Medicaid State Plan - Attachment 2

Groups Covered and Eligibility Determinations

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State Definition of a Health Maintenance Organization:

A "Health Maintenance organization" is: any organization receiving a certificate of registration or a certificate of authority by the insurance commissioner which provides comprehensive health care services to enrolled participants on a group practice per capita prepayment basis or on a prepaid individual practice plan or otherwise accepts prepayment for health care services and which qualifies as a health maintenance. organization pursuant to chapter 48.46 Revised Code of Washington (RCW) or as a health care service contractor pursuant to chapter 48.44 RCW: or the Washington Basic Health Plan operating pursuant to chapter 70.47 RCW.

An Health Maintenance Organization also meets the requirements of 42 CFR 434.20 (c)(2).

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GROUPS COVERED AND AGENCIES RESPONSIBLE FOR
ELIGIBILITY DETERMINATIONS

Agency*	Citation(s)	Groups Covered

PAGE 1 SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

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Agency*	Citation(s)	Groups Covered
IV-A		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
		2. Deemed Recipients of AFDC.
1902(a)(10)(A)(i)(I) Of the Act		*b & c SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS. SEE S14. S25. S28, S30, S51, S53, S54, S55*
406(h) and 1902(a)(10)(A)(i)(I) of the Act		d. An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of section 406(h) of the Act.
1902(a) of the Act		e. Individuals deemed to be receiving AFDC who meet the requirements of section 473(b)(1) or (2) for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made under title IV-E of the Act.

*Agency that determines eligibility for coverage.

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Agency*	Citation(s)	Groups Covered
IV-A	A.	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
407(b), 1902 (a)(10)(A)(i) And 1905(m)(l)	3.	Qualified Family Members *SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS SEE S14, S25, S28, S30, S51, S53, S54, S55*
1902(a)(52) and 1925 of the Act	4.	Families terminated from AFDC solely because of earnings, hours of employment, or loss of earned income disregards entitled up to twelve months of extended benefits in accordance with section 1925 of the Act. (This provision expires on September 30, 1998.)

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Citation(s)	Groups Covered
	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
1902(a)(10)(A)(i)(V) and 1905(m) of the Act	*10. SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS SEE S14, S25, S28, S30, S51, S53, S55*
1902(e)(5) of the Act	11. a. A woman who, while pregnant, was eligible for, applied for, and receives Medicaid under the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.
1902(e)(6) of the Act	b. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.

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COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
42 CFR 435.117 1902(e)(4) of the Act	12. A child born in the United States to a woman who was eligible for and receiving Medicaid (including coverage of an alien for labor and delivery as emergency medical services) for the date of the child's birth, including retroactively. The child is deemed eligible for one year from birth.
42 CPR 435.120	13. Aged, Blind and Disabled Individuals Receiving Cash Assistance _X_ a. Individuals receiving SSI. This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981 persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act. _X_ Aged _X_ Blind _X_ Disabled

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Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
435.121 1619(b)(1) of the Act		13. / / b. Individuals who meet more restrictive requirements for Medicaid than the SSI requirements. (This includes persons who qualify for benefits under section 1619(a) of the Act or who meet the requirements for SSI status under section 1619(b)(1) of the Act and who met the State's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under section 1619(a) or met the requirements under section 1619(b)(1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the 1619(a) eligibility standard or the requirements of section 1619(b) of the Act.) ___ Aged ___ Blind ___ Disabled The more restrictive categorical eligibility criteria are described below: (Financial criteria are described in ATTACHMENT 2.6-A).

*Agency that determines eligibility for coverage.

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Agency*	Citation(s)	Groups Covered
SSI		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	1902(a)(10)(A)(i)(II) and 1905(q) of the Act	14. Qualified severely impaired blind and disabled individuals under age 65, who- a. For the month preceding the first month of eligibility under the requirements of section 1905 (q) (2) of the Act, received SSI, a State supplemental payment under section 1616 of the Act or under section 212 of P.L. 93-66 or benefits under section 1619 (a) of the Act and were eligible for Medicaid; or b. For the month of June 1987, were considered to be receiving SSI under section 1619(b) of the Act and were eligible for Medicaid. These individuals must- (1) Continue to meet the criteria for blindness or have the disabling physical or mental impairment under which the individual was found to be disabled; (2) Except for earnings, continue to meet all non-disability-related requirements for eligibility for SSI benefits; (3) Have unearned income in amounts that would not cause them to be ineligible for a payment under section 1611(b) of the Act;

*Agency that determines eligibility for coverage.

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Agency*	Citation(s)	Groups Covered
SSI	A.	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
		(4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and
		(5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.
		/ / Not applicable with respect to individuals receiving only SSP because the State either does not make SSP payments or does not provide Medicaid to SSP-only recipients.

* Agency that determines eligibility for coverage.

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Agency*	Citation(s)		Groups Covered
		A.	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
1619(b)(3) of the Act		/ /	The state applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under section 1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under section 1619(b)(1) of the Act and who met the State's more restrictive requirements in the month before the month they qualified for SSI under section 1619(a) or met the requirements of section 1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under section 1619(a) of the Act or meet the SSI requirements under section 1619(b)(1) of the Act.

*Agency that determines eligibility for coverage.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Agency*	Citation(s)	Groups Covered
SSI		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
1634(c) of the Act		15. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who-- a. Are at least 18 years of age; b. Lose SSI eligibility because they become entitled to OASDI child's benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility. / / c. The State applies more restrictive eligibility requirements than those under SSI, and part or all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility. / / d. The State applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility.
42 CFR 435.122		16. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional State supplements (if the agency Provides Medicaid under S435.230), because of requirements that do not apply under title XIX of the Act.
42 CFR 435.130		17. Individuals receiving mandatory State supplements.

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Agency*	Citation(s)	Groups Covered
SSI	A.	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
42 CFR 435.131	18.	Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the State's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for having his or her needs included in computing the cash payment.

/X/ In December 1973, Medicaid coverage of the essential spouse was limited to the following group(s):

X Aged X Blind X Disabled

/ / Not applicable. In December 1973, the essential spouse was not eligible for Medicaid.

*Agency that determines eligibility for coverage.

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Agency*	Citation(s)	Groups Covered
SSI	A.	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
42 CFR 435.132	19.	Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they-- a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and b. Remain institutionalized; and c. Continue to need institutional care.
42 CFR 435.133	20.	Blind and disabled individuals who- a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and b. Were eligible for Medicaid in December 1973 as blind or disabled; and c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.

*Agency that determines eligibility for coverage.

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Agency*	Citation(s)	Groups Covered
SSI	A.	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
42 CFR 435.134	21.	Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.
		/X/ Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).
		/X/ Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).
		/ / Not applicable with respect to intermediate care facilities; the State did or does not cover this service.

*Agency that determines eligibility for coverage.

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Agency*	Citation(s)	Groups Covered
SSI		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
42 CFR 435.135		22. Individuals who - a. Are receiving OASDI and were receiving SSI/SSP but became ineligible for SSI/SSP after April 1977; and b. Would still be eligible for SSI or SSP if cost-of-living increases in OASDI paid under section 215(i) of the Act received after the last month for which the individual was eligible for and received SSI/SSP and OASDI, concurrently, were deducted from income. / / Not applicable with respect to individuals receiving only SSP because the State either does not make such payments or does not provide Medicaid to SSP-only recipients. / / Not applicable because the State applies more restrictive eligibility requirements than those under SSI. / / The State applies more restrictive eligibility requirements than those under SSI and the amount of increase that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.

*Agency that determines eligibility for coverage.

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Agency*	Citation(s)	Groups Covered
SSI		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
1634 of the Act		23. Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21. and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634(b) of the Act.
		/ / Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.
		/ / The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equaling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.

*Agency that determines eligibility for coverage.

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Agency*	Citation(s)	Groups Covered
SSI	A.	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
1634(d) of the Act	24.	Disabled widows, disabled widowers, and disabled unmarried divorced spouses who had been married to the insured individual for a period of at least ten years before the divorce became effective, who have attained the age of 50, who are receiving title II payments, and who because of the receipt of title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive title II payments, who would be eligible for SSI or SSP if the amount of the title II benefit were not counted as income, and who are not entitled to Medicare Part A.
	___	The State applies more restrictive eligibility requirements for its blind or disabled than those of the SSI program.
	___	In determining eligibility as categorically needy, the State disregards the amount of the title II benefits identified in §1634(d)(1)(A) in determining the income of the individual, but does not disregard any more of this income than would reduce the individual's income to the SSI income standard.
	___	In determining eligibility as categorically needy, the State disregards only part of the amount of the benefits identified in §1634(d)(1)(A) in determining the income of the individual, which amount would not reduce the individual's income below the SSI income standard. The amount of these benefits to disregarded is specified in Supplement 4 to Attachment 2.6-A.
	___	In determining eligibility as categorically needy, the State chooses not to deduct any of the benefit identified in §1634(d)(1)(A) in determining the income of the individual.

*Agency that determines eligibility for coverage.

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Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
	1902(a)(10(E)(i), 1905(p) and 1860D-14(a)(3)(D) of the Act	25. Qualified Medicare beneficiaries- a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under section 1818A of the Act); b. Whose income does not exceed 100 percent of the Federal poverty level; and c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer index. (Medical assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of this plan.)
	1902(a)(10)(E)(ii), 1905(p)(3)(A)(i) And 1905(s) of the Act	26. Qualified disabled and working individuals- a. Who are entitled to hospital insurance benefits under Medicare Part A under section 1818A of the Act; b. Whose income does not exceed 200 percent of the Federal poverty level; and

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Agency*	Citation(s)	Groups Covered
		A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued) a. Whose resources do not exceed two times the SSI resource limit. a. Who are not otherwise eligible for medical assistance under Title XIX of the Act. (Medical assistance for this group is limited to Medicare Part A premiums under section 1818A of the Act.)
	1902(a)(10)(E)(iii), 1905(p)(3)(A)(ii), and 1860D-14(a)(3)(D) of the Act	27. Specified Low-Income Medicare Beneficiaries -- a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act); b. whose income is greater than 100 percent but less than 120 percent of the Federal poverty level; and c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index. (Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)

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Agency*	Citation(s)	Groups Covered
	A.	Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
1902(a)(10)(E)(iv) and 1905(p)(3)(A)(ii) and 1860D-14(a)(3)(D) of the Act	28.	Qualifying Individuals -- a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act); b. whose income is at least 120 percent but less than 135 percent of the Federal poverty level; c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.

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Agency*	Citation(s)	Groups Covered
IV-A	B.	Optional Groups Other Than the Medically Needy
42 CFR 435.210 1902 (a) (10)(A)(ii) and 1905(a) of the Act	/ /	1. Individuals described below who meet the income and resources requirements of AFDC, SSI, or an optional state supplement as specified in 42 CFR 435.230, but who do not receive cash assistance.
Section 1902 (V)(1) (42 U.S.C. 1396a)		/ / The plan covers individuals not receiving SSI who the State finds blind or disabled and who are determined otherwise eligible for assistance during the period of time prior to which a final determination of disability or blindness is made by Social Security Administration. The State applies the definitions of disability and blindness found in Section 1614 (a) of the Social Security Act.
42 CFR	/X/	2. Individuals who would be eligible for AFDC, SSI or an optional State supplement as specified in 42 CFR 435.230, if they were not in a medical institution.

*Agency that determines eligibility for coverage

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Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
42 CFR 435.212 & 1902(e)(2) of the Act, P.L. 99-272 (section 9517) P.L. 101-508 (section 4732)	___	3. The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act, or a managed care organization (MCO), or a primary care case management organization (PCCM) program, but who have enrolled in the entity for less than the minimum enrollment period listed below. Coverage under this section is limited to HMO or PCCM services and family planning services described in section 1905(a)(4)(C) of the Act.

_X_ The State elects not to guarantee eligibility.

___ The State elects to guarantee eligibility. The minimum enrollment period is _____ months (not to exceed six).

The State measures the minimum enrollment period from:

___ The date beginning the period of enrollment in the HMO or PCCM, without any intervening disenrollment, regardless of Medicaid eligibility.

___ The date beginning the period of enrollment in the HMO or PCCM as a Medicaid patient (including periods when payment is made under this section), without any intervening disenrollment.

___ The date beginning the last period of enrollment in the HMO or PCCM as a Medicaid patient (not including periods when payment is made under this section), without any intervening disenrollment of periods of enrollment as a privately paying patient. (A new minimum enrollment period begins each time the individual becomes Medicaid eligible other than under this section.)

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Agency*	Citation(s)	Groups Covered
1932(a)(4) of the Act	B.	Optional Groups Other Than the Medically Needy (Continued) The Medicaid Agency may elect to restrict the disenrollment rights of Medicaid enrollees of MCOs, PIHPs, PAHPs, and PCCMs in accordance with the regulations at 42 CFR 438.56. This requirements applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible. ___ Disenrollment rights are restricted for a period of ___ months (not to exceed 12 months). During the first three months of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least once per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment. _X_ No restrictions upon disenrollment rights.
1903(m)(2)(H), 1902 (a)(52) of the Act P.L. 101-508 42 CFR 438.56(g)		In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with an MCO, PIHP, PAHP, or PCCM when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract. _X_ The agency elects to reenroll the above individuals who are ineligible in a month but in the succeeding two months become eligible, into the same entity in which they were enrolled at the time eligibility was lost. ___ The agency elects not to reenroll above individuals into the same entity in which they were previously enrolled.

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Agency*	Citation(s)		Groups Covered
IV-A	B.		Optional Groups Other Than the Medically Needy (Continued)
42 CFR 435.217	X	4.	A group or groups of individuals who would be eligible for Medicaid under the plan if they were in a NF or an ICF/MR, who but for the provision of home and community-based services under a waiver granted under 42 CFR Part 441, Subpart G would require institutionalization, and who will receive home and community-based services under the waiver. The group or groups covered are listed in the waiver request. This option is effective on the effective date of the State's section 1915(c) waiver under which this group(s) is covered. In the event an existing 1915(c) waiver is amended to cover this group(s), this option is effective on the effective date of the amendment.
	X	5.	PACE enrollees

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Agency*	Citation(s)	Groups Covered
IV-A	B.	Optional Groups Other Than the Medically Needy (Continued)
1902(a)(10)(A)(ii)(VII) of the Act	/X/	5. Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act. /X/ The State covers all individuals as described above. / / The State covers only the following group or groups of individuals: ___ Aged ___ Blind ___ Disabled ___ Individuals under the age of-- ___ 21 ___ 20 ___ 19 ___ 18 ___ Caretaker relatives ___ Pregnant women

*Agency that determines eligibility for coverage.

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Agency*	Citation(s)	Groups Covered

PAGE 14 SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

SEE S14, S25, S28, S30, S51, S53, S54, S55

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Agency*	Citation(s)	Groups Covered

PAGE 14a SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

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Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

SSI
42 CFR 435.230 /X/ 10. States using SSI criteria with agreements under sections 1616 and 1634 of the Act.

The following groups of individuals who receive only a State supplementary payment (but no SSI payment) under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.

c. Available to all individuals in the State.

d. Paid to one or more of the classifications of individuals listed below, who would be eligible for SSI except for the level of their income.

X (1) All aged individuals.

X (2) All blind individuals.

X (3) All disabled individuals.

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Agency*	Citation(s)		Groups Covered
	B.		Optional Groups Other Than the Medically Needy (Continued)
	X	(4)	Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.
SSI 42 CFR 435.230	X	(5)	Blind individuals in domiciliary facilities or other group living arrangements as refined under SSI.
	X	(6)	Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.
	X	(7)	Individuals receiving a Federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
	___	(8)	Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.
	___	(9)	Individuals in additional classifications approved by the Secretary as follows:

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Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
SSI		The supplement varies in income standard by political subdivisions according to cost-of-living differences. _X_ Yes. ___ No. The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

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Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

42 CFR 435.121
435.230
1902(a)(10)
(A)(ii)(XI)
of the Act

/ /

11. Section 1902(8 States and SSI criteria States without agreements under section 1616 or 1634 of the Act.

The following groups of individuals who receive a State supplementary payment under an approved optional State supplementary payment program that meets the following conditions. The supplement is--

a. Based on need and paid in cash on a regular basis.

b. Equal to the difference between the individual's countable income and the income standard used to determine eligibility for the supplement.

c. Available to all individuals in each classification and available on a Statewide basis.

d. Paid to one or more of the classifications of individuals listed below:

___ (1) All aged individuals.

___ (2) All blind individuals.

___ (3) All disabled individuals.

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Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

___ (4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.

___ (5) Blind individuals in domiciliary facilities or other group living arrangements as defined under SSI.

___ (6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.

___ (7) Individuals receiving federally administered optional State supplement that meets the conditions specified i 42 CPR 435.230.

___ (8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CPR 435.230.

___ (9) Individuals in additional classifications approved by the Secretary as follows:

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Agency*	Citation(s)	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

The supplement varies in income standard by political subdivisions according to cost-of-living differences.

___ Yes

___ No

The standards for optional State supplementary payments are listed in Supplement 6 of ATTACHMENT 2.6-A.

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Agency*	Citation(s)		Groups Covered
		B.	Optional Groups Other Than the Medically Needy (Continued)
SSI 42 CFR 435.231 1902(a)(10) (A)(ii)(V) of the Act	/X/	12.	Individuals who are in institutions for at least 30 consecutive days and who are eligible under a special income level. Eligibility begins on the first day of the 30-day period. These individuals meet the income standards specified in Supplement 1 to ATTACHMENT 2.6-A.
		/X/	The state covers all individuals as described above.
		/ /	The state covers only the following group or groups of individuals:
1902(a)(10)(A) (ii) and 1905(a) of the Act			___ Aged ___ Blind ___ Disabled ___ Individuals under the age of-- ___ 21 ___ 20 ___ 19 ___ 18 ___ Caretaker relatives ___ Pregnant women

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Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
1902(e)(3) of the Act	/ /	13. Certain disabled children age 18 or under who are living at home, who would be eligible for Medicaid under the plan if they were in a. *institution, and for whom the State has made a determination as required under section 1902(e)(3)(B) of the Act. *medical institution Supplement 3 to ATTACHMENT 2.2-A describes the method that is used to determine the cost effectiveness of caring for this group of disabled children at home.
IV-A 1902(a)(10)(A)(ii)(IX) And 1902(l) Of the Act	/ /	14.*Superseded by Medicaid MAGI Eligibility & Benefits See S14, S25, S24, S30, S51, S54, S55*

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Agency*	Citation(s)	Groups Covered

PAGE 21 SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

SEE S14, S25, S28, S30, S51, S53, S54, S55

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Agency*	Citation(s)	Groups Covered
		B. Optional Groups Other Than the Medically Needy (Continued)
1902(a)(ii)(X) and 1902(m)(1) and (3) of the Act	/ /	16. Individuals-- a. Who are 65 years of age or older or are disabled, as determined under section 1614(a)(3) of the Act. Both aged and disabled individuals are covered under this eligibility group. b. Whose income does not exceed the income level (established at an amount up to 100 percent of the Federal income poverty level) specified in Supplement 1 to ATTACHMENT 2.6-A for a family of the same size; and c. Whose resources do not exceed the maximum amount allowed under SSI; under the State's more restrictive financial criteria; or under the State's medically needy program as specified in ATTACHMENT 2.6-A.

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Citation(s)	Groups Covered

PAGE 1 SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS12

SEE S14, S25, S28, S30, S51, S53, S54, S55

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Citation	Groups Covered
	B. Optional Groups Other Than the Medically Needy (Continued)
1906 of the Act	18. Individuals required to enroll in cost-effective employer-based group health plans remain eligible for a minimum enrollment period of _____ months.
1902(a)(10)(F) and 1902(u)(1) of the Act	19. Individuals entitled to elect COBRA continuation coverage and whose income as determined under Section 1612 of the Act for purposes of the SSI program, is no more than 100 percent of the Federal poverty level, whose resources are no more than twice the SSI resource limit for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid expenditures for an equivalent set of services. See Supplement 11 to Attachment 2.6-A.

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Citation	Groups Covered

PAGE 23b SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

SEE S14, S25, S28, S30, S51, S53, S54, S55

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Citation	Groups Covered

B. Optional Groups Other Than the Medically Needy (Continued)

20. *SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS SEE S14, S25, S28, S30, S51, S53, S54, S55*

_X_ 21. A child under age _19_ who has been determined eligible for a total of _12_ months regardless of changes in circumstances other than the attainment of the maximum age stated above.

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Citation			Groups Covered
	B.		Optional Groups Other Than the Medically Needy (Continued)
1902(a)(10)(A)(ii)(XVIII) of the Act	X	(24)	Women who: (a) Have been screened for breast cancer under the Centers for Disease Control and Prevention and Cervical Cancer Early Detection Program established under title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that Act and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix; (b) Are not otherwise covered under creditable coverage, as defined in section 2701(c) of the Public Health Service Act; (c) Are not eligible for Medicaid under any mandatory categorically needy eligibility group; and (d) Have not attained age 65.
1920B of the Act	___	(25)	Women who are determined by a “qualified entity” (as defined in 1920B (b) based on preliminary information, to be a woman described in 1902 (aa) the Act related to certain breast and cervical cancer patients. The presumptive period begins on the day that the determination is made. The period ends on the date that the State makes a determination with respect to the woman’s eligibility for Medicaid, or if the woman does not apply for Medicaid (or a Medicaid application was not made on her behalf) by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on that last day.

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Citation		Groups Covered
	B.	Optional Groups Other Than the Medically Needy (Continued)
1902(a)(10)(A)(ii)(XIII) of the Act	/ /	23. BBA Work Incentives Eligibility Group - Individuals with a disability whose net family income is below 250 percent of the Federal poverty level for a family of the size involved and who, except for earned income, meet all criteria for receiving benefits under the SSI program. See page 12c of Attachment 2.6-A.
1902(a)(10)(A)(ii)(XV) of the Act	/X/	24. TWWIIA Basic Coverage Group - Individuals with a disability at least 16 but less than 65 years of age whose income and resources do not exceed a standard established by the State. See page 12d of Attachment 2.6-A..
1902(a)(10)(A)(ii)(XVI) of the Act	/X/	25. TWWIIA Medical Improvement Group - Employed individuals at least 16 but less than 65 years of age with a medically improved disability whose income and resources do not exceed a standard established by the State. See page 12h of Attachment 2.6-A.. NOTE: If the State elects to cover this group, it MUST also cover the Basic Coverage Group described in no. 24 above.

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Agency*	Citation(s)	Groups Covered
IV-A	C.	Optional Coverage of the Medically Needy
42 CFR 435.301		This plan includes the medically needy. / / No. /X/ Yes. This plan covers:
	1.	Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.
1902(e) of the Act	2.	Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60th day falls.
1902(a)(10)(C)(ii)(I) of the Act	3.	Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902(a)(10)(A)(i) of the Act.

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Agency*	Citation(s)	Groups Covered

C. Optional Coverage of the Medically Needy (Continued)

4. RESERVED

42 CFR 435.308

5. /X/ a. Financially eligible individuals who are not described in section C.3. above and who are under the age of--

___ 21
___ 20
_X_ 19
___ 18 or under age 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training

/X/ b. Reasonable classifications of financially eligible individuals under the ages of 21, 20, 19, or 18 as specified below:

_X_ (1) Individuals for whom public agencies are assuming full or partial financial responsibility and who are:

_X_ (a) In foster homes (and are under the age of _21_).

_X_ (b) In private institutions (and are the age of _21_).

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Agency*	Citation(s)	Groups Covered

C. Optional Coverage of the Medically Needy (Continued)

X (c) In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of 21).

X (2) Individuals in adoptions subsidized in full or part by a public agency (who are under the age of 21),

X (3) Individuals in NFs (who are under the age of 21). NF services are provided under this plan.

X (4) In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of 21).

X (5) Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of 21). Inpatient psychiatric services for individuals under age 21 are provided under this plan.

___ (6) Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.

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Agency*	Citation(s)		Groups Covered
		C.	Optional Coverage of the Medically Needy (Continued)
IV - A	42 CFR 435.310	6.	Caretaker Relatives
IV – A	42 CFR 435.320 and 42 CFR 435.330	XX 7.	Aged Individuals
IV - A	42 CFR 435.322 and 42 CFR 435.330	XX 8.	Blind individuals
IV - A	42 CFR 435.324 and 42 CFR 435.330	XX 9.	Disabled individuals
	42 CFR 435.326	10.	Individuals who would be eligible if they were not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.
	42 CFR 435.326	11.	Blind and disabled individuals who: a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; b. Were eligible as medically needy in December 1973 as blind or disabled; and c. For each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria.

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Citation(s)	Groups Covered
	C. Optional Coverage of the Medically Needy (Continued)
1906 of the Act	12. Individuals required to enroll in cost effective employer-based group health plans remain eligible for a minimum enrollment period of _____ months.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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REQUIREMENTS RELATING TO DETERMINING ELIGIBILITY FOR MEDICARE PRESCRIPTION DRUG LOW-INCOME SUBSIDIES

Citation	Groups Covered
1935(a) and 1920(a)(66) 42 CFR 423.774 And 423.904	The agency provides for making Medicare prescription drug Low Income Subsidy determinations under Section 1935(c) of the Social Security Act. 1. The agency makes determinations of eligibility for premium and cost sharing subsidies under and in accordance with section 1860D-14 of the Social Security Act. 2. The agency provides for informing the Secretary of such determinations in cases in which such eligibility is established or redetermined. 3. The agency provides for screening of individuals for Medicare cost-sharing described in Section 1905(p)(3) of the Act and offering enrollment to eligible individuals under the State Plan or under a waiver of the State Plan.

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REASONABLE CLASSIFICATIONS OF INDIVIDUALS UNDER
THE AGE OF 21, 20, 19, AND 18

PAGE SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

SEE S14, S25, S28, S30, S51, S53, S54, S55

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THERE IS NO SUPPLEMENT 2 TO ATTACHMENT 2.2-A

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Method for Determining Cost Effectiveness of Caring for
Certain Disabled Children At Home

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State WASHINGTON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	A. General Conditions of Eligibility
	Each individual covered under the plan:
42 CFR Part 435, Subpart G	1. Is financially eligible (using the methods and standards described in Parts B and C of this Attachment) to receive services.
42 CFR Part 435, Subpart F	2. Meets the applicable non-financial eligibility conditions.
	a. For the categorically needy:
	(i) Superseded by Medicaid MAGI Eligibility & Benefits See S14, S25, S28, S30, S51, S53, S54, S55
	(ii) For SSI-related individuals, meets the non-financial criteria of the SSI program or more restrictive SSI-related categorically needy criteria.
1902(m) of the Act	*(iii) Superseded by Medicaid MAGI Eligibility & Benefits See S14, S25, S28, S30, S51, S53, S54, S55*
	(iv) For financially eligible aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, meets the non-financial criteria of section 1902(m) of the Act.

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Citation	Condition or Requirement
	b. For the medically needy, meets the non-financial eligibility conditions of 42 CFR Part 435.
1905(p) of the Act	c. For financially eligible qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, meets the non-financial criteria of section 1905(p) of the Act.
1905(s) of the Act	d. For financially eligible qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, meets the non-financial criteria of section 1905(s).
42 CFR 435.406	3. a - f *Superseded by Medicaid MAGI Eligibility & Benefits See S14, S25, S28, S30, S51, S53, S54, S55*

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Citation	Condition or Requirement

PAGE 2a SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

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PAGE 2B SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

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Citation	Condition or Requirement

PAGE 3 SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

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Citation	Condition or Requirement
42 CFR 435.1008	5. a. Is not an inmate of a public institution. Public institutions do not include medical institutions, nursing facilities and intermediate care facilities for the mentally retarded, or publicly operated community residences that serve no more than 16 residents, or certain child care institutions.
42 CFR 435.1008 1905(a) of the Act	b. Is not a patient under age 65 in an institution for mental diseases except as an inpatient under age 22 receiving active treatment in an accredited psychiatric facility or program. / / Not applicable with respect to individuals under age 22 in psychiatric facilities or programs. Such services are not provided undo. the plan.
42 CFR 433.145 1912 of the Act	6. Is required, as a condition of eligibility, to assign his or her own rights, or the rights of any other person who is eligible for Medicaid and on whose behalf the individual has legal authority to execute an assignment to medical support and payments for medical care from any third party. (Medical support is defined as support specified as being for medical care by a court or administrative order.)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Citation		Condition or Requirement
		An applicant or recipient must also cooperate in establishing the paternity of any eligible child and in obtaining medical support and payments for himself or herself and any other person who is eligible for Medicaid and on whose behalf the individual can make an assignment; except that individuals described in §1902(1)(1)(A) of the Social Security Act (pregnant women and women in the postpartum period) are exempt from these requirements involving paternity and obtaining support. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate. An applicant or recipient must also cooperate in identifying any third party who may be liable to pay for care that is covered under the State plan and providing information to assist in pursuing these third parties. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate. / / Assignment of rights is automatic because of State law.
42 CFR 435.910	7.	Is required, as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number). Exception, aliens seeking medical assistance for the treatment of an emergency medical condition under Section 1903(v)(2) of the Social Security Act (Section 1137(f).

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Citation	Condition or Requirement

PAGE 3B SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

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Citation	Condition or Requirement
1906 of the Act	10. Is required to apply for enrollment in an employer-based cost-effective group health plan, if such plan is available to the individual. Enrollment is a condition of eligibility except for the individual who is unable to enroll on his/her own behalf (failure of a parent to enroll a child does not affect a child's eligibility).
U.S. Supreme Court case New York State Department Of Social Services v. Dublino 413 U.S. (1973)	11. Is required to apply for coverage under Medicare Parts A, B and/or D if it is likely that the individual would meet the eligibility criteria for any or all or those programs. The state agrees to pay any applicable premiums and cost-sharing (except those applicable under Part D) for individuals required to apply for Medicare. Application for Medicare is a condition of eligibility unless the state does not pay the Medicare premiums, deductibles or co-insurance (except those applicable under Part D) for persons covered by the Medicaid eligibility group under which the individual is applying.

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Citation(s)	Condition or Requirement
	B. Post-eligibility Treatment of Institutionalized Individuals' Incomes
	1. The following items are not considered in the post-eligibility process:
1902(0) of the Act	a. SSI and SSP benefits paid under §1611(e)(1)(E) and (G) of the Act to individuals who receive care in a hospital, nursing home, SNF, or ICF.
Bondi v. Sullivan (SSI)	b. Austrian Reparation Payments (pension (reparation) payments made under §500 - 506 of the Austrian General Social Insurance Act). Applies only if State follows SSI program rules with respect to the payments.
1902(r)(1) of the Act	c. German Reparations Payments (reparation payments made by the Federal Republic of Germany).
105/206 of P. L. 100-383	d. Japanese and Aleutian Restitution Payments.
1. (a) of P.L. 103-286	e. Netherlands Reparation Payments based on Nazi, but not Japanese, persecution (during World War II).
10405 of P.L. 101-239	f. Payments from the Agent Orange Settlement Fund or any other fund established pursuant to the settlement in the In re Agent orange product liability litigation, M.D.L. No.381 (E.D.N.Y.)
6(h)(2) of P.L. 101-426	g. Radiation Exposure Compensation.
12005 of P. L. 103-66	h. VA pensions limited to $90 per month under 38 U.S.C. 5503.

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Citation	Condition or Requirement
1924 of the Act 435.725 435.733 435.832	2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual's or couple's income to the cost of institutionalized care: Personal Needs Allowance (PNA) of not less than $30 For Individuals and $60 For Couples For All Institutionalized Persons. a. Aged, blind, disabled: Individuals $57.28 Couples $114.56 For the following persons with greater need: Supplement 12 to Attachment 2.6-A describes the greater need describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met. b. AFDC related: Children $57.28 Adults $57.28 For the following persons with greater need: Supplement 12 to Attachment 2.6-A describes the greater need describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met. c. Individual under age 21 covered in the plan as specified in Item B.7. of Attachment 2.2 -A.. $57.28

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Citation	Condition or Requirement
	For the following persons with greater need: Supplement 12 to Attachment 2.6-A describes the greater need describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.
1924 of the Act	3. In addition to the amounts under item 2. , the following monthly amounts are deducted from the remaining income of an institutionalized individual with a community spouse: a. The monthly income allowance for the community spouse, calculated using the formula in §1924(d)(2), is the amount by which the maintenance needs standard exceeds the community spouse's income. The maintenance needs standard cannot exceed the maximum prescribed in §1924 (d)(3)(C). The maintenance needs standard consists of a poverty level component plus an excess shelter allowance. _X_ The poverty level component is calculated using the applicable percentage (set out §1924(d)(3)(B) of the Act) of the official poverty level. ___ The poverty level component is calculated using a percentage greater than the applicable percentage, equal to %, of the official poverty level (still subject to maximum maintenance needs standard). ___ The maintenance needs standard for all community spouses is set at the maximum permitted by §1924(d)(3)(C). Except that, when applicable, the State will set the community spouse's monthly income allowance at the amount by which exceptional maintenance needs, established at a fair hearing; exceed the community spouse's income, or at the amount of any court-ordered support.

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State WASHINGTON

Citation	Condition or Requirement

In determining any excess shelter allowance, utility expenses are calculated using:

_X_ the standard utility allowance under §5(e) of the Food Stamp Act of 1977 or

___ the actual unreimbursable amount of the community spouse's utility expenses less any portion of such amount included in condominium or cooperative charges.

b. The monthly income allowance for other dependent family members living with the community spouse is:

_X_ one-third of the amount by which the poverty level component (calculated under §1924(d)(3)(A)(i) of the Act, using the applicable percentage specified in §1924 (d)(3)(B)) exceeds the dependent family member's monthly income.

___ a greater amounted calculated as follows:

The following definition is used in lieu of the definition provided by the Secretary to determine the dependency of family members under §1924 (d)(1): N/A

c. Amounts for health care expenses described below that are incurred by and for the institutionalized individual and are not subject to payments by a third party:

(i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.

(ii) Necessary medical or remedial care recognized under State law but not covered under the State, plan. (Reasonable limits on amounts are described in Supplement-3 to ATTACHMENT 2.6-A.)

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Citation	Condition or Requirement
435.725 435.733 435.832	4. In addition to any amounts deductible under the items above, the following monthly amounts are deducted from the remaining monthly income of an institutionalized individual or an institutionalized couple: a. An amount for the maintenance needs of each member of a family living in the institutionalized individual's home with no community spouse living in the home. The amount must be based on a reasonable assessment of need but must not exceed the higher of the: • AFDC level or • Medically needy level: (Check one) ___ AFDC levels in Supplement 1 _X_ Medically needy level in Supplement 1 ___ Other: $ b. Amounts for health care expenses described below that have not been deducted under 3.c. above (i.e., for an institutionalized individual with a community spouse), are incurred by and for the institutionalized individual or institutionalized couple, and are not subject to the payment by a third party: (i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments. (ii) Necessary medical or remedial care recognized under State law but not covered under the State plan. (Reasonable limits on amount are described in Supplement 3 to ATTACHMENT 2.6-A.)
435.725 435.733 435.832	5. At the option of the State, as specified below, the following is deducted from any remaining monthly income of an institutionalized individual or an institutionalized couple: A monthly amount for the maintenance of the home of the individual or couple for not longer than 6 months if a physician has certified that the individual, or one member of the institutionalized couple, is likely to return to the home within that period: ___ No _X_ Yes (the applicable amount is shown on page 5a.)

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Citation	Condition or Requirement
	_X_ Amount for maintenance of home is: 100% FPL ___ Amount for maintenance of home is the actual maintenance costs not to exceed $_____. ___ Amount for maintenance of home is deductible when countable income is determined under §1924(d)(1) of the Act only if the individual's home and the community spouse's home are different. ___ Amount for maintenance of home is not deductible when countable income is determined under §1924 (d)(1) of the Act.
	6. SSI benefits paid under section 1611(e)(1)(E) and (G) of the Act to individuals who receive care in a hospital or nursing facility.
	7. Except as provided under Section 1924 of the Act, the policies reflected in C. apply. See Supplement 13 for additional policies related to Section 1924.

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Citation(s)	Condition or Requirement
42 CFR 435.711 435.721, 435.831	C. Financial Eligibility For individuals who are AFDC or SSI recipients, the income and resource levels and methods for determining countable income and resources of the AFDC and SSI program apply, unless the plan provides for more restrictive levels and methods than SSI for SSI recipients under section 1902(f) of the Act, or more liberal methods under section 1902(r)(2) of the Act, as specified below. For individuals who are not AFDC or SSI recipients in a non-section 1902(f) State and those who are deemed to be cash assistance recipients, the financial eligibility requirements specified in this section C apply.

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Citation	Condition or Requirement
X	Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for mandatory and optional categorically needy poverty level related groups, and for medically needy groups.
___	Supplement 7 to ATTACHMENT 2.6-A specifies the income levels for categorically needy aged, blind and disabled persons who are covered under requirements more restrictive than SSI.
___	Supplement 4 to ATTACHMENT 2.6-A specifies the methods for determining income eligibility used by States that have more restrictive methods than SSI, permitted under section 1902 (f) of the Act.
___	Supplement 5 to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that have more restrictive methods than SSI, permitted under section 1902 (f) of the Act.
X	Supplement 8a to ATTACHMENT 2 .6-A specifies the methods for determining income eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902(r)(2) of the Act.
X	Supplement 8b to ATTACHMENT 2.6-A specifies the methods for determining resource eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under section 1902 (r) (2) of the Act.
X	Supplement 8c to ATTACHMENT 2.6A specifies the method of determining resource eligibility for a person qualifying for the State's long-term care partnership permitted under sections 1902(r)(2) and 1917 of the Act.
___	Supplement 14 to ATTACHMENT 2.6-A specifies income levels used by States for determining eligibility of Tuberculosis-infected individuals whose eligibility is determined under §1902 (z) (1) of the Act.

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation	Condition or Requirement
1902(r)(2) of the Act	1. Methods of Determining Income a. AFDC-related individuals (except for poverty level related pregnant women, infants, and children). (1) & (2) Superseded by Medicaid MAGI Eligibility & Benefits. See S14, S25, S28, S30, S51, S54, S55
1902(e)(6) the Act	(3) Agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.

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Citation(s)	Condition or Requirement
42 CFR 435.721 435.831, and 1902(m)(1)(B)(m)(4) and 1902(r)(2) of the Act	b. Aged individuals. In determining countable income or aged individuals, including aged individuals with incomes up to the Federal poverty level described in section 1902(m)(1) of the Act, the following methods are used: ___ The methods of the SSI program only. _X_ The methods of the SSI program and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

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Citation(s)	Condition or Requirement
	/ / For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 206-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.
	/ / For institutional couples, the methods specified under section 1611(e)(5) of the Act.
	/ / For optional State supplement recipients under section 435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A.
	/ / For optional State supplement, recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements –
	____ SSI methods only
	____ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.
	____ Methods more restrictive an/or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.
	In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses.

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Citation	Condition or Requirement
42 CFR 435.721 and 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act	c. Blind individuals. In determining countable income for blind individuals, the following methods are used: ___ The methods of the SSI program only. _X_ SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. ___ For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A, and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. ___ For institutional couples, the methods specified under section 1611(e)(5) of the Act. ___ For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A. ___ For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements- ___ SSI methods only. ___ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A. ___ Methods more restrictive and/ or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.

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Citation(s)		Condition or Requirement
		In determining relative responsibility, the agency Considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.
42 CFR 435.721, and 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act	d.	Disabled individuals. In determining countable income of disabled individuals, including individuals with incomes up to the Federal poverty level described in section 1902(m) of the Act the following methods are used:
		___ The methods of the SSI program.
		_X_ SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.
		___ For institutional couples: the methods specified under section 1611(e)(5) of the Act.
		___ For optional State supplement recipients under §435.230: income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A.
		___ For individuals other than optional State supplement recipients (except aged and disabled individuals described in section 1903(m)(1) of the Act): more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.

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Citation	Condition or Requirement
	___ For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 Agreements-- ___ SSI methods only. ___ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A. ___ Methods more restrictive and/or more liberal than SSI, except for aged and disabled individuals described in section 1902(m)(1) of the Act. More restrictive methods are described in Supplement-4-to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8a to ATTACHMENT 2.6-A. In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.

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Citation(s)	Condition or Requirement

PAGE 11A SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

SEE S14, S25, S28, S30, S51, S53, S54, S55

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)	Condition or Requirement
	(2) Superseded by Medicaid MAGI Eligibility & Benefits. See S14, S25, S28, S30, S51, S53, S54, S55 .
1902(e)(6) of the Act	(3) The agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.
1905(p)(1), 1902(m)(4), and 1902(r)(2) of the Act	f. Qualified Medicare beneficiaries. In determining countable income for qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, the following methods are used: _X_ The methods of the SSI program only. ___ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A. ___ For institutional couples, the methods specified under section 1611(e)(5) of the Act.

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Citation	Condition or Requirement
	If an individual receives a title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level. For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period. For individuals not receiving title II income, the revised poverty levels are effective no later than the date of publication.
1905(s) of the Act	g. (1) Qualified disabled and working individuals. In determining countable income for qualified disabled and working individuals covered under 1902(a)(10)(E)(ii) of the Act, the methods of the SSI program are used.
1905(p) of the Act	(2) Specified low-income Medicare beneficiaries. In determining countable income for specified low-income Medicare beneficiaries covered under 1902(a)(10)(E)(iii) of the Act, the same method as in f. is used.

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Citation	Condition or Requirement
1902(u) of the Act	(h) COBRA Continuation Beneficiaries In determining countable income for COBRA continuation beneficiaries, the following disregards are applied: ___ The disregards of the SSI program; ___ The agency uses methodologies for treatment income more restrictive than the SSI program These more restrictive methodologies are described in Supplement 4 to Attachment 2.6. NOTE: For COBRA continuation beneficiaries specific at 1902(u)(4), costs incurred from medical care or for any other type of remedial care shall not be taken into account in determining income, except as provided in section 1612(b)(4)(B)(ii).

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Citation		Condition or Requirement
1902(a)(10)(A) (ii)(XIII) of the Act	(i)	Working Individuals with Disabilities - BBA In determining countable income and resources for working individuals with disabilities under the BBA, the following methodologies are applied: ___ The methodologies of the SSI program. ___ The agency uses methodologies for treatment of income and resources more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 (income) and/or Supplement 5 (resources) to Attachment 2.6-A. ___ The agency uses more liberal income and/or resource methodologies than the SSI program. More liberal methodologies are described in Supplement 8a to Attachment 2.6-A. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A.

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Citation		Condition or Requirement
1902(a)(10)(A) (ii)(XV) of the Act	(ii)	Working Individuals with Disabilities - Basic Coverage Group – TWWIIA In determining financial eligibility for working individuals with disabilities under this provision, the following standards and methodologies are applied: ___ The agency does not apply any income or resource standard. NOTE: If the above option is chosen, no further eligibility-related options should be elected. _X_ The agency applies the following income and/or resource standards): 220% FPL - income standard

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Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XV) of the Act (cont.)	Income Methodologies In determining whether an individual meets the income standard described above, the agency uses the following methodologies. _X_ The income methodologies of the SSI program. ___ The agency uses methodologies for treatment of income that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A. ___ The agency uses more liberal income methodologies than the SSI program. More liberal income methodologies are described in Supplement 8a to Attachment 2.6-A.

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Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XV) of the Act (cont.)	Resource Methodologies In determining whether the individual meets the resource standard described above, the agency uses the following methodologies. Unless one of the following items is checked the agency, under the authority of section 1902(r)(2) of the Act, disregards all funds held in retirement funds and accounts, including private retirement accounts such as IRAs and other individual accounts, and employer-sponsored retirement plans such as 401(k) plans, Keogh plans, and employer pension plans. Any disregard involving retirement accounts is separately described in Supplement 8b to Attachment 2.6-A. ___ The agency disregards funds held in employer-sponsored retirement plans, but not private retirement plans. ___ The agency disregards funds in retirement accounts in a manner other than those described above. The agency's disregards are specified in Supplement 8b to Attachment 2.6-A.

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Citation		Condition or Requirement
1902(a)(10)(A) (ii)(XV) of the Act (cont.)	___	The agency does not disregard funds in retirement accounts.
	___	The agency uses resource methodologies in addition to any indicated above that are more liberal than those used by the SSI program. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A.
	___	The agency uses the resource methodologies of the SSI program.
	___	The agency uses methodologies for treatment of resources that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 5 to Attachment 2.6-A.

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Citation		Condition or Requirement
1902(a)(10)(A) (ii)(XVI) of the Act	(iii)	Working Individuals with Disabilities - Employed Medically Improved Individuals - TWWIIA In determining financial eligibility for employed medically improved individuals under this provision, the following standards and methodologies are applied: ___ The agency does not apply any income or resource standard. NOTE: If the above option is chosen, no further eligibility-related options should be elected. _X_ The agency applies the following income and/or resource standard(s): 220% FPL - income standard

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Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XVI) of the Act (cont.)	Income Methodologies In determining whether an individual meets the income standard described above, the agency uses the following methodologies. _X_ The income methodologies of the SSI program. ___ The agency uses methodologies for treatment of income that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A. ___ The agency uses more liberal income methodologies than the SSI program. More liberal methodologies are described in Supplement 8a to Attachment 2.6-A.

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Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XVI) of the Act (cont.)	Resource Methodologies In determining whether the individual meets the resource standard described above, the agency uses the following methodologies. Unless one of the following items is checked the agency, under the authority of section 1902(r)(2) of the Act, disregards all funds held in retirement funds and accounts, including private retirement accounts such as IRAs and other individual accounts, and employer-sponsored retirement plans such as 401(k) plans, Keogh plans, and employer pension plans. Any disregard involving retirement accounts is separately described in Supplement 8b to Attachment 2.6-A. ___ The agency disregards funds held in employer-sponsored retirement plans, but not private retirement plans. ___ The agency disregards funds in retirement accounts in a manner other than those listed above. The agency's disregards are specified in Supplement 8b to Attachment 2.6-A.

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Citation		Condition or Requirement
1902(a)(10)(A) (ii)(XVI) of the Act (cont.)	___	The agency does not disregard funds in retirement accounts.
	___	The agency uses resource methodologies in addition to any indicated above that are more liberal than those used by the SSI program. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A.
	___	The agency uses the resource methodologies of the SSI program.
	___	The agency uses methodologies for treatment of resources that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 5 to Attachment 2.6-A.

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Citation	Condition or Requirement
1902(a)(10)(A) (ii)(XVI) and 1905(v)(2) of the Act	Definition of Employed – Employed Medically Improved Individuals - TWWIIA

X The agency uses the statutory definition of "employed", i.e., earning at least the minimum wage, and working at least 40 hours per month.

___ The agency uses an alternative definition of "employed" that provides for substantial and reasonable threshold criteria for hours of work, wages, or other measures. The agency's threshold criteria are described below:

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Citation	Condition or Requirement
1902(a)(10)(A)(ii)(XIII), (XV), (XVI), and 1916(g) of the Act	Payment of Premiums or Other Cost Sharing Charges For individuals eligible under the BBA eligibility group described in No. 23 on page 23e of Attachment 2.2-A: ___ The agency requires payment of premiums or other cost-sharing charges on a sliding scale based on income. The premiums or other cost-sharing charges, and how they are applied, are described below:

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Citation	Condition or Requirement
1902(a)(10)(A)(ii)(XIII), (XV), (XVI), and 1916(g) of the Act (cont.)	For individuals eligible under the Basic Coverage Group described in No. 24 on page 23e of Attachments 2.2-A, and the Medical Improvement Group described in No. 25 on page 23e of Attachment 2.2-A: NOTE: Regardless of the option selected below, the agency MUST require that individuals whose annual adjusted gross income, as defined under IRS statute, exceeds $75,000 pay 100 percent of premiums. _X_ The agency requires individuals to pay premiums or other cost-sharing charges on a sliding scale based on income. For individuals with net annual income below 450 percent of the Federal poverty level for a family of the size involved, the amount of premiums cannot exceed 7.5 percent of the individual's income. The premiums or other cost-sharing charges, and how they are applied, are described on page 12o.

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Citation	Condition or Requirement
Sections 1902(a)(10)(A)(ii)(XV), (XVI), and 1916(g) of the Act (cont.)	Premiums and Other Cost-Sharing Charges For the Basic Coverage Group and the Medical Improvement Group, the agency's premium or other cost-sharing charges, and how they are applied, are described below. Individuals pay a monthly premium equal to a total of the following: • 50 percent of unearned income in excess of the medically needy income level • 5 percent of all unearned income • 2.5 percent of earned income after deducting $65 Except that the premium amount shall not exceed 7.5 percent of total income.

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Citation(s)		Condition or Requirement
1902(k) of the Act	2.	Medicaid Qualifying Trusts In the case of a Medicaid qualifying trust described in section 1902(k)(2) of the Act, the amount from the trust that is deemed available to \ the individual who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted under the trust to distribute to the individual. This amount is deemed available to the individual, whether or not the distribution is actually made. This provision does not apply to any trust or initial trust decree established before April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded. /X/ The agency does not count the funds in a trust as described above in any instance where the State determines that it would work an undue hardship. Supplement 10 of ATTACHMENT 2.6-A specifies what constitutes an undue hardship.
1902(a)(10) of the Act	3.	Medically needy income levels (MNILs) are based on family size. Supplement 1 to ATTACHMENT 2.6-A specifies the MNILs for all covered medically needy groups. If the agency chooses more restrictive levels under section 1902(f) of the Act, Supplement 1 so indicates.

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Citation	Condition or Requirement
42 CFR 435.732, 435.831	4. Handling of Excess Income - Spend-down for the Medically Needy in All States and the Categorically Needy in 1902(f) States only a. Medically Needy (1) Income 1n excess of the MNIL is considered as available for payment of medical care and services. The Medicaid agency measures available income for periods of either 3 or 6 month(s) (not to exceed 6 months) to determine the amount of excess countable incoc applicable to the cost of medical care and services. (2) If countable income exceeds the MNIL standard, the agency deducts the following incurred expenses in the following order: (a) Health insurance premiums, deductibles and coinsurance charges. (b) Expenses for necessary medical and remedial care not included in the plan. (c) Expenses for necessary medical and remedial care included in the plan. ___ Reasonable limits on amounts of expense deducted from income under a.(2)(a) and (b) above are listed below. * In determining countable income for the medically needy, costs of health insurance premiums, except Medicare are deducted from monthly income.
1902(a)(17) of the Act	Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

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Citation	Condition or Requirement
1903(f)(2) of the Act	a. Medically Needy (Continued) ___ (3) If countable income exceeds the MNIL standard, the agency deducts spenddown payments made to the State by the individual.

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Citation(s)	Condition or Requirement
	b. Categorically Needy - Section 1902 (f) States
42 CFR 435.732	The agency applies the following policy under the provisions of section 1902(f) of the Act. The following amounts are deducted from income to determine the individual's countable income: (1) Any SSI benefit received. (2) Any State supplement received that is within the scope of an agreement described in section 1616 or 1634 of the Act, or a State supplement within the scope of section 1902(a)(10)(A)(ii)(XI) of the Act. (3) Increases in OASDI that are deducted under §§435.134 and 435.135 for individuals specified in that section, in the manner elected by the State under that section. (4) Other deductions from income described in this plan at Attachment 2.6-A. Supplement 4. (5) Incurred expenses for necessary medical and remedial services recognized under State law.
1902(a)(17) of the Act, P.L. 100-203	Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

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Citation	Condition or Requirement
	4. b. Categorically Needy - Section 1902(f) States (contd)
1903(f)(2) of the Act	___ (6) Spenddown payments made to the State by the individual. NOTE: FFP will be reduced to the extent a State is paid a spenddown payment by the individual.

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Citation	Condition or Requirement

5. Methods for Determining Resources

a. AFDC-related individuals let for poverty level related pregnant women, infants, and children).

(1) In determining countable resources for AFDC-related individuals, the following methods are used:

(a) The methods under the State's approved A plan; and

/ / (b) The methods under the State's approved A plan and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.

(2) In determining relative financial responsibility, the agency considers only t resources of spouses living in the same household as available to spouses and the resources of parents as available to children living-with parents until the children become 21.

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Citation	Condition or Requirement
	5. Methods for Determining Resources
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r) of the Act	b. Aged individuals. For aged individuals covered under section 1902(a)(10)(A)(ii))(X) of the Act, the agency used the following methods for treatment of resources: ___ The methods of the SSI program. _X_ SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A. ___ Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describes the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specifies the more liberal methods.

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Citation		Condition or Requirement
		In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses.
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B), and 1902(r) of the Act	c.	Blind individuals. For blind individuals the agency uses the following methods for treatment of resources: ___ The methods of the SSI program. _X_ SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A. ___ Methods that are more restrictive and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describe the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specify the more liberal methods. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.

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Citation	Condition or Requirement
1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902 (r)(2) of the Act	d. Disabled individuals, including individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act. The agency uses the following methods for the treatment of resources: ___ The methods of the SSI program. _X_ SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. ___ Methods that are more restrictive (except for individuals described in section 1902(m)(1) of the Act) and/or more liberal than those under the SSI program. More restrictive methods are described in Supplement 5 to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8b to ATTACHMENT 2.6-A. In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
1902(l)(3) and 1902(r)(2) of the Act	e. Superseded by Medicaid MAGI Eligibility & Benefits. See S14, S25, S28, S30, S51, S53, S54, S55

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Citation(s)			Condition or Requirement
1905(p)(1) (C) and (D) and 1902(r)(2) of the Act	5.	h.	For Qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) the Act, the agency uses the following methods for treatment of resources:
		X	The methods of the SSI program only.
		___	The methods of the SSI program and/or more liberal methods as described in Supplement 8b to ATTACHMENT 2.6-A.
1905(s) of the Act		i.	For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the agency uses SSI program methods for the treatment of resources.
1902(u) of the Act		j.	For COBRA continuation beneficiaries, the agency uses the following-methods for treatment of resources.
		___	The methods of the SSI program only.
		___	More restrictive methods applied under section 1902(f) of the Act as described in Supplement 5 to Attachment 2.6-A.

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Citation	Condition or Requirement
1902(a)(10)(E)(iii) of the Act	k. Specified low-income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act- The agency uses the same method as in 5.h. of Attachment 2.6-A..
	6. Resource Standard - Categorically Needy
	a. 1902(f) States (except as specified under items 6.c. and d. below) for aged, blind and disabled individuals: ___ Same as SSI resource standards. ___ More restrictive. The resource standards for other individuals are the same as those in the related cash assistance program.
	b. Non-1902(f) States (except as specified under items 6.c. and d. below) The resource standards are the same as those in the related cash assistance program. Supplement 8 to ATTACHMENT 2.6-A specifies for 1902(f) States the categorically needy resource levels for all covered categorically needy groups.

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation		Condition or Requirement
1902(m)(1)(C) and (m)(2)(B) of the Act	e.	For aged and disabled individuals described in section 1902(m)(1) of the Act who are covered under section 1902(a)(10)(A)(ii)(X) of the Act, the resource standard is: ___ Same as SSI resource standards. ___ Same as the medically needy resource standards, which are higher than the SSI resource standards (if the State covers the medically needy). Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels far these individuals.

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Citation	Condition or Requirement
	7. Resource Standard - Medically Needy
	a. Resource standards are based on family size.
1902(a)(10)(C)(i) of the Act	b. A single standard is employed in determining resource resource eligibility for all groups.
	___ c. In 1902(f) States, the resource standards are more restrictive than in 7.b. above for-- ___ Aged ___ Blind ___ Disabled Supplement 2 to ATTACHMENT 2.6-A specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive levels under 7.c., Supplement 2 to ATTACHMENT 2.6-A so indicates.
1902(a)(10)(E), 1905(p)(1)(C), and 1860D-14(a)(3)(D) of the Act	8. Resource Standard - Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries and Qualifying Individuals For Qualified Medicare Beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, Specified Low-Income Medicare Beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act, and Qualifying Individuals covered under 1902(a)(10)(E)(iv) of the Act, the resource standard is three times the SSI resource limit, adjusted annually since 1996 by the increase in the consumer price index.

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Citation	Condition or Requirement
1902(a)(10)(E)(ii), 1905(s) and 1860D-14(a)(3)(D) of the Act	9. Resource Standard - Qualified Disabled and Working Individuals For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the resource standard for an individual or a couple (in the case of an individual with a spouse) is two times the SSI resource limit.
1902(u) of the Act	10. For COBRA continuation beneficiaries, the resource standard is: ___ Twice the SSI resource standard for an individual. ___ More restrictive standard as applied under section 1902(f) of the Act as described in Supplement 8 to Attachment 2.6-A.

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Citation	Condition or Requirement
1902(u) of the Act	10. Excess Resources a. Categorically Needy, Qualified Medicare Beneficiaries, Qualified Disabled and Working Individuals, and Specified Low-Income Medicare Beneficiaries Any excess resources make the individual ineligible. b. Categorically Needy Only X This State has a section 1634 agreement with SSI. Receipt of SSI is provided for individuals while disposing of excess resources. c. Medically Needy Any excess resources make the individual ineligible.

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Citation(s)	Condition or Requirement
42 CFR 435.914	11. Effective Date of Eligibility

a. Groups Other Than Qualified Medicare Beneficiaries

(1) For the prospective period.

Coverage is available for the full month if the following individuals are eligible at any time during the month.

_X_ Aged, blind, disabled.
_X_ AFDC-related

Coverage is available only for the period during the month for which the following individuals meet the eligibility requirements.

___ Aged, blind, disabled.
___ AFDC-related.

(2) For the retroactive period.

Coverage is available for three months before the date of application if the following individuals would have been eligible had they applied:

___ Aged, blind, disabled.
___ AFDC-related.

Coverage is available beginning the first day of the third month before the date of application if the following individuals would have been eligible at any time during that month, had they applied.

_X_ Aged, blind, disabled.
_X_ AFDC-related.

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s)			Condition or Requirement
		____	(3) Superseded by Medicaid MAGI Eligibility & Benefits. See S14, S25, S28, S30, S51, S53, S54, S55
1902(e)(8) and 1905(a) of the Act	_X_	b.	For qualified Medicare beneficiaries defined in section 1905(p)(1) of the Act coverage is available beginning with the first day of the month after the month in which the individual is first determined to be a qualified Medicare beneficiary under section 1905(p)(1). The eligibility determination is valid for-- _X_ 12 months ___ 6 months ___ ___ months (no less than 6 months and no more than 12 months)

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Citation		Condition or Requirement
1902 (a) (18) and 1902 (f) of the Act	12.	Pre-OBRA 93 Transfer of Resources - Categorically and Medically Needy, Qualified Medicare Beneficiaries and Qualified Disabled and Working Individuals. The agency complies with the provisions of section 1917 of the Act with respect to the transfer of resources. Disposal of resources at less than fair market value affects eligibility for certain services as detailed in Supplement 9 to Attachment 2.6-A.
1917(c)	13.	Transfer of Assets - All eligibility groups The agency complies with the provisions of section. 1917 (c) of the Act, as enacted by OBRA 93, with regard to the transfer of assets. Disposal of assets at less than fair market value affects eligibility for certain services as detailed in Supplement 9(a) to ATTACHMENT 2.6-A, except in instances where the agency determines that the transfer rules would work an undue hardship.
1917(d)	14.	Treatment of Trusts - All eligibility groups The agency complies with the provisions of section 1917 (d) of the Act, as amended by OBRA 93, with regard to trusts. ___ The agency uses more restrictive methodologies under section 1902 (f) of the Act, and applies those methodologies in dealing with trusts; ___ The agency meets the requirements in section 1917(d)(f)(B) of the Act for use of Miller trusts. The agency does not count the funds in a trust in any instance where the agency determines that the transfer would work an undue hardship, as described in Supplement 10 to ATTACHMENT 2.6-A.

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Citation		Condition or Requirement
1924 of the Act	15.	The agency complies with the provisions of §1924 with respect to income and resource eligibility and post eligibility determinations for individuals who are expected to be institutionalized for at least 30 consecutive days and who have a spouse living in the community. When applying the formula used to determine the amount of resources in initial eligibility determinations, the State standard for community spouses is: ____ the maximum standard permitted by law; ____ the minimum standard permitted by law; or $45,104 a standard that is an amount between the minimum and the maximum. For the fiscal biennium beginning July 1, 2007, and each biennium thereafter, the maximum resource allowance amount for the community spouse will be adjusted for economic trends and conditions by increasing the amount allowable by the consumer price index as published by the Federal Bureau of Labor Statistics. However, in no case will the amount allowable exceed the maximum resource allowance permissible under the Social Security Act.

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INCOME ELIGIBILITY LEVELS

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INCOME ELIGIBILITY LEVELS (Continued)

3. Aged and Disabled Individuals

The levels for determining income eligibility for groups of aged and disabled individuals under the provisions of section 1902(m)(1) of the Act are as follows:

Based on _____ percent of the official Federal income poverty line.

Family Size	Income Level
1	$_____
2	$_____
3	$_____
4	$_____
5	$_____

4. Special Income Level for Institutionalized Individuals

300 percent of the SSI Federal Benefit Level for en individual in his or her own home who has no income.

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INCOME LEVELS (Continued)

D. MEDICALLY NEEDY

_X_ Applicable to all groups.

___ Applicable to all groups except those specified below. Excepted group income levels are also listed on an attached page 3.

(1) Family Size	(2) Net income level protected for maintenance for _3 or 6_ months	(3) Amount by which Column (2) exceeds limits specified in CFR 435.1007[1/]	(4) Net income level for persons living in rural areas for _____ months	(5) Amount by which Column (4) exceeds limits specified in 42 CFR 435.1007[1/]
___ Urban only				
_X_ Urban & rural				
1	$ 467	$	$	$
2	$ 592	$	$	$
3	$ 667	$	$	$
4	$ 742	$	$	$
For each Additional Person, Add: _____				
_____	$ _____	$ _____	$ _____	$ _____

[1/] The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

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INCOME LEVELS (Continued)

D. MEDICALLY NEEDY

X Applicable to all groups. ___ Applicable to all groups except those specified below. Excepted group income levels are also listed on an attached page 3.

(1) Family Size	(2) Net income level protected for maintenance for 3 or 6 months ___ urban only X urban & rural	(3) Amount by which Column (2) exceeds limits specified in CFR 435.1007[1/]	(4) Net income level for persons living in rural areas for ___ months	(5) Amount by which Column (4) exceeds limits specified in 42 CFR 435.1007[1/]
5	$ 858	$	$	$
6	$ 975	$	$	$
7	$ 1,125	$	$	$
8	$ 1,242	$	$	$
9	$ 1,358	$	$	$
10	$ 1,483	$	$	$
For each Additional Person, Add:				
	$ 0	$	$	$

[1/] The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.

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RESOURCE LEVELS

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4. Aged and Disabled Individuals

/X/ Same as SSI resource levels.

/ / More restrictive than SSI levels and are as follows:

Family Size	Resource Level
1	2,000
2	3,000
3	3,050
4	3,100
5	3,150

/X/ Same as medically needy resource levels (applicable only if State has a medically needy program.

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RESOURCE LEVELS (Continued)

B. MEDICALLY NEEDY

Applicable to all groups—

/ / Except those specified below under the provisions of section 1902(f) of the Act.

Family Size	Resource Level
1	2,000
2	3,000
3	3,050
4	3,100
5	3,150
6	3,200
7	3,250
8	3,300
9	3,350
10	3,400
For each additional person	50

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REASONABLE LIMITS ON AMOUNTS FOR NECESSARY MEDICAL
OR REMEDIAL CARE NOT COVERED UNDER MEDICAID

The deduction for medical and remedial care expenses that were incurred as the result of imposition of a transfer of assets penalty period is limited to zero.

Reasonable and necessary medical expenses not covered by Medicaid, incurred within the three month period prior to the month of application are allowable deductions. Expenses incurred prior to this three month period are not allowable deductions. Institutional long-term care medical expenses are allowed as a deduction at an amount equal to the Medicaid reimbursement rate.

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METHODS FOR TREATMENT OF INCOME THAT DIFFER FROM
THOSE OF THE SSI PROGRAM

(Section 1902(f) more restrictive methods and criteria and State supplement criteria in SSI criteria States without section 1634 agreements and in section 1902(f) States. Use to reflect more liberal methods only if you limit to State supplement recipients. DO NOT USE this supplement to reflect more liberal policies that you elect under the authority of section1902(r)(2) of the Act. Use Supplement 8a for section 1902(r)(2) methods.)

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MORE RESTRICTIVE METHODS OF TREATING RESOURCES
THAN THOSE OF THE SSI PROGRAM – Section 1902 (f) States only

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METHODS FOR TREATMENT OF RESOURCES FOR INDIVIDUALS
WITH INCOMES RELATED TO FEDERAL POVERTY LEVELS

(Do not complete if you are electing more liberal methods under the authority of section 1902(r)(2) of the Act instead of the authority specific to Federal poverty levels. Use Supplement 8b for section 1902(r)(2) methods.)

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FEDERALLY ADMINISTRATED OPTIONAL STATE SUPPLEMENT:
PAYMENT GROUPS/INCOME LEVELS

	Gross Income Level	Standard	SSI Benefit	State Supplement
Statewide Standard – Living Alone/1				
Individuals:	$2,199	$733 773	$733 733	$0 **40
Couples:				
1. Both individuals eligible:	3,041	1100	1100	0
2. Eligible individual w/one Essential person on Rolls before 1/1/74:	**No individuals identified in this category in November 2003			
3. Eligible individual with Ineligible spouse Enrolled after 1/1/74:	2199	773	733	**40

/1: Living alone includes room and board living arrangements.

Statewide Standard – Shared Living (Supplied Housing):				
Individuals:	1,396	489 529	489 489	0 **40
Couples:				
1. Both individuals eligible:	2,199	733	733	0
2. Eligible individual w/one Essential person on Rolls before 1/1/74:	**No individuals identified in this category in November 2003			
3. Eligible individual with Ineligible spouse Enrolled after 1/1/74:	1,396	529	489	40

**Over age 65 or blind

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INCOME LEVELS FOR 1902(f) STATES - CATEGORICALLY NEEDY
WHO ARE COVERED UNDER REQUIREMENTS MORE RESTRICTIVE THAN SSI

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RESOURCE STANDARDS FOR 1902 (f) STATES – CATEGORICALLY NEEDY

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MORE LIBERAL METHODS OF TREATING INCOME
UNDER SECTION 1902 (r) (2) OF THE ACT*

/ / Section 1902(f) State /X/ Non-Section1902 (f) State

1. The following is not considered available income for the Medical'. Needy Program and the Optional Categorically Needy Program as defined in clauses (IV), (V), and (VI) of Section 1902 (a)(10) (A) (ii) of the Social Security Act.

   Effective July 1, 1986, if the community income received in the name of the non-applicant or ineligible spouse, living in a separate residence, exceeds the community income received in the name of the applicant/recipient spouse, the applicant/recipient spouse's interest in that excess is considered unavailable to the applicant/recipient.

2 Superseded by Medicaid MAGI Eligibility & Benefits. See S14, S25, S28, S30, S51, S53, S54, S55

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4. The following income regulation applies to individuals described in subclauses (A) (i) (III), (A) (i) (IV), (A) (i) (VI), (A) (i) (VII)*, (A) (ii), and (C) (i) (III) of subsection 1902(a) (10), and section 1905(p) of the Social Security Act.

   Effective April 1, 1992, to the extent that total gross income does not exceed the limitations in 1903(f), unearned income withheld, prior receipt by the individual, for income tax purposes, or otherwise withheld beyond the individual's control, is considered exempt when determining eligibility.

* Superseded by Medicaid MAGI Eligibility & Benefits. See S14, S25, S28, S30, S51, S53, S54, S55

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5. The following income regulation applies to individuals described in sub clause (C)(i)(III) of subsection 1902(a)(10) of the Social Security Act.

Effective July 1, 1992, income of an individual is exempt in an amount equal to the maintenance allowance of the individual's spouse, living in the same household, who is eligible under clause (VI) of section 1902 (a) (10) (A) (ii) of the Act, less the income of the spouse.

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6. The following applies to individuals covered under Section 1902 (a)(10)(A)(ii)(IV) of the Act, who are defined in 1905 (a) (iii) and (vii).

Disregard income equal to the difference between the Federal Benefit Rate and the Categorically Needy Income Level for individuals and couples as in effect on January 1, 2002 and as described in supplement 6 to Attachment 2.6-A, Page 1.

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MORE LIBERAL METHODS OF TREATING INCOME UNDER
SECTION 1902(r)(2) OF THE ACT

8. A more liberal method of treating income is established for the following Medicare Cost-sharing programs:

(a) Qualified Medicare Beneficiary as described in 1902(a)(10)(E)(i) and 1905 (p)(1) of the Act; and

(b) Specified Low-Income Medicare Beneficiary as described in 1902(a)(10)(E)(iii) and 1905 (p)(3) (A)(ii) of the Act.

When determining the available income of an individual for the above Medicare Cost-sharing programs, the department shall exclude from countable income an amount equal to that expended on medical expenses.

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MORE LIBERAL METHOD OF TREATING INCOME UNDER
SECTION 1902(r)(2) OF THE ACT

9. Effective January 1, 2005, disregard the difference between the medically needy standard described on Supplement 1 to Attachment 2.6-A, page 8 and the SSI benefit for an individual described on Supplement 6 to Attachment 2.6-A, page 1. This applies to all medically needy groups: children, pregnant women, and the aged, blind and persons with disabilities.

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MORE LIBERAL METHODS OF TREATING INCOME UNDER
SECTION 1902(r)(2) OF THE ACT

10. Effective July 1, 2008, disregard the difference between the TANF payment standard by family size, and the AFDC payment standard by family size, as described in Supplement 1 to Attachment 2.6-A, Page 1, of the Medicaid State Plan for institutionalized AFDC-related eligibility groups under 1902(a)(10)(A)(ii)(IV) of the Act.

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MORE LIBERAL METHODS OF TREATING INCOME UNDER
SECTION 1902(r)(2) OF THE ACT

11. Wages paid by the Census Bureau for temporary employment related to census activities are excluded for the following eligibility groups:

_X_* Qualified children and pregnant women under 1902(a)(10)(A)(i)(lll).

_X_* Poverty level pregnant women and infants (133 – 185% FPL) under 1902(a)(10)(A)(i)(IV)

_X_* Poverty level children under age 6 (133 – 185% FPL) under 1902(a)(10)(A)(i)(VI)

_X_* Poverty level children under age 19 (100% FPL) under 1902(a)(10)(A)(i)(VII)

_X_ Optional categorically needy groups under 1902(a)(10)(A)(ii) as listed below.

- 1902(a)(10)(A)(ii)(XI) - recipients of optional State supplemental payments
- 1902(a)(10)(A)(ii)(XV)
- 1902(a)(10)(A)(ii)(XVI)

Note: The Special Income Level Group under 1902(a)(10(A)(ii)(V), the individuals who would be Eligible if an Institution Group under 1902(a)(10)(A)(ii)(VI), and the Hospice Group under 1902(a)(10)(A)(ii)(VII) cannot be included in this disregard.

_X_ Medically Needy under 1902(a)(10)(C)(i)(lll)

___ All aged, blind or disabled groups in 209(b) states under 1902(f).

_X_ QMBs, SLMBs and QIs under 1905(p).

* Removed by Medicaid MAGI Eligibility & Benefits. See S14, S25, S28, S30, S51, S53, S54, S55

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LESS RESTRICTIVE METHODS OF TREATING INCOME UNDER SECTION 1902 (r) (2) OF THE ACT

X For all eligibility groups not subject to the limitations on payment explained in section 1903 (f) of the Act*: All wages paid by the Census Bureau for temporary employment related to Census 2000 activities are excluded.

* Less restrictive methods may not result in exceeding gross income limitations under section 1903(f).

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LESS RESTRICTIVE METHODS OF TREATING INCOME UNDER SECTION 1902(r)(2) OF THE ACT

___ For all eligibility groups subject to 1902(r)(2) and not subject to the limitations on payment explained in 1903(f) of the Act: All otherwise countable income deposited in an IDA account funded under the Assets for Independence Act is excluded.

___ For all eligibility groups subject to 1902(r)(2) and not subject to the limitations on payment explained in 1903(f) of the Act: All otherwise countable income deposited in an IDA account funded under the Assets for Independence Act is excluded.

___ For all eligibility groups subject to 1902(r)(2) and not subject to the limitations on payment explained in 1903(f) of the Act: All interest earned on an IDA account funded under the Assets for Independence Act is excluded.

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MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 19 02 (r) (2) OF THE ACT

[ ] Section 1902 (f) State [X] Non-Section 1902 (f) State

1. The following resource regulation applies to the Medically Needy Program and the Optional Categorically Needy Program as defined in clauses (IV),(V), and (VI) of Section 1902(a)(10)(A)(ii) of the Social Security Act.

   Effective January 10, 1988, it is presumed that one-half of the total resources held jointly by the husband and wife, or held separately by the applicant/recipient, are owned by each spouse. (TN 88-5, Approved 5/4/89 - Washington v. Bowen)

2. To the extent that it does not conflict with Section 1924 of the Social Security Act, the following resource regulation applies to the Medically Needy Program and the Optional Categorically Needy Program as defined in clauses (IV, (V), and (VI) of Section 1902 (a)(10)(A)(ii) of the Social Security Act.

   Effective January 1, 1989, it is presumed that one-half of the total resources held jointly by the husband and wife, or held separately by the applicant/recipient, are owned by each spouse (TN 89-2, Approved 8/17/90)

3. The following resource regulation applies to individuals described in clause (A) (ii) , and subclause (C) (i) (III) of subsection 1902(a)(10) of the Social Security Act.

   Effective August 1, 1993, to the extent that it is not transferred, a sales contract on property that was the principal place of residence at the time of institutionalization is an exempt resource. The contract must provide a reasonable rate of return: 1) the interest is consistent with prevailing rates at the time of the sale; and 2) the payment of amount owed is anticipated within the lifetime of the client but does not exceed thirty years. Both interest and principal received in the form of payments are considered unearned income, unless otherwise exempted.

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MORE LIBERAL METHODS OF TREATING RESOURCES
UNDER SECTION 1902(r)(2) OF THE ACT, Continued.

[ ] Section 1902 (f) State [X] Non-Section 1902 (f) State

4. The following resource regulation applies to individuals described in clauses (A)(ii), and subclause (C)(i)(III) of subsection 1902(a)(10) of the Social Security Act.

Effective July 1, 1990, individuals, non-cash resources, that cannot be expected to be converted into cash within 20 working days, are not considered available to the extent that an ongoing bona fide effort to convert them into cash is unsuccessful. (TN 90-21, Approved 11/5/90)

5. The following resource policy applies to institutionalized individuals eligible under subclauses (IV), (V), and (VI) of clause (A) (ii) of section 1902 (a) (10).

Effective October 1, 1991, non-exempt resources in excess of the Supplemental Security Income (SSI) resource levels found in SUPPLEMENT 2 TO ATTACHMENT 2.6-A, Page 6, can, at the individuals option, be reduced by incurred expenses listed in C. 4. a. (2) of ATTACHMENT 2.6-A (Page 14) as long as such expenses have not been used to reduce excess income. (TN 90-17, Approved 10/4/91)

6. The following resource policy applies to institutionalized individuals eligible under subparagraph (C) of Section 1902 (a) (10).

Effective October 1, 1991,. non-exempt resources in excess of the Medically Needy resource levels found in SUPPLEMENT 2 TO ATTACHMENT 2.6-A, Page 7, can, at the individuals option, be reduced by incurred expenses listed in C. 4. a. (2) of ATTACHMENT 2.6-A (Page 14) as long as such expenses have not been used to reduce excess income. (TN 90-17, Approved 10/4/91)

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7. (Removed by Medicaid Eligibility and Benefits. See S14, S25, S28, S30, S51, S52, S53, & S54

8. The following resource methodology applies to individuals described in sub-clause (C)(i)(III) of subsection 1902(a)(10) of the Social Security Act.

All resources will be excluded in determining eligibility for children under 19 years of age or women who are pregnant.

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9. The following resource methodology applies to SSI-related individuals described in clause (A)(ii), and sub-clause (C)(i)(III) of subsection 1902(a)(10) of the Social Security Act.

Furnishings, clothing, and ordinary household and personal items which provide the essentials of living, basic comfort, and convenience are excluded without limit when determining eligibility.

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MORE LIBERAL METHODS OF TREATING RESOURCES UNDER SECTION 1902 (r) (2) OF THE ACT.

[ ] Section 1902 (f) State [X } Non-Section 1902 (f) State

A resource disregard is given to an aged, blind or disabled person who has purchased a long term care insurance policy approved by the Washington Insurance Commissioner, under Washington Long-Term Care Partnership Program.

The resource disregard shall be equal to the amount paid for licensed nursing facility and/or home and community-based services covered under Medicaid.

Pursuant to Section 1917 (c) (2) (C)(ii), a transfer of resources disregarded under this provision shall not be subject to a penalty period.

If retained, the disregarded resources are subject to Medicaid estate recoveries under Section 1917 (b) (1) (c) (i) of the Act.

Washington State Insurance Commissioner shall ensure that long-term care brokers fully disclose the impact of Medicaid estate recovery to buyers, or potential buyers, of such insurance.

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MORE LIBERAL METHODS OF TREATING RESOURCES UNDER SECTION 1902 (r) (2) OF THE ACT.

[ ] Section 1902 (f) State [X] Non-Section 1902 (f) State

The following applies to all individuals covered under Section 1902 (a) (10) (A) (ii) (I), Section 1902 (a) (10) (C) , and Section 1905 (p) of the Act.

When determining the countable resources for a Holocaust survivor, exclude recoveries of insurance proceeds or other assets.

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LESS RESTRICTIVE METHODS OF TREATING RESOURCES UNDER SECTION 1902(r)(2) OF THE ACT

For all eligibility groups subject to 1902(r)(2) of the Act: All funds in IDA accounts funded under the Assets for Independence Act is excluded.

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STATE LONG-TERM CARE INSURANCE PARTNERSHIP

1902(r)(2) The following more liberal methodology applies to individuals who are 1917(b)(1)(C) eligible for medical assistance under one of the following eligibility groups:

A. Optional categorically needy groups under 1902(a)(10)(A)(ii)(V),(VI)and (VII).

An individual who is a beneficiary under a long-term care insurance policy that meets the requirements of a "qualified State long-term care insurance partnership" policy (partnership policy) as set forth below, is given a resource disregard as described in this amendment. The amount of the disregard is equal to the amount of the insurance benefit payments made to or on behalf of the individual. The term "long-term care insurance policy" includes a certificate issued under a group insurance contract.

a. Disregard during the person's lifetime the value of assets the person designates for protection from recovery in an amount not to exceed the dollar amount of long term care benefits utilized under a partnership policy;

b. Disregard appreciation of or the protected asset's increase in value (including an increase in value due to income, dividends, or profits) for a partnership participant to the extent the increase does not cause the amount of the person's total disregard to exceed the dollar value of benefits utilized under a partnership policy;

c. Disregard additional assets that become available to a partnership participant with an unused amount of asset protection at the time of qualifying for the partnership, up to the dollar amount of long-term care benefits utilized under a partnership policy; and

d. Trusts excluded under 1917(d)(4)(A) and (C) or annuities and similar legal instruments under 1917(e) are excluded from the provision.

_X__ The State Medicaid Agency (Agency) stipulates that the following requirements will be satisfied in order for a long-term care policy to qualify for a disregard. Where appropriate, the Agency relies on attestations by the State Office of the Insurance Commissioner (Commissioner) or other State official charged with regulation and oversight of insurance policies sold in the state, regarding information within the expertise of the Office of the Insurance Commissioner.

(1) The policy is a qualified long-term care insurance policy as defined in section 7702B(b) of the Internal Revenue Code of 1986.

(2) The policy meets the requirements of the long-term care insurance model regulation and long-term care insurance model Act promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000) as those requirements are set forth in section 1917(b)(5)(A) of the Social Security Act.

(3) The policy was issued no earlier than the effective date of this State plan amendment.

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State WASHINGTON

STATE LONG-TERM CARE INSURANCE PARTNERSHIP (cont)

A. The insured individual was a resident of a Partnership State when coverage first became effective under the policy. If the policy is later exchanged for a different long-term care policy, the individual was a resident of a Partnership State when coverage under the earliest policy became effective.

(4) The policy meets the inflation protection requirements set forth in section 1917(b)(1)(C)(iii)(IV) of the Social Security Act.

The Commissioner requires the issuer of the policy to make regular reports to the Secretary that include notification regarding when benefits provided under the policy have been paid and the amount of such benefits paid, notification regarding when the policy otherwise terminates, and such other information as the Secretary determines may be appropriate to the administration of such partnerships.

(5) The State does not impose any requirement affecting the terms or benefits of a partnership policy that the state does not also impose on non-partnership policies.

B. The State Office of the Insurance Commissioner assures that any individual who sells a partnership policy receives training, and demonstrates evidence of an understanding of such policies and how they relate to other public and private coverage of long-term care.

C. The Agency provides information and technical assistance to the State Office of the Insurance Commissioner regarding the training described above.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

TRANSFER OF RESOURCES

1902(f) and 1917 of the Act	The agency provides for the denial of eligibility by reason of disposal of resources for less than fair market value. The criteria specified in Sections 1613(a), 1917(c) and 1924(f) of the Social Security Act are followed.

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b. / / The period of ineligibility is less than 24 months, as specified below:

c. / / The agency has provisions for waiver of denial of eligibility in any instance where the State determines that a denial would work an undue hardship.

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2. Transfer of the home of an individual who is an inpatient in a medical institution.

/ / A period of ineligibility applies to inpatients in an SNF, ICF or other medical institution as permitted under section 1917(c)(2)(B)(i).

a. Subject to the exceptions on page 2 of this supplement, an individual is ineligible for 24 months after the date on which he disposed of the home. However, if the uncompensated value of the home is less than the average amount payable under this plan for 24 months of care in an SNF, the period of ineligibility is a shorter time, bearing a reasonable relationship (based on the average amount payable under this plan as medical assistance for care in an SNF) to the uncompensated value of the home as follows:

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b. / / Subject to the exceptions on page 2 of this supplement, if the uncompensated value of the home is more than the average amount payable under this plan as medical assistance for 24 months of care in an SNF, the period of ineligibility is more than 24 months after the date on which he disposed of the home. The period of ineligibility bears a reasonable relationship (based upon the average amount payable under this plan as medical assistance for care in an SNF) to the uncompensated value of the home as follows:

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No individual is ineligible by reason of item A.2 if-

(i) A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual can reasonably be expected to be discharged from the medical institution and to return to that home;

(ii) Title to the home was transferred to the individual's spouse or child who is under age 21. or (for States eligible to participate in the State program under title XVI of the Social Security Act) is blind or permanently and totally disabled or (for States not eligible to participate in the State program under title XVI of the Social Security Act) is blind or disabled as defined in section 1614 of the Act;

(iii) A satisfactory showing is made to the agency (in accordance with any regulations of the Secretary of Health and Human Services) that the individual intended to dispose of the home either at fair market value or for other valuable consideration; or

(iv) The agency determines that denial of eligibility would work an undue hardship.

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3. 1902(f) States

/ / Under the provisions of section 1902(f) of the Social Security Act, the following transfer of resource criteria more restrictive than those established under section 1917(c) of the Act, apply:

B. Other than those procedures specified elsewhere in the supplement, the procedures for implementing denial of eligibility by reason of disposal of resources for less than fair market value are as follows:

1. If the uncompensated value of the transfer is $12,000 or less:

2. If the uncompensated value of the transfer is more than $12,000:

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3. If the agency sets a period of ineligibility of less than 24 months and applies it to all transfers of resources (regardless of uncompensated value):

4. Other procedures:

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TRANSFER OF ASSETS

1917 (c) The agency provides for the denial of certain Medicaid services by reason of disposal of assets for less than fair market value.

1. Institutionalized individuals may be denied certain Medicaid services upon disposing of assets for less than fair market value en or after the look-back date.

The agency withholds payment to institutionalized individuals for the following services:

Payments based on a level of cars in a nursing facility;

Payments based on a nursing facility level of care in a medical institution;

Home and community-based services under a 1915 waiver.

2. Non-institutionalized individuals:

___ The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section - 1905 (a) of the Social Security Act:

The agency withholds payment to non-institutionalized individuals for the following services:

Home health services (section 1905(a)(7);

Home and community care for function-ally disabled and elderly adults (section 1905(a) 22);

Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

___ The following other long-term care services for which medical assistance is otherwise under the agency plan:

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TRANSFER OF ASSETS

3. Penalty Date-The beginning date of each penalty period imposed for an uncompensated transfer of assets is:

X the first day of the month in which transferred;

___ the first day of the month following the month of transfer.

4. Penalty Period - Institutionalized Individuals-
In determining the penalty for an institutionalized individual, the agency uses:

X the average monthly cost to a private patient of nursing facility services in the agency;

___ the average monthly - cost to a private patient of nursing facility services in the community in which the individual is institutionalized.

5. Penalty Period - Non-institutionalized Individuals-
The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services; imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

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TRANSFER OF ASSETS

6. Penalty period for amounts of transfer less than cost of nursing facility care

a. Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency:

___ Does not impose a penalty;

X Imposes a penalty for less than a full month, based on the proportion of the agency's private nursing facility rate that was transferred.

b. Where an individual makes a series of transfers, each less than the private nursing facility rate for a month, the agency:

___ Does not impose a penalty;

X Imposes a series of penalties, each for less that a full month.

7. Transfers made so that penalty periods would overlap
The agency:

___ Totals the value of all assets transferred to produce a single penalty period;

X Calculates the individual penalty periods and imposes them sequentially.

8. Transfers made so that penalty periods would not overlap
The agency:

_X_ Assigns each transfer its own penalty period;

___ Uses the method outlined below:

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TRANSFER OF ASSETS

9. Penalty periods – transfer by a spouse that results in a penalty period for the individual-

(a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

When both spouses are institutionalized, the agency will divide any existing period of ineligibility between the spouses. When both spouses are in a nursing facility, the period of ineligibility may be divided by two with each spouse assigned one-half of the total number of months of ineligibility. When one spouse is receiving community-based services, such spouse may be assigned a greater number of months of ineligibility than the spouse in a nursing facility.

(b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

10. Treatment of income as an asset-
When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

___ The agency will impose partial month penalty periods.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

___ For transfers of individual income payments, the agency will impose partial month penalty periods.

_X_ For transfers of the right to an income stream, the agency will use the actuarial value of all payments transferred.

___ The agency uses an alternate method to calculate penalty periods, as described below:

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11. Imposition of a penalty would work an undue hardship-
The agency does not apply the transfer of assets provisions in any case in which the agency determines that such an application would work an undue hardship. The agency will use the following procedures in making undue hardship determinations:

When the client has transferred assets, the agency reviews the client's situation with the client or the client's representative and makes a determination whether the denial of eligibility would create undue hardship. If undue hardship exists, the client's transfer of assets is disregarded. Such decision must be made within forty-five days of the initial application.

If the client is denied, the client is sent a written notice of the agency's decision within forty-five days of the initial application which includes notice the client is entitled to request a fair hearing on the agency's decision.

The following criteria will be used to determine whether the agency will not count assets transferred because the penalty would work an undue hardship:

Undue hardship means that the application of the transfer penalty would result in the client's inability to meet shelter, food, clothing and health care needs.

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TRANSFER OF ASSETS

1917(c) **FOR TRANSFERS OF ASSETS FOR LESS THAN FAIR MARKET VALUE MADE ON OR AFTER FEBRUARY 8, 2006,** the agency provides for the denial of certain Medicaid services.

1. Institutionalized individuals are denied coverage of certain Medicaid services upon disposing of assets for less than fair market value on or after the look-back date.

   The agency does not provide medical assistance coverage for institutionalized individuals for the following services:

   Nursing facility services

   Nursing facility level of care provided in a medical institution

   Home and community-based services under a 1915(c) or (d) waiver

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TRANSFER OF ASSETS (cont.)

2. Non-institutionalized individuals

__ The agency applies these provisions to the following non-institutionalized eligibility groups. These groups can be no more restrictive than those set forth in section 1905(a) of the Social Security Act:

The agency withholds payment to non-institutionalized individuals for the following services:

Home health services (section 1905(a)(7));

Home and community care for functionally disabled elderly adults (section 1905(a)(22));

Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

__ The following other long-term care services for which payment for medical assistance is otherwise made under the agency plan:

The agency withholds payment to non-institutionalized individuals for the following service:

Program of All Inclusive Care for the Elderly (PACE)

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TRANSFER OF ASSETS (cont.)

3. Penalty Date--The beginning date of each penalty period imposed for an uncompensated transfer of assets is:

   1. For individuals applying for Medicaid payment of long-term care services, the date on which the individual is eligible for medical assistance under the State plan and would otherwise be receiving institutional level care services described in paragraph 1 that, were it not for the imposition of the penalty period, would be covered by Medicaid (based on an approved application for such care);

   or

   2. For individuals receiving Medicaid payment for long-term care services, the first day of the month following 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:

   and

   - Which does not occur during any other period of ineligibility for services by reason of a transfer of assets penalty.

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State WASHINGTON

TRANSFER OF ASSETS (cont.)

4. Penalty Period - Institutionalized Individuals

In determining the penalty for an institutionalized individual, the agency uses:

_X_ The average monthly cost to a private patient of nursing facility services in the State at the time of application;

___ The average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized at the time of application.

5. Penalty Period - Non-institutionalized Individuals
-

The agency imposes a penalty period determined by using the same method as is used for an institutionalized individual, including the use of the average monthly cost of nursing facility services:

___ Imposes a shorter penalty period than would be imposed for institutionalized individuals, as outlined below:

6. Penalty period for amounts of transfer less than cost of nursing facility care

_X__ Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency imposes a penalty for less than a full month, based on the option selected in item 4.

_X_ The state adds together all transfers for less than fair market value made during the look-back period in more than one month and calculates a single period of ineligibility, that begins on the earliest date that would otherwise apply if the transfer had been made in a single lump sum.

7. Penalty periods - transfer by a spouse that results in a penalty period for the individual

(a) The agency apportions any existing penalty period between the spouses using the method outlined below, provided the spouse is eligible for Medicaid. A penalty can be assessed against the spouse, and some portion of the penalty against the individual remains.

(b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.

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TRANSFER OF ASSETS (cont.)

8. Treatment of a transfer of income

When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value.

When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

_X_ For transfers of individual income payments, the agency will impose partial month penalty periods using the methodology selected in 6. above.

_X_ For transfers of the right to an income stream, the agency will base the penalty period on the combined actuarial value of all payments transferred.

9. Imposition of a penalty would work an undue hardship

The agency does not impose a penalty for transferring assets for less than fair market value in any case in which the agency determines that such imposition would work an undue hardship. The agency will use the following criteria in making undue hardship determinations:

Application of a transfer of assets penalty would deprive the individual:

(a) Of medical care such that the individual's health or life would be endangered; or

(b) Of food, clothing, shelter, or other necessities of life.

10. Procedures for Undue Hardship Waivers

The agency has established a process under which hardship waivers may be requested that provides for:

(a) Notice to a recipient subject to a penalty that an undue hardship exception exists;

(b) A timely process for determining whether an undue hardship waiver will be granted; and

(c) A process, which is described in the notice, under which an adverse determination can be appealed.

These procedures shall permit the facility in which the institutionalized individual is residing to file an undue hardship waiver application on behalf of the individual with the consent of the individual or the individual's personal representative.

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TRANSFER OF ASSETS (cont.)

11. Bed Hold Waivers For Hardship Applicants

The agency provides that while an application for an undue hardship waiver is pending in the case of an individual who is a resident of a nursing facility:

___ Payments to the nursing facility to hold the bed for the individual will be made for a period not to exceed_____ days (may not be greater than 30).

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CONSIDERATION OF MEDICAID QUALIFYING TRUSTS – UNDUE HARDSHIP

The agency does not apply the trust provisions in any case in which the agency determines that such application would work an undue hardship.

The following criteria will be used to determine whether the agency will not apply the trust provisions because doing so would work an undue hardship:

Undue hardship means the application of the trust provisions would result in the client's inability to meet shelter, food, clothing and health care needs.

Under the agency's undue hardship provisions, the agency exempts, the funds in an irrevocable burial trust.

The maximum value of the exemption for an irrevocable burial trust is
$_____.

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Citation	Condition or Requirement
	COST EFFECTIVENESS METHODOLOGY FOR COBRA CONTINUATION BENEFICIARIES
1902(u) of the Act	Premium payments are made by the agency only if such payments are likely to be cost-effective. The agency specifies the guidelines used in determining cost effectiveness by selecting one of the following methods. ___ The methodology as described in SMM section 3598. ___ Another cost-effective methodology as described below.

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VARIATIONS FROM THE BASIC PERSONAL NEEDS ALLOWANCE (PNA)

1. The PNA is increased for persons who reside in a Medicaid-certified state operated VA Home based on these higher needs.

   A VA Home is usually located more than 50 miles from the person's last community residence prior to institutionalization, resulting in additional expenses for transportation and communication;

   VA Homes provide opportunities for the resident's involvement in the governance of programs for a multiple facility organization. This requires extra funds for inter-facility travel and additional expenses.

   The PNA is increased to $70.00 for persons residing in a VA Home who are subject to provisions in 1902(r)(1)(B) of the Social Security Act and receive a veteran's pension in excess of $90.00 per month.

   The PNA is increased to $160.00 for persons residing in a VA Home who are not eligible to receive a veteran's pension in excess of $90.00 per month as described in 1902(r)(1)(B) of the Social Security Act.

2. The PNA is increased by the amount of income garnished for child support subject to the following limitations:

   The increase applies only to a garnishment made in the same time period covered by the PNA.

   The increase does not apply to any amount of the garnishment that is deducted under another provision in the post-eligibility process.

3. The PNA is increased for persons participating in a department-approved training or rehabilitative work program. These persons retain earned income to meet the needs of work-related expenses, such as, clothing, transportation or special tools/equipment, etc.

   The person's retained income plus the usual PNA may not exceed a one-person MNIL.

4 The PNA is increased for an institutionalized person's income tax under the following limitations. The withholdings from earned or unearned income are necessary to meet expected Federal, State or local income tax liability.

   Federal, State, or local income taxes that are not covered by earned or unearned income withholding but are owed or have been paid.

   The person's income tax deduction plus the usual PNA may not exceed the one-person MNIL.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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VARIATIONS FROM THE BASIC PERSONAL NEEDS ALLOWANCE

Disclosure Statement for Post-Eligibility Preprint

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is #0938-0673. The time required to complete this information collection is estimated at 3 hours per response, including the time to review instructions, searching existing data resources, gathering the date needed and completing and reviewing the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestion for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland, 21244-1850 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C., 20503.

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The following resource regulation applies to individuals described in clause (A)(ii), and subclause (C)(i)(III) of subsection 1-02(a)(10) of the Social Security Act.

Effective July 1, 1990, individuals, non-cash resources, that cannot be expected to be converted into cash within 20 working days, are not considered available to the extent that an ongoing bona fide effort to convert them into cash is unsuccessful.

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LESS RESTRICTIVE RESOURCE METHODS ALLOWED UNDER 1902(r) OF THE SOCIAL SECURITY ACT.

The following resource policy applies to institutionalized individuals eligible under subclauses (IV), (V), and (VI) of clause (A)(ii) of section 1902(a)(10).

Effective October 1, 1991, non-exempt resources in excess of the Supplemental Security Income (SSI) resource levels found in SUPPLEMENT 2 TO ATTACHMENT 2.6-A, Page 2, can, at the individual's option, be reduced by incurred expenses listed in C. 4. a. (2) of ATTACHMENT 2.6-A (Page 11) as long as such expenses have not been used to reduce excess income.

The following resource policy applies to institutionalized individuals eligible under subparagraph (C) of section 1902(a)(10).

Effective October 1, 1991, non-exempt resources in excess of the Medically Needy resource levels found in SUPPLEMENT 2 TO ATTACHMENT 2.6-A, Page 1, can, at the individual's option, be reduced by incurred expenses listed in C.4.a.(2) of ATTACHMENT 2.6-A (Page 11) as long as such expenses have not been used to reduce excess income.

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ELIGIBILITY UNDER SECTION 1931 OF THE ACT

PAGE SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

SEE S14, S25, S28, S30, S51, S53, S54, S55

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Citation	Condition or Requirement
	Section 1924 Provisions
	A. Income and resource eligibility policies used to determine eligibility for institutionalized individuals who have spouses living in the community are consistent with Section 1924.
	B. In the determination of resource eligibility the State resource standard is the maximum resource allowance permissible under section 1924 of the Social Security Act.
	C. The definition of undue hardship for purposes of determining if institutionalized spouses receive Medicaid in spite of having excess countable resources is described below.
	Undue hardship means the client's inability to meet shelter, food, clothing, and health care needs.

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

This supplement describes the individuals with greater need; describes the greater need; describes the basis or formula for determining the deductible.

Personal Needs Allowance for Title XVI-related individuals with greater need - Work Related.

1. Individuals participating in a department approved training or rehabilitative work program.

2. These individuals retain earned income to meet the needs for work related expenses, such as, clothing, transportation, special tools/equipment, etc.

3. The retained income plus personal needs allowance may not exceed a one person MINIL.

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INCOME AND RESOURCE REQUIREMENTS FOR TUBERCULOSIS (TB) INFECTED INDIVIDUALS

PAGE REMOVED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Personal Needs Allowance, cont.

INCOME TAX DEDUCTION.

Under 42 CFR 435 .725 (c) (1), allow the following Personal Needs Allowance (PNA) when combined with other reasonable amounts for clothing and other personal needs of the individual while in the institution, not to exceed the Medically Needy Income Level (MNIL).

1. Withholdings from earned and unearned income necessary to meet expected Federal, State or local tax liability.

2. Federal, State or local income taxes that are not covered by earned or unearned income withholding but are owed or have been paid.

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PERSONAL NEEDS ALLOWANCE - NURSING FACILITY RESIDENTS WITH HIGHER NEEDS

A personal needs allowance (PNA) is allowed for nursing facility residents who require guardianship and/or attorney services. The individual has one or more of the following needs:

1. Guardianship Fees

   Guardianship fees will be allowed under a court order, including an order that establishes or continues a legal guardianship and the order requires a future review or accounting in an amount not to exceed $175.00 per month.

2. Guardianship-related Attorney's Fees

   Attorney's fees are limited to an amount not to exceed $700 for the initial establishment of a guardianship.

   Attorney Fees are limited to an amount not to exceed $600 during any three year period for the review of a guardianship.

3. Unusual cases

   A method is provided to allow greater fees in cases where the court determines after a hearing that the increase is reasonable.

The monthly total amount allowed for guardianship and attorney fees plus all other personal needs allowance may not exceed a one person MNIL.

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PERSONAL NEEDS ALLOWANCE - NURSING FACILITY RESIDENTS WITH HIGHER NEEDS

A personal needs allowance (PNA), of $160.00 per month, is allowed for nursing home residents who meet any four of the five following criteria.

The individual is a resident of a nursing facility that:

1. Is located in excess of 50 miles from the individual's last community residence, prior to Institutionalization, resulting in additional expenses for transportation and communication.

2. Provides regular access, at resident's expense, to long-distance phone services and cable television.

3. In addition to providing nursing care, provides co-located, less intensive services for higher functioning individuals, including integrated social activities for both groups, promoting an active lifestyle that necessitates a higher PNA.

4. Provides on campus access to goods and services, including, but not limited to, a barber shop, commissary and snack bar that allows for normal activities of daily living that necessitates a higher PNA.

5. Provides opportunity for resident's involvement in governance of programs for a multiple facility organization. This requires additional funds for inter-facility travel and additional expenses.

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ASSET VERIFICATION SYSTEM

1940(a) 1. of the Act

The agency will provide for the verification of assets for purposes of determining or re-determining Medicaid eligibility for aged, blind and disabled Medicaid applicants and recipients using an Asset Verification System (AVS) that meets the following minimum requirements.

- The request and response system must be electronic:
  - Verification inquiries must be sent electronically via the internet or similar means from the agency to the financial institution (FI).
  - The system cannot be based on mailing paper-based requests.
  - The system must have the capability to accept responses electronically.
- The system must be secure, based on a recognized industry standard of security (e.g., as defined by the U.S. Commerce Department's National Institute of Standards and Technology, or NIST).
- The system must establish and maintain a database of FIs that participate in the agency's AVS.
- Verification requests also must be sent to FIs other than those identified by applicants and recipients, based on some logic such as geographic proximity to the applicant's home address, or other reasonable factors whenever the agency determines that such requests are needed to determine or re-determine the individual's eligibility.
- The verification requests must include a request for information on both open and closed accounts, going back up to 5 years as determined by the State.

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ASSET VERIFICATION SYSTEM

- System Development

___ A. The agency itself will develop an AVS.

In 3 below, provide any additional information the agency wants to include.

___ B. The agency will hire a contractor to develop an AVS.

In 3 below provide any additional information the agency wants to include.

_X_ C. The agency will be joining a consortium to develop an AVS.

In 3 below, identify the States participating in the consortium. Also, provide any other information the agency wants to include pertaining to how the consortium will implement the AVS requirements.

___ D. The agency already has a system in place that meets the requirements for an acceptable AVS.

In 3 below, describe how the existing system meets the requirements in Section 1.

___ E. Other alternative not included in A. – D. above.

In 3 below, describe this alternative approach and how it will meet the requirements in Section 1.

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ASSET VERIFICATION SYSTEM

- Provide the AVS implementation information requested for the implementation approach checked in Section 2, and any other information the agency may want to include.

  Washington intends to join with Oregon and other willing Western states to create a consortium of states intended to ensure that Medicaid Aged, Blind, and/or Disabled (ABD) asset information housed in financial institutions in cities within Washington and bordering Washington will be located for ABD recipient/applicant asset verification. The consortium will contract with an existing asset verification entity like HMS, Acuity, or some other entity that has existing contracts with Washington border cities and states. Washington is required to put forth a Request for Proposal process when contracting with vendors for services. The system and entity chosen will be able to comply with the following requirements:

  (i) An electronic process for asset verification.

  (ii) A database of financial institutions that provide data to the entity, meeting the geographic requirements of the consortium.

  (iii) A 5-year “look-back” of the assets on individual applicants, recipients, spouses, and partners.

  (iv) A secure system based on a recognized industry standard as defined by the U.S Commerce Department’s National Institute.

  (v) Verification requests will include both open and closed asset account information.

  (vi) The acceptable asset verification entity will provide adequate data for the generation of all required reports expected to meet federal reporting requirements, such as the number of requests, number of responses, and amounts of undisclosed assets found.

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DISQUALIFICATION FOR LONG-TERM CARE ASSISTANCE FOR INDIVIDUALS WITH SUBSTANTIAL HOME EQUITY

1917(f) The State agency denies reimbursement for nursing facility services and other long-term care services covered under the State Plan for an individual who does not have a spouse, child under 21, or adult disabled child residing in the individual's home, when the individual's equity interest in the home exceeds the following amount:

_X_ $500,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000).

___ An amount that exceeds $500,000 but does not exceed $750,000 (increased by the annual percentage increase in urban component of the consumer price index beginning with 2011, rounded to the nearest $1,000).

The amount chosen by the State is _____

_____ This higher standard applies statewide.

_____ This higher standard does not apply statewide. It only applies in the following areas of the State:

_____ This higher standard applies to all eligibility groups.

_____ This higher standard only applies to the following eligibility groups:

The State has a process under which this limitation will be waived in cases of undue hardship.

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METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

The State will determine the appropriate FMAP rate for expenditures for individuals enrolled in the adult group described in 42 CFR 435.119 and receiving benefits in accordance with 42 CFR Part 440 Subpart C. The adult group FMAP methodology consists of two parts: an individual-based determination related to enrolled individuals, and as applicable, appropriate population-based adjustments.

Part 1 – Adult Group Individual Income-Based Determinations

For individuals eligible in the adult group, the state will make an individual income-based determination for purposes of the adult group FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the MAGI Conversion Plan (Part

2) approved by CMS on March 31, 2014. In general, and subject to any adjustments described

in this SPA, under the adult group FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the newly eligible FMAP is not available. The relevant MAGI-converted standards for each population group in the new adult group are described in Table 1.

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Table 1: Adult Group Eligibility Standards and FMAP Methodology Features

Covered Populations Within New Adult Group		**Applicable Population Adjustment**			
Population Group	**Relevant Population Group Income Standard** For each population group, indicate the lower of: 1. The reference in the MAGI Conversion Plan (Part 2) to the relevant income standard and the appropriate cross-reference, or • 133% FPL	**Resource Proxy**	**Enrollment Cap**	**Special Circumstances**	**Other Adjustments**
		Enter "Y" (Yes), "N" (No), or "NA" in the appropriate column to indicate if the population adjustment will apply to each population group. Provide additional information in corresponding attachments.			
A	B	C	D	E	F
Parents/Caretaker Relatives	Attachment A, Column C, Line 1 of Part 2 of the CMS-approved MAGI Conversion Plan, including any subsequent CMS-approved modifications to the MAGI Conversion Plan	No	No	No	No
Disabled Persons, non-institutionalized	Attachment A, Column C, Line 2 of Part 2 of the CMS-approved MAGI Conversion Plan, including any subsequent CMS-approved modifications to the MAGI Conversion Plan	No	No	No	No
Disabled Persons, institutionalized	Attachment A, Column C, Line 3 of Part 2 of the CMS-approved Conversion Plan, including any subsequent CMS-approved modifications to the MAGI Conversion Plan	No	No	No	No
Children Age 19 or 20	Attachment A, Column C, Line 4 of Part 2 of the CMS-approved MAGI Conversion Plan, including any subsequent CMS-approved modifications to the MAGI Conversion Plan	n/a	n/a	n/a	n/a
Childless Adults	Attachment A, Column C, Line 5 of Part 2 of the CMS-approved MAGI Conversion Plan, including any subsequent CMS-approved modifications to the MAGI Conversion Plan	n/a	n/a	Yes	n/a

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Part 2 – Population-based Adjustments to the Newly Eligible Population Based on Resource Test, Enrollment Cap or Special Circumstances

2. **Optional Resource Criteria Proxy Adjustment (42 CFR 433.206(d))**

The state:

__ Applies a resource proxy adjustment to a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

_X_ Does not apply a resource proxy adjustment (Skip items 2 through 3 and go to Section B).

Table 1 indicates the group or groups for which the state applies a resource proxy adjustment to the expenditures applicable for individuals eligible and enrolled under 42 CFR 435.119. A resource proxy adjustment is only permitted for a population group(s) that was subject to a resource test that was applicable on December 1, 2009.

The effective date(s) for application of the resource proxy adjustment is specified and described in Attachment B.

Data source used for resource proxy adjustments:
The state:

__ Applies existing state data from periods before January 1, 2014.

__ Applies data obtained through a post-eligibility statistically valid sample of individuals.

Data used in resource proxy adjustments is described in Attachment B.

Resource Proxy Methodology: to be submitted as a new SPA at a later date.

3. **Enrollment Cap Adjustment (42 CFR 433.206(e))**

1. __ An enrollment cap adjustment is applied by the state (complete items 2 through 4).

X An enrollment cap adjustment is not applied by the state (skip items 2 through 4 and go to Section C).

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2. Attachment C describes any enrollment caps authorized in section 1115 demonstrations as of December 1, 2009 that are applicable to populations that the state covers in the eligibility group described at 42 CFR 435.119 and received full benefits, benchmark benefits, or benchmark equivalent benefits as determined by CMS. The enrollment cap or caps are as specified in the applicable section 1115 demonstration special terms and conditions as confirmed by CMS, or in alternative authorized cap or caps as confirmed by CMS. Attach CMS correspondence confirming the applicable enrollment cap(s).

4. The state applies a combined enrollment cap adjustment for purposes of claiming FMAP in the adult group:

__ Yes. The combined enrollment cap adjustment is described in Attachment C

__ No.

5. Enrollment Cap Methodology: Attachment C describes the methodology for calculating the enrollment cap adjustment, including the use of combined enrollment caps, if applicable.

6. **Special Circumstances (42 CFR 433.206(g)) and Other Adjustments to the Adult Group FMAP Methodology**

The state:

X Applies a special circumstances adjustment(s).

__ Does not apply a special circumstances adjustment.

The state:

X Applies additional adjustment(s) to the adult group FMAP methodology (complete item 3).

__ Does not apply any additional adjustment(s) to the adult group FMAP methodology (skip item 3 and go to Part 3).

Attachment D describes the special circumstances and other proxy adjustment(s) that are applied, including the population groups to which the adjustments apply and the methodology for calculating the adjustments.

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Part 3 – One-Time Transitions of Previously Covered Populations into the New Adult Group

7. **Transitioning Previous Section 1115 and State Plan Populations to the New Adult Group**

X Individuals previously eligible for Medicaid coverage through a section 1115 demonstration program or a mandatory or optional state plan eligibility category will be transitioned to the new adult group described in 42 CFR 435.119 in accordance with a CMS-approved transition plan and/or a section 1902(e)(14)(A) waiver. For purposes of claiming federal funding at the appropriate FMAP for the populations transitioned to new adult group, the adult group FMAP methodology is applied pursuant to and as described in Attachment E, and where applicable, is subject to any special circumstances or other adjustments described in Attachment D.

__ The state does not have any relevant populations requiring such transitions.

Part 4 - Applicability of Special FMAP Rates

8. **Expansion State Designation**

The state:

__ Does not meet the definition of expansion state in 42 CFR 433.204(b). (Skip section B and go to Part 5)

X Meets the definition of expansion state as defined in 42 CFR 433.204(b), determined in accordance with the CMS letter confirming expansion state status, dated 02/22/2013,.

9. **Qualification for Temporary 2.2 Percentage Point Increase in FMAP.**

The state:

X Does not qualify for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7).

__ Qualifies for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7), determined in accordance with the CMS letter confirming eligibility for the temporary FMAP increase, dated_. The state will not claim any federal funding for individuals determined eligible under 42 CFR 435.119 at the FMAP rate described in 42 CFR 433.10(c)(6).

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Part 5 - State Attestations

The State attests to the following:

10. The application of the adult group FMAP methodology will not affect the timing or approval of any individual's eligibility for Medicaid.

11. The application of the adult group FMAP methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

ATTACHMENTS

Not all of the attachments indicated below will apply to all states; some attachments may describe methodologies for multiple population groups within the new adult group. Indicate those of the following attachments which are included with this SPA:

X Attachment A – Conversion Plan Standards Referenced in Table 1

__ Attachment B – Resource Criteria Proxy Methodology

__ Attachment C – Enrollment Cap Methodology

X Attachment D – Special Circumstances Adjustment and Other Adjustments to the Adult Group FMAP Methodology

X Attachment E – Transition Methodologies

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Attachment A

Most Recent Updated Summary Information for Part 2 of Modified Adjusted Gross Income (MAGI) Conversion Plan*

	Population Group	Net Standard as of 12/1/09	Converted Standard for FMAP Claiming	Same as converted eligibility standard? (yes, no, or n/a/)	Source of information in column C (New SIPP conversion or Part 1 of approved stte MAGI conversion plan)	Data source for Conversion (SIPP or state data)
	A	B	C	D	E	F
Conversions for FMAP Claiming Purposes						
1	Parents/Caretaker Relatives Dollar standards by family size 1 2 3 4 5 6 7 8 9 10 or higher Add-on	 $359 $453 $562 $661 $762 $866 $1,000 $1,107 $1,215 $1,321 n/a	 $511 $658 $820 $972 $1,127 $1,284 $1,471 $1,631 $1,792 $1,951 n/a	Yes	Part 1 of approved state MAGI conversion plan	State data
2	Noninstitutionalized Disabled persons SSI FBR%	100%	103%	n/a	New SIPP conversion	SIPP
3	Institutionalized Disabled persons SSI FBR%	300%	300%	n/a	ABD conversion template	n/a
4	Children age 19 – 20	n/a	n/a	n/a	n/a	n/a
5	Childless adults FPL%	n/a	n/a	n/a	n/a	n/a

n/a: Not applicable

*The numbers in this summary chart will be updated automatically in the case of modification in the CMS approved MAGI conversion plan.

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ATTACHMENT D

Washington State administered a Presumptive SSI program until January 1, 2014. As of January 1, 2014, these individuals were placed into the newly eligible group and will be claimed at 100% federal match. The newly eligibles are indicated by ACES Coverage Group N05, corresponding to RAC Group 1201. The Department of Social and Health Services (DSHS) has recently submitted a request to set up a new ACES Coverage Group, which can be mapped to a new RAC Code. Once this is complete, claiming for the clients in the Presumptive SSI group can be set at 75% (or an updated annual figure). Until then, the Medicaid Agency (the Health Care Authority (HCA)) needs a process to ensure claiming at only 75% for these individuals and that the weekly federal draws take this into account. To do this, HCA will utilize an approved cost allocation methodology, which is processing data through a base.

Using a base, a certain percentage of expenditures or clients can be assigned to two groups (in Washington, it would be two groups). Consider Presumptive SSI. If, for example, 15% of the expenditures in the newly eligibles are for Presumptive SSI clients, then 15% of the expenditures for the newly eligibles would be placed in one portion of the base and the other 85% of the expenditures would be placed in the other half. The 15% would target a cost objective code that would allocate 75% federal match, while the remaining 85% would target a cost objective code that would allocate 100% federal match. The initial percentages would be based on the budgeted amounts, and then going forward, estimates would be made at the beginning of each month. The estimates will be based on previous actuals. “True-ups” to the estimates will be performed monthly after fiscal month close. A journal voucher (JV) will be processed to adjust to the actuals ensuring the accounting records are correct. The JV process is as follows:

12. Obtain the client IDs for these presumptive SSI clients from the Automated Client Eligibility System (ACES) maintained by DSHS, by identifying those that are in the Adult Blind/Disabled (ABD) cash assistance program.

13. Match these clients to the medical eligibility data in Provider One to obtain a list of ABD clients that are also eligible for Medicaid in the newly eligible population segment at the same time.

14. On a monthly basis, HCA Budget pulls all expenses for these clients. Medicaid claims data for clients is obtained from various Washington State systems, including Provider One, SSPS (Social Service Payment System), etc. The Journal Voucher data is then provided to HCA Accounting to ensure federal match for these clients is exactly 75% (or updated annual figure).

Regarding the 15% figure, preliminary data suggest that for SFY14 the percentage for ProviderOne payments is 10%. The corresponding figure for DSHS expenditures may be higher. The monthly updating of the percentage figures for the base (15% and 85% in the example above) will be done manually by the accounting staff Actual expenditures for the true- ups will be determined by pulling claims experience – from Provider One on the part of HCA, and from the Social Services Payment System (SSPS) on the part of DSHS. Percentages would be determined as the percent of the newly eligible (RAC 1201/ACES group N05) constituted by the Presumptive SSI Clients. The list of the Presumptive SSI clients will be determined by DSHS using their ACES eligibility system, drawing from the list of ABD Cash Assistance clients that will be eligible in months corresponding to the months of expenditures.

With respect to the CMS 64, the monthly JV process ensures a “true-up” of the expenditures so that on a quarterly basis, the actual dollars for the Presumptive SSI are claimed appropriately at exactly 75% federal match.

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Washington State administered a Presumptive SSI program (PSSI) until January 1, 2014. PSSI benefits included expedited Medicaid coverage and a state-funded cash benefit under the Aged Blind or Disabled (ABD) program for qualifying adults.

As of January 1, 2014, these individuals receive their health care coverage as part of the newly Medicaid-eligible group (Group VIII). In the Automated Client Eligibility System (ACES), they are enrolled in the N05 coverage group for newly eligibles, but in the ProviderOne (P1) payment system, they are identified by the Recipient Assistance Code (RAC) of '1217'. This identification ensures claiming at the applicable Expansion State Federal Medicaid Assistance Percentage (ESFMAP) rate.

The addition of RAC 1217 to P1 in February 2015 automates the process of identifying newly eligibles who are concurrently receiving ABD cash and the process for claiming the applicable ESFMAP for this group. For claims paid for services prior to that time, however, a manual process will continue for as long as necessary to ensure claiming at the correct rate. That process consists of matching the client IDs of those receiving ABD cash who at the same time were approved for services under RAC 1201. RAC 1201 continues to be used for all newly eligibles, but is no longer used for those receiving the ABD cash benefit.

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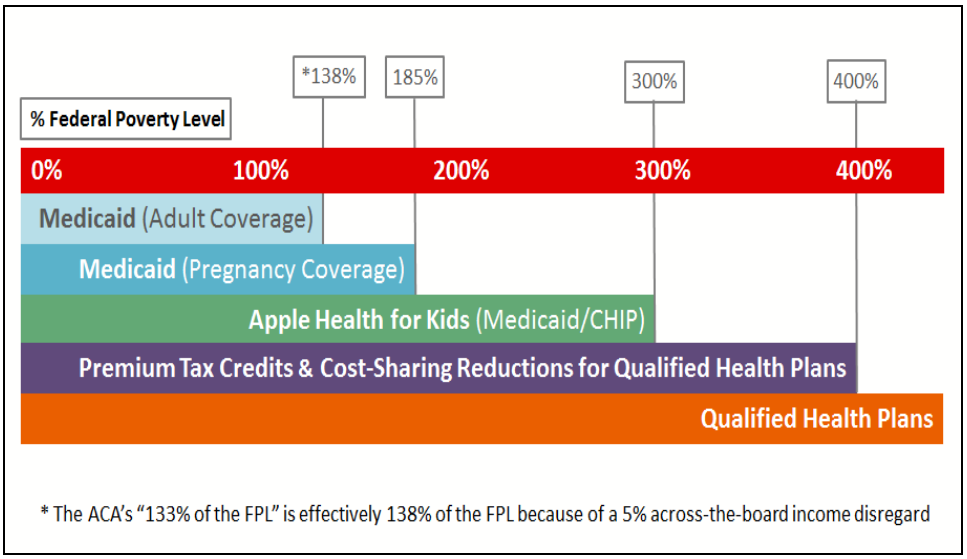
Attachment E

Washington State Revised 2014 Transition Plan

As a requirement of Washington State's 1115 Transitional Bridge Demonstration waiver, preliminary planning began early in 2012 and was revised early in 2013 as the details of the Insurance Affordability Program (IAP) continuum that will be available in 2014 evolved. An overview is shown in the following chart.



A broad range of discussions, presentations and webinars has been hosted to clarify general Medicaid expansion and transition details for Tribes, stakeholders, health plans and others interested. The timeline and critical milestones for preparation/planning, seamless transition and administrative closeout of the Transitional Bridge Demonstration in particular, were reviewed with CMS earlier in 2013. Underlying details have been revised following Washington State's 2013 extended Legislative sessions (ending June 30, 2013) and to incorporate evolving CMS guidance. The following chart summarizes the plan, referencing the impacted elements in red. While definition of the Alternative Benefit Plan has been delayed by about 4 months from the original plan we don't expect an impact on readiness for 2014 implementation.

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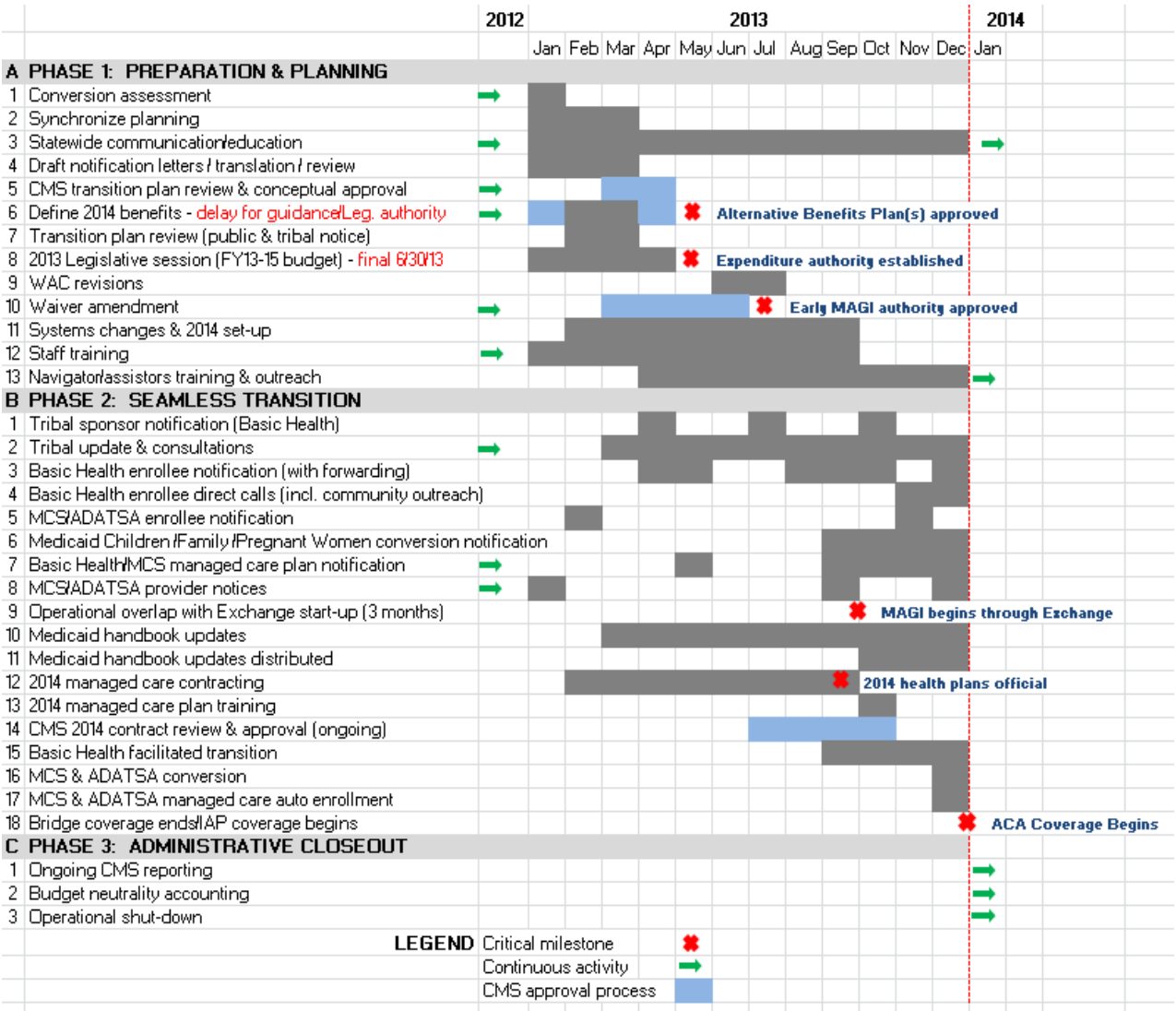
Attachment E (cont)



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A. Coverage in 2014

Through the authority of the Transitional Bridge waiver Washington State will adopt MAGI-based eligibility determination methods beginning on October 1, 2013 to help facilitate a streamlined enrollment process for 2014 for all IAPs. (A general fact sheet on 2014 eligibility for Medicaid/CHIP is available at: http://www.hca.wa.gov/hcr/me/documents/ME2014_Changes_Comparison_Fact_Sheet.pdf. Populations covered through current 1115 Demonstrations will transition to 2014 coverage as follows.

Eligibility Category			**Benefits**	**Delivery System**
Population	**Current Authority**	**1/1/2014 Authority**		
Medical Care Services-Disability Lifeline Medical Care Services-ADATSA Basic Health (up to 133% FPL based on MAGI methods)	Early Medicaid expansion adults (1115 Transitional Bridge waiver)	Mandatory State Plan expansion adults up to 133% FPL *(renewal typically occurs 12 months from enrollment under State Plan)*	Alternative Benefit Plan	Same as current Medicaid State Plan – primarily managed care, some FFS
Basic Health (over 133% FPL based on MAGI methods)	Early Medicaid expansion adults (1115 Transitional Bridge waiver)	State Health Benefit Exchange adults not eligible for Medicaid *(renewal typically occurs during open enrollment period under marketplace rules)*	Essential Health benefits	Qualified Health Plans
Take Charge (Pre-pregnancy family planning up to 250% FPL)	Family planning waiver	Waiver amendment in process to limit eligibility to: (a) individuals not eligible for Medicaid, with incomes up to 250% FPL and (b) Youth/victims of domestic violence requiring confidential services	Family planning services	Approved Take Charge providers - local clinics, doctors' offices and pharmacies

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B. Process for Transition

During the preparation and planning for the required Transitional Bridge close-out, an assessment of demonstration populations was conducted to determine the potential to (a) automate conversion to the 2014 State Plan expansion adult group or (b) support seamless transition through the WashingtonHealthPlanFinder (www.wahealthplanfinder.org.)

Screening of cases showed that income requirements for eligibility to the Medical Care Services-Disability Lifeline and Medical Care Services-ADATSA demonstration populations (i.e., "Transition Eligibles") aligned fully with eligibility for the 2014 Medicaid expansion adults. An automated conversion will occur for individuals enrolled in these programs in December 2013.

Screening of the Basic Health "Transition Eligible" population determined that an automated conversion would not be possible - details required to support MAGI household and income requirements are not available in current data, nor available in the sponsorship program through which external organizations subsidize enrollment in Basic Health (e.g., Tribes.) In addition, collection of additional (tax-related) data not needed for Basic Health eligibility determination would have required Legislative action *before* all details of the MAGI determination methodology were known. The process for transition of Basic Health individuals will involve heavy facilitation through multiple notices and assistance from Basic Health sponsors (e.g., Tribes), health plans who serve current enrollees, and advocacy organizations. Individuals may also obtain coverage for 2014 through Washington's healthplanfinder portal, paper forms, or other call-center/personal assistance.

The Take Charge program covers a limited family planning benefit to help participants avoid unintended pregnancies. The 2013 Legislature authorized continuation of the program in 2014 for individuals not otherwise eligible for Medicaid, and for youth requiring confidential access to services. Otherwise, current beneficiaries will continue coverage through their certification period. They will then receive a renewal notice requiring them to apply for coverage in the same manner as other Medicaid recipients. (A waiver amendment is being drafted.)

Population	Action by State	Action by Beneficiary (or Sponsor)
Automated Conversion to 2014 Medicaid		
Medical Care Services-Disability Lifeline and Medical Care Services-ADATSA	15. Standard beneficiary notice of program termination and automated conversion to Medicaid, with reasons and official authorization	None
Seamless Facilitated Transition to 2014 IAP (Medicaid or HBE)		
Basic Health	16. Beneficiary notice re program termination and action needed to activate 2014 coverage, with reasons and official authorization 17. Training of health plans, community-based organizations, Tribes/other sponsors to provide additional support	Individuals will choose from electronic, phone, mail-in and other assisted options (e.g., current sponsors) to expedite 2014 coverage
Take Charge	18. Based on waiver amendment beneficiaries will be asked to follow standard 2014 Medicaid application process	Individuals will not need to take action until their 2014 renewal notification

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C. Notification/Notices

As shown in the Transitional Bridge Demonstration waiver Gantt chart above, planning for communication with beneficiaries, health plans, providers and sponsors began in 2012. Conversations with Take Charge providers has been increasing since December 2012 when the Governor's budget for 2013-15 leveraged the ACA-related opportunities to streamline current programs whose enrollees would have expanded benefits available through 2014 IAP options.

As required, notices comply with the notice requirements in 42 CFR 431.206, 431.210 and 431.213 and where applicable, information on appeal and hearing rights as outlined in 42 CFR 431.220 and 431.221 is included. In general, the terms and conditions of the Transitional Bridge waiver which expires December 31, 2013, make the need for hearing and appeal rights not relevant since the programs will not continue for Transition Eligibles.

A full list and sample of actual notices is included in Attachment 1. Multiple versions of these notices have been reviewed through email, webinar, teleconference and verbal interactions with State agency staff, advocates, Tribal representatives and others. The notification process is as follows:

Population	Timing and Delivery of Beneficiary Notices	Support for Questions
Basic Health	**Letter # a: Member alert** Preliminary announcement mailed early July 2013 along with the monthly notice for premium payment (September coverage)	19. Online at www.wahealthplanfinder.org. 20. Call 1-800-660-9480 or Exchange 21. Mail to PO Box 946, Olympia, WA 98507 22. Email at CustomerSupport@wahbexchange.org 23. Call 1-855-923-4633 to find a cost free in-person assister 24. Health plans, community organizations, and other tribal sponsors, etc. 25. Follow-up personal phone call (and facilitation) will occur for individuals who have not activated coverage for 2014 by the end of November
	Letter # b: 90-day first notice Notification of need to provide details for 2014 coverage determination through the Washington HealthPlanFinder – included in September notice for premium payment for November coverage	
	Letter # c: 60-day second notice Follow-up notification of need to provide details for 2014 coverage determination through the Washington HealthPlanFinder – included in October notice for premium payment for December coverage *for those who have not already completed 2014 coverage action*	

Attachment E (cont)

Population	Timing and Delivery of Beneficiary Notices	Support for Questions
Basic Health (cont)	**Letter # d: termination notice where individual has activated 2014 coverage** Final notice to be mailed in December	
	Letter # e: termination notice where individual has not activated 2014 coverage Final notice to be mailed in December	
Medical Care Services-Disability Lifeline And Medical Care Services-ADATSA	**Letter # f:** MCS/ADATSA conversion notice Official notice of automatic upgrade to Medicaid coverage – mailed the end of November.	26. Online at www.wahealthplanfinder.org. 27. Call 1-855-923-4633 or 1-855-627-9604 28. Fax to 360-841-7620 29. Mail to PO Box 946, Olympia, WA 98507 30. Email at CustomerSupport@wahbexchange.org 31. Call 1-855-923-4633 to find a cost free in-person assister 32. Local Community Service Offices (CSO).
Take Charge	Standard renewal letter – no change	Family planning clinics and all other standard Medicaid support avenues

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Medicaid Furnished Out of State

Medicaid may be furnished to eligible individuals by Canadian providers under the following conditions:

1. Medical services are required because of a medical emergency and a Canadian provider is the closest source of care or

2. Needed medical services are more readily available in Canada and the aggregate cost of care is equal to or less than the aggregate cost of the same care when provided within the state.

In order for the department to reimburse Canadian providers each participating provider must:

1. Have a signed agreement with the department and bill at U.S. exchange rate in effect at the time the service was provided.

2. Satisfy all Medicaid conditions of participation,

3. Meet functionally equivalent licensing requirements, and

4. Be subject to the same utilization control standards as in-state providers.

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