Be eligible for CN apple health for kids described in WAC 182-505-0210; or CN family medical described in WAC 182-505-0240; or family and children's institutional medical described in WAC 182-514-0230 through 182-514-0260. Clients not meeting the citizenship requirements for federally funded medicaid described in WAC 388-424-0010 are not eligible to receive waiver services. Nursing facility services for noncitizen children require prior approval by aging and disability services administration (ADSA) under the state funded nursing facility program described in WAC 182-507-0125; or~~

~~(d) Be eligible for the temporary assistance for needy families (TANF) program as described in WAC 388-400-0005. Clients not meeting disability or blind criteria described in WAC 182-512-0050 are not eligible for waiver services.~~

~~(3) The department allows a client to reduce countable resources in excess of the standard. This is described in WAC 388-513-1350.~~

~~(4) To be eligible for waiver services, a client must meet the program requirements described in:~~

~~(a) WAC 388-515-1505 through 388-515-1509 for COPES, New Freedom, PACE, and WMIP services; or~~

~~(b) WAC 388-515-1510 through 388-515-1514 for DDD waivers.~~

~~(5) To be eligible for hospice services under the CN program, a client must:~~

~~(a) Meet the program requirements described in chapter 182-551 WAC; and~~

~~(b) Be eligible for a noninstitutional categorically needy program (CN) if not residing in a medical institution thirty days or more; or~~

~~(c) Reside at home and benefit by using home and community based waiver rules described in WAC 388-515-1505 through 388-515-1509 (SSI-related clients with income over the effective one-person MNIL and gross income at or below the 300 percent of the FBR or clients with a community spouse); or~~

~~(d) Receive home and community waiver (HCS) or DDD waiver services in addition to hospice services. The client's responsibility to~~

~~pay toward the cost of care (participation) is applied to the waiver service provider first; or~~

~~(e) Be eligible for institutional CN if residing in a medical institution thirty days or more.~~

~~(6) To be eligible for institutional or hospice services under the MN program, a client must be:~~

~~(a) Eligible for MN children's medical program described in WAC 182-514-0230, 182-514-0255, or 182-514-0260; or~~

~~(b) Related to the SSI-program as described in WAC 182-512-0050 and meet all requirements described in WAC 388-513-1395; or~~

~~(c) Eligible for the MN SSI-related program described in WAC 182-512-0150 for hospice clients residing in a home setting; or~~

~~(d) Eligible for the MN SSI-related program described in WAC 388-513-1305 for hospice clients not on a medically needy waiver and residing in an alternate living facility.~~

~~(e) Be eligible for institutional MN if residing in a medical institution thirty days or more described in WAC 388-513-1395.~~

~~(7) To determine resource eligibility for an SSI-related client under the CN or MN program, the department:~~

~~(a) Considers resource eligibility and standards described in WAC 388-513-1350; and~~

~~(b) Evaluates the transfer of assets as described in WAC 388-513-1363, 388-513-1364, or 388-513-1365.~~

~~(8) To determine income eligibility for an SSI-related client under the CN or MN program, the department:~~

~~(a) Considers income available as described in WAC 388-513-1325 and 388-513-1330;~~

~~(b) Excludes income for CN and MN programs as described in WAC 388-513-1340;~~

~~(c) Disregards income for the MN program as described in WAC 388-513-1345; and~~

~~(d) Follows program rules for the MN program as described in WAC 388-513-1395.~~

~~(9) A client who meets the requirements of the CN program is approved for a period of up to twelve months.~~

~~(10) A client who meets the requirements of the MN program is approved for a period of months described in WAC 388-513-1395 for:~~

~~(a) Institutional services in a medical institution; or~~

~~(b) Hospice services in a medical institution.~~

~~(11) The department determines eligibility for state funded programs under the following rules:~~

~~(a) A client who is eligible for ABD cash assistance program described in WAC 388-400-0060 but is not eligible for federally funded medicaid due to citizenship requirements receives MCS medical described in WAC 182-508-0005. A client who is eligible for MCS may receive institutional services but is not eligible for hospice or HCB waiver services.~~

~~(b) A client who is not eligible for ABD cash assistance but is eligible for MCS coverage only described in WAC 182-508-0005 may receive institutional services but is not eligible for hospice or HCB waiver services.~~

~~(c) A noncitizen client who is not eligible under subsections (11)(a) or (b) and needs long-term care services may be eligible under WAC 182-507-0110 and 82-507-0125. This program must be pre-approved by aging and disability services administration (ADSA).~~

~~(12) A client is eligible for medicaid as a resident in a psychiatric facility, if the client:~~

~~(a) Has attained institutional status as described in WAC 388-513-1320; and~~

~~(b) Is under the age of twenty-one at the time of application; or~~

~~(c) Is receiving active psychiatric treatment just prior to their twenty-first birthday and the services extend beyond this date and the client has not yet reached age twenty-two; or~~

~~(d) Is at least sixty-five years old.~~

~~(13) The department determines a client's eligibility as it does for a single person when the client's spouse has already been determined eligible for LTC services.~~

~~(14) If an individual under age twenty one is not eligible for medicaid under SSI-related in WAC 182-512-0050 or ABD cash assistance described in WAC 388-400-0060 or MCS described in WAC 182-508-0005, consider eligibility under WAC 182-514-0255 or 182-514-0260.~~

~~(15) Noncitizen clients under age nineteen can be considered for the apple health for kids program described in WAC 182-505-0210 if they are admitted to a medical institution for less than thirty days. Once a client resides or is likely to reside in a medical institution for thirty days or more, the department determines eligibility under WAC 182-514-0260 and must be preapproved for coverage by ADSA as described in WAC 182-507-0125.~~

~~(16) Noncitizen clients not eligible under subsection (15) of this section can be considered for LTC services under WAC 182-507-0125. These clients must be preapproved by ADSA.~~

~~(17) The department determines a client's total responsibility to pay toward the cost of care for LTC services as follows:~~

~~(a) For SSI-related clients residing in a medical institution see WAC 388-513-1380;~~

~~(b) For clients receiving HCS CN waiver services see WAC 388-515-1509;~~

~~(c) For clients receiving DDD CN waiver services see WAC 388-515-1514; or~~

~~(d) For TANF related clients residing in a medical institution see WAC 182-514-0265.~~

~~(18) Clients not living in a medical institution who are considered to be receiving SSI-benefits for the purposes of medicaid do not pay service participation toward their cost of care. Clients living in a residential setting do pay room and board as described in WAC 388-515-1505 through 388-515-1509 or WAC 388-515-1514. Groups deemed to be receiving SSI and for medicaid purposes are eligible to receive CN medicaid. These groups are described in WAC 182-512-0880.~~)) This section describes how the medicaid agency or its designee determines a client's eligibility for Washington apple health (WAH) long-term care coverage for clients residing in a medical institution, receiving home and community based waiver services, or receiving hospice services under the categorically needy (CN) or medically needy (MN) programs. Also described are the eligibility requirements for these services under state-funded medical care services (MCS) program and the state funded long-term care services program.

This chapter includes the following sections;

(1) WAC 182-513-1316, General eligibility requirements for WAH long-term care programs.

(2) WAC 182-513-1317, Income and resource criteria for an institutionalized client.

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

(4) WAC 182-513-1319, State-funded programs for noncitizen clients.

NEW SECTION

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

(a) Meet the general eligibility requirements for medical programs described in WAC 182-503-0505;

(b) Attain institutional status as described in WAC 182-513-1320;

(c) Meet the functional eligibility described in:

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

(ii) Chapter 388-828 WAC for DDA waiver or institutional services; and

(d) Meet either:

(i) SSI-related WAH criteria as described in WAC 182-512-0050; or

(ii) MAGI-based WAH criteria as described in WAC 182-503-0510(2). A client who is eligible for MAGI-based WAH is not subject to the provisions described in subsection (2) of this section.

(2) An SSI-related client, including supplemental security income (SSI) recipients, who needs LTC services must also:

(a) Not have a penalty period of ineligibility as described in WAC 182-513-1363, 182-513-1364, or 182-513-1365;

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

(c) Disclose to the state any interest the applicant or spouse has in an annuity and meet annuity requirements described in chapter 182-516 WAC.

(3) An SSI recipient must submit a signed health care coverage application form attesting to the provisions described in subsection (2) of this section. A signed and completed eligibility review for long-term care benefits can be accepted for SSI clients applying for long-term care services.

(4) To be eligible for WAH LTC waiver services, a client must also meet the program requirements described in:

(a) WAC 182-515-1505 through 182-515-1509 for COPES, New Freedom PACE, and WMIP services; or

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

(5) A client who is eligible for categorically needy WAH coverage is certified for twelve months.

(6) A client who is eligible for medically needy WAH coverage is approved for a period of months described in WAC 182-513-1395(6) for:

(a) Institutional services in a medical institution; or

(b) Hospice services in a medical institution.

(7) The medicaid agency or its designee determines a client's eligibility as it does for a single person when the client's spouse has already been determined eligible for LTC services.

NEW SECTION

WAC 182-513-1317 Income and resource criteria for an institutionalized client. (1) This section provides an overview of the income and resource eligibility rules for a client who lives in an institutional setting. The term "institution" is defined in WAC 182-500-0050.

(2) To determine income eligibility for an SSI-related WAH long-term care (LTC) client under the categorically needy (CN) program, the medicaid agency or its designee:

(a) Considers income available as described in WAC 182-513-1325 and 182-513-1330;

(b) Excludes income as described in WAC 182-513-1340;

(c) Compares remaining gross nonexcluded income to the special income level (SIL) (three hundred percent of the federal benefit rate (FBR)). A client's gross income must be equal to or less than the SIL to be eligible for CN coverage.

(3) To determine income eligibility for an SSI-related WAH LTC client under the medically needy (MN) program, the agency or its designee:

(a) Considers income available as described in WAC 182-513-1325 and 182-513-1330;

(b) Excludes income as described in WAC 182-513-1340;

(c) Disregards income as described in WAC 182-513-1345; and

(d) Follows the income standards and eligibility rules described in WAC 182-513-1395.

(4) To be resource eligible under the SSI-related WAH LTC CN or MN program, the client must:

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

(b) Not have a penalty period of ineligibility due to a transfer of asset as described in WAC 182-513-1363 or 182-513-1364;

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

(5) The agency or its designee allows an institutionalized client to reduce countable resources in excess of the standard. This is described in WAC 182-513-1350.

(6) A client is eligible for medicaid as a resident in a psychiatric facility, if the client:

(a) Has attained institutional status as described in WAC 182-513-1320; and

(b) Is under the age of twenty-one at the time of application; or

(c) Is receiving active psychiatric treatment just prior to their twenty-first birthday and the services extend beyond this date and the client has not yet reached age twenty-two; or

(d) Is at least sixty-five years old.

(7) To determine CN or MN income eligibility for a MAGI-based WAH LTC client, the medicaid agency or its designee follows the rules described in WAC 182-514-0230 through 182-514-0265.

(8) There is no asset test for MAGI-based WAH LTC programs as described in WAC 182-514-0245.

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

(a) For SSI-related WAH clients residing in a medical institution see WAC 182-513-1380;

(b) For MAGI-based WAH clients residing in a medical institution see WAC 182-514-0265. Clients who are eligible for the MAGI-based WAH adult medical program described in WAC 182-505-0250 are not required to contribute toward the cost of care. Nursing home care is included in the alternative benefit plan scope of care for these clients.

NEW SECTION

WAC 182-513-1318 Income and resource criteria for home and community based (HCB) waiver programs and hospice clients. (1) This section provides an overview of the income and resource eligibility rules for a client to be eligible for a home and community based (HCB) waiver program or the Washington apple health (WAH) hospice program.

(2) To determine income eligibility for an SSI-related WAH long-term care (LTC) waiver client under the categorically needy (CN) program, the medicaid agency or its designee:

(a) Considers income available as described in WAC 182-513-1325 and 182-513-1330;

(b) Excludes income as described in WAC 182-513-1340;

(c) Compares remaining gross non excluded income to:

(i) The special income level (SIL) (three hundred percent of the federal benefit rate (FBR)); or

(ii) For home and community based (HCB) service programs authorized by aging and long-term supports administration (ALTSA), a higher standard is determined following the rules described in WAC 182-514-1508 if a client's income is above the SIL but net income is below the medically needy income level (MNIL).

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

(4) There is no WAH HCB waiver medically needy program.

(5) To be resource eligible under the SSI-related WAH LTC CN waiver programs, the client must:

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

(b) Not have a penalty period of ineligibility due to a transfer of asset as described in WAC 182-513-1363, 182-513-1364, or 182-513-1365;

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

(6) The agency or its designee allows an HCB waiver client to use verified unpaid medical expenses to reduce countable resources in excess of the standard. This is described in WAC 182-513-1350.

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

(a) For clients receiving HCS CN waiver services see WAC 182-515-1509;

(b) For clients receiving DDA CN waiver services see WAC 182-515-1514.

(8) HCB waiver clients who are "deemed eligible" for SSI benefits as described in WAC 182-512-0880 do not pay service participation toward their cost of personal care. Clients living in a residential setting do pay room and board as described in WAC 182-515-1505 through 182-515-1509 or 182-515-1514.

(9) To be eligible for hospice services under the CN program, a client must:

(a) Meet the program requirements described in chapter 182-551 WAC governing client eligibility for hospice care; and

(b) Be eligible for a noninstitutional CN program if not residing in a medical institution thirty days or more.

(10) A client who is not eligible for a noninstitutional CN program who needs hospice care is eligible for the WAH hospice program if they meet the following criteria:

(a) Meet the hospice program requirements described in chapter 182-551 WAC; and

(b) Reside at home and would be eligible for coverage by using home and community services waiver rules described in WAC 182-515-1505 through 182-515-1509 (SSI-related clients with income over the effective one-person MNIL and gross income at or below the three hundred percent of the FBR or clients with a community spouse); or

(c) Receive WAH HCBS waiver services in addition to hospice services. The client's responsibility to pay toward the cost of care (participation) is applied to the waiver service provider first; or

(d) Be eligible for institutional CN if residing in a medical institution (including a hospice care center) for thirty days or more.

(11) To be eligible for hospice services under the MN program, a client must be:

(a) Eligible for the MN SSI-related program described in WAC 182-512-0150 for hospice clients residing in a home setting; or

(b) Eligible for the MN SSI-related program described in WAC 182-513-1305 for hospice clients not receiving HCBS waiver services who reside in an alternate living facility.

(c) Be eligible for institutional MN if residing in a medical institution thirty days or more described in WAC 182-513-1395.

NEW SECTION

WAC 182-513-1319 State-funded programs for noncitizen clients. (1) This section describes the programs that are available for noncitizen clients who do not meet the citizenship criteria described in WAC 182-503-0530 to be eligible for federally funded Washington apple health (WAH) coverage.

(2) Lawfully residing noncitizen clients who need nursing facility care or care in an alternate living facility may receive long-term care (LTC) coverage if the client meets the eligibility and incapacity criteria of the medical care services (MCS) program described in WAC 182-508-0005.

(3) Clients who receive MCS coverage are not eligible for home and community based (HCB) waiver programs or hospice care.

(4) Noncitizen clients under the age of nineteen who are eligible for the WAH for kids program described in WAC 182-505-0210 are eligible for LTC services if the client is admitted to a medical institution for less than thirty days. Once the client resides or is likely

to reside in a medical institution for thirty days or more, the medicaid agency or its designee determines eligibility under WAC 182-514-0260, subject to being preapproved for coverage by aging and long-term supports administration (ALTSA) as described in WAC 182-507-0125.

(5) Noncitizen clients age nineteen or older may be eligible for the state-funded long-term care services WAH program described in WAC 182-507-0125. These clients must be preapproved by ALTSA as the program has enrollment limits. When the program is full, a client who needs LTC services is placed on a waiting list for services. Such an individual is not eligible for WAH waiver programs described in chapter 182-515 WAC.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1325 Determining available income for an SSI-related single client for long-term care (LTC) services (institutional, waiver or hospice). This section describes income the department considers available when determining an SSI-related single client's eligibility for LTC services (institutional, waiver or hospice).

(1) Refer to WAC ((~~388-513-1330~~)) 182-513-1330 for rules related to available income for legally married couples.

(2) The department must apply the following rules when determining income eligibility for SSI-related LTC services:

(a) WAC 182-512-0600 Definition of income;

(b) WAC 182-512-0650 Available income;

(c) WAC 182-512-0700 Income eligibility;

(d) WAC 182-512-0750 Countable unearned income;

(e) WAC 182-514-0840(3) Self-employment income-allowable expenses;

(f) WAC ((~~388-513-1315~~)) 182-513-1315(15), Eligibility for long-term care (institutional, waiver, and hospice) services; and

(g) WAC ((~~388-450-0155, 388-450-0156, 388-450-0160~~)) 182-512-0785, 182-512-0790, 182-512-0795, and 182-509-0155 for sponsored immigrants and how to determine if sponsors' income counts in determining benefits.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1330 Determining available income for legally married couples for long-term care (LTC) services. This section describes income the department considers available when determining a legally married client's eligibility for LTC services.

(1) The department must apply the following rules when determining income eligibility for LTC services:

(a) WAC 182-512-0600 Definition of income SSI-related medical;

(b) WAC 182-512-0650 Available income;

(c) WAC 182-512-0700 Income eligibility;

(d) WAC 182-512-0750 Countable unearned income;

(e) WAC 182-512-0840(3) Self-employment income-allowance expenses;

(f) WAC 182-512-0960, SSI-related medical clients; and

(g) WAC ((~~388-513-1315~~)) 182-513-1315, Eligibility for long-term care (institutional, waiver, and hospice) services.

(2) For an institutionalized client married to a community spouse who is not applying or approved for LTC services, the department considers the following income available, unless subsection (4) applies:

(a) Income received in the client's name;

(b) Income paid to a representative on the client's behalf;

(c) One-half of the income received in the names of both spouses; and

(d) Income from a trust as provided by the trust.

(3) The department considers the following income unavailable to an institutionalized client:

(a) Separate or community income received in the name of the community spouse; and

(b) Income established as unavailable through a court order.

(4) For the determination of eligibility only, if available income described in subsection((~~s~~)) (2)(a) through (d) of this section minus income exclusions described in WAC ((~~388-513-1340~~)) 182-513-1340 exceeds the special income level (SIL), then:

(a) The department follows community property law when determining ownership of income;

(b) Presumes all income received after marriage by either or both spouses to be community income; ((~~and~~))

(c) Considers one-half of all community income available to the institutionalized client((~~.~~)); and

(d) If the total of ((~~subsection (4)~~)) (c) of this subsection plus the client's own income is over the SIL, follow subsection (2) of this section.

(5) The department considers income generated by a transferred resource to be the separate income of the person or entity to which it is transferred.

(6) The department considers income available to the client not generated by a transferred resource available to the client, even when the client transfers or assigns the rights to the stream of income to:

(a) The spouse; or

(b) A trust for the benefit of their spouse.

((~~(8)~~)) (7) The department evaluates the transfer of a resource described in subsection (5) of this section according to WAC ((~~388-513-1363, 388-513-1364, and 388-513-1365~~)) 182-513-1363, 182-513-1364, and 182-513-1365 to determine whether a penalty period of ineligibility is required.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1340 Determining excluded income for long-term care (LTC) services. This section describes income the department excludes when determining a client's eligibility and participation in the cost of care for LTC services with the exception described in subsection (31) of this section.

(1) Crime victim's compensation;

(2) Earned income tax credit (EITC) for twelve months after the month of receipt;

(3) Native American benefits excluded by federal statute (refer to WAC ((~~388-450-0040~~)) 182-512-0700);

(4) Tax rebates or special payments excluded by other statutes;

(5) Any public agency's refund of taxes paid on real property and/or on food;

(6) Supplemental security income (SSI) and certain state public assistance based on financial need;

(7) The amount a representative payee charges to provide services when the services are a requirement for the client to receive the income;

(8) The amount of expenses necessary for a client to receive compensation, e.g., legal fees necessary to obtain settlement funds;

(9) ((~~Any portion of a grant, scholarship, or fellowship used to pay tuition, fees, and/or other necessary educational expenses at any educational institution~~)) Education benefits described in WAC 182-509-0335;

(10) Child support payments received from an absent parent for a child living in the home are considered the income of the child;

(11) Self-employment income allowed as a deduction by the Internal Revenue Service (IRS);

(12) Payments to prevent fuel cut-offs and to promote energy efficiency that are excluded by federal statute;

(13) Assistance (other than wages or salary) received under the Older Americans Act;

(14) Assistance (other than wages or salary) received under the foster grandparent program;

(15) Certain cash payments a client receives from a governmental or nongovernmental medical or social service agency to pay for medical or social services;

(16) Interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement that are left to accumulate and become part of the separately identified burial funds set aside;

(17) Tax exempt payments received by Alaska natives under the Alaska Native Settlement Act established by P.L. 100-241;

(18) Compensation provided to volunteers in ACTION programs under the Domestic Volunteer Service Act of 1973 established by P.L. 93-113;

(19) Payments made from the Agent Orange Settlement Fund or any other funds to settle Agent Orange liability claims established by P.L. 101-201;

(20) Payments made under section six of the Radiation Exposure Compensation Act established by P.L. 101-426;

(21) Payments made under the Energy Employee Occupational Compensation Program Act of 2000, (EEOICPA) Pub. L. 106-398;

(22) Restitution payment, and interest earned on such payment to a civilian of Japanese or Aleut ancestry established by P.L. 100-383;

(23) Payments made under sections 500 through 506 of the Austrian General Social Insurance Act;

(24) Payments made from *Susan Walker v. Bayer Corporation, et, al.*, 95-C-5024 (N.D. Ill.) (May 8, 1997) settlement funds;

(25) Payments made from the Ricky Ray Hemophilia Relief Fund Act of 1998 established by P.L. 105-369;

(26) Payments made under the Disaster Relief and Emergency Assistance Act established by P.L. 100-387;

(27) Payments made under the Netherlands' Act on Benefits for Victims of Persecution (WUV);

(28) Payments made to certain survivors of the Holocaust under the Federal Republic of Germany's Law for Compensation of National Socialist Persecution or German Restitution Act;

(29) Interest or dividends received by the client is excluded as income. Interest or dividends received by the community spouse of an institutional individual is counted as income of the community spouse. Dividends and interest are returns on capital investments such as stocks, bond, or savings accounts. Institutional status is defined in WAC ((~~388-513-1320~~)) 182-513-1320;

(30) Income received by an ineligible or nonapplying spouse from a governmental agency for services provided to an eligible client, e.g., chore services;

(31) Department of Veterans Affairs benefits designated for:

(a) The veteran's dependent when determining LTC eligibility for the veteran. The VA dependent allowance is considered countable income to the dependent unless it is paid due to unusual medical expenses (UME);

(b) Unusual medical expenses, aid and attendance allowance, special monthly compensation (SMC) and housebound allowance, with the exception described in subsection (32) of this section;

(32) Benefits described in subsection (31)(b) of this section for a client who receives long-term care services are excluded when determining eligibility, but are considered available as a third-party resource (TPR) when determining the amount the client contributes in the cost of care.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1345 Determining disregarded income for institutional or hospice services under the medically needy (MN) program. This section describes income the department disregards when determining a client's eligibility for institutional or hospice services under the MN program. The department considers disregarded income available when determining a client's participation in the cost of care.

(1) The department disregards the following income amounts in the following order:

(a) Income that is not reasonably anticipated, or is received infrequently or irregularly, when such income does not exceed:

(i) Twenty dollars per month if unearned; or

(ii) Ten dollars per month if earned.

(b) The first twenty dollars per month of earned or unearned income, unless the income paid to a client is:

(i) Based on need; and

(ii) Totally or partially funded by the federal government or a private agency.

(2) For a client who is related to the supplemental security income (SSI) program as described in WAC 182-512-0050(1), the first sixty-five dollars per month of earned income not excluded under WAC ((~~388-513-1340~~)) 182-513-1340, plus one-half of the remainder.

(3) Department of Veterans Affairs benefits designated for:

(a) The veteran's dependent when determining LTC eligibility for the veteran. The VA dependent allowance is considered countable income to the dependent unless it is paid due to unusual medical expenses (UME);

(b) Unusual medical expenses, aid and attendance allowance, special monthly compensation (SMC) and housebound allowance, with the exception described in subsection (4) of this section.

(4) Benefits described in subsection (3)(b) of this section for a client who receives long-term care services are excluded when determining eligibility, but are considered available as a third-party resource (TPR) when determining the amount the client contributes in the cost of care.

(5) Income the Social Security Administration (SSA) withholds from SSA Title II benefits for the recovery of an SSI overpayment.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1350 Defining the resource standard and determining resource eligibility for long-term care (LTC) services. This section describes how the department defines the resource standard and countable or excluded resources when determining a client's eligibility for LTC services. The department uses the term "resource standard" to describe the maximum amount of resources a client can have and still be resource eligible for program benefits.

(1) The resource standard used to determine eligibility for LTC services equals:

(a) Two thousand dollars for:

(i) A single client; or

(ii) A legally married client with a community spouse, subject to the provisions described in subsections (9) through (12) of this section; or

(b) Three thousand dollars for a legally married couple, unless subsection (4) of this section applies.

(2) Effective January 1, 2012, if an individual purchases a qualified long-term care partnership policy approved by the Washington insurance commissioner under the Washington long-term care partnership program, the department allows the individual with the long-term care partnership policy to retain a higher resource amount based on the dollar amount paid out by a partnership policy. This is described in WAC ((~~388-513-1400~~)) 182-513-1400.

(3) When both spouses apply for LTC services the department considers the resources of both spouses as available to each other through the month in which the spouses stopped living together.

(4) When both spouses are institutionalized, the department will determine the eligibility of each spouse as a single client the month following the month of separation.

(5) If the department has already established eligibility and authorized services for one spouse, and the community spouse needs LTC services in the same month, (but after eligibility has been established and services authorized for the institutional spouse), then the department applies the standard described in subsection (1)(a) of this section to each spouse. If doing this would make one of the spouses

ineligible, then the department applies subsection (1)(b) of this section for a couple.

(6) When a single institutionalized individual marries, the department will redetermine eligibility applying the rules for a legally married couple.

(7) The department applies the following rules when determining available resources for LTC services:

(a) WAC 182-512-0300, Resource eligibility;

(b) WAC 182-512-0250, How to determine who owns a resource; and

(c) WAC ((~~388-470-0060~~)) 182-512-0260, Resources of an alien's sponsor.

(8) For LTC services the department determines a client's countable resources as follows:

(a) The department determines countable resources for SSI-related clients as described in chapter 182-512 WAC ((~~182-512-0350 through 182-512-0550~~)) and resources excluded by federal law with the exception of:

(i) WAC 182-512-0550 pension funds owned by an:

((~~(I)~~)) (A) Ineligible spouse. Pension funds are defined as funds held in an individual retirement account (IRA) as described by the IRS code; or

((~~(II)~~)) (B) Work-related pension plan (including plans for self-employed individuals, known as Keogh plans).

(ii) WAC 182-512-0350 (1)(b) clients who have submitted an application for LTC services on or after May 1, 2006, and have an equity interest greater than five hundred thousand dollars in their primary residence are ineligible for LTC services. This exception does not apply if a spouse or blind, disabled or dependent child under age twenty-one is lawfully residing in the primary residence. Clients denied or terminated LTC services due to excess home equity may apply for an undue hardship waiver described in WAC ((~~388-513-1367~~)) 182-513-1367. Effective January 1, 2011, the excess home equity limits increase to five hundred six thousand dollars. On January 1, 2012, and on January 1st of each year thereafter, this standard may be increased or decreased by the percentage increased or decreased in the consumer price index-urban (CPIU). For current excess home equity standard starting January 1, 2011, and each year thereafter, see ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

(b) For an SSI-related client one automobile per household is excluded regardless of value if it is used for transportation of the eligible individual/couple.

(i) For an SSI-related client with a community spouse, the value of one automobile is excluded regardless of its use or value.

(ii) A vehicle not meeting the definition of automobile is a vehicle that has been junked or a vehicle that is used only as a recreational vehicle.

(c) For an SSI-related client, the department adds together the countable resources of both spouses if subsections (3), (6), and (9)(a) or (b) of this section apply, but not if subsection (4) or (5) of this section apply.

(d) For an SSI-related client, excess resources are reduced:

(i) In an amount equal to incurred medical expenses such as:

(A) Premiums, deductibles, and coinsurance/copayment charges for health insurance and medicare;

(B) Medically necessary ((~~medical~~)) care recognized under state law, but not covered under the state's medicaid plan;

(C) Medically necessary ((~~medical~~)) care covered under the state's medicaid plan incurred prior to medicaid eligibility. Expenses for nursing facility care are reduced at the state rate for the facility that the client owes the expense to.

(ii) As long as the incurred medical expenses:

(A) Were not incurred more than three months before the month of the medicaid application;

(B) Are not subject to third-party payment or reimbursement;

(C) Have not been used to satisfy a previous spend down liability;

(D) Have not previously been used to reduce excess resources;

(E) Have not been used to reduce client responsibility toward cost of care;

(F) Were not incurred during a transfer of asset penalty described in WAC ((~~388-513-1363, 388-513-1364, and 388-513-1365~~)) 182-513-1363, 182-513-1364, and 182-513-1365; and

(G) Are amounts for which the client remains liable.

(e) Expenses not allowed to reduce excess resources or participation in personal care:

(i) Unpaid expense(s) prior to waiver eligibility to an adult family home (AFH) or assisted living facility is not a medical expense.

(ii) Personal care cost in excess of approved hours determined by the CARE assessment described in chapter 388-106 WAC is not a medical expense.

(f) The amount of excess resources is limited to the following amounts:

(i) For LTC services provided under the categorically needy (CN) program:

(A) Gross income must be at or below the special income level (SIL), 300% of the federal benefit rate (FBR).

(B) In a medical institution, excess resources and income must be under the state medicaid rate based on the number of days in the medical institution in the month.

(C) For CN waiver eligibility, incurred medical expenses must reduce resources within allowable resource limits for CN-waiver eligibility. The cost of care for the waiver services cannot be allowed as a projected expense.

(ii) For LTC services provided under the medically needy (MN) program when excess resources are added to countable income, the combined total is less than the:

(A) State medical institution rate based on the number of days in the medical institution in the month, plus the amount of recurring medical expenses; or

(B) State hospice rate based on the number of days in the medical institution in the month plus the amount of recurring medical expenses, in a medical institution.

(C) For MN waiver eligibility, incurred medical expenses must reduce resources within allowable resource limits for MN-waiver eligibility. The cost of care for the waiver services cannot be allowed as a projected expense.

(g) For a client not related to SSI, the department applies the resource rules of the program used to relate the client to medical eligibility.

(9) For legally married clients when only one spouse meets institutional status, the following rules apply. If the client's current period of institutional status began:

(a) Before October 1, 1989, the department adds together one-half the total amount of countable resources held in the name of:

(i) The institutionalized spouse; or

(ii) Both spouses.

(b) On or after October 1, 1989, the department adds together the total amount of nonexcluded resources held in the name of:

(i) Either spouse; or

(ii) Both spouses.

(10) If subsection (9)(b) of this section applies, the department determines the amount of resources that are allocated to the community spouse before determining countable resources used to establish eligibility for the institutionalized spouse, as follows:

(a) If the client's current period of institutional status began on or after October 1, 1989, and before August 1, 2003, the department allocates the maximum amount of resources ordinarily allowed by law. Effective January 1, 2009, the maximum allocation is one hundred and nine thousand five hundred and sixty dollars. This standard may change annually on January 1st based on the consumer price index. (For the current standard starting January 2009 and each year thereafter, see long-term care standards at ((~~http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx); or

(b) If the client's current period of institutional status began on or after August 1, 2003, the department allocates the greater of:

(i) A spousal share equal to one-half of the couple's combined countable resources as of the first day of the month of the current period of institutional status, up to the amount described in subsection (10)(a) of this section; or

(ii) The state spousal resource standard of forty-eight thousand six hundred thirty-nine dollars (this standard may change every odd year on July 1st). This standard is based on the consumer price index published by the federal bureau of labor statistics. For the current standard starting July 2009 and each year thereafter, see long-term care standards at ((~~http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

(c) Resources are verified on the first moment of the first day of the month institutionalization began as described in WAC 182-512-0300(1).

(11) The amount of the spousal share described in subsection (10)(b)(i) of this section can be determined anytime between the date that the current period of institutional status began and the date that eligibility for LTC services is determined. The following rules apply to the determination of the spousal share:

(a) Prior to an application for LTC services, the couple's combined countable resources are evaluated from the date of the current period of institutional status at the request of either member of the couple. The determination of the spousal share is completed when necessary documentation and/or verification is provided; or

(b) The determination of the spousal share is completed as part of the application for LTC services if the client was institutionalized prior to the month of application, and declares the spousal share exceeds the state spousal resource standard. The client is required to

provide verification of the couple's combined countable resources held at the beginning of the current period of institutional status.

(12) The amount of allocated resources described in subsection (10) of this section can be increased, only if:

(a) A court transfers additional resources to the community spouse; or

(b) An administrative law judge establishes in ((~~a fair~~)) an administrative hearing described in chapter ((~~388-02~~)) 182-526 WAC, that the amount is inadequate to provide a minimum monthly maintenance needs amount for the community spouse.

(13) The department considers resources of the community spouse unavailable to the institutionalized spouse the month after eligibility for LTC services is established, unless subsection (6) or (14)(a), (b), or (c) of this section applies.

(14) A redetermination of the couple's resources as described in subsection (8) of this section is required, if:

(a) The institutionalized spouse has a break of at least thirty consecutive days in a period of institutional status; or

(b) The institutionalized spouse's countable resources exceed the standard described in subsection (1)(a) of this section, if subsection (9)(b) of this section applies; or

(c) The institutionalized spouse does not transfer the amount described in subsection((~~s~~)) (10) or (12) of this section to the community spouse by either:

(i) The end of the month of the first regularly scheduled eligibility review; or

(ii) The reasonable amount of additional time necessary to obtain a court order for the support of the community spouse.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1363 Evaluating the transfer of assets on or after May 1, 2006 for persons applying for or receiving long-term care (LTC) services. This section describes how the department evaluates asset transfers made on or after May 1, 2006, and their ((~~affect~~)) effect on LTC services. This applies to transfers by the client, spouse, a guardian or through an attorney in fact. Clients subject to asset transfer penalty periods are not eligible for LTC services. LTC services for the purpose of this rule include nursing facility services, services offered in any medical institution equivalent to nursing facility services, and home and community-based services furnished under a waiver program. Program of all-inclusive care of the elderly (PACE) and hospice services are not subject to transfer of asset rules. The department must consider whether a transfer made within a specified time before the month of application, or while the client is receiving LTC services, requires a penalty period.

• Refer to WAC ((~~388-513-1364~~)) 182-513-1364 for rules used to evaluate asset transfers made on or after April 1, 2003, and before May 1, 2006.

• Refer to WAC ((~~388-513-1365~~)) 182-513-1365 for rules used to evaluate asset transfer made prior to April 1, 2003.

(1) When evaluating the effect of the transfer of asset made on or after May 1, 2006, on the client's eligibility for LTC services the

department counts sixty months before the month of application to establish what is referred to as the "look-back" period.

(2) The department does not apply a penalty period to transfers meeting the following conditions:

(a) The total of all gifts or donations transferred do not exceed the average daily private nursing facility rate in any month;

(b) The transfer is an excluded resource described in WAC ((~~388-513-1350~~)) 182-513-1350 with the exception of the client's home, unless the transfer of the home meets the conditions described in ((~~subsection (2)~~))(d) of this subsection;

(c) The asset is transferred for less than fair market value (FMV), if the client can provide evidence to the department of one of the following:

(i) An intent to transfer the asset at FMV or other adequate compensation. To establish such an intent, the department must be provided with written evidence of attempts to dispose of the asset for fair market value as well as evidence to support the value (if any) of the disposed asset.

(ii) The transfer is not made to qualify for LTC services, continue to qualify, or avoid Estate Recovery. Convincing evidence must be presented regarding the specific purpose of the transfer.

(iii) All assets transferred for less than fair market value have been returned to the client.

(iv) The denial of eligibility would result in an undue hardship as described in WAC ((~~388-513-1367~~)) 182-513-1367.

(d) The transfer of ownership of the client's home, if it is transferred to the client's:

(i) Spouse; or

(ii) Child, who:

(A) Meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c); or

(B) Is less than twenty-one years old; or

(C) Lived in the home for at least two years immediately before the client's current period of institutional status, and provided verifiable care that enabled the individual to remain in the home. A physician's statement of needed care is required; or

(iii) Brother or sister, who has:

(A) Equity in the home((~~,~~)); and

(B) Lived in the home for at least one year immediately before the client's current period of institutional status.

(e) The asset is transferred to the client's spouse or to the client's child, if the child meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c);

(f) The transfer meets the conditions described in subsection (3), and the asset is transferred:

(i) To another person for the sole benefit of the spouse;

(ii) From the client's spouse to another person for the sole benefit of the spouse;

(iii) To trust established for the sole benefit of the individual's child who meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c);

(iv) To a trust established for the sole benefit of a person who is sixty-four years old or younger and meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c); or

(3) The department considers the transfer of an asset or the establishment of a trust to be for the sole benefit of a person described in subsection (2)(f) of this section, if the transfer or trust:

(a) Is established by a legal document that makes the transfer irrevocable;

(b) Provides that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time during the life of the primary beneficiary; and

(c) Provides for spending all assets involved for the sole benefit of the individual on a basis that is actuarially sound based on the life expectancy of that individual or the term of the trust, whichever is less; and

(d) The requirements in subsection (2)(c) of this section do not apply to trusts described in WAC 388-561-0100 (6)(a) and (b) and (7)(a) and (b).

(4) The department does not establish a period of ineligibility for the transfer of an asset to a family member prior to the current period of long-term care service if:

(a) The transfer is in exchange for care services the family member provided the client;

(b) The client has a documented need for the care services provided by the family member;

(c) The care services provided by the family member are allowed under the medicaid state plan or the department's HCB waiver services;

(d) The care services provided by the family member do not duplicate those that another party is being paid to provide;

(e) The FMV of the asset transferred is comparable to the FMV of the care services provided;

(f) The time for which care services are claimed is reasonable based on the kind of services provided; and

(g) Compensation has been paid as the care services were performed or with no more time delay than one month between the provision of the service and payment.

(5) The department considers the transfer of an asset in exchange for care services given by a family member that does not meet the criteria as described under subsection (4) of this section as the transfer of an asset without adequate consideration.

(6) If a client or the client's spouse transfers an asset within the look-back period without receiving adequate compensation, the result is a penalty period in which the individual is not eligible for LTC services.

(7) If a client or the client's spouse transfers an asset on or after May 1, 2006, the department must establish a penalty period by adding together the total uncompensated value of all transfers made on or after May 1, 2006. The penalty period:

(a) For a LTC services applicant, begins on the date the client would be otherwise eligible for LTC services based on an approved application for LTC services or the first day after any previous penalty period has ended; or

(b) For a LTC services recipient, begins the first of the month following ten-day advance notice of the penalty period, but no later than the first day of the month that follows three full calendar months from the date of the report or discovery of the transfer; or the first day after any previous penalty period has ended; and

(c) Ends on the last day of the number of whole days found by dividing the total uncompensated value of the assets by the statewide average daily private cost for nursing facilities at the time of application or the date of transfer, whichever is later.

(8) If an asset is sold, transferred, or exchanged, the portion of the proceeds:

(a) That is used within the same month to acquire an excluded resource described in WAC ((~~388-513-1350~~)) 182-513-1350 does not affect the client's eligibility;

(b) That remain after an acquisition described in ((~~subsection (8)~~)) (a) of this subsection becomes an available resource as of the first day of the following month.

(9) If the transfer of an asset to the client's spouse includes the right to receive a stream of income not generated by a transferred resource, the department must apply rules described in WAC ((~~388-513-1330~~)) 182-513-1330 (5) through (7).

(10) If the transfer of an asset for which adequate compensation is not received is made to a person other than the client's spouse and includes the right to receive a stream of income not generated by a transferred resource, the length of the penalty period is determined and applied in the following way:

(a) The total amount of income that reflects a time frame based on the actuarial life expectancy of the client who transfers the income is added together;

(b) The amount described in ((~~subsection (10)~~)) (a) of this subsection is divided by the statewide average daily private cost for nursing facilities at the time of application; and

(c) A penalty period equal to the number of whole days found by following subsection((~~s~~)) (7)(a), (b), and (c) of this section.

(11) A penalty period for the transfer of an asset that is applied to one spouse is not applied to the other spouse, unless both spouses are receiving LTC services. When both spouses are receiving LTC services;

(a) We divide the penalty between the two spouses.

(b) If one spouse is no longer subject to a penalty (e.g., the spouse is no longer receiving institutional services or is deceased) any remaining penalty that applies to both spouses must be served by the remaining spouse.

(12) If a client or the client's spouse disagrees with the determination or application of a penalty period, that person may request a hearing as described in chapter ((~~388-02~~)) 182-526 WAC.

(13) Additional statutes which apply to transfer of asset penalties, real property transfer for inadequate consideration, disposal of realty penalties, and transfers to qualify for assistance can be found at:

(a) RCW 74.08.331 Unlawful practices—Obtaining assistance—Disposal of realty;

(b) RCW 74.08.338 Real property transfers for inadequate consideration;

(c) RCW 74.08.335 Transfers of property to qualify for assistance; and

(d) RCW 74.39A.160 Transfer of assets—Penalties.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1364 Evaluating the transfer of an asset made on or after April 1, 2003 for long-term care (LTC) services. This section

describes how the department evaluates the transfer of an asset made on or after April 1, 2003, by a client who is applying or approved for LTC services. The department must consider whether a transfer made within a specified time before the month of application requires a penalty period in which the client is not eligible for these services. Refer to WAC ((~~388-513-1365~~)) 182-513-1365 for rules used to evaluate the transfer of an asset made before April 1, 2003. Refer to WAC ((~~388-513-1363~~)) 182-513-1363 for rules used to evaluate the transfer of an asset made on or after May 1, 2006.

(1) The department does not apply a penalty period to the following transfers by the client, if they meet the conditions described:

(a) Gifts or donations totaling one thousand dollars or less in any month;

(b) The transfer of an excluded resource described in WAC ((~~388-513-1350~~)) 182-513-1350 with the exception of the client's home, unless the transfer of the client's home meets the conditions described in ((~~subsection (1)~~)) (d) of this subsection;

(c) The transfer of an asset for less than fair market value (FMV), if the client can provide evidence to the department of one of the following:

(i) An intent to transfer the asset at FMV or other adequate compensation;

(ii) The transfer is not made to qualify for LTC services;

(iii) The client is given back ownership of the asset;

(iv) The denial of eligibility would result in an undue hardship.

(d) The transfer of ownership of the client's home, if it is transferred to the client's:

(i) Spouse; or

(ii) Child, who:

(A) Meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c); or

(B) Is less than twenty-one years old; or

(C) Lived in the home for at least two years immediately before the client's current period of institutional status, and provided care that enabled the client to remain in the home; or

(iii) Brother or sister, who has:

(A) Equity in the home; and

(B) Lived in the home for at least one year immediately before the client's current period of institutional status.

(e) The transfer of an asset, if the transfer meets the conditions described in subsection (4) of this section, and the asset is transferred:

(i) To another person for the sole benefit of the spouse;

(ii) From the client's spouse to another person for the sole benefit of the spouse;

(iii) To trust established for the sole benefit of the client's child who meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c);

(iv) To a trust established for the sole benefit of a person who is sixty-four years old or younger and meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c); or

(f) The asset is transferred to the client's spouse or to the client's child, if the child meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c).

(2) The department does not establish a period of ineligibility for the transfer of an asset to a family member prior to the current period of institutional status, if:

(a) The transfer is in exchange for care services the family member provided the client;

(b) The client has a documented need for the care services provided by the family member;

(c) The care services provided by the family member are allowed under the medicaid state plan or the department's ((~~waivered~~)) HCB waiver services;

(d) The care services provided by the family member do not duplicate those that another party is being paid to provide;

(e) The FMV of the asset transferred is comparable to the FMV of the care services provided;

(f) The time for which care services are claimed is reasonable based on the kind of services provided; and

(g) Compensation has been paid as the care services were performed or with no more time delay than one month between the provision of the service and payment.

(3) The department considers the transfer of an asset in exchange for care services given by a family member that does not meet the criteria as described under subsection (2) of this section as the transfer of an asset without adequate consideration.

(4) The department considers the transfer of an asset or the establishment of a trust to be for the sole benefit of a person described in subsection (1)(e) of this section, if the transfer or trust:

(a) Is established by a legal document that makes the transfer irrevocable;

(b) Provides that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time during the life of the primary beneficiary; and

(c) Provides for spending all assets involved for the sole benefit of the individual on a basis that is actuarially sound based on the life expectancy of that individual or the term or the trust, whichever is less; and

(d) The requirements in ((~~subsection (4)~~)) (c) of this ((~~section~~)) subsection do not apply to trusts described in WAC ((~~388-561-0100~~)) 182-516-0100 (6)(a) and (b).

(5) If a client or the client's spouse transfers an asset within the look-back period described in WAC ((~~388-513-1365~~)) 182-513-1365 without receiving adequate compensation, the result is a penalty period in which the client is not eligible for LTC services. If a client or the client's spouse transfers an asset on or after April 1, 2003, the department must establish a penalty period as follows:

(a) If a single or multiple transfers are made within a single month, then the penalty period:

(i) Begins on the first day of the month in which the transfer is made; and

(ii) Ends on the last day of the number of whole days found by dividing the total uncompensated value of the assets by the statewide average daily private cost for nursing facilities at the time of application.

(b) If multiple transfers are made during multiple months, then the transfers are treated as separate events and multiple penalty periods are established that begin on the latter of:

(i) The first day of the month in which the transfer is made; or

(ii) The first day after any previous penalty period has ended and end on the last day of the whole number of days as described in ((~~subsection (5)~~)) (a)(ii) of this subsection.

(6) If an asset is sold, transferred, or exchanged, the portion of the proceeds:

(a) That is used within the same month to acquire an excluded resource described in WAC ((~~388-513-1350~~)) 182-513-1350 does not affect the client's eligibility;

(b) That remain after an acquisition described in subsection (6)(a) becomes an available resource as of the first day of the following month.

(7) If the transfer of an asset to the client's spouse includes the right to receive a stream of income not generated by a transferred resource, the department must apply rules described in WAC ((~~388-513-1330~~)) 182-513-1330 (5) through (7).

(8) If the transfer of an asset for which adequate compensation is not received is made to a person other than the client's spouse and includes the right to receive a stream of income not generated by a transferred resource, the length of the penalty period is determined and applied in the following way:

(a) The total amount of income that reflects a time frame based on the actuarial life expectancy of the client who transfers the income is added together;

(b) The amount described in ((~~subsection (8)~~)) (a) of this subsection is divided by the statewide average daily private cost for nursing facilities at the time of application; and

(c) A penalty period equal to the number of whole days found by following subsection((~~s~~)) (5)(a) and (b) and ((~~(8)~~)) (a) and (b) of this subsection is applied that begins on the latter of:

(i) The first day of the month in which the client transfers the income; or

(ii) The first day of the month after any previous penalty period has ended.

(9) A penalty period for the transfer of an asset that is applied to one spouse is not applied to the other spouse, unless:

(a) Both spouses are receiving LTC services; and

(b) A division of the penalty period between the spouses is requested.

(10) If a client or the client's spouse disagrees with the determination or application of a penalty period, that person may request a hearing as described in chapter ((~~388-02~~)) 182-526 WAC.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1365 Evaluating the transfer of an asset made on or after March 1, 1997, and before April 1, 2003, for long-term care (LTC) services. This section describes how the department evaluates the transfer of an asset made on or after March 1, 1997, and before April 1, 2003, by a client who is applying or approved for LTC services. The department must consider whether a transfer made within a specified time before the month of application requires a penalty period in which the client is not eligible for these services. Refer to WAC ((~~388-513-1364~~)) 182-513-1364 for rules used to evaluate the transfer of an asset made on or after March 31, 2003. Refer to WAC ((~~388-513-1363~~)) 182-513-1363 for rules used to evaluate the transfer of an asset made on or after May 1, 2006.

(1) The department disregards the following transfers by the client, if they meet the conditions described:

(a) Gifts or donations totaling one thousand dollars or less in any month;

(b) The transfer of an excluded resource described in WAC ((~~388-513-1350~~)) 182-513-1350 with the exception of the client's home, unless the transfer meets the conditions described in ((~~subsection (1)~~)) (d) of this subsection;

(c) The transfer of an asset for less than fair market value (FMV), if the client can provide evidence to the department that satisfies one of the following:

(i) An intent to transfer the asset at FMV or other adequate compensation;

(ii) The transfer is not made to qualify for LTC services;

(iii) The client is given back ownership of the asset;

(iv) The denial of eligibility would result in an undue hardship.

(d) The transfer of ownership of the client's home, if it is transferred to the client's:

(i) Spouse; or

(ii) Child, who:

(A) Meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c); or

(B) Is less than twenty-one years old; or

(iii) A son or daughter, who:

(A) Lived in the home for at least two years immediately before the client's current period of institutional status; and

(B) Provided care that enabled the client to remain in the home; or

(iv) A brother or sister, who has:

(A) Equity in the home, and

(B) Lived in the home for at least one year immediately before the client's current period of institutional status.

(e) The transfer of an asset other than the home, if the transfer meets the conditions described in subsection (4) of this section, and the asset is transferred:

(i) To the client's spouse or to another person for the sole benefit of the spouse;

(ii) From the client's spouse to another person for the sole benefit of the spouse;

(iii) To the client's child who meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c) or to a trust established for the sole benefit of this child; or

(iv) To a trust established for the sole benefit of a person who is sixty-four years old or younger and meets the disability criteria described in WAC 182-512-0050 (1)(b) or (c).

(f) The transfer of an asset to a member of the client's family in exchange for care the family member provided the client before the current period of institutional status, if a written agreement that describes the terms of the exchange:

(i) Was established at the time the care began;

(ii) Defines a reasonable FMV for the care provided that reflects a time frame based on the actuarial life expectancy of the client who transfers the asset; and

(iii) States that the transferred asset is considered payment for the care provided.

(2) When the fair market value of the care described in subsection (1)(f) of this section is less than the value of the transferred

asset, the department considers the difference the transfer of an asset without adequate consideration.

(3) The department considers the transfer of an asset in exchange for care given by a family member without a written agreement as described under subsection (1)(f) of this section as the transfer of an asset without adequate consideration.

(4) The transfer of an asset or the establishment of a trust is considered to be for the sole benefit of a person described in subsection (1)(e) of this section, if the transfer or trust:

(a) Is established by a legal document that makes the transfer irrevocable; and

(b) Provides for spending all funds involved for the benefit of the person for whom the transfer is made within a time frame based on the actuarial life expectancy of that person.

(5) When evaluating the effect of the transfer of an asset on a client's eligibility for LTC services received on or after October 1, 1993, the department counts the number of months before the month of application to establish what is referred to as the "look-back" period. The following number of months apply as described:

(a) Thirty-six months, if all or part of the assets were transferred on or after August 11, 1993; and

(b) Sixty months, if all or part of the assets were transferred into a trust as described in WAC ((~~388-561-0100~~)) 182-516-0100.

(6) If a client or the client's spouse transfers an asset within the look-back period without receiving adequate compensation, the result is a penalty period in which the client is not eligible for LTC services. If a client or the client's spouse transfers an asset on or after March 1, 1997, and before April 1, 2003, the department must establish a penalty period as follows:

(a) If a single or multiple transfers are made within a single month, then the penalty period:

(i) Begins on the first day of the month in which the transfer is made; and

(ii) Ends on the last day of the number of whole months found by dividing the total uncompensated value of the assets by the statewide average monthly private cost for nursing facilities at the time of application.

(b) If multiple transfers are made during multiple months, then the transfers are treated as separate events and multiple penalty periods are established that:

(i) Begin on the latter of:

(A) The first day of the month in which the transfer is made; or

(B) The first day after any previous penalty period has ended; and

(ii) End on the last day of the whole number of months as described in ((~~subsection (6)~~)) (a)(ii) of this subsection.

(7) If an asset is sold, transferred, or exchanged, the portion of the proceeds:

(a) That is used within the same month to acquire an excluded resource described in WAC ((~~388-513-1350~~)) 182-513-1350 does not affect the client's eligibility;

(b) That remains after an acquisition described in ((~~subsection (7)~~)) (a) of this subsection becomes an available resource as of the first day of the following month.

(8) If the transfer of an asset to the client's spouse includes the right to receive a stream of income not generated by a transferred

resource, the department must apply rules described in WAC ((~~388-513-1330~~)) 182-513-1330 (5) through (7).

(9) If the transfer of an asset for which adequate compensation is not received is made to a person other than the client's spouse and includes the right to receive a stream not generated by a transferred resource, the length of the penalty period is determined and applied in the following way:

(a) The total amount of income that reflects a time frame based on the actuarial life expectancy of the client who transfers the income is added together;

(b) The amount described in ((~~(9)~~)) (a) of this subsection is divided by the statewide average monthly private cost for nursing facilities at the time of application; and

(c) A penalty period equal to the number of whole months found by following ((~~subsections (9)~~)) (a) and (b) of this subsection is applied that begins on the latter of:

(i) The first day of the month in which the client transfers the income; or

(ii) The first day of the month after any previous penalty period has ended.

(10) A penalty period for the transfer of an asset that is applied to one spouse is not applied to the other spouse, unless:

(a) Both spouses are receiving LTC services; and

(b) A division of the penalty period between the spouses is requested.

(11) If a client or the client's spouse disagrees with the determination or application of a penalty period, that person may request a hearing as described in chapter ((~~388-02~~)) 182-526 WAC.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1366 Evaluating the transfer of an asset made before March 1, 1997, for long-term care (LTC) services. This section describes how the department evaluates the transfer of an asset made before March 1, 1997, by a client who is applying or approved for LTC services. The department must consider whether a transfer made within a specified time before the month of application requires a penalty period in which the client is not eligible for these services. Refer to WAC ((~~388-513-1365~~)) 182-513-1365 for rules used to evaluate the transfer of an asset on or after March 1, 1997.

(1) When evaluating the transfer of an asset made before March 1, 1997, the department must apply rules described in WAC ((~~388-513-1365~~)) 182-513-1365 (1) through (4) and (7) through (11) in addition to the rules described in this section.

(2) When evaluating the effect of the transfer of an asset on a client's eligibility for LTC services received before October 1, 1993, the department counts the number of months before the month of application to establish what is referred to as the "look-back" period. The following number of months apply as described:

(a) Thirty months, if the asset was transferred before August 11, 1993; or

(b) Thirty-six months, if the asset was transferred on or after August 11, 1993.

(3) If a client or the client's spouse transferred an asset without receiving adequate compensation before August 11, 1993, the department must establish a penalty period that:

(a) Runs concurrently for transfers made in more than one month in the look-back period; and

(b) Begins on the first day of the month in which the asset is transferred and ends on the last day of the month which is the lesser of:

(i) Thirty months after the month of transfer; or

(ii) The number of whole months found by dividing the total uncompensated value of the assets by the statewide average monthly private cost for nursing facilities at the time of application.

(4) If a client or the client's spouse transferred an asset without receiving adequate compensation on or after August 11, 1993, and before March 1, 1997, the department must establish a penalty period as follows:

(a) If the transfer is made during the look-back period, then the penalty period:

(i) Begins on the first day of the month in which the transfer is made; and

(ii) Ends on the last day of the number of whole months described in ((~~subsection (3)~~)) (b)(ii) of this subsection.

(b) If the transfer is made while the client is receiving LTC services or during a period of ineligibility, then the penalty period:

(i) Begins on the latter of the first day of the month:

(A) In which the transfer is made; or

(B) After a previous penalty period has ended; and

(ii) Ends on the last day of the number of whole months described in ((~~subsection (3)~~)) (b)(ii) of this subsection.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1367 Hardship waivers for long-term care (LTC) services. Clients who are denied or terminated from LTC services due to a transfer of asset penalty (described in WAC ((~~388-513-1363, 388-513-1364 and 388-513-1365~~)) 182-513-1363, 182-513-1364, and 182-513-1365), or having excess home equity (described in WAC ((~~388-513-1350~~)) 182-513-1350) may apply for an undue hardship waiver. Notice of the right to apply for an undue hardship waiver will be given whenever there is a denial or termination based on an asset transfer or excess home equity. This section:

- Defines undue hardship;
- Specifies the approval criteria for an undue hardship request;
- Establishes the process the department follows for determining undue hardship; and
- Establishes the appeal process for a client whose request for an undue hardship is denied.

(1) When does undue hardship exist?

(a) Undue hardship may exist:

(i) When a transfer of an asset occurs between:

(A) Registered domestic partners as described in chapter 26.60 RCW; or

(B) Same-sex couples who were married in states and the District of Columbia where same-sex marriages are legal; and

(C) The transfer would not have caused a period of ineligibility if made between an opposite sex married couple under WAC ((~~388-513-1363~~)) 182-513-1363.

(ii) When a client who transferred the assets or income, or on whose behalf the assets or income were transferred, either personally or through a spouse, guardian or attorney-in-fact, has exhausted all reasonable means including legal remedies to recover the assets or income or the value of the transferred assets or income that have caused a penalty period; and

(iii) The client provides sufficient documentation to support their efforts to recover the assets or income; or

(iv) The client is unable to access home equity in excess of the standard described in WAC ((~~388-513-1350~~)) 182-513-1350; and

(v) When, without LTC benefits, the client is unable to obtain:

(A) Medical care to the extent that his or her health or life is endangered; or

(B) Food, clothing, shelter or other basic necessities of life.

(b) Undue hardship can be approved for an interim period while the client is pursuing recovery of the assets or income.

(2) Undue hardship does not exist:

(a) When the transfer of asset penalty period or excess home equity provision inconveniences a client or restricts their lifestyle but does not seriously deprive him or her as defined in subsection (1)(a)(iii) of this section;

(b) When the resource is transferred to a person who is handling the financial affairs of the client; or

(c) When the resource is transferred to another person by the individual that handles the financial affairs of the client.

((~~(d)~~)) (3) Undue hardship may exist under subsection (2)(b) and (c) of this section if DSHS has found evidence of financial exploitation.

((~~(3)~~)) (4) How is an undue hardship waiver requested?

(a) An undue hardship waiver may be requested by:

(i) The client;

(ii) The client's spouse;

(iii) The client's authorized representative;

(iv) The client's power of attorney; or

(v) With the consent of the client or their guardian, a medical institution, as defined in WAC ((~~182-500-0005~~)) 182-500-0050, in which an institutionalized client resides.

(b) Request must:

(i) Be in writing;

(ii) State the reason for requesting the hardship waiver;

(iii) Be signed by the requestor and include the requestor's name, address and telephone number. If the request is being made on behalf of a client, then the client's name, address and telephone number must be included;

(iv) Be made within thirty days of the date of denial or termination of LTC services; and

(v) Returned to the originating address on the denial/termination letter.

((~~(4)~~)) (5) What if additional information is needed to determine a hardship waiver? ((~~(a)~~)) A written notice to the client is sent requesting additional information within fifteen days of the request for

an undue hardship waiver. Additional time to provide the information can be requested by the client.

((~~(5)~~)) (6) What happens if my hardship waiver is approved?

(a) The department sends a notice within fifteen days of receiving all information needed to determine a hardship waiver. The approval notice specifies a time period the undue hardship waiver is approved.

(b) Any changes in a client's situation that led to the approval of a hardship must be reported to the department ((~~by the tenth of the month following~~)) within thirty days of the change per WAC ((~~388-418-0007~~)) 182-504-0110.

((~~(6)~~)) (7) What happens if my hardship waiver is denied?

(a) The department sends a denial notice within fifteen days of receiving the requested information. The letter will state the reason it was not approved.

(b) The denial notice will have instructions on how to request an administrative hearing. The department must receive an administrative hearing request within ninety days of the date of the adverse action or denial.

((~~(7)~~)) (8) What statute or rules govern administrative hearings? ((~~(a)~~)) An administrative hearing held under this section is governed by chapters 34.05 RCW and ((~~chapter 388-02~~)) 182-526 WAC and this section. If a provision in this section conflicts with a provision in chapter ((~~388-02~~)) 182-526 WAC, the provision in this section governs.

((~~(8)~~)) (9) Can the department revoke an approved undue hardship waiver? ((~~(a)~~)) The department may revoke approval of an undue hardship waiver if any of the following occur:

((~~(i)~~)) (a) A client, or his or her authorized representative, fails to provide timely information and/or resource verifications as it applies to the hardship waiver when requested by the department per WAC ((~~388-490-0005 and 388-418-0007~~)) 182-503-0050 and 182-504-0120 or 182-504-0125;

((~~(ii)~~)) (b) The lien or legal impediment that restricted access to home equity in excess of five hundred thousand dollars is removed; or

((~~(iii)~~)) (c) Circumstances for which the undue hardship was approved have changed.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1380 Determining a client's financial participation in the cost of care for long-term care (LTC) services. This rule describes how the department allocates income and excess resources when determining participation in the cost of care (the post-eligibility process). The department applies rules described in WAC ((~~388-513-1315~~)) 182-513-1315 to define which income and resources must be used in this process.

(1) For a client receiving institutional or hospice services in a medical institution, the department applies all subsections of this rule.

(2) For a client receiving waiver services at home or in an alternate living facility, the department applies only those subsections of this rule that are cited in the rules for those programs.

(3) For a client receiving hospice services at home, or in an alternate living facility, the department applies rules used for the community options program entry system (COPES) for hospice applicants with gross income under the medicaid special income level (SIL) (300% of the federal benefit rate (FBR)), if the client is not otherwise eligible for another noninstitutional categorically needy medicaid program. (Note: For hospice applicants with income over the medicaid SIL, medically needy medicaid rules apply.)

(4) The department allocates nonexcluded income in the following order and the combined total of ((~~(4)~~)) (a), (b), (c), and (d) of this subsection cannot exceed the effective one-person medically needy income level (MNIL):

(a) A personal needs allowance (PNA) of:

(i) Seventy dollars for the following clients who live in a state veteran's home and receive a needs based veteran's pension in excess of ninety dollars:

(A) A veteran without a spouse or dependent child.

(B) A veteran's surviving spouse with no dependent children.

(ii) The difference between one hundred sixty dollars and the needs based veteran's pension amount for persons specified in ((~~subsection (4)~~)) (a)(i) of this ((~~section~~)) subsection who receive a veteran's pension less than ninety dollars.

(iii) One hundred sixty dollars for a client living in a state veterans' home who does not receive a needs based veteran's pension;

(iv) Forty-one dollars and sixty-two cents for all clients in a medical institution receiving ABD cash assistance.

(v) For all other clients in a medical institution the PNA is fifty-seven dollars and twenty-eight cents.

(vi) Current PNA and long-term care standards can be found at ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

(b) Mandatory federal, state, or local income taxes owed by the client.

(c) Wages for a client who:

(i) Is related to the supplemental security income (SSI) program as described in WAC 182-512-0050(1); and

(ii) Receives the wages as part of a department-approved training or rehabilitative program designed to prepare the client for a less restrictive placement. When determining this deduction employment expenses are not deducted.

(d) Guardianship fees and administrative costs including any attorney fees paid by the guardian, after June 15, 1998, only as allowed by chapter 388-79 WAC.

(5) The department allocates nonexcluded income after deducting amounts described in subsection (4) of this section in the following order:

(a) Current or back child support garnished or withheld from income according to a child support order in the month of the garnishment if it is for the current month:

(i) For the time period covered by the PNA; and

(ii) Is not counted as the dependent member's income when determining the family allocation amount.

(b) A monthly maintenance needs allowance for the community spouse not to exceed, effective January 1, 2008, two thousand six hundred ten dollars, unless a greater amount is allocated as described in subsection (7) of this section. The community spouse maintenance al-

lowance may change each January based on the consumer price index. Starting January 1, 2008, and each year thereafter the community spouse maintenance allocation can be found in the long-term care standards chart at ((~~http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx. The monthly maintenance needs allowance:

(i) Consists of a combined total of both:

(A) One hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st; and

(B) Excess shelter expenses as described under subsection (6) of this section.

(ii) Is reduced by the community spouse's gross countable income; and

(iii) Is allowed only to the extent the client's income is made available to the community spouse.

(c) A monthly maintenance needs amount for each minor or dependent child, dependent parent or dependent sibling of the community spouse or institutionalized person who:

(i) Resides with the community spouse: ((~~(A)~~)) For each child, one hundred and fifty percent of the two-person FPL minus that child's income and divided by three (child support received from a noncustodial parent is considered the child's income). This standard is called the community spouse (CS) and family maintenance standard and can be found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

(ii) Does not reside with the community spouse or institutionalized person, in an amount equal to the effective one-person MNIL for the number of dependent family members in the home less the dependent family member's income.

(iii) Child support received from a noncustodial parent is the child's income.

(d) Medical expenses incurred by the institutional client and not used to reduce excess resources. Allowable medical expenses and reducing excess resources are described in WAC ((~~388-513-1350~~)) 182-513-1350.

(e) Maintenance of the home of a single institutionalized client or institutionalized couple:

(i) Up to one hundred percent of the one-person federal poverty level per month;

(ii) Limited to a six-month period;

(iii) When a physician has certified that the client is likely to return to the home within the six-month period; and

(iv) When social services staff documents the need for the income exemption.

(6) For the purposes of this section, "excess shelter expenses" means the actual expenses under ((~~subsection (6)~~)) (b) of this subsection less the standard shelter allocation under ((~~subsection (6)~~)) (a) of this subsection. For the purposes of this rule:

(a) The standard shelter allocation is based on thirty percent of one hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st and is found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx; and

(b) Shelter expenses are the actual required maintenance expenses for the community spouse's principal residence for:

(i) Rent;
(ii) Mortgage;
(iii) Taxes and insurance;
(iv) Any maintenance care for a condominium or cooperative; and
(v) The food stamp standard utility allowance described in WAC 388-450-0195, provided the utilities are not included in the maintenance charges for a condominium or cooperative.

(7) The amount allocated to the community spouse may be greater than the amount in subsection (6)(b) of this section only when:

(a) A court enters an order against the client for the support of the community spouse; or

(b) A hearings officer determines a greater amount is needed because of exceptional circumstances resulting in extreme financial duress.

(8) A client who is admitted to a medical facility for ninety days or less and continues to receive full SSI benefits is not required to use the SSI income in the cost of care for medical services. Income allocations are allowed as described in this section from non-SSI income.

(9) Standards described in this section for long-term care can be found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1395 Determining eligibility for institutional or hospice services for individuals living in a medical institution under the medically needy (MN) program. This section describes how the department determines a client's eligibility for institutional or hospice services in a medical institution and for facility care only under the MN program. In addition, this section describes rules used by the department to determine whether a client approved for these benefits is also eligible for noninstitutional medical assistance in a medical institution under the MN program.

(1) To be eligible for institutional or hospice services under the MN program for individuals living in a medical institution, a client must meet the financial requirements described in subsection (5) of this section. In addition, a client must meet program requirements described in WAC ((~~388-513-1315~~)) 182-513-1315; and

(a) Be an SSI-related client with countable income as described in subsection (4)(a) of this section that is more than the special income level (SIL); or

(b) Be a child not described in ((~~subsection (1)~~)) (a) of this subsection with countable income as described in subsection (4)(b) of this section that exceeds the categorically needy (CN) standard for the ((~~children's medical~~)) Washington apple health (WAH) for kids program.

(2) For an SSI-related client, excess resources are reduced by medical expenses as described in WAC ((~~388-513-1350~~)) 182-513-1350 to the resource standard for a single or married individual.

(3) The department determines a client's countable resources for institutional and hospice services under the MN programs as follows:

(a) For an SSI-related client, the department determines countable resources per WAC ((~~388-513-1350~~)) 182-513-1350.

(b) For a child not described in ((~~subsection (3)~~)) (a) of this subsection, no determination of resource eligibility is required.

(4) The department determines a client's countable income for institutional and hospice services under the MN program as follows:

(a) For an SSI-related client, the department reduces available income as described in WAC ((~~388-513-1325 and 388-513-1330~~)) 182-513-1325 and 182-513-1330 by:

(i) Excluding income described in WAC ((~~388-513-1340~~)) 182-513-1340;

(ii) Disregarding income described in WAC ((~~388-513-1345~~)) 182-513-1345; and

(iii) Subtracting previously incurred medical expenses incurred by the client and not used to reduce excess resources. Allowable medical expenses and reducing excess resources are described in WAC ((~~388-513-1350~~)) 182-513-1350.

(b) For a child not described in ((~~subsection (4)~~)) (a) of this subsection, the department:

(i) Follows the income rules described in WAC 182-505-0210 for the ((~~children's medical~~)) WAH for kids program; and

(ii) Subtracts the medical expenses described in this subsection ((~~(4)~~)).

(5) If the income remaining after the allowed deductions described in WAC ((~~388-513-1380~~)) 182-513-1380, plus countable resources in excess of the standard described in WAC ((~~388-513-1350~~)) 182-513-1350(1), is less than the department-contracted rate times the number of days residing in the facility the client:

(a) Is eligible for institutional or hospice services in a medical institution, and medical assistance;

(b) Is approved for twelve months; and

(c) Participates income and excess resources toward the cost of care as described in WAC ((~~388-513-1380~~)) 182-513-1380.

(6) If the income remaining after the allowed deductions described in WAC ((~~388-513-1380~~)) 182-513-1380 plus countable resources in excess of the standard described in WAC ((~~388-513-1350~~)) 182-513-1350(1) is more than the department-contracted rate times the number of days residing in the facility the client:

(a) Is not eligible for payment of institutional services; and

(b) Eligibility is determined for medical assistance only as described in chapter 182-519 WAC.

(7) If the income remaining after the allowed deductions described in WAC ((~~388-513-1380~~)) 182-513-1380 is more than the department contracted nursing facility rate based on the number of days the client is in the facility, but less than the private nursing rate plus the amount of medical expenses not used to reduce excess resources the client:

(a) Is eligible for nursing facility care only and is approved for a three or six month based period as described in chapter 182-519 WAC. This does not include hospice in a nursing facility; and

(i) Pays the nursing home at the current state rate;

(ii) Participates in the cost of care as described in WAC ((~~388-513-1380~~)) 182-513-1380; and

(iii) Is not eligible for medical assistance or hospice services unless the requirements in subsection (6)(b) of this section is met.

(b) Is approved for medical assistance for a three or six month base period as described in chapter 182-519 WAC, if:

(i) No income and resources remain after the post eligibility treatment of income process described in WAC ((~~388-513-1380~~)) 182-513-1380.

(ii) Medicaid certification is approved beginning with the first day of the base period.

(c) Is approved for medical assistance for up to three or six months when they incur additional medical expenses that are equal to or more than excess income remaining after the post eligibility treatment of income process described in WAC ((~~388-513-1380~~)) 182-513-1380.

(i) This process is known as spenddown and is described in WAC 182-519-0100.

(ii) Medicaid certification is approved on the day the spenddown is met.

(8) If the income remaining after the allowed deductions described in WAC ((~~388-513-1380~~)) 182-513-1380, plus countable resources in excess of the standard described in WAC ((~~388-513-1350~~)) 182-513-1350 is more than the private nursing facility rate times the number of days in a month residing in the facility, the client:

(a) Is not eligible for payment of institutional services.

(b) Eligibility is determined for medical assistance only as described in chapter 182-519 WAC.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1400 Long-term care (LTC) partnership program (index). Under the long term care (LTC) partnership program, individuals who purchase qualified long-term care partnership insurance policies can apply for long-term care medicaid under special rules for determining financial eligibility. These special rules generally allow the individual to protect assets up to the insurance benefits received from a partnership policy so that such assets will not be taken into account in determining financial eligibility for long-term care medicaid and will not subsequently be subject to estate recovery for medicaid and long-term care services paid. The Washington long term care partnership program is effective on December 1, 2011.

The following rules govern long-term care eligibility under the long-term care partnership program:

(1) WAC ((~~388-513-1405~~)) 182-513-1405 Definitions.

(2) WAC ((~~388-513-1410~~)) 182-513-1410 What qualifies as a LTC partnership policy?

(3) WAC ((~~388-513-1415~~)) 182-513-1415 What assets can't be protected under the LTC partnership provisions?

(4) WAC ((~~388-513-1420~~)) 182-513-1420 Who is eligible for asset protection under a LTC partnership policy?

(5) WAC ((~~388-513-1425~~)) 182-513-1425 When would I not qualify for LTC medicaid if I have a LTC partnership policy that does not have exhausted benefits?

(6) WAC ((~~388-513-1430~~)) 182-513-1430 What change of circumstances must I report when I have a LTC partnership policy paying a portion of my care?

(7) WAC ((~~388-513-1435~~)) 182-513-1435 Will Washington recognize a LTC partnership policy purchased in another state?

(8) WAC ((~~388-513-1440~~)) 182-513-1440 How many of my assets can be protected?

(9) WAC ((~~388-513-1445~~)) 182-513-1445 How do I designate a protected asset and what proof is required?

(10) WAC ((~~388-513-1450~~)) 182-513-1450 How does transfer of assets affect LTC partnership and medicaid eligibility?

(11) WAC ((~~388-513-1455~~)) 182-513-1455 If I have protected assets under a LTC partnership policy, what happens after my death?

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1405 Definitions. For purposes of this section, the following terms have the meanings given them. Additional definitions can be found at chapter ((~~388-500~~)) 182-500 WAC and WAC ((~~388-513-1301~~)) 182-513-1301.

"Issuer" means any entity that delivers, issues for delivery, or provides coverage to, a resident of Washington, any policy that claims to provide asset protection under the Washington long-term care partnership act, chapter 48.85 RCW. Issuer as used in this chapter specifically includes insurance companies, fraternal benefit societies, health care service contractors, and health maintenance organizations.

"Long-term care (LTC) insurance" means a policy described in Chapter 284-83 WAC.

"Long-term care services" means services received in a medical institution, or under a home and community based waiver authorized by home and community services (HCS) or ((~~division of~~)) developmental disabilities administration (DDA). Hospice services are considered long-term care services for the purposes of the long-term care partnership when medicaid eligibility is determined under chapter ((~~388-513 or 388-515~~)) 182-513 or 182-515 WAC.

"Protected assets" means assets that are designated as excluded or not taken into account upon determination of long-term care medicaid eligibility described in WAC ((~~388-513-1315~~)) 182-513-1315. The protected or excluded amount is up to the dollar amount of benefits that have been paid for long-term care services by the qualifying long-term care partnership policy on the medicaid applicant's or client's behalf. The assets are also protected or excluded for the purposes of estate recovery described in chapter ((~~388-527~~)) 182-527 WAC, in up to the amount of benefits paid by the qualifying policy for medical and long-term care services.

"Qualified long-term care insurance partnership" means an agreement between the Centers for Medicare and Medicaid Services (CMS), and the health care authority (HCA) 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 an individual 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. These policies are described in chapter 284-83 WAC.

"Reciprocity Agreement" means an agreement between states approved under section 6021(b) of the Deficit Reduction Act of 2005, Public Law 109-171 (DRA) under which the states agree to provide the same asset protections for qualified partnership policies purchased by

an individual while residing in another state and that state has a reciprocity agreement with the state of Washington.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1415 What assets can't be protected under the LTC partnership provisions? The following assets cannot be protected under a LTC partnership policy.

(1) Resources in a trust described in WAC ((~~388-561-0100~~)) 182-516-0100 (6) and (7).

(2) Annuity interests in which Washington must be named as a preferred remainder beneficiary as described in WAC ((~~388-561-0201~~)) 182-516-0201.

(3) Home equity in excess of the standard described in WAC ((~~388-513-1350~~)) 182-513-1350. Individuals who have excess home equity interest are not eligible for long-term care medicaid services.

(4) Any portion of the value of an asset that exceeds the dollar amount paid out by the LTC partnership policy.

(5) The unprotected value of any partially protected asset (an example would be the home) is subject to estate recovery described in chapter ((~~388-527~~)) 182-527 WAC.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1425 When would I not qualify for LTC medicaid if I have a LTC partnership policy in pay status? You are not eligible for LTC medicaid when the following applies:

(1) The income you have available to pay toward your cost of care described in WAC ((~~388-513-1380~~)) 182-513-1380, combined with the amount paid under the qualifying LTC partnership policy, exceeds the monthly private rate at the institution.

(2) The income you have available to pay toward your cost of care on a home and community based (HCB) waiver described in chapter ((~~388-515~~)) 182-515 WAC, combined with the amount paid under the qualifying LTC partnership policy, exceeds the monthly private rate in a home or residential setting.

(3) You fail to meet another applicable eligibility requirement for LTC medicaid.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1430 What change of circumstances must I report when I have a LTC partnership policy paying a portion of my care? You must report changes described in WAC ((~~388-418-0005~~)) 182-418-0005 plus the following:

(1) You must report and verify the value of the benefits that your issuer has paid on your behalf under the LTC partnership policy upon request by the department, and at each annual eligibility review.

(2) You must provide proof when you have exhausted the benefits under your LTC partnership policy.

(3) You must provide proof if you have given away or transferred assets that you have previously designated as protected. Although, there is no penalty for the transfer of protected assets once you have been approved for LTC medicaid, the value of transferred assets reduces the total dollar amount that is designated as protected and must be verified.

(4) You must provide proof if you have sold an asset or converted a protected asset into cash or another type of asset. You will need to make changes in the asset designation and verify the type of transaction and new value of the asset.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1450 How does transfer of assets affect LTC partnership and medicaid eligibility? (1) If you transfer an asset within the sixty months prior to the medicaid application or after medicaid eligibility has been established, we will evaluate the transfer based on WAC ((~~388-513-1363~~)) 182-513-1363 and determine if a penalty period applies unless:

(a) You have already been receiving institutional services;

(b) Your LTC partnership policy has paid toward institutional services for you; and

(c) The value of the transferred assets has been protected under the LTC partnership policy.

(2) The value of the transferred assets that exceed your LTC partnership protection will be evaluated for a transfer penalty.

(3) If you transfer assets whose values are protected, you lose that value as future protection unless all the transferred assets are returned.

(4) The value of your protected assets less the value of transferred assets equals the adjusted value of the assets you are able to protect.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-513-1455 If I have protected assets under a LTC partnership policy, what happens after my death? Assets designated as protected prior to death are not subject to estate recovery for medical or LTC services paid on your behalf as described in chapter ((~~388-527~~)) 182-527 WAC as long as the following requirements are met:

(1) A personal representative who asserts an asset is protected under this section has the initial burden of providing proof as described in chapter ((~~388-527~~)) 182-527 WAC.

(2) A personal representative must provide verification from the LTC insurance company of the dollar amount paid out by the LTC partnership policy.

(3) If the LTC partnership policy paid out more than was previously designated, the personal representative has the right to assert that additional assets should be protected based on the increased protection. The personal representative must use the DSHS LTCP asset designation form and send it to the office of financial recovery.

(4) The amount of protection available to you at death through the estate recovery process is decreased by the FMV of any protected assets that were transferred prior to death.

AMENDATORY SECTION (Amending WSR 13-03-096, filed 1/15/13, effective 1/15/13)

WAC 182-515-1500 Payment standard for persons in certain group living facilities. (1) A monthly grant payment of thirty-eight dollars and eighty-four cents will be made to eligible persons in ((~~the following facilities:~~

~~(a) Congregate care facilities (CCF);~~

~~(b) Adult residential rehabilitation centers/adult residential treatment facilities (AARC/ARTF); and~~

~~(c) Division of developmental disabilities (DDD) group home facilities~~)) alternative living facilities (ALF) described in WAC 182-513-1301.

(2) The payment covers the person's need for clothing, personal maintenance, and necessary incidentals (CPI).

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1506 What are the general eligibility requirements for home and community based (HCB) services authorized by home and community services (HCS) and hospice? (1) To be eligible for home and community based (HCB) services and hospice you must:

(a) Meet the program and age requirements for the specific program:

(i) COPES, per WAC 388-106-0310;

(ii) PACE, per WAC 388-106-0705;

(iii) WMIP waiver services, per WAC 388-106-0750;

(iv) New Freedom, per WAC 388-106-1410;

(v) Hospice, per chapter 182-551 WAC; or

(vi) Roads to community living (RCL), per WAC 388-106-0250, 388-106-0255 and 388-106-0260.

(b) Meet the disability criteria for the supplemental security income (SSI) program as described in WAC 182-512-0050;

(c) Require the level of care provided in a nursing facility described in WAC 388-106-0355;

(d) Be residing in a medical institution as defined in WAC 182-500-0050, or likely to be placed in one within the next thirty days without HCB services provided under one of the programs listed in ((~~subsection (1)~~)) (a) of this subsection;

(e) Have attained institutional status as described in WAC ((~~388-513-1320~~)) 182-513-1320;

(f) Be determined in need of services and be approved for a plan of care as described in ((~~subsection (1)~~)) (a) of this subsection;

(g) Be able to live at home with community support services and choose to remain at home, or live in a department-contracted:

(i) Enhanced adult residential care (EARC) facility;

(ii) Licensed adult family home (AFH); or

(iii) Assisted living (AL) facility.

(h) Not be subject to a penalty period of ineligibility for the transfer of an asset as described in WAC ((~~388-513-1363 through 388-513-1365~~)) 182-513-1363 through 182-513-1365;

(i) Not have a home with equity in excess of the requirements described in WAC ((~~388-513-1350~~)) 182-513-1350.

(2) Refer to WAC ((~~388-513-1315~~)) 182-513-1315 for rules used to determine countable resources, income, and eligibility standards for long-term care services.

(3) Current income and resource standard charts are located at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.html~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1507 What are the financial requirements for home and community based (HCB) services authorized by home and community services (HCS) when you are eligible for a noninstitutional SSI-related categorically needy (CN) medicaid program? (1) You are eligible for medicaid under one of the following programs:

(a) Supplemental security income (SSI) eligibility described in WAC 388-474-0001 and chapter 182-510 WAC. This includes SSI clients under 1619B status;

(b) SSI-related CN medicaid described in WAC 182-512-0100 (2)(a) and (b);

(c) SSI-related health care for workers with disabilities program (HWD) described in WAC 182-511-1000. If you are receiving HWD, you are responsible to pay your HWD premium as described in WAC 182-511-1250((~~;~~

~~(d) Aged, blind, or disabled (ABD) cash assistance described in WAC 388-400-0060 and are receiving CN medicaid~~)).

(2) You do not have a penalty period of ineligibility for the transfer of an asset as described in WAC ((~~388-513-1363 through 388-513-1365~~)) 182-513-1363 through 182-513-1365. This does not apply to PACE or hospice services.

(3) You do not have a home with equity in excess of the requirements described in WAC ((~~388-513-1350~~)) 182-513-1350.

(4) You do not have to meet the initial eligibility income test of having gross income at or below the special income level (SIL).

(5) You do not pay (participate) toward the cost of your personal care services.

(6) If you live in a department contracted facility listed in WAC ((~~388-515-1506~~)) 182-515-1506 (1)(g), you pay room and board up to the ((~~ADSA~~)) aging and disability services (ADS) room and board standard. The ((~~ADSA~~)) ADS room and board standard is based on the federal benefit rate (FBR) minus the current personal needs allowance (PNA) for HCS CN waivers in an alternate living facility.

(a) If you live in an assisted living (AL) facility, enhanced adult residential center (EARC), or adult family home (AFH) you keep a PNA of sixty-two dollars and seventy-nine cents and use your income to pay up to the room and board standard.

(b) If ((~~subsection (6)~~)) (a) of this subsection applies and you are receiving HWD described in WAC 182-511-1000, you are responsible to pay your HWD premium as described in WAC 182-511-1250, in addition to the ((~~ADSA~~)) ADS room and board standard.

(7) If you are eligible for aged, blind or disabled (ABD) cash assistance program described in WAC 388-400-0060 and receiving SSI-related CN medicaid, you do not participate in the cost of personal care and you may keep the following:

(a) When you live at home, you keep the cash grant amount authorized under WAC 388-478-0033;

(b) When you live in an AFH, you keep a PNA of thirty-eight dollars and eighty-four cents, and pay any remaining income and ABD cash grant to the facility for the cost of room and board up to the ((~~ADSA~~)) ADS room and board standard; or

(c) When you live in an assisted living facility or enhanced adult residential center, you are only eligible to receive an ABD cash grant of thirty-eight dollars and eighty-four cents as described in WAC ((~~388-478-0045~~)) 182-515-1500, which you keep for your PNA.

(8) Current resource and income standards are located at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

(9) Current PNA and ((~~ADSA~~)) ADS room and board standards are located at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/ltcstandardsPNAchartsubfile.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1508 How does the department determine if you are financially eligible for home and community based (HCB) services authorized by home and community services (HCS) and hospice if you are not eligible for medicaid under a categorically needy (CN) program listed in WAC ((~~388-515-1507~~)) 182-515-1507(1)? (1) If you are not eligible for medicaid under a categorically needy (CN) program listed in WAC ((~~388-515-1507~~)) 182-515-1507(1), the department must determine your eligibility using institutional medicaid rules. This section explains how you may qualify using institutional medicaid rules.

(2) You must meet the general eligibility requirements described in WAC ((~~388-513-1315 and 388-515-1506~~)) 182-513-1315 and 182-515-1506.

(3) You must meet the following resource requirements:

(a) Resource limits described in WAC ((~~388-513-1350~~)) 182-513-1350.

(b) If you have resources over the standard allowed in WAC ((~~388-513-1350~~)) 182-513-1350, the department reduces resources over the standard by your unpaid medical expenses described in WAC ((~~388-513-1350~~)) 182-513-1350 if you verify these expenses.

(4) You must meet the following income requirements:

(a) Your gross nonexcluded income must be at or below the special income level (SIL) which is three hundred percent of the federal benefit rate (FBR); or

(b) For home and community based (HCB) service programs authorized by HCS your gross nonexcluded income is:

(i) Above the special income level (SIL) which is three hundred percent of the federal benefit rate (FBR); and

(ii) Net income is no greater than the effective one-person medically needy income level (MNIL). Net income is calculated by reducing gross nonexcluded income by:

(A) Medically needy (MN) disregards found in WAC ((~~388-513-1345~~)) 182-513-1345; and

(B) The average monthly nursing facility state rate is five thousand six hundred and twenty six dollars. This rate will be updated annually starting October 1, 2012, and each year thereafter on October 1st. This standard will be updated annually in the long-term care standard section of the EAZ manual described at ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardsp-na.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

(5) The department follows the rules in WAC ((~~388-515-1325, 388-513-1330, and 388-513-1340~~)) 182-513-1325, 182-513-1330, and 182-513-1340 to determine available income and income exclusions.

(6) Current resource and income standards (including the SIL, MNIL and FBR) for long-term care are found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardsp-na.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1509 How does the department determine how much of my income I must pay towards the cost of my care if I am only eligible for home and community based (HCB) services under WAC ((~~388-515-1508~~)) 182-515-1508? If you are only eligible for medicaid under WAC ((~~388-515-1508~~)) 182-515-1508, the department determines how much you must pay based upon the following:

(1) If you are single and living at home as defined in WAC 388-106-0010, you keep all your income up to the federal poverty level (FPL) for your personal needs allowance (PNA).

(2) If you are married living at home as defined in WAC 388-106-0010, you keep all your income up to the effective one-person medically needy income level (MNIL) for your PNA if your spouse lives at home with you. If you are married and living apart from your spouse, you're allowed to keep your income up to the FPL for your PNA.

(3) If you live in an assisted living (AL) facility, enhanced adult residential center (EARC), or adult family home (AFH), you:

(a) Keep a PNA from your gross nonexcluded income. The PNA is sixty-two dollars and seventy-nine cents effective July 1, 2008; and

(b) Pay for your room and board up to the ((~~ADSA~~)) ADS room and board standard.

(4) In addition to paying room and board, you may also have to pay toward the cost of personal care. This is called your participation. Income that remains after the PNA and ((~~any~~)) room and board ((~~deduction~~)) liability if residing in an alternate living facility is reduced by allowable deductions in the following order:

(a) If you are working, the department allows an earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income((~~.~~));

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

(c) Current or back child support garnished or withheld from your income according to a child support order in the month of the garnishment if it is for the current month. If the department allows this as deduction from your income, the department will not count it as your child's income when determining the family allocation amount;

(d) A monthly maintenance needs allowance for your community spouse not to exceed that in WAC ((~~388-513-1380~~)) 182-513-1380 (5)(b) unless a greater amount is allocated as described in ((~~subsection~~)) (e) of this ((~~section~~)) subsection. This amount:

(i) Is allowed only to the extent that your income is made available to your community spouse; and

(ii) Consists of a combined total of both:

(A) One hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st and can be found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx; and

(B) Excess shelter expenses. For the purposes of this section, excess shelter expenses are the actual required maintenance expenses for your community spouse's principal residence. These expenses are determined in the following manner:

(I) Rent, including space rent for mobile homes, plus;

(II) Mortgage, plus;

(III) Taxes and insurance, plus;

(IV) Any required payments for maintenance care for a condominium or cooperative, plus;

(V) The food assistance standard utility allowance (SUA) described in WAC 388-450-0195 provided the utilities are not included in the maintenance charges for a condominium or cooperative, minus;

(VI) The standard shelter allocation. This standard is based on thirty percent of one hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st and can be found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx; and

(VII) Is reduced by your community spouse's gross countable income.

(iii) The amount allocated to the community spouse may be greater than the amount in ((~~subsection~~)) (d)(ii) of this subsection only when:

(A) There is a court order approving a higher amount for the support of your community spouse; or

(B) A hearings officer determines a greater amount is needed because of exceptional circumstances resulting in extreme financial duress.

(e) A monthly maintenance needs amount for each minor or dependent child, dependent parent, or dependent sibling of your community or institutionalized spouse. The amount the department allows is based on the living arrangement of the dependent. If the dependent:

(i) Resides with your community spouse, for each child, one hundred fifty percent of the two-person FPL minus that child's income and divided by three (child support received from a noncustodial parent is considered the child's income);

(ii) Does not reside with the community spouse, the amount is equal to the effective one-person MNIL based on the number of dependent family members in the home less their separate income (child support received from a noncustodial parent is considered the child's income).

(f) Your unpaid medical expenses which have not been used to reduce excess resources. Allowable medical expenses are described in WAC ((~~388-513-1350~~)) 182-513-1350.

(g) The total of the following deductions cannot exceed the SIL (three hundred percent of the FBR):

(i) Personal needs allowance in subsections (1), (2), and (3)(a) and (b) of this section; and

(ii) Earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income in ((~~subsection (4)~~)) (a) of this subsection; and

(iii) Guardianship fees and administrative costs in ((~~subsection (4)~~)) (b) of this subsection.

(5) You must pay your provider the combination of the room and board amount and the cost of personal care services after all allowable deductions.

(6) You may have to pay third party resources described in WAC 182-501-0200 in addition to the room and board and participation. The combination of room and board, participation, and third party resources is the total amount you must pay.

(7) Current income and resource standards for long-term care (including SIL, MNIL, FPL, FBR) are located at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

(8) If you are in multiple living arrangements in a month (an example is a move from an adult family home to a home setting on HCB services), the department allows you the highest PNA available based on all the living arrangements and services you have in a month.

(9) Current PNA and ((~~ADSA~~)) ADS room and board standards are located at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/ltcstandardsPNAchartsubfile.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1510 Division of developmental disabilities ((~~(DDD)~~)) administration (DDA) home and community based ((~~services~~)) (HCB) waivers. The four sections that follow describe the general and financial eligibility requirements for home and community based (HCB) waivers authorized by the ((~~division of~~)) developmental disabilities ((~~(DDD) home and community based services (HCBS) waivers~~)) administration (DDA).

(1) WAC ((~~388-515-1511~~)) 182-515-1511 describes the general eligibility requirements under the ((~~DDD HCBS~~)) DDA HCB waivers.

(2) WAC ((~~388-515-1512~~)) 182-515-1512 describes the financial requirements for the ((~~DDD~~)) DDA waivers if you are eligible for medicaid under the noninstitutional categorically needy program (CN).

(3) WAC ((~~388-515-1513~~)) 182-515-1513 describes the initial financial requirements for the ((~~DDD~~)) DDA HCB waivers if you are not

eligible for medicaid under a categorically needy program (CN) listed in WAC ((~~388-515-1512~~)) 182-515-1512(1).

(4) WAC ((~~388-515-1514~~)) 182-515-1514 describes the post eligibility financial requirements for the ((~~DDD~~)) DDA waivers if you are not eligible for medicaid under a categorically needy program CN listed in WAC ((~~388-515-1512~~)) 182-515-1512(1).

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1511 What are the general eligibility requirements for waiver services under the ((~~division of~~)) developmental disabilities ((~~(DDD)~~)) administration (DDA) home and community based ((~~services (HCBS)~~)) (HCB) waivers? (1) This section describes the general eligibility requirements for waiver services under the ((~~DDD~~)) DDA home and community based ((~~services (HCBS)~~)) (HCB) waivers.

(2) The requirements for services for ((~~DDD HCBS~~)) DDA HCB waivers are described in chapter 388-845 WAC. The department establishes eligibility for ((~~DDD HCBS~~)) DDA HCB waivers. To be eligible, you must:

(a) Be an eligible client of the ((~~division of~~)) developmental disabilities ((~~(DDD)~~)) administration (DDA);

(b) Meet the disability criteria for the supplemental security income (SSI) program as described in WAC 182-512-0050;

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

(d) Have attained institutional status as described in WAC ((~~388-513-1320~~)) 182-513-1320;

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

(f) Need waiver services as determined by your plan of care or individual support plan, and:

(i) Be able to live at home with waiver services; or

(ii) Live in a department contracted facility, which includes:

(A) A group home;

(B) Group training home;

(C) Child foster home, group home or staffed residential facility;

(D) Adult family home (AFH); or

(E) Adult residential care (ARC) facility.

(iii) Live in your own home with supported living services from a certified residential provider; or

(iv) Live in the home of a contracted companion home provider; and

(g) Be both medicaid eligible under the ((~~categorically needy program (CN)~~)) HCB waiver eligibility described in WAC 182-515-1510 and be approved for services by ((~~the division of developmental disabilities~~)) DDA.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1512 What are the financial requirements for the ((~~DDD~~)) DDA waiver services if I am eligible for medicaid under the noninstitutional categorically needy program (CN)? (1) You ((~~automatically~~)) meet income and resource eligibility for ((~~DDD~~)) DDA waiver services if you are eligible for medicaid under a categorically needy program (CN) under one of the following programs:

(a) Supplemental security income (SSI) eligibility described in WAC 388-474-0001 and chapter 182-510 WAC. This includes SSI clients under 1619B status((~~. These clients have medicaid eligibility determined and maintained by the Social Security Administration~~));

(b) Health care for workers with disabilities (HWD) described in WAC 182-511-1000 through 182-511-1250;

(c) SSI-related (CN) medicaid described in WAC 182-512-0100 (2) (a) and (b) or meets the requirements in WAC 182-512-0880 and is (CN) eligible after the income disregards have been applied((~~;~~

~~(d) CN medicaid for a child as described in WAC 182-505-0210 (1), (2), (7) or (8); or~~

~~(e) Aged, blind or disabled (ABD) cash assistance described in WAC 388-400-0060~~)).

(2) If you are eligible for a CN medicaid program listed in subsection (1) ((~~above~~)) of this section, you do not have to pay (participate) toward the cost of your personal care and/or habilitation services. You are responsible to pay room and board if residing in a residential setting.

(3) If you are eligible for a CN medicaid program listed in subsection (1) ((~~above~~)) of this section, you do not need to meet the initial eligibility income test of gross income at or below the special income level (SIL), which is three hundred percent of the federal benefit rate (FBR).

(4) If you are eligible for a CN medicaid program listed in subsection (1) of this section, you pay up to the ((~~ADSA~~)) aging and disability services (ADS) room and board standard ((~~described in WAC 388-515-1507~~)) based on the medically needy income level (MNIL) minus the sixty-two dollars and seventy-nine cents personal needs allowance (PNA). Room and board and long-term care standards are located at ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)): http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

((~~(a)~~)) If you live in an ARC, AFH or ((~~DDD~~)) DDA group home, you keep a personal needs allowance (PNA) and use your income to pay up to the ((~~ADSA~~)) ADS room and board standard. Effective January 1, 2009, the PNA is sixty-two dollars and seventy-nine cents.

(5) If you are eligible for ((~~a~~)) the premium based medicaid program ((~~such as~~)), health care for workers with disabilities (HWD), you must continue to pay the medicaid premium to remain eligible for that ((~~CN-P~~)) CN program and pay the ADS room and board rate if residing in a residential ALF setting.

(6) If you are eligible for a CN medicaid program listed in subsection (1) of this section you are subject to equity interest in primary residence, annuity disclosure requirements and are not subject to a penalty period of ineligibility described in WAC 182-513-1315.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1513 How does the department determine if I am financially eligible for ((~~DDD~~)) DDA waiver service medical coverage if I am not eligible for medicaid under a categorically needy program (CN) listed in WAC ((~~388-515-1512~~)) 182-515-1512(1)? If you are not eligible for medicaid under a categorically needy program (CN) listed in WAC ((~~388-515-1512~~)) 182-515-1512(1), we must determine your eligibility using institutional medicaid rules. This section explains how you may qualify under this program. You may be required to pay towards the cost of your care if you are eligible under this program. The rules explaining how much you have to pay are listed in WAC ((~~388-515-1514~~)) 182-515-1514. To qualify, you must meet both the resource and income requirements.

(1) Resource limits are described in WAC ((~~388-513-1350~~)) 182-513-1350. If you have resources which are higher than the standard allowed, we may be able to reduce resources by your unpaid medical expenses described in WAC ((~~388-513-1350~~)) 182-513-1350.

(2) You are not subject to a transfer of asset penalty described in WAC ((~~388-513-1363 through 388-513-1365~~)) 182-513-1363 through 182-513-1365.

((~~(d)~~)) (3)Not have a home with equity in excess of the requirements described in WAC ((~~388-513-1350~~)) 182-513-1350.

((~~(3)~~)) (4) Must disclose to the state any interest the applicant or spouse has in an annuity and meeting annuity requirements described in chapter 182-516 WAC.

(5) Your gross nonexcluded income must be at or below the special income level (SIL) which is three hundred percent of the federal benefit level. The department follows the rules in WAC ((~~388-515-1325, 388-513-1330 and 388-513-1340~~)) 182-513-1325, 182-513-1330, and 182-513-1340 to determine available income and income exclusions.

((~~(4)~~)) (6) Refer to WAC ((~~388-513-1315~~)) 182-513-1315 for rules used to determine countable resources, income and eligibility standards for long-term care services.

((~~(5)~~)) (7) Current income and resources standards are located at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

AMENDATORY SECTION (Amending WSR 13-01-017, filed 12/7/12, effective 1/1/13)

WAC 182-515-1514 How does the department determine how much of my income I must pay towards the cost of my ((~~DDD~~)) DDA waiver services if I am not eligible for medicaid under a categorically needy program (CN) listed in WAC ((~~388-515-1512~~)) 182-515-1512(1)? If you are not eligible for medicaid under a categorically needy program (CN) listed in WAC ((~~388-515-1512~~)) 182-515-1512(1), the department determines how much you must pay based upon the following:

(1) If you are an SSI-related client living at home as defined in WAC 388-106-0010, you keep all your income up to the SIL (three hundred percent of the FBR) for your personal needs allowance (PNA).

(2) If you are an SSI-related client and you live in an ARC, AFH or ((~~DDD~~)) DDA group home, you:

(a) Keep a personal needs allowance (PNA) from your gross nonexcluded income. Effective January 1, 2009, the PNA is sixty-two dollars and seventy-nine cents; and

(b) Pay for your room and board up to the ((~~ADSA~~)) ADS room and board rate described in ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)): http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx.

(3) In addition to paying room and board, you may also have to pay toward the cost of personal care. This is called your participation. Income that remains after the PNA and any room and board deduction described in subsection (2) ((~~above~~)) of this section, is reduced by allowable deductions in the following order:

(a) If you are working, we allow an earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income;

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

(c) Current or back child support garnished or withheld from your income according to a child support order in the month of the garnishment if it is for the current month. If we allow this as deduction from your income, we will not count it as your child's income when determining the family allocation amount;

(d) A monthly maintenance needs allowance for your community spouse not to exceed that in WAC ((~~388-513-1380~~)) 182-513-1380 (5)(b) unless a greater amount is allocated as described in ((~~subsection~~)) (e) of this ((~~section~~)) subsection. This amount:

(i) Is allowed only to the extent that your income is made available to your community spouse; and

(ii) Consists of a combined total of both:

(A) One hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st and can be found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx; and

(B) Excess shelter expenses. For the purposes of this section, excess shelter expenses are the actual required maintenance expenses for your community spouse's principal residence. These expenses are determined in the following manner:

(I) Rent, including space rent for mobile homes, plus;

(II) Mortgage, plus;

(III) Taxes and insurance, plus;

(IV) Any required payments for maintenance care for a condominium or cooperative plus;

(V) The food assistance standard utility allowance (SUA) provided the utilities are not included in the maintenance charges for a condominium or cooperative, minus;

(VI) The standard shelter allocation. This standard is based on thirty percent of one hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st and can be found at: ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml~~)) http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx; and

(VII) Is reduced by your community spouse's gross countable income.

(iii) May be greater than the amount in ((~~subsection~~)) (d)(ii) of this subsection only when:

(A) There is a court order approving a higher amount for the support of your community spouse; or

(B) A hearings officer determines a greater amount is needed because of exceptional circumstances resulting in extreme financial duress.

(e) A monthly maintenance needs amount for each minor or dependent child, dependent parent or dependent sibling of your community or institutionalized spouse. The amount we allow is based on the living arrangement of the dependent. If the dependent:

(i) Resides with your community spouse, for each child, one hundred fifty percent of the two-person FPL minus that child's income and divided by three (child support received from a noncustodial parent is considered the child's income);

(ii) Does not reside with the community spouse, the amount is equal to the effective one-person MNIL based on the number of dependent family members in the home less their separate income (child support received from a noncustodial parent is considered the child's income).

(f) Your unpaid medical expenses which have not been used to reduce excess resources. Allowable medical expenses are described in WAC ((~~388-513-1350~~)) 182-513-1350.

(g) The total of the following deductions cannot exceed the SIL (three hundred percent of the FBR):

(i) Personal needs allowances in subsection (1) of this section for in home or subsection (2)(a) of this section in a residential setting; and

(ii) Earned income deduction of the first sixty-five dollars plus one-half of the remaining earned income in ((~~subsection (3)~~)) (a) of this subsection; and

(iii) Guardianship fees and administrative costs in ((~~subsection (3)~~)) (b) of this subsection.

(4) If you are eligible for aged, blind or disabled (ABD) cash assistance described in WAC 388-400-0060 and CN medicaid based on ABD criteria, you do not participate in the cost of personal care and you may keep the following:

(a) When you live at home, you keep the cash grant amount authorized under the ABD cash program;

(b) When you live in an AFH, you keep a PNA of thirty-eight dollars and eighty-four cents, and pay any remaining income and ABD cash grant to the facility for the cost of room and board up to the ((~~AD-SA~~)) ADS room and board standard described in ((~~http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardsp-na.shtml~~)): http://www.hca.wa.gov/medicaid/Eligibility/Pages/index.aspx; or

(c) When you live in an ARC or ((~~DDD~~)) DDA group home, you are only eligible to receive a cash grant of thirty-eight dollars and eighty-four cents which you keep for your PNA.

(5) You may have to pay third party resources (TPR) described in WAC 182-501-0200 in addition to room and board and the cost of personal care and/or habilitation services (participation) after all allowable deductions have been considered is called your total responsibility. You pay this amount to the ARC, AFH or ((~~DDD~~)) DDA group home provider.

AMENDATORY SECTION (Amending WSR 12-13-056, filed 6/15/12, effective 7/1/12)

WAC 182-507-0125 State-funded long-term care services program. (1) The state-funded long-term care services program is subject to caseload limits determined by legislative funding. Services cannot be authorized for eligible persons prior to a determination by the aging and ((~~disability services~~)) long-term supports administration ((~~(ADSA)~~)) (ALTSA) that caseload limits will not be exceeded as a result of the authorization.

(2) Long-term care services are defined in this section as services provided in one of the following settings:

(a) In a person's own home, as described in WAC 388-106-0010;

(b) Nursing facility, as defined in WAC 388-97-0001;

(c) Adult family home, as defined in RCW 70.128.010;

(d) Assisted living facility, as described in WAC ((~~388-513-1301~~)) 182-513-1301;

(e) Enhanced adult residential care facility, as described in WAC ((~~388-513-1301~~)) 182-513-1301;

(f) Adult residential care facility, as described in WAC ((~~388-513-1301~~)) 182-513-1301.

(3) Long-term care services will be provided in one of the facilities listed in subsection (2)(b) through (f) of this section unless nursing facility care is required to sustain life.

(4) To be eligible for the state-funded long-term care services program described in this section, an adult nineteen years of age or older must meet all of the following conditions:

(a) Meet the general eligibility requirements for medical programs described in WAC ((~~388-503-0505~~)) 182-503-0505 (2) and (3)((~~(a), (b), (e), and (f)~~)) with the exception of subsection (3)(c) and (d) of this section;

(b) Reside in one of the settings described in subsection (2) of this section;

(c) Attain institutional status as described in WAC ((~~388-513-1320~~)) 182-513-1320;

(d) Meet the functional eligibility described in WAC 388-106-0355 for nursing facility level of care;

(e) Not have a penalty period due to a transfer of assets as described in WAC ((~~388-513-1363, 388-513-1364, 388-513-1365, and 388-513-1366~~)) 182-513-1363, 182-513-1364, or 182-513-1365;

(f) Not have equity interest in a primary residence more than the amount described in WAC ((~~388-513-1350 (7)(a)(ii)~~)) 182-513-1350; and

(g) Any annuities owned by the adult or spouse must meet the requirements described in chapter ((~~388-561~~)) 182-516 WAC.

(5) An adult who is related to the supplemental security income (SSI) program as described in WAC ((~~388-475-0050~~)) 182-512-0050 (1), (2), and (3) must meet the financial requirements described in WAC ((~~388-513-1325, 388-513-1330, and 388-513-1350~~)) 182-513-1315.

(6) An adult who does not meet the SSI-related criteria in subsection (2) of this section may be eligible under the family institutional medical program rules described in WAC ((~~388-505-0250 or 388-505-0255~~)) 182-514-0230.

(7) An adult who is not eligible for the state-funded long-term care services program under categorically needy (CN) rules may qualify under medically needy (MN) rules described in:

(a) WAC ((~~388-513-1395~~)) 182-513-1395 for adults related to SSI; or

(b) WAC ((~~388-505-0255~~)) 182-514-0255 for adults up to age twenty-one related to family institutional medical.

(8) All adults qualifying for the state-funded long-term care services program will receive CN scope of medical coverage described in WAC ((~~388-501-0060~~)) 182-500-0020.

(9) The department determines how much an individual is required to pay toward the cost of care using the following rules:

(a) For an SSI-related individual residing in a nursing home, see rules described in WAC ((~~388-513-1380~~)) 182-513-1380.

(b) For an SSI-related individual residing in one of the other settings described in subsection (2) of this section, see rules described in WAC ((~~388-515-1505~~)) 182-515-1505.

(c) For an individual eligible under the family institutional program, see WAC ((~~388-505-0265~~)) 182-514-0265.

(10) A person is not eligible for state-funded long-term care services if that person entered the state specifically to obtain medical care.

(11) A person eligible for the state-funded long-term care services program is certified for a twelve month period.