RULE-MAKING ORDER
PERMANENT RULE ONLY

CR-103P (December 2017)
(Implements RCW 34.05.360)

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FILED

DATE: December 27, 2018
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WSR 19-02-046

Agency: Health Care Authority

Effective date of rule:

Permanent Rules

☒ 31 days after filing.

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

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

☐ Yes ☒ No If Yes, explain:

Purpose: The Health Care Authority is correcting WAC references, removing "medical assistance" from definition section titles, and correcting a reference to the name of a WAC section title.

Citation of rules affected by this order:

New:
Repealed:
Amended: 182-500-0025, 182-500-0065, 182-503-0540, 182-512-0010, 182-512-0300, 182-519-0100, 182-519-0110
Suspended:

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 18-21-187 on October 24, 2018 (date).

Describe any changes other than editing from proposed to adopted version: None

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

Name:
Address:
Phone:
Fax:
TTY:
Email:
Web site:
Other:

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

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

The number of sections adopted in order to comply with:

Federal statute:	New	____	Amended	____	Repealed	____
Federal rules or standards:	New	____	Amended	____	Repealed	____
Recently enacted state statutes:	New	____	Amended	____	Repealed	____

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

	New	____	Amended	____	Repealed	____

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

	New	____	Amended	____	Repealed	____

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

	New	____	Amended	7	Repealed	____

The number of sections adopted using:

Negotiated rule making:	New	____	Amended	____	Repealed	____
Pilot rule making:	New	____	Amended	____	Repealed	____
Other alternative rule making:	New	____	Amended	7	Repealed	____

Date Adopted: December 27, 2018	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-500-0025 ((~~Medical assistance~~)) Definitions—D. "Delayed certification" means agency or the agency's designee approval of a person's eligibility for medical assistance made after the established application processing time limits.

"Dental consultant" means a dentist employed or contracted by the agency or the agency's designee.

"Department" means the state department of social and health services.

"Disabled" means unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that:

((~~(1)~~)) (a) Can be expected to result in death;

((~~(2)~~)) (b) Has lasted or can be expected to last for a continuous period of not less than twelve months; or

((~~(3)~~)) (c) In the case of a child age seventeen or younger, means any physical or mental impairment of comparable severity.

Decisions on SSI-related disability are subject to the authority of federal statutes and rules codified at 42 U.S.C. Sec 1382c and 20 C.F.R., parts 404 and 416, as amended, and controlling federal court decisions, which define the old-age, survivors, and disability insurance (OASDI) and SSI disability standard and determination process. See WAC ((~~388-500-0015~~)) 182-500-0015 for definition of "blind."

"Domestic partner" means an adult who meets the requirements for a valid state registered domestic partnership as established by RCW 26.60.030 and who has been issued a certificate of state registered domestic partnership from the Washington secretary of state.

"Dual eligible client" means a client who has been found eligible as a categorically needy (CN) or medically needy (MN) medicaid client and is also a medicare beneficiary. This does not include a client who is only eligible for a medicare savings program as described in chapter ((~~388-517~~)) 182-517 WAC.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

WAC 182-500-0065 ((~~Medical assistance~~)) Definitions—L. "Limitation extension" see WAC ((~~388-501-0169~~)) 182-501-0169.

"Limited casualty program (LCP)" means the medically needy (MN) program.

AMENDATORY SECTION (Amending WSR 14-16-052, filed 7/29/14, effective 8/29/14)

WAC 182-503-0540 Assignment of rights and cooperation. (1) When you become eligible for any of the agency's health care programs, you assign certain rights to the state of Washington. You assign all rights to any type of coverage or payment for health care that comes from:

(a) A court order;

(b) An administrative agency order; or

(c) Any third-party benefits or payment obligations for medical care which are the result of **subrogation** or contract (see WAC ((~~388-501-0100~~)) 182-501-0100).

(2) When you sign the application you assign the rights described in subsection (1) of this section to the state for:

(a) Yourself; and

(b) Any eligible person for whom you can legally make such assignment.

(3) You must cooperate with us in identifying, using or collecting third-party benefits. If you do not cooperate, your health care coverage may end unless you can show good reason not to cooperate with us. Examples of good reason include, but are not limited to:

(a) Your reasonable belief that cooperating with us would result in serious physical or emotional harm to you, a child in your care, or a child related to you; and

(b) Your being incapacitated without the ability to cooperate with us.

(4) Your WAH coverage will not end due solely to the noncooperation of any third party.

(5) You will have to pay for your health care services if you:

(a) Received and kept the third-party payment for those services; or

(b) Refused to give to the provider of care your legal signature on insurance forms.

(6) The state is limited to the recovery of its own costs for health care costs paid on behalf of a recipient of health care coverage. The legal term which describes the method by which the state acquires the rights of a person for whom the state has paid costs is called subrogation.

AMENDATORY SECTION (Amending WSR 11-23-091, filed 11/17/11, effective 11/21/11)

WAC 182-512-0010 Supplemental security income (SSI) standards((~~,~~)), SSI-related categorically needy income level (CNIL)((~~,~~)), and countable resource standards. (1) The SSI payment standards, also known as the federal benefit rate (FBR), change each January 1st.

(2) See WAC 388-478-0055 for the amount of the state supplemental payments (SSP) for SSI recipients.

(3) See WAC ((~~388-513-1305~~)) 182-513-1205 for standards of clients living in an alternate living facility.

(4) The SSI-related CNIL standards are the same as the SSI payment standards for single persons and couples. Those paying out shelter costs have a higher standard than people who have supplied shelter.

(5) The countable resource standards for SSI and SSI-related CN medical programs are:

(a) One person	$2,000
(b) A legally married couple	$3,000

AMENDATORY SECTION (Amending WSR 11-24-018, filed 11/29/11, effective 12/1/11)

WAC 182-512-0300 SSI-related medical—Resources eligibility. (1) At 12:00 a.m. on the first day of the month a client's countable resources must be at or below the resource standard to be eligible for noninstitutional medical benefits for that month. If the total of the client's countable resources is above the resource standard at 12:00 a.m. on the first day of the month, the client is ineligible for noninstitutional medical benefits for that entire month regardless of resource status at the time of application during that month. For resource eligibility relating to long-term care eligibility see chapter ((~~388-513~~)) 182-513 WAC.

(2) An excluded resource converted to another excluded resource remains excluded.

(3) Cash received from the sale of an excluded resource becomes a countable resource the first of the month following conversion unless the cash is((~~,~~)):

(a) Used to replace the excluded resource; ((~~or~~))

(b) Invested in another excluded resource in the same month or within the longer time allowed for home sales under WAC ((~~388-475-0350~~)) 182-512-0350; or

(c) Spent.

(4) The unspent portion of a nonrecurring lump sum payment is counted as a resource on the first of the month following its receipt with the following exception: The unspent portion of any Title II (SSA) or Title XVI (SSI) retroactive payment is excluded as a resource for nine months following the month of receipt. These exclusions apply to lump sums received by the client, client's spouse or any other person who is financially responsible for the client.

(5) Clients applying for SSI-related medical coverage for long-term care (LTC) services must meet different resource rules. See chapter ((~~388-513~~)) 182-513 WAC for LTC resource rules.

(6) The transfer of a resource without adequate consideration does not affect medical program eligibility except for LTC services described in chapters ((~~388-513 and 388-515~~)) 182-513 and 182-515 WAC. In those programs, the transfer may make a client ineligible for medical benefits for a period of time. See WAC ((~~388-513-1363 through 388-513-1366~~)) 182-513-1363 for LTC rules.

AMENDATORY SECTION (Amending WSR 15-17-012, filed 8/7/15, effective 9/7/15)

WAC 182-519-0100 Eligibility for the medically needy program. (1) A person who meets the following conditions may be eligible for medically needy (MN) coverage under the special rules in chapters 182-513 and 182-515 WAC:

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

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

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

(2) A supplemental security income (SSI)-related person who lives in a medicaid agency-contracted alternate living facility may be eligible for MN coverage under WAC 182-513-1305.

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

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

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

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

(a) A child;

(b) A pregnant woman;

(c) A refugee;

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

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

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

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

(b) All health insurance premiums, except for medicare Part A through Part D premiums, expected to be paid by the person or family member during the base period or periods;

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

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

(e) A child or pregnant woman applying for MN coverage is eligible for income deductions allowed under temporary assistance for needy families (TANF) and state family assistance (SFA) rules and not under the rules for CN programs based on the federal poverty level. See WAC

182-509-0001(4) for exceptions to the TANF and SFA rules that apply to medical programs and not to the cash assistance program.

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

(7) The MNIL for all other people is described in WAC 182-519-0050. If a person has countable income at or below the MNIL, the person is certified as eligible for up to twelve months of MN medical coverage.

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

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

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

(b) The person pays for the expense within the current or retroactive base period under WAC 182-519-0110.

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

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

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

(13) There is no automatic redetermination process for MN coverage. A person must apply for each eligibility period under the MN program.

(14) A person who requests a timely administrative hearing under WAC ((~~388-458-0040~~)) 182-518-0025(5) is not eligible for continued benefits beyond the end of the original certification date under the MN program.

AMENDATORY SECTION (Amending WSR 15-17-012, filed 8/7/15, effective 9/7/15)

WAC 182-519-0110 Spenddown of excess income for the medically needy program. (1) A person who applies for Washington apple health (WAH) and is eligible for medically needy (MN) coverage with a spenddown may choose a three-month or a six-month base period. A base period is a time period used to compute the spenddown liability amount.

The months must be consecutive calendar months, unless a condition in subsection (4) of this section applies.

(2) A base period begins on the first day of the month a person applies for WAH, unless a condition in subsection (4) of this section applies.

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

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

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

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

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

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

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

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

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

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

(8) Once a person's spenddown amount is determined, qualifying medical expenses are deducted. A qualifying medical expense must:

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

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

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

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

(ii) Thirty days after the base period ends.

(d) Be an incurred expense for the person:

(i) The person's spouse;

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

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

(e) Meet one of the following conditions:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(11) If a person submits verification of qualifying medical expenses with his or her application that meet or exceed the spenddown liability, the person is eligible for MN medical coverage for the remainder of the base period unless their circumstances change. See WAC ((~~388-418-0005~~)) 182-504-0105 to determine which changes must be reported to the agency or its designee. The beginning of eligibility is determined under WAC 182-504-0020.

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

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

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

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

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

(15) Once a person meets the spenddown requirement and the certification begin date is established, newly identified expenses are not considered toward that spenddown unless:

(a) There is a good reason for the delay in submitting the expense; or

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

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

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

(b) The person has medical issues that prevent him or her from submitting proof on time; or

(c) The person meets the criteria for needing ((~~a supplemental accommodation under chapter 388-472 WAC~~)) equal access under WAC 182-503-0120.

(17) The agency or its designee does not pay for any expense or portion of an expense used to meet a person's spenddown liability.

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

(a) Bill the person for more than the amount assigned to the remaining spenddown liability; or

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

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

(20) If the medical expense assigned to spenddown was incurred outside of a period of MN eligibility, or if the expense is not covered by WAH, the agency or its designee does not pay any portion of the bill.