



RULE-MAKING ORDER

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

Agency: Health Care Authority, Washington Apple Health

Permanent Rule Only

Effective date of rule:

Permanent Rules

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

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

- Yes
 - No
- If Yes, explain:

Purpose: This rule amendment is necessary to correct department names and rule numbers and to make other housekeeping changes.

Citation of existing rules affected by this order:

Repealed:
 Amended: 182-519-0050, -0100, and -0110
 Suspended:

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 15-12-098 on June 2, 2015.
 Describe any changes other than editing from proposed to adopted version: N/A

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

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

Date adopted: August 7, 2015

NAME (TYPE OR PRINT)
Wendy Barcus

SIGNATURE

TITLE
HCA Rules Coordinator

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
 STATE OF WASHINGTON
 FILED
DATE: August 07, 2015
TIME: 7:55 AM
WSR 15-17-012

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

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

The number of sections adopted in order to comply with:

Federal statute:	New	_____	Amended	_____	Repealed	_____
Federal rules or standards:	New	_____	Amended	_____	Repealed	_____
Recently enacted state statutes:	New	_____	Amended	_____	Repealed	_____

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

New	_____	Amended	_____	Repealed	_____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

New	_____	Amended	_____	Repealed	_____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

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	Repealed	_____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

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

AMENDATORY SECTION (Amending WSR 12-20-001, filed 9/19/12, effective 10/20/12)

WAC 182-519-0050 Monthly income and countable resource standards for medically needy (MN). (1) Changes to the medically needy income level (MNIL) occur on January 1st of each calendar year when the Social Security Administration (SSA) issues a cost-of-living adjustment (~~for that year~~).

(2) Medically needy (MN) standards for (~~persons~~) people who meet institutional status requirements are in WAC (~~(388-513-1395)~~) 182-513-1395. The standard for a client who lives in an alternate living facility (~~can be found~~) is in WAC (~~(388-513-1305)~~) 182-513-1305.

(3) The resource standards for institutional programs are (~~found~~) in WAC (~~(388-513-1350)~~) 182-513-1350. The institutional standard chart (~~can be~~) is found at: <http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml>.

(4) Countable resource standards for the noninstitutional MN program are:

- (a) One person \$2,000
- (b) A legally married couple \$3,000
- (c) For each additional family member add \$50

(5) (~~For individuals~~) People who do not meet institutional status requirements (~~to~~) use the "effective" MNIL income standard (~~used~~) to determine eligibility for the (~~medically needy~~) MN program (~~is the "effective" MNIL~~). The "effective" MNIL is the one-person federal benefit rate (FBR) established by SSA each year, or the MNIL listed below, whichever amount is higher. The FBR is the supplemental security income (SSI) payment standard. For example, in 2012, the FBR is six hundred ninety-eight dollars.

1	2	3	4	5	6	7	8	9	10
467	592	667	742	858	975	1125	1242	1358	1483

AMENDATORY SECTION (Amending WSR 12-20-001, filed 9/19/12, effective 10/20/12)

WAC 182-519-0100 Eligibility for the medically needy program.

(1) (~~An individual~~) A person who meets the following conditions may be eligible for medically needy (MN) coverage under the special rules in chapters (~~388-513-WAC~~) 182-513 and (~~388-515~~) 182-515 WAC:

(a) Meets the institutional status requirements of WAC (~~388-513-1320~~) 182-513-1320;

(b) Resides in a medical institution as described in WAC (~~388-513-1395~~) 182-513-1395; or

(c) Receives waiver services under a medically needy in-home waiver (MNIW) (~~according to WAC 388-515-1550~~) under WAC 182-515-1550 or a medically needy residential waiver (MNRW) (~~according to WAC 388-515-1540~~) under WAC 182-515-1540.

(2) (~~An SSI-related individual~~) A supplemental security income (SSI)-related person who lives in a (~~department contracted~~) medicaid agency-contracted alternate living facility may be eligible for MN

coverage under ~~((the rules described in WAC 388-513-1305))~~ WAC 182-513-1305.

(3) ~~((An individual))~~ A person may be eligible for MN coverage under this chapter when he or she is:

(a) Not covered under subsection (1) and (2) of this section; and

(b) Eligible for categorically needy (CN) medical coverage in all other respects, except that his or her CN countable income is above the CN income standard.

(4) MN coverage may be available if the ~~((individual))~~ person is:

(a) A child;

(b) A pregnant woman;

(c) A refugee;

(d) An SSI-related ~~((individual))~~ person, including an aged, blind, or disabled ~~((individual))~~ person, with countable income under the CN income standard, who is an ineligible spouse of an SSI recipient; or

(e) A hospice client with countable income ~~((which is))~~ above the special income level (SIL).

(5) ~~((An individual))~~ A person who is not eligible for CN medical ~~((and))~~ who ~~((is applying))~~ applies for MN coverage has the right to income deductions in addition to, or instead of, those used to ~~((arrive at))~~ calculate CN countable income. These deductions to income are applied to each month of the base period to ((determine)) calculate MN countable income~~((The following deductions are used to calculate countable income for MN))~~:

(a) The agency disregards the difference between the medically needy income level (MNIL) described in WAC 182-519-0050 and the federal benefit rate (FBR) established by the Social Security Administration each year. The FBR is the one-person ((Supplemental Security Income-))SSI((+)) payment standard;

(b) All health insurance premiums, ~~((with the exception of))~~ except for medicare Part A~~((, Part B, Part C and))~~ through Part D premiums, expected to be paid by the ~~((individual))~~ person or family member during the base period~~((+s))~~ or periods;

(c) Any allocations to a spouse or to dependents for an SSI-related ~~((individual))~~ person who is married or who has dependent children. Rules for allocating income are described in WAC 182-512-0900 through 182-512-0960;

(d) For an SSI-related ~~((individual))~~ person who is married and lives in the same home as his or her spouse who receives home and community-based waiver services under chapter ~~((388-515))~~ 182-515 WAC, an income deduction equal to the ~~((medically needy income level +))MNIL((+))~~, minus the nonapplying spouse's income; and

(e) A child or pregnant woman ~~((who is))~~ applying for MN coverage is eligible for income deductions allowed under ~~((TANF/SFA))~~ temporary assistance for needy families (TANF) and state family assistance (SFA) rules and not under the rules for CN programs based on the federal poverty level. See WAC ~~((182-109-0001(4))~~ 182-509-0001(4) for exceptions to the TANF~~((+))~~ and SFA rules ~~((which))~~ that apply to medical programs and not to the cash assistance program.

(6) The MNIL for ~~((individuals who qualify))~~ a person who qualifies for MN coverage under subsection (1) of this section is based on rules in ~~((chapter 388-513 and 388-515))~~ chapters 182-513 and 182-515 WAC.

(7) The MNIL for all other ~~((individuals))~~ people is described in WAC 182-519-0050. If ~~((an individual))~~ a person has countable income

~~((which is))~~ at or below the MNIL, ~~((he or she))~~ the person is certified as eligible for up to twelve months of MN medical coverage.

(8) If ~~((an individual))~~ a person has countable income ~~((which is))~~ over the MNIL, the countable income that exceeds the agency's MNIL standards is called "excess income."

(9) ~~((When individuals have))~~ A person with "excess income" ~~((they are))~~ is not eligible for MN coverage until ~~((they provide evidence to))~~ the person gives the agency or its designee evidence of medical expenses incurred by ~~((themselves))~~ that person, their spouse, or family members ~~((who live))~~ living in the home for whom they are financially responsible. See WAC 182-519-0110(8). An expense ~~((has been))~~ is incurred when:

(a) The ~~((individual has received the))~~ person receives medical treatment or medical supplies, is financially liable for the medical expense ~~((but)),~~ and has not ~~((yet))~~ paid the bill; or

(b) The ~~((individual has paid))~~ person pays for the expense within the current or retroactive base period ~~((described in))~~ under WAC 182-519-0110.

(10) Incurred medical expenses or obligations may be used to offset any portion of countable income that is over the MNIL. This is the process of meeting "spenddown."

(11) The agency or its designee calculates the amount of ~~((an individual's))~~ a person's spenddown by multiplying the monthly excess income amount by the number of months in the certification period ~~((as described in))~~ under WAC 182-519-0110. The qualifying medical expenses must be greater than or equal to the total calculated spenddown amount.

(12) ~~((An individual))~~ A person who is considered for MN coverage under this chapter may not spenddown excess resources to become eligible for the MN program. Under this chapter ~~((individuals are)),~~ a person is ineligible for MN coverage if ~~((their))~~ the person's resources exceed the program standard in WAC 182-519-0050. ~~((An individual))~~ A person who is considered for MN coverage under WAC ~~((388-513-1395))~~ 182-513-1395, 182-514-0250 or 182-514-0255 is allowed to spenddown excess resources.

(13) There is no automatic redetermination process for MN coverage. ~~((An individual))~~ A person must ~~((submit an application))~~ apply for each eligibility period under the MN program.

(14) ~~((An individual))~~ A person who requests a timely administrative hearing under WAC 388-458-0040 is not eligible for continued benefits beyond the end of the original certification date under the MN program.

AMENDATORY SECTION (Amending WSR 12-20-001, filed 9/19/12, effective 10/20/12)

WAC 182-519-0110 Spenddown of excess income for the medically needy program. (1) ~~((An individual))~~ A person who applies for ~~((medical assistance))~~ Washington apple health (WAH) and is eligible for medically needy (MN) coverage with a spenddown may choose a three-month or a six-month base period. A base period is a time period used to compute the ~~((amount of the))~~ spenddown liability amount. The months must be consecutive calendar months, unless ~~((one of the))~~ a condition~~((s))~~ in subsection (4) of this section applies.

(2) A base period begins on the first day of the month(~~, in which an individual~~) a person applies for (~~medical assistance, subject to the exceptions~~) WAH, unless a condition in subsection (4) of this section applies.

(3) (~~An individual~~) A person may request a separate base period to cover (~~the time period~~) up to three calendar months immediately (~~prior to~~) before the month of application. This is called a retroactive base period.

(4) A base period may vary from the terms in subsections (1), (2), or (3) of this section if:

(a) A three-month base period would overlap a previous eligibility period; (~~or~~)

(b) The (~~individual~~) person has countable resources (~~that are~~) over the applicable standard for any part of the required base period; (~~or~~)

(c) The (~~individual~~) person is not or will not be able to meet the temporary assistance to needy families (TANF)-related or supplemental security income (SSI)-related requirement for the required base period; (~~or~~)

(d) The (~~individual~~) person is eligible for categorically needy (CN) coverage for part of the required base period; or

(e) The (~~individual~~) person was not otherwise eligible for MN coverage for each (~~of the~~) month(~~s~~) of the retroactive base period.

(5) (~~An individual's~~) The medicaid agency or its designee calculates a person's spenddown liability (~~is calculated by the agency or its designee~~). The MN countable income from each month of the base period is compared to the effective medically needy income level (MNIL) (~~described in~~) under WAC 182-519-0050. Income (~~which is~~) over the effective MNIL standard (based on the (~~individual's~~) person's household size) in each month in the base period is added together to determine the total spenddown amount.

(6) If household income varies and (~~an individual's~~) a person's MN countable income falls below the effective MNIL for one or more months, the difference (~~is used to~~) offsets the excess income in other months of the base period. (~~If this results in~~) See WAC 182-519-0100(7) if a spenddown amount (~~of~~) results in zero dollars and cents(~~, see WAC 182-519-0100(7)~~).

(7) If (~~an individual's~~) a person's income decreases, the agency or its designee approves CN coverage for each month in the base period when the (~~individual's~~) person's countable income and resources are equal to or below the applicable CN standards. Children (~~under the age of nineteen~~) age eighteen and younger and pregnant women who become CN eligible in any month of the base period (~~remain~~) are continuously eligible for CN coverage for the remainder of the certification, even if there is a subsequent increase in income.

(8) Once (~~an individual's~~) a person's spenddown amount (~~has been~~) is determined, qualifying medical expenses are deducted. (~~To be considered~~) A qualifying medical expense(~~, the expense~~) must:

(a) Be an expense for which the (~~individual~~) person is financially liable;

(b) Not have been used to meet another spenddown;

(c) Not be the confirmed responsibility of a third party. The agency or its designee allows the entire expense if (~~the~~) a third party has not confirmed its coverage of the expense within:

(i) Forty-five days of the date of service; or

(ii) Thirty days after the base period ends.

(d) Be an incurred expense for the ((individual)) person:

(i) The ((individual's)) person's spouse;

(ii) A family member((,)) residing in the person's home ((of the individual,)) for whom the ((individual)) person is financially responsible; or

(iii) A relative((,)) residing in the person's home ((of the individual,)) who is financially responsible for the ((individual)) person.

(e) Meet one of the following conditions:

(i) Be an unpaid liability at the beginning of the base period;

(ii) Be for paid or unpaid medical services ((either paid or unpaid and)) incurred during the base period;

(iii) Be for medical services incurred and paid during the three-month retroactive base period if eligibility for ((medical assistance)) WAH was not established in that base period. Paid expenses that meet this requirement may be applied towards the current base period; or

(iv) Be for medical services incurred during a previous base period ((and)), either unpaid or paid ((for)), if it was necessary for the ((individual)) person to make a payment due to delays in the certification for that base period.

(9) An exception to ((the provisions in)) subsection (8) of this section exists for qualifying medical expenses ((that have been)) paid on ((behalf of the individual)) the person's behalf by a publicly administered program during the current or the retroactive base period. The agency or its designee uses the qualifying medical expenses to meet the spenddown liability. To qualify for this exception, the program must:

(a) Not be federally funded or make ((the)) payments from federally matched funds;

(b) Not pay the expenses ((prior to)) before the first day of the retroactive base period; and

(c) Provide proof of the expenses paid on the person's behalf ((of the individual)).

(10) Once the agency or its designee ((has determined that)) determines the expenses ((meet the definition of)) are a qualified medical expense ((as defined in)) under subsection (8) or (9) of this section, the expenses are subtracted from the spenddown liability to determine the date the ((individual is eligible)) person's eligibility for medical coverage ((to)) begins. Qualifying medical expenses are deducted in the following order:

(a) First, medicare and other health insurance deductibles, coinsurance charges, enrollment fees, copayments, and premiums that are the ((individual's)) person's responsibility under medicare Part A((, Part B, Part C and)) through Part D. (Health insurance premiums are income deductions under WAC 182-519-0100(5));

(b) Second, medical expenses incurred and paid by the ((individual)) person during the three-month retroactive base period if eligibility for ((medical assistance)) WAH was not established in that base period;

(c) Third, current payments on, or unpaid balance of, medical expenses incurred ((prior to)) before the current base period ((which have not been)) that were not used to establish eligibility for medical coverage in ((any other)) another base period. The agency or its designee sets no limit on the age of an unpaid expense; however, the expense must ((still)) be a current liability and be unpaid at the beginning of the base period;

(d) Fourth, other medical expenses that ~~((would not be))~~ are not covered by the agency's or its designee's medical programs, minus any third-party payments ~~((which))~~ that apply to the charges. A licensed health care provider must provide or prescribe the items or services allowed as a medical expense ~~((must have been provided or prescribed by a licensed health care provider))~~;

(e) Fifth, other medical expenses ~~((which have been))~~ incurred by the ~~((individual))~~ person during the base period that are potentially payable by the MN program (minus any confirmed third-party payments that apply to the charges)~~((7))~~. This deduction is allowed even if payment is denied for these services because they exceed the agency's or its designee's limits on amount, duration, or scope of care. Scope of care is described in WAC 182-501-0060 and 182-501-0065; and

(f) Sixth, other medical expenses ~~((that have been))~~ incurred by the ~~((individual))~~ person during the base period that are potentially payable by the MN program (minus any confirmed third-party payments that apply to the charges) and that are within the agency's or its designee's limits on amount, duration, or scope of care.

(11) If ~~((an individual))~~ a person submits verification of qualifying medical expenses with his or her application that meet~~((s))~~ or exceed~~((s))~~ the spenddown liability, ~~((he or she))~~ the person is eligible for MN medical coverage for the remainder of the base period unless their circumstances change. See WAC 388-418-0005 to determine which changes must be reported to the agency or its designee. The beginning of eligibility is determined ~~((as described in))~~ under WAC 182-504-0020.

(12) If ~~((an individual))~~ a person cannot meet the spenddown amount ~~((at the time))~~ when the application is submitted, the ~~((individual))~~ person is not eligible until he or she provides proof of additional qualifying expenses that meet the spenddown liability.

(13) Each dollar of a qualifying medical expense may count once against a spenddown period that leads to eligibility for MN coverage. However, medical expenses may be used more than once ~~((under the following circumstances))~~ if:

(a) The ~~((individual))~~ person did not meet his or her total spenddown liability and become eligible in a previous base period and the bill remains unpaid; or

(b) The medical expense was ~~((a bill))~~ incurred and paid within three months of the current application, and the agency or its designee could not establish WAH eligibility ~~((for medical assistance))~~ for the ~~((individual))~~ person in the retroactive base period.

(14) The ~~((individual))~~ person must provide the proof of qualifying medical expense~~((s))~~ information to the agency or its designee~~((The deadline for providing medical expense information is))~~ within thirty days after the base period ends, unless there is a good reason for delay.

(15) Once ~~((an individual))~~ a person meets the spenddown requirement and the certification begin date ~~((has been))~~ is established, newly identified expenses ~~((cannot be))~~ are not considered toward that spenddown unless:

(a) There is a good reason for the delay in submitting the expense; or ~~((there was an error by))~~

(b) The agency or its designee ~~((in))~~ made an error when determining the correct begin date.

(16) Good reasons for delay in providing medical expense information to the agency or its designee include, but are not limited to:

(a) The ~~((individual))~~ person did not receive a timely bill from his or her medical provider or insurance company;

(b) The ~~((individual))~~ person has medical issues that prevent~~((s))~~ him or her from submitting proof ~~((in a timely manner))~~ on time; or

(c) The ~~((individual))~~ person meets the criteria for needing a supplemental accommodation under chapter 388-472 WAC.

~~((17))~~ The agency or its designee ~~((is not responsible to))~~ does not pay for any expense or portion of an expense ~~((that has been))~~ used to meet ~~((an individual's))~~ a person's spenddown liability.

~~((18))~~ If an expense is potentially payable under the MN program, and only a portion of the medical expense ~~((has been))~~ is assigned to meet spenddown, the medical provider ~~((may))~~ must not:

~~((a))~~ Bill the ~~((individual))~~ person for more than the amount ~~((which was))~~ assigned to the remaining spenddown liability~~((,))~~ ; or

~~((b))~~ Accept or retain any additional amount for the covered service from the ~~((individual))~~ person. Any additional amount may be billed to the agency or its designee. See WAC 182-502-0160, Billing a client.

~~((18))~~ ~~((19))~~ (19) The agency or its designee determines whether any payment is due to the medical provider on medical expenses ~~((that have been))~~ partially assigned to meet a spenddown liability~~((, according to))~~ under WAC 182-502-0100.

~~((19))~~ ~~((20))~~ (20) If the medical expense assigned to spenddown was incurred outside of a period of MN eligibility, or if the expense is not ~~((the type that is))~~ covered by ~~((the agency's or its designee's medical assistance programs))~~ WAH, the agency or its designee ~~((is not responsible for))~~ does not pay any portion of the bill.