EXPEDITED RULE MAKING

CR-105 (December 2017)
(Implements RCW 34.05.353)

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STATE OF WASHINGTON
FILED

DATE: November 14, 2022
TIME: 10:21 AM

WSR 22-23-082

Agency: Health Care Authority

Title of rule and other identifying information: (describe subject)
WAC 182-507-0125 State-funded long-term care services
WAC 182-513-1105 Personal needs allowance (PNA) and room and board standards in a medical institution and alternate living facility (ALF)
WAC 182-513-1215 Community first choice (CFC)—Eligibility
WAC 182-513-1220 Community first choice (CFC)—Spousal impoverishment protections for noninstitutional Washington apple health clients
WAC 182-513-1225 Medicaid personal care (MPC)
WAC 182-513-1240 The hospice program
WAC 182-513-1350 Defining the resource standard and determining resource eligibility for SSI-related long-term care (LTC) services
WAC 182-513-1355 Allocating resources to a community spouse when determining resource eligibility for SSI-related long-term care services
WAC 182-513-1380 Determining a client's financial participation in the cost of care for long-term care in a medical institution
WAC 182-513-1385 Determining the community spouse monthly maintenance needs allowance and dependent allowance in post-eligibility treatment of income for long-term care (LTC) programs
WAC 182-513-1660 Medicaid alternative care (MAC) and tailored supports for older adults (TSOA)—Spousal impoverishment
WAC 182-514-0230 Purpose
WAC 182-515-1506 Home and community based (HCB) waiver services authorized by home and community services (HCS)—General eligibility
WAC 182-515-1507 Home and community based (HCB) waiver services authorized by home and community services (HCS)—Financial eligibility if a client is eligible for an SSI-related noninstitutional categorically needy (CN) medicaid program
WAC 182-515-1508 Home and community based (HCB) waiver services authorized by home and community services (HCS)—Financial eligibility using SSI-related institutional rules
WAC 182-515-1509 Home and community based (HCB) waiver services authorized by home and community services (HCS)—Client financial responsibility
WAC 182-515-1511 Home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA)—General eligibility
WAC 182-515-1512 Home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA)—Financial eligibility if a client is eligible for a noninstitutional SSI-related categorically needy (CN) program
WAC 182-515-1513 Home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA)—Financial eligibility using SSI-related institutional rules
WAC 182-515-1514 Home and community based (HCB) services authorized by the developmental disabilities administration (DDA)—Client financial responsibility
WAC 182-517-0100 Federal medicare savings programs

Purpose of the proposal and its anticipated effects, including any changes in existing rules: Correct a website address

Reasons supporting proposal: In each of the rules listed above the agency is replacing an incorrect website address with the correct address for the Washington Apple Health income and resource standards. The correct address is https://www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

Statutory authority for adoption: RCW 41.05.021, 41.06.160

Statute being implemented: RCW 41.05.021, 41.06.160

Is rule necessary because of a:

Federal Law?	☐ Yes	☒ No
Federal Court Decision?	☐ Yes	☒ No
State Court Decision?	☐ Yes	☒ No

If yes, CITATION:

Name of proponent: (person or organization) Health Care Authority

☐ Private
☐ Public
☒ Governmental

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting:	Brian Jensen	PO Box 42716, Olympia, WA 98504-2716	360-725-0815
Implementation:	Paige Lewis	PO Box 42722, Olympia, WA 98504-2722	360-725-0757
Enforcement:	Paige Lewis	PO Box 42722, Olympia, WA 98504-2722	360-725-0757

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters: None

Expedited Adoption - Which of the following criteria was used by the agency to file this notice:

☐ Relates only to internal governmental operations that are not subject to violation by a person;

☐ Adopts or incorporates by reference without material change federal statutes or regulations, Washington state statutes, rules of other Washington state agencies, shoreline master programs other than those programs governing shorelines of statewide significance, or, as referenced by Washington state law, national consensus codes that generally establish industry standards, if the material adopted or incorporated regulates the same subject matter and conduct as the adopting or incorporating rule;

☒ Corrects typographical errors, make address or name changes, or clarify language of a rule without changing its effect;

☐ Content is explicitly and specifically dictated by statute;

☐ Have been the subject of negotiated rule making, pilot rule making, or some other process that involved substantial participation by interested parties before the development of the proposed rule; or

☐ Is being amended after a review under RCW 34.05.328.

Expedited Repeal - Which of the following criteria was used by the agency to file notice:

☐ The statute on which the rule is based has been repealed and has not been replaced by another statute providing statutory authority for the rule;

☐ The statute on which the rule is based has been declared unconstitutional by a court with jurisdiction, there is a final judgment, and no statute has been enacted to replace the unconstitutional statute;

☐ The rule is no longer necessary because of changed circumstances; or

☐ Other rules of the agency or of another agency govern the same activity as the rule, making the rule redundant.

Explanation of the reason the agency believes the expedited rule-making process is appropriate pursuant to RCW 34.05.353(4): The expedited rule-making process is appropriate because the proposed rules correct typographical errors.

NOTICE

THIS RULE IS BEING PROPOSED UNDER AN EXPEDITED RULE-MAKING PROCESS THAT WILL ELIMINATE THE NEED FOR THE AGENCY TO HOLD PUBLIC HEARINGS, PREPARE A SMALL BUSINESS ECONOMIC IMPACT STATEMENT, OR PROVIDE RESPONSES TO THE CRITERIA FOR A SIGNIFICANT LEGISLATIVE RULE. IF YOU OBJECT TO THIS USE OF THE EXPEDITED RULE-MAKING PROCESS, YOU MUST EXPRESS YOUR OBJECTIONS IN WRITING AND THEY MUST BE SENT TO

Name: HCA Rules Coordinator

Agency: Health Care Authority

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AND RECEIVED BY (date) January 24, 2023

Date: November 11, 2022

Name: Wendy Barcus

Title: HCA Rules Coordinator

Signature:

AMENDATORY SECTION (Amending WSR 17-03-116, filed 1/17/17, effective 2/17/17)

WAC 182-515-1506 Home and community based (HCB) waiver services authorized by home and community services (HCS)—General eligibility. (1) To be eligible for home and community based (HCB) waiver services a person must:

(a) Meet the program and age requirements for the specific program:

(i) Community options program entry system (COPES), under WAC 388-106-0310;

(ii) Residential support waiver (RSW), under WAC 388-106-0310; or

(iii) New Freedom, under WAC 388-106-0338.

(b) Meet the disability criteria for the supplemental security income (SSI) program under WAC 182-512-0050;

(c) Require the level of care provided in a nursing facility under WAC 388-106-0355;

(d) Reside in a medical institution as defined in WAC 182-500-0050, or be likely to be placed in one within the next ((~~thirty~~)) 30 days without HCB waiver services provided under one of the programs listed in (a) of this subsection;

(e) Attain institutional status under WAC 182-513-1320;

(f) Assessed for HCB waiver services, be approved for a plan of care, and receiving an HCB waiver service under (a) of this subsection;

(g) Be able to live at home with community support services and choose to remain at home, or live in a department-contracted alternate living facility under WAC 182-513-1100.

(2) A person is not eligible for home and community based (HCB) waiver services if the person:

(a) Is subject to a penalty period of ineligibility for the transfer of an asset under WAC 182-513-1363; or

(b) Has a home with equity in excess of the requirements under WAC 182-513-1350.

(3) See WAC 182-513-1315 for rules used to determine countable resources, income, and eligibility standards for long-term care (LTC) services.

(4) Current income and resource standards are found at ((~~http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

AMENDATORY SECTION (Amending WSR 17-23-039, filed 11/8/17, effective 1/1/18)

WAC 182-515-1507 Home and community based (HCB) waiver services authorized by home and community services (HCS)—Financial eligibility if a client is eligible for an SSI-related noninstitutional categorically needy (CN) medicaid program. (1) A client is financially eligible for home and community based (HCB) waiver services if the client:

(a) Is receiving coverage under one of the following categorically needy (CN) medicaid programs:

(i) SSI program under WAC 182-510-0001. This includes SSI clients under Section 1619(b) of the Social Security Act;

(ii) SSI-related noninstitutional CN program under chapter 182-512 WAC; or

(iii) Health care for workers with disabilities program (HWD) under chapter 182-511 WAC.

(b) Does not have a penalty period of ineligibility for the transfer of an asset under WAC 182-513-1363; and

(c) Does not own a home with equity in excess of the requirements under WAC 182-513-1350.

(2) A client eligible under this section does not pay toward the cost of care, but must pay room and board if living in an alternate living facility (ALF) under WAC 182-513-1100.

(3) A client eligible under this section who lives in a department-contracted ALF described under WAC 182-513-1100:

(a) Keeps a personal needs allowance (PNA) under WAC 182-513-1105; and

(b) Pays towards room and board under WAC 182-513-1105.

(4) A client who is eligible under the HWD program must pay the HWD premium under WAC 182-511-1250, in addition to room and board, if residing in an ALF.

(5) Current resource, income, PNA, and room and board standards are found at ((~~www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

AMENDATORY SECTION (Amending WSR 17-03-116, filed 1/17/17, effective 2/17/17)

WAC 182-515-1508 Home and community based (HCB) waiver services authorized by home and community services (HCS)—Financial eligibility using SSI-related institutional rules. (1) If a person is not eligible for a categorically needy (CN) program under WAC 182-515-1507, the agency determines eligibility for home and community based (HCB) waiver services authorized by home and community services (HCS) using institutional medicaid rules. This section explains how a person may qualify using institutional rules.

(2) A person must meet:

(a) General eligibility requirements under WAC 182-513-1315 and 182-515-1506;

(b) The resource requirements under WAC 182-513-1350;

(c) The following income requirements:

(i) Available income must be at or below the special income level (SIL), defined under WAC 182-513-1100; or

(ii) If available income is above the SIL, net available income is no greater than the effective one-person medically needy income level (MNIL). Net income is calculated by reducing available income by:

(A) Medically needy (MN) disregards found under WAC 182-513-1345;

(B) The average monthly nursing facility state rate;

(C) Health insurance premiums, other than medicare; and

(D) Outstanding medical bills, prorated monthly over a ((~~twelve-month~~)) 12-month certification period, that meet the requirements of WAC 182-513-1350.

(3) The agency determines available income and income exclusions under WAC 182-513-1325, 182-513-1330, and 182-513-1340.

(4) A person eligible under this section is responsible to pay toward the cost of care and room and board, as described under WAC 182-515-1509.

(5) Current resource, income standards, and the average state nursing facility rate for long-term care are found at ((~~http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

AMENDATORY SECTION (Amending WSR 22-16-040, filed 7/27/22, effective 8/27/22)

WAC 182-515-1509 Home and community based (HCB) waiver services authorized by home and community services (HCS)—Client financial responsibility. (1) A client eligible for home and community based (HCB) waiver services authorized by home and community services (HCS) under WAC 182-515-1508 must pay toward the cost of care and room and board under this section.

(a) Post-eligibility treatment of income, participation, and participate are all terms that refer to a client's responsibility towards cost of care.

(b) Room and board is a term that refers to a client's responsibility toward food and shelter in an alternate living facility (ALF).

(2) The agency determines how much a client must pay toward the cost of care for HCB waiver services authorized by HCS when living in their own home:

(a) A single client who lives in their own home (as defined in WAC 388-106-0010) keeps a personal needs allowance (PNA) of up to 300% of the federal benefit rate (FBR) for the supplemental security income (SSI) cash grant program and must pay the remaining available income toward cost of care after allowable deductions described in subsection (4) of this section. The Washington apple health income and resource standards chart identifies 300% of the FBR as the medical special income level (SIL).

(b) A married client who lives with the client's spouse in their own home (as defined in WAC 388-106-0010) keeps a PNA of up to the effective one-person medically needy income level (MNIL) and pays the remainder of the client's available income toward cost of care after allowable deductions under subsection (4) of this section.

(c) A married client who lives in their own home and apart from the client's spouse keeps a PNA of up to the SIL but must pay the remaining available income toward cost of care after allowable deductions under subsection (4) of this section.

(d) A married couple living in their own home where each client receives HCB waiver services is each allowed to keep a PNA of up to

the SIL but must pay remaining available income toward cost of care after allowable deductions under subsection (4) of this section.

(e) A married couple living in their own home where each client receives HCB waiver services, one spouse authorized by the developmental disabilities administration (DDA) and the other authorized by HCS, is allowed the following:

(i) The client authorized by DDA pays toward the cost of care under WAC 182-515-1512 or 182-515-1514; and

(ii) The client authorized by HCS retains the SIL and pays the remainder of the available income toward cost of care after allowable deductions under subsection (4) of this section.

(3) The agency determines how much a client must pay toward the cost of care for HCB waiver services authorized by HCS and room and board when living in a department contracted alternate living facility (ALF) defined under WAC 182-513-1100. A client:

(a) Keeps a PNA of under WAC 182-513-1105;

(b) Pays room and board up to the room and board standard under WAC 182-513-1105; and

(c) Pays the remainder of available income toward the cost of care after allowable deductions under subsection (4) of this section.

(4) If income remains after the PNA and room and board liability under subsection (2) or (3) of this section, the remaining available income must be paid toward the cost of care after it is reduced by deductions in the following order:

(a) An earned income deduction of the first $65 plus one-half of the remaining earned income;

(b) Guardianship fees and administrative costs including any attorney fees paid by the guardian only as allowed under chapter 388-79A WAC;

(c) Current or back child support garnished or withheld from the client's income according to a child support order in the month of the garnishment if it is for the current month. If the agency allows this as a deduction from income, the agency does not count it as the child's income when determining the family allocation amount in WAC 182-513-1385;

(d) A monthly maintenance-needs allowance for the community spouse as determined under WAC 182-513-1385. If the community spouse is also receiving long-term care services, the allocation is limited to an amount that brings the community spouse's income to the community spouse's PNA, as calculated under WAC 182-513-1385;

(e) A monthly maintenance-needs allowance for each dependent of the institutionalized client, or the client's spouse, as calculated under WAC 182-513-1385;

(f) Incurred medical expenses which have not been used to reduce excess resources. Allowable medical expenses are under WAC 182-513-1350.

(5) The total of the following deductions cannot exceed the special income level (SIL) defined under WAC 182-513-1100:

(a) The PNA allowed in subsection (2) or (3) of this section, including room and board;

(b) The earned income deduction in subsection (4)(a) of this section; and

(c) The guardianship fees and administrative costs in subsection (4)(b) of this section.

(6) A client may have to pay third-party resources defined under WAC 182-513-1100 in addition to the room and board and participation.

(7) A client must pay the client's provider the sum of the room and board amount, and the cost of care after all allowable deductions, and any third-party resources defined under WAC 182-513-1100.

(8) A client on HCB waiver services does not pay more than the state rate for cost of care.

(9) When a client lives in multiple living arrangements in a month, the agency allows the highest PNA available based on all the living arrangements and services the client has received in a month.

(10) Standards described in this section are found at ((~~www.hca.wa.gov/health-care-services-supports/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

AMENDATORY SECTION (Amending WSR 17-03-116, filed 1/17/17, effective 2/17/17)

WAC 182-515-1511 Home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA)—General eligibility. (1) To be eligible for home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA), a person must:

(a) Meet specific program requirements under chapter 388-845 WAC;

(b) Be an eligible client of the DDA;

(c) Meet the disability criteria for the supplemental security income (SSI) program under WAC 182-512-0050;

(d) Need the level of care provided in an intermediate care facility for the intellectually disabled (ICF/ID);

(e) Have attained institutional status under WAC 182-513-1320;

(f) Be able to reside in the community and choose to do so as an alternative to living in an ICF/ID;

(g) Be assessed for HCB waiver services, be approved for a plan of care, and receive HCB waiver services under (a) of this subsection, and:

(i) Be able to live at home with HCB waiver services; or

(ii) Live in a department-contracted facility with HCB waiver services, such as:

(A) A group home;

(B) A group training home;

(C) A child foster home, group home, or staffed residential facility;

(D) An adult family home (AFH); or

(E) An adult residential care (ARC) facility.

(iii) Live in the person's own home with supported living services from a certified residential provider; or

(iv) Live in the home of a contracted companion home provider.

(2) A person is not eligible for home and community based (HCB) waiver services if the person:

(a) Is subject to a penalty period of ineligibility for the transfer of an asset under WAC 182-513-1363; or

(b) Has a home with equity in excess of the requirements under WAC 182-513-1350.

(3) See WAC 182-513-1315 for rules used to determine countable resources, income, and eligibility standards for long-term care (LTC) services.

(4) Current income and resource standard charts are found at ((~~http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

AMENDATORY SECTION (Amending WSR 17-23-039, filed 11/8/17, effective 1/1/18)

WAC 182-515-1512 Home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA)—Financial eligibility if a client is eligible for a noninstitutional SSI-related categorically needy (CN) program. (1) A client is financially eligible for home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA) if:

(a) The client is receiving coverage under one of the following categorically needy (CN) medicaid programs:

(i) Supplemental security income (SSI) program under WAC 182-510-0001. This includes SSI clients under 1619(b) status; or

(ii) Health care for workers with disabilities (HWD) under chapter 182-511 WAC; or

(iii) SSI-related noninstitutional (CN) program under chapter 182-512 WAC; or

(iv) The foster care program under WAC 182-505-0211 and the client meets disability requirements under WAC 182-512-0050.

(b) The client does not have a penalty period of ineligibility for the transfer of an asset as under WAC 182-513-1363; and

(c) The client does not own a home with equity in excess of the requirements under WAC 182-513-1350.

(2) A client eligible under this section does not pay toward the cost of care, but must pay room and board if living in an alternate living facility (ALF) under WAC 182-513-1100.

(3) A client eligible under this section who lives in a department-contracted ALF described under WAC 182-513-1100:

(a) Keeps a personal needs allowance (PNA) under WAC 182-513-1105; and

(b) Pays towards room and board up to the room and board standard under WAC 182-513-1105.

(4) A client who is eligible under the HWD program must pay the HWD premium under WAC 182-511-1250, in addition to room and board if residing in an ALF.

(5) Current resource, income, PNA and room and board standards are found at ((~~www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

AMENDATORY SECTION (Amending WSR 17-03-116, filed 1/17/17, effective 2/17/17)

WAC 182-515-1513 Home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA)—Financial eligibility using SSI-related institutional rules. (1) If a person is not eligible for a categorically needy (CN) program under WAC 182-515-1512, the agency determines eligibility for home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA) using institutional medicaid rules. This section explains how a person may qualify using institutional rules.

(2) A person must meet:

(a) General eligibility requirements under WAC 182-513-1315 and 182-515-1511;

(b) Resource requirements under WAC 182-513-1350; and

(c) Have available income at or below the special income level (SIL) defined under WAC 182-513-1100.

(3) The agency determines available income and income exclusions according to WAC 182-513-1325, 182-513-1330, and 182-513-1340.

(4) A person eligible under this section is responsible to pay income toward the cost of care and room and board, as described under WAC 182-515-1514.

(5) Current resource, income standards are found at ((~~http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

AMENDATORY SECTION (Amending WSR 20-08-082, filed 3/27/20, effective 4/27/20)

WAC 182-515-1514 Home and community based (HCB) services authorized by the developmental disabilities administration (DDA)—Client financial responsibility. (1) A client eligible for home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA) under WAC 182-515-1513 must pay toward the cost of care and room and board under this section.

(a) Post-eligibility treatment of income, participation, and participate are all terms that refer to a client's responsibility towards cost of care.

(b) Room and board is a term that refers to a client's responsibility toward food and shelter in an alternate living facility (ALF).

(2) The agency determines how much a client must pay toward the cost of care for home and community based (HCB) waiver services authorized by the DDA when the client is living at home, as follows:

(a) A single client who lives at home (as defined in WAC 388-106-0010) keeps a personal needs allowance (PNA) of up to the special income level (SIL) defined under WAC 182-513-1100.

(b) A single client who lives at home on the roads to community living program authorized by DDA keeps a PNA up to the SIL but must

pay any remaining available income toward cost of care after allowable deductions described in subsection (4) of this section.

(c) A married client who lives with the client's spouse at home (as defined in WAC 388-106-0010) keeps a PNA of up to the SIL but must pay any remaining available income toward cost of care after allowable deductions under subsection (4) of this section.

(d) A married couple living at home where each client receives HCB waiver services, one authorized by DDA and the other authorized by home and community services (HCS) is allowed the following:

(i) The client authorized by DDA keeps a PNA of up to the SIL but must pay any remaining available income toward the client's cost of care after allowable deductions in subsection (4) of this section; and

(ii) The client authorized by HCS pays toward the cost of care under WAC 182-515-1507 or 182-515-1509.

(3) The agency determines how much a client must pay toward the cost of care for HCB wavier services authorized by DDA and room and board when the client is living in a department-contracted ALF defined under WAC 182-513-1100. A client:

(a) Keeps a PNA under WAC 182-513-1105;

(b) Pays room and board up to the room and board standard under WAC 182-513-1105; and

(c) Pays the remainder of available income toward the cost of care after allowable deductions under subsection (4) of this section.

(4) If income remains after the PNA and room and board liability under subsection (2) or (3) of this section, the remaining available income must be paid toward the cost of care after it is reduced by allowable deductions in the following order:

(a) An earned income deduction of the first $65, plus one-half of the remaining earned income;

(b) Guardianship fees and administrative costs including any attorney fees paid by the guardian only as allowed under chapter 388-79A WAC;

(c) Current or back child support garnished or withheld from the client's income according to a child support order in the month of the garnishment if it is for the current month. If the agency allows this as a deduction from income, the agency does not count it as the child's income when determining the family allocation amount in WAC 182-513-1385;

(d) A monthly maintenance-needs allowance for the community spouse under WAC 182-513-1385. If the community spouse is on long-term care services, the allocation is limited to an amount that brings the community spouse's income to the community spouse's PNA;

(e) A monthly maintenance-needs allowance for each dependent of the institutionalized client, or the client's spouse, as calculated under WAC 182-513-1385; and

(f) Incurred medical expenses which have not been used to reduce excess resources. Allowable medical expenses are under WAC 182-513-1350.

(5) The total of the following deductions cannot exceed the SIL defined under WAC 182-513-1100:

(a) The PNA described in subsection (2) or (3) of this section, including room and board;

(b) The earned income deduction in subsection (4)(a) of this section; and

(c) The guardianship fees and administrative costs in subsection (4)(b) of this section.

(6) A client may have to pay third-party resources defined under WAC 182-513-1100 in addition to the room and board and participation.

(7) A client must pay the client's provider the sum of the room and board amount, the cost of care after all allowable deductions, and any third-party resources defined under WAC 182-513-1100.

(8) A client on HCB waiver services does not pay more than the state rate for cost of care.

(9) When a client lives in multiple living arrangements in a month, the agency allows the highest PNA available based on all the living arrangements and services the client has received in a month.

(10) Standards described in this section are found at ((~~www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

AMENDATORY SECTION (Amending WSR 16-04-087, filed 1/29/16, effective 2/29/16)

WAC 182-514-0230 Purpose. (1) This chapter describes eligibility requirements for the Washington apple health (WAH) modified adjusted gross income (MAGI)-based long-term care program (LTC) for children and adults who have been admitted to an institution as defined in WAC 182-500-0050 for at least ((~~thirty~~)) 30 days. The rules are stated in the following sections:

(a) WAC 182-514-0240 General eligibility;

(b) WAC 182-514-0245 Resource eligibility;

(c) WAC 182-514-0250 Program for adults age ((~~nineteen~~)) 19 and older;

(d) WAC 182-514-0260 Program for children under age ((~~nineteen~~)) 19;

(e) WAC 182-514-0263 Non-SSI-related institutional medically needy coverage for pregnant women and people age ((~~twenty~~)) 20 and younger.

(f) WAC 182-514-0270 Involuntary commitment to Eastern or Western State Hospital.

(2) A noninstitutional WAH program recipient does not need to submit a new application for LTC coverage if admitted to an institution under this section. Admission to an institution constitutes a change of circumstances. Eligibility is based on institutional status under WAC 182-513-1320.

(3) In this chapter, "medicaid agency" or "agency" means the Washington state health care authority and includes the agency's designee. See chapter 182-500 WAC for additional definitions.

(4) Income standards used in this chapter are listed at ((~~http://www.hca.wa.gov/medicaid/eligibility/pages/standards.aspx~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

AMENDATORY SECTION (Amending WSR 17-03-116, filed 1/17/17, effective 2/17/17)

WAC 182-507-0125 State-funded long-term care services. (1) **Caseload limits.**

(a) The state-funded long-term care services program is subject to caseload limits determined by legislative funding.

(b) The aging and long-term support administration (ALTSA) must preauthorize state-funded long-term care service before payments begin.

(c) ALTSA cannot authorize a service, under chapter 388-106 WAC, if doing so would exceed statutory caseload limits.

(2) **Location of services.** State-funded long-term care services may be provided in:

(a) The person's own home, defined in WAC 388-106-0010;

(b) An adult family home, defined in WAC 182-513-1100;

(c) An assisted living facility, defined in WAC 182-513-1100;

(d) An enhanced adult residential care facility, defined in WAC 182-513-1100;

(e) An adult residential care facility, defined in WAC 182-513-1100; or

(f) A nursing facility, defined in WAC 182-500-0050, but only if nursing facility care is necessary to sustain life.

(3) **Client eligibility.** To be eligible for the state-funded long-term care services program, a person must meet all of the following conditions:

(a) General eligibility requirements for medical programs under WAC 182-503-0505, except (c) and (d) of this subsection;

(b) Be age ((~~nineteen~~)) 19 or older;

(c) Reside in one of the locations under subsection (2) of this section;

(d) Attain institutional status under WAC 182-513-1320;

(e) Meet the functional eligibility requirements under WAC 388-106-0355 for nursing facility level of care;

(f) Not have a penalty period due to a transfer of assets under WAC 182-513-1363;

(g) Not have equity interest in a primary residence more than the amount under WAC 182-513-1350; and

(h) Meet the requirements under chapter 182-516 WAC for annuities owned by the person or the person's spouse.

(4) **General limitations.**

(a) If a person entered Washington only to obtain medical care, the person is ineligible for state-funded long-term care services.

(b) The certification period for state-funded long-term care services may not exceed ((~~twelve~~)) 12 months.

(c) People who qualify for state-funded long-term care services receive categorically needy (CN) medical coverage under WAC 182-501-0060.

(5) **Supplemental security income (SSI)-related program limitations.**

(a) A person who is related to the SSI program under WAC 182-512-0050 (1), (2), and (3) must meet the financial requirements under WAC 182-513-1315 to be eligible for state-funded long-term care services.

(b) An SSI-related person who is not eligible for the state-funded long-term care services program under CN rules may qualify under medically needy (MN) rules under WAC 182-513-1395.

(c) The agency determines how much an SSI-related person is required to pay toward the cost of care, using:

(i) WAC 182-513-1380, if the person resides in a nursing facility.

(ii) WAC 182-515-1505 or 182-515-1510, if the person resides in one of the locations listed in subsection (2)(a) through (e) of this section.

(6) **Modified adjusted gross income (MAGI)-based program limitations.**

(a) A person who is related to the MAGI-based program may be eligible for state-funded long-term care services under this section and chapter 182-514 WAC if the person resides in a nursing facility.

(b) A MAGI-related person is not eligible for residential or in-home care state-funded long-term care services unless the person also meets the SSI-related eligibility criteria under subsection (5)(a) of this section.

(c) A MAGI-based person does not pay toward the cost of care in a nursing facility.

(7) Current resource, income, PNA, and room and board standards are found at ((~~http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/standards-ltc~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

AMENDATORY SECTION (Amending WSR 22-08-104, filed 4/6/22, effective 5/7/22)

WAC 182-513-1105 Personal needs allowance (PNA) and room and board standards in a medical institution and alternate living facility (ALF). (1) This section describes the personal needs allowance (PNA), which is an amount set aside from a client's income that is intended for personal needs, and the room and board standard.

(2) The PNA in a state veteran's nursing facility:

(a) Is indicated on the chart described in subsection (8) of this section as "All other PNA Med Inst.", for a veteran without a spouse or dependent children receiving a needs-based veteran's pension in excess of $90;

(b) Is indicated on the chart described in subsection (8) of this section as "All other PNA Med Inst.", for a veteran's surviving spouse with no dependent children receiving a needs-based veteran's pension in excess of $90; or

(c) Is $160 for a client who does not receive a needs-based veteran's pension.

(3) The PNA in a medical institution for clients receiving aged, blind, or disabled (ABD) cash assistance or temporary assistance for needy families (TANF) cash assistance is the client's personal and incidental (CPI) cash payment, as described in WAC 388-478-0006, based on residing in a medical institution, which is $41.62.

(4) The PNA in an alternate living facility (ALF) for clients receiving ABD cash assistance or TANF cash assistance is the CPI, as described in WAC 388-478-0006, based on residing in an ALF that is not an adult family home, which is $38.84.

(5) The PNA for clients not described in subsections (2), (3), and (4) of this section, who reside in a medical institution or in an ALF, is indicated on the chart described in subsection (8) of this section as "All other PNA Med Inst." and "HCS & DDA Waivers, CFC & MPC PNA in ALF."

(6) Effective January 1, 2018, and each year thereafter, the amount of the PNA in subsection (5) of this section may be adjusted by the percentage of the cost-of-living adjustment (COLA) for old-age, survivors, and disability social security benefits as published by the federal Social Security Administration. This adjustment is subject to state legislative funding.

(7) The room and board standard in an ALF used by home and community services (HCS) and the developmental disabilities administration (DDA) is based on the federal benefit rate (FBR) minus the current PNA as described under subsection (5) of this section.

(8) The current PNA and room and board standards used in long-term services and supports are published under the institutional standards on the Washington apple health (medicaid) income and resource standards chart located at ((~~www.hca.wa.gov/health-care-services-supports/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

AMENDATORY SECTION (Amending WSR 21-10-051, filed 4/29/21, effective 5/30/21)

WAC 182-513-1215 Community first choice (CFC)—Eligibility. (1) A client who is determined functionally eligible for community first choice (CFC) services under WAC 388-106-0270 through 388-106-0295 is financially eligible to receive CFC services if the client is:

(a) Eligible for a noninstitutional Washington apple health (medicaid) program which provides categorically needy (CN) or alternative benefits plan (ABP) scope of care;

(b) Through September 30, 2023, a spousal impoverishment protections institutional (SIPI) spouse under WAC 182-513-1220; or

(c) Determined eligible for a home and community based (HCB) waiver program under chapter 182-515 WAC.

(2) A client whose only coverage is through one of the following programs is not eligible for CFC:

(a) Medically needy program under WAC 182-519-0100;

(b) Premium-based children's program under WAC 182-505-0215;

(c) Medicare savings programs under WAC 182-517-0300;

(d) Family planning program under WAC 182-505-0115;

(e) Take charge program under WAC 182-532-0720;

(f) Medical care services program under WAC 182-508-0005;

(g) Pregnant minor program under WAC 182-505-0117;

(h) Alien emergency medical program under WAC 182-507-0110 through 182-507-0120;

(i) State-funded long-term care (LTC) for noncitizens program under WAC 182-507-0125; or

(j) Kidney disease program under chapter 182-540 WAC.

(3) Transfer of asset penalties under WAC 182-513-1363 do not apply to CFC applicants, unless the client is applying for long-term services and supports (LTSS) that are available only through one of the HCB waivers under chapter 182-515 WAC.

(4) Home equity limits under WAC 182-513-1350 do apply.

(5) Post-eligibility treatment of income rules do not apply if the client is eligible under subsection (1)(a) or (b) of this section.

(6) Clients eligible under subsection (1)(a) or (b) of this section, who reside in an alternate living facility (ALF):

(a) Keep a personal needs allowance (PNA) under WAC 182-513-1105; and

(b) Pay up to the room and board standard under WAC 182-513-1105 except when CN eligibility is based on the rules under WAC 182-513-1205.

(7) A client who receives CFC services under the health care for workers with disabilities (HWD) program under chapter 182-511 WAC must pay the HWD premium in addition to room and board under WAC 182-513-1105, if residing in an ALF.

(8) Post-eligibility treatment of income rules do apply if a client is eligible under subsection (1)(c) of this section.

(9) A client may have to pay third-party resources as defined under WAC 182-513-1100 in addition to the room and board and participation.

(10) PNA, MNIL, and room and board standards are found at ((~~www.hca.wa.gov/health-care-services-supports/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-

help-others-apply-and-access-apple-health/program-standard-income-and-resources.

AMENDATORY SECTION (Amending WSR 21-10-051, filed 4/29/21, effective 5/30/21)

WAC 182-513-1220 Community first choice (CFC)—Spousal impoverishment protections for noninstitutional Washington apple health clients. (1) This section is effective through September 30, 2023.

(2) The agency or its designee determines eligibility for community first choice (CFC) using spousal impoverishment protections under this section, when an applicant:

(a) Is married to, or marries, a person not in a medical institution;

(b) Meets institutional level of care and eligibility for CFC services under WAC 388-106-0270 through 388-106-0295;

(c) Is ineligible for a noninstitutional categorically needy (CN) SSI-related program:

(i) Due to spousal deeming rules under WAC 182-512-0920, or due to exceeding the resource limit in WAC 182-512-0010, or both; or

(ii) In an ALF due to combined spousal resources exceeding the resource limit in WAC 182-512-0010; and

(d) Meets the aged, blindness, or disability criteria under WAC 182-512-0050.

(3) The agency or its designee determines countable income using the SSI-related income rules under chapter 182-512 WAC but uses only the applicant's or recipient's separate income and not the income of the applicant's or recipient's spouse.

(4) The agency or its designee determines countable resources using the SSI-related resource rules under chapter 182-512 WAC, except pension funds owned by the spousal impoverishment protections community (SIPC) spouse are not excluded as described under WAC 182-512-0550:

(a) For the applicant or recipient, the resource standard is $2000.

(b) Before determining countable resources used to establish eligibility for the applicant, the agency allocates the state spousal resource standard to the SIPC spouse.

(c) The resources of the SIPC spouse are unavailable to the spousal impoverishment protections institutionalized (SIPI) spouse the month after eligibility for CFC services is established unless subsection (9) of this section applies.

(5) The SIPI spouse has until the end of the month of the first regularly scheduled eligibility review to transfer countable resources in excess of $2000 to the SIPC spouse.

(6) A redetermination of the couple's resources under subsection (4) of this section is required if:

(a) The SIPI spouse has a break in CFC services of at least ((~~thirty~~)) 30 consecutive days;

(b) The SIPI spouse's countable resources exceed the standard under subsection (4)(a) of this section; or

(c) The SIPI spouse does not transfer the amount under subsection (5) of this section to the SIPC spouse by the end of the month of the first regularly scheduled eligibility review.

(7) If the applicant lives at home and the applicant's separate countable income is at or below the SSI categorically needy income level (CNIL) and the applicant is resource eligible, the applicant is a SIPI spouse and is financially eligible for noninstitutional CN coverage and CFC services.

(8) If the applicant lives in an ALF, has separate countable income at or below the standard under WAC 182-513-1205(2), and is resource eligible, the applicant is a SIPI spouse and is financially eligible for noninstitutional CN coverage and CFC services.

(9) If the applicant is employed and has separate countable income at or below the standard under WAC 182-511-1060, the applicant is a SIPI spouse and is financially eligible for noninstitutional CN coverage and CFC services.

(10) Once a person no longer receives CFC services for ((~~thirty~~)) 30 consecutive days, the agency redetermines eligibility without using spousal impoverishment protection, under WAC 182-504-0125.

(11) If the applicant's separate countable income is above the standards under subsections (7), (8), and (9) of this section, the applicant is not eligible for CFC services under this section.

(12) The spousal impoverishment protections under this section expire on September 30, 2023.

(13) Standards are found at ((~~www.hca.wa.gov/health-care-services-supports/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

AMENDATORY SECTION (Amending WSR 17-23-039, filed 11/8/17, effective 1/1/18)

WAC 182-513-1225 Medicaid personal care (MPC). (1) Medicaid personal care (MPC) is a state-plan benefit available to a client who is determined:

(a) Functionally eligible for MPC services under WAC 388-106-0200 through 388-106-0235; and

(b) Financially eligible for a noninstitutional categorically needy (CN) or alternative benefits plan (ABP) Washington apple health (medicaid) program.

(2) MPC services may be provided to a client residing at home, in a department-contracted adult family home (AFH), or in a licensed assisted living facility that is contracted with the department to provide adult residential care services.

(3) A client who resides in an alternate living facility (ALF) listed in subsection (2) of this section:

(a) Keeps a personal needs allowance (PNA) under WAC 182-513-1105; and

(b) Pays room and board up to the room and board standard under WAC 182-513-1105, unless CN eligibility is determined using rules under WAC 182-513-1205.

(4) A client who receives MPC services under the health care for workers with disabilities (HWD) program under chapter 182-511 WAC must pay the HWD premium in addition to room and board under WAC 182-513-1105, if residing in an ALF.

(5) A client may have to pay third-party resources as defined under WAC 182-513-1100 in addition to room and board.

(6) Current PNA and room and board standards are found at ((~~www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

AMENDATORY SECTION (Amending WSR 17-03-116, filed 1/17/17, effective 2/17/17)

WAC 182-513-1240 The hospice program. (1) General information.

(a) The hospice program provides palliative care to people who elect to receive hospice services and are certified as terminally ill by their physician.

(b) Program rules governing election of hospice services are under chapter 182-551 WAC.

(c) A person may revoke an election to receive hospice services at any time by signing a revocation statement.

(d) Transfer of asset rules under WAC 182-513-1363 do not apply to the hospice program in any setting, regardless of which apple health program the person is eligible to receive.

(2) When hospice is a covered service.

(a) A person who receives coverage under a categorically needy (CN), medically needy (MN), or alternative benefits plan (ABP) program is eligible for hospice services as part of the program specific benefit package.

(b) A person who receives coverage under the alien emergency medical (AEM) program under WAC 182-507-0110 may be eligible for payment for hospice services if preapproved by the agency.

(c) A person who receives coverage under the medical care services (MCS) program is not eligible for coverage of hospice services.

(3) When HCB waiver rules are used to determine eligibility for hospice.

(a) A person who is not otherwise eligible for a CN, MN, or ABP noninstitutional program who does not reside in a medical institution, may be eligible for CN coverage under the hospice program by using home and community based (HCB) waiver rules under WAC 182-515-1505 to determine financial eligibility.

(b) When HCB waiver rules are used, the following exceptions apply:

(i) A person on the hospice program may reside in a medical institution, including a hospice care center, ((~~thirty~~)) 30 days or longer and remain eligible for hospice services; and

(ii) A person residing at home on the hospice program who has available income over the special income limit (SIL), defined under WAC 182-513-1100, is not eligible for CN coverage. If available income is over the SIL, the agency or its designee determines eligibility for medically needy coverage under WAC 182-519-0100.

(c) When HCB waiver rules are used, a person may be required to pay income and third-party resources (TPR) as defined under WAC 182-513-1100 toward the cost of hospice services. The cost of care calculation is described under WAC 182-515-1509.

(d) When a person already receives HCB waiver services and elects hospice, the person must pay any required cost of care towards the HCB waiver service provider first.

(4) Eligibility for hospice services in a medical institution:

(a) A person who elects to receive hospice services, resides in a medical institution for ((~~thirty~~)) 30 days or longer, and has income:

(i) Equal to or less than the SIL is income eligible for CN coverage. Eligibility for institutional hospice is determined under WAC 182-513-1315; or

(ii) Over the SIL may be eligible for MN coverage under WAC 182-513-1245.

(b) A person eligible for hospice services in a medical institution may have to pay toward the cost of nursing facility or hospice care center services. The cost of care calculation is under WAC 182-513-1380.

(5) Changes in coverage. The agency or its designee redetermines a person's eligibility under WAC 182-504-0125 if the person:

(a) Revokes the election of hospice services and is eligible for coverage using HCB waiver rules only, described in subsection (3) of this section; or

(b) Loses CN, MN, or ABP eligibility.

(6) Personal needs allowance and income and resource standards for hospice and home and community based (HCB) waiver programs are found at ((~~http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

AMENDATORY SECTION (Amending WSR 22-13-058, filed 6/8/22, effective 7/9/22)

WAC 182-513-1350 Defining the resource standard and determining resource eligibility for SSI-related long-term care (LTC) services. (1) General information.

(a) This section describes how the agency or the agency's designee defines the resource standard and countable or excluded resources when determining a person's eligibility for SSI-related long-term care (LTC) services.

(b) "Resource standard" means the maximum amount of resources a person can have and still be resource eligible for program benefits.

(c) For a person not SSI-related, the agency applies program specific resource rules to determine eligibility.

(2) Resource standards.

(a) The resource standard for the following people is $2000:

(i) A single person; or

(ii) An institutionalized spouse.

(b) The resource standard for a legally married couple is $3000, unless subsection (3)(b)(ii) of this section applies.

(c) The resource standard for a person with a qualified long-term care partnership policy under WAC 182-513-1400 may be higher based on the dollar amount paid out by a partnership policy.

(d) Determining the amount of resources that can be allocated to the community spouse when determining resource eligibility is under WAC 182-513-1355.

(3) Availability of resources.

(a) General. The agency or the agency's designee applies the following rules when determining available resources for LTC services:

(i) WAC 182-512-0300 SSI-related medical—Resources eligibility;

(ii) WAC 182-512-0250 SSI-related medical—Ownership and availability of resources; and

(iii) WAC 182-512-0260 SSI-related medical—How to count a sponsor's resources.

(b) Married couples.

(i) When both spouses apply for LTC services, the resources of both spouses are available to each other through the month in which the spouses stopped living together.

(ii) When both spouses are institutionalized, the agency or the agency's designee determines the eligibility of each spouse as a single person the month following the month of separation.

(iii) If the agency or the agency's designee has already established eligibility and authorized services for one spouse, and the community spouse needs LTC services in the same month, but after eligibility has been established and services authorized for the institutionalized spouse, then the agency applies the standard under subsection (2)(a) of this section to each spouse. If doing this would make one of the spouses ineligible, then the agency applies subsection (2)(b) of this section for the couple.

(iv) The resources of the community spouse are unavailable to the institutionalized spouse the month after eligibility for LTC services is established, unless (v) or (vi) of this subsection applies.

(v) When a single institutionalized individual marries, the agency or the agency's designee redetermines eligibility applying the resource and income rules for a legally married couple.

(vi) A redetermination of the couple's resources under this section is required if:

(A) The institutionalized spouse has a break of at least 30 consecutive days in a period of institutional status;

(B) The institutionalized spouse's countable resources exceed the standard under subsection (2)(a) of this section, and WAC 182-513-1355 (2)(b) applies; or

(C) The institutionalized spouse does not transfer the amount, under WAC 182-513-1355 (3) or (5), to the community spouse by either:

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

(II) A reasonable amount of time necessary to obtain a court order for the support of the community spouse.

(4) Countable resources.

(a) The agency or the agency's designee determines countable resources using the following sections:

(i) WAC 182-512-0200 SSI-related medical—Definition of resources.

(ii) WAC 182-512-0250 SSI-related medical—Ownership and availability of resources.

(iii) WAC 182-512-0260 SSI-related medical—How to count a sponsor's resources.

(iv) WAC 182-512-0300 SSI-related medical—Resources eligibility.

(v) WAC 182-512-0350 SSI-related medical—Property and contracts excluded as resources;

(vi) WAC 182-512-0400 SSI-related medical—Vehicles excluded as resources;

(vii) WAC 182-512-0450 SSI-related medical—Life insurance excluded as a resource; and

(viii) WAC 182-512-0500 SSI-related medical—Burial funds, contracts and spaces excluded as resources.

(ix) Chapter 182-516 WAC, Trusts, annuities, life estates, and promissory notes—Effect on medical programs.

(b) The agency or the agency's designee determines excluded resources based on federal law and WAC 182-512-0550, except:

(i) For institutional and HCB waiver programs, pension funds owned by a nonapplying spouse are counted toward the resource standard.

(ii) For long-term services and supports (LTSS), based on the need for either nursing facility level of care or intermediate care facility for the intellectually disabled level of care, one home is excluded only if it meets the home equity limits of subsection (8) of this section. See WAC 182-512-0350 (1)(b).

(c) The agency or the agency's designee adds together the countable resources of both spouses if subsections (3)(b)(i) and (iv) apply, but not if subsection (3)(b)(ii) or (iii) apply. For a person with a community spouse, see WAC 182-513-1355.

(5) Excess resources.

(a) For LTC programs, a person may reduce excess resources by deducting incurred medical expenses under subsection (6) of this section;

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

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

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

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

(ii) For LTC services provided under the medically needy (MN) program, see:

(A) WAC 182-513-1395 for LTC programs; and

(B) WAC 182-513-1245 for hospice.

(c) Excess resources not otherwise applied to medical expenses will be applied to the projected cost of care for services in a medical institution under WAC 182-513-1380.

(6) Allowable medical expenses.

(a) The following incurred medical expenses may be used to reduce excess resources:

(i) Premiums, deductibles, coinsurance, or copayment charges for health insurance and medicare;

(ii) Medically necessary care defined under WAC 182-500-0070, but not covered under the state's medicaid plan. Information regarding covered services is under chapter 182-501 WAC;

(iii) Medically necessary care defined under WAC 182-500-0070 incurred prior to medicaid eligibility. Expenses for nursing facility care are reduced at the state rate for the specific facility that provided the services.

(b) To be allowed, the medical expense must:

(i) Have been incurred no more than three months before the month of the medicaid application;

(ii) Not be subject to third-party payment or reimbursement;

(iii) Not have been used to satisfy a previous spenddown liability;

(iv) Not have been previously used to reduce excess resources;

(v) Not have been used to reduce participation;

(vi) Not have been incurred during a transfer of asset penalty under WAC 182-513-1363; and

(vii) Be an amount for which the person remains liable.

(7) Nonallowable expenses. The following expenses are not allowed to reduce excess resources:

(a) Unpaid adult family home (AFH) or assisted living facility expenses incurred prior to medicaid eligibility;

(b) Personal care cost in excess of approved hours determined by the CARE assessment under chapter 388-106 WAC; and

(c) Expenses excluded by federal law.

(8) Excess home equity.

(a) A person with an equity interest in a primary residence in excess of the home equity limit is ineligible for long-term services and supports (LTSS) that are based on the need for either nursing facility level of care or intermediate care facility for the intellectually disabled level of care, unless one of the following persons lawfully resides in the home:

(i) That person's spouse; or

(ii) That person's dependent child under age 21, blind child, or disabled child.

(b) The home equity provision applies to all applications for LTSS received on or after May 1, 2006.

(c) The excess home equity limit is the federal maximum allowed. On January 1st of each year, this standard may change by the percentage in the consumer price index for all consumers (CPI-U). The current maximum home equity limit is posted by the Centers for Medicare and Medicaid Services. (See subsection (9) of this section for institutional resource standards.)

(d) A person who is denied or terminated LTC services due to excess home equity may apply for an undue hardship waiver under WAC 182-513-1367.

(9) Institutional resource standards are found at ((~~https://www.hca.wa.gov/health-care-services-supports/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

AMENDATORY SECTION (Amending WSR 17-03-116, filed 1/17/17, effective 2/17/17)

WAC 182-513-1355 Allocating resources to a community spouse when determining resource eligibility for SSI-related long-term care services. (1) The agency or its designee uses this section to calculate the resource allocation from the institutionalized spouse to the community spouse for the determination of the institutionalized spouse's resource eligibility under WAC 182-513-1350 (2)(a)(ii).

(2) If the institutionalized spouse's most recent continuous period of institutionalization (MRCPI) began:

(a) Before October 1, 1989, the agency adds together one-half the total amount of countable resources, as determined under WAC 182-513-1350(4), held in the name of:

(i) The institutionalized spouse; and

(ii) Both spouses.

(b) On or after October 1, 1989, the agency or its designee adds together the total amount of countable resources, as determined under WAC 182-513-1350(4), held in the name of:

(i) Either spouse; and

(ii) Both spouses.

(3) If subsection (2)(b) of this section applies, the agency or its designee determines the amount of resources allocated to the community spouse, before determining the amount of countable resources used to establish eligibility for the institutionalized spouse under WAC 182-513-1350:

(a) If the institutionalized spouse's MRCPI began on or after October 1, 1989, and before August 1, 2003, the agency or its designee allocates the federal spousal resource maximum;

(b) If the institutionalized spouse's MRCPI began on or after August 1, 2003, the agency or its designee allocates the greater of:

(i) A spousal share equal to one-half of the couple's combined countable resources, up to the federal spousal resource maximum; or

(ii) The state spousal resource standard.

(4) Countable resources under subsection (3)(b) of this section determined as of the first day of the month in which MRCPI began.

(5) The agency or its designee uses a community spouse evaluation to determine the amount of the spousal share under subsection (3)(b)(i) of this section.

(6) The agency or its designee completes a community spouse resource evaluation:

(a) Upon request by the institutionalized spouse, or the institutionalized spouse's community spouse;

(b) At any time between the date that the MRCPI began and the date that eligibility for long-term care (LTC) is determined; and

(c) Upon receipt of any verification required to establish the amount of the couple's resources in the month of MRCPI.

(7) The community spouse resource evaluation can be completed prior to an application for LTC or as part of the LTC application if:

(a) The beginning of the MRCPI was prior to the month of application; and

(b) The spousal share exceeds the state spousal resource standard.

(8) The amount of allocated resources under subsection (3) of this section can be increased, but only if:

(a) A court has entered an order against the institutionalized spouse for the support of the community spouse or a dependent of either spouse; or

(b) A final order is entered under chapter 182-526 WAC, ruling that the institutionalized spouse or community spouse established that the income generated by the resources allocated under subsection (3) of this section is insufficient to raise the community spouse's income to the monthly maintenance needs allowance (MMNA) determined under WAC 182-513-1385, but only after the application of the income-first rule under 42 U.S.C. 1396r-5 (d)(6).

(9) If a final order establishes that the conditions identified in subsection (8)(b) of this section have been met, then an amount of

allocated resources under subsection (3) of this section will be substituted by an amount adequate to provide such an MMNA.

(10) The institutionalized spouse has until the end of the month of the first regularly scheduled eligibility review to transfer countable resources in excess of $2000 to the community spouse.

(11) Standards in this section are found at ((~~http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

AMENDATORY SECTION (Amending WSR 21-09-092, filed 4/21/21, effective 5/22/21)

WAC 182-513-1380 Determining a client's financial participation in the cost of care for long-term care in a medical institution. This rule describes how the agency or the agency's designee allocates income and excess resources when determining participation in the cost of care in a medical institution.

(1) The agency or the agency's designee defines which income and resources must be used in this process under WAC 182-513-1315.

(2) The agency or the agency's designee allocates nonexcluded income in the following order, and the combined total of (a), (b), (c), and (d) of this subsection cannot exceed the effective one-person medically needy income level (MNIL):

(a) A personal needs allowance (PNA) under WAC 182-513-1105.

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

(c) Wages for a client who:

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

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

(d) Guardianship fees and administrative costs, including any attorney fees paid by the guardian, as allowed under chapter 388-79A WAC.

(3) The agency or the agency's designee allocates nonexcluded income after deducting amounts under subsection (2) of this section in the following order:

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

(i) For the current month;

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

(iii) Not counted as the dependent member's income when determining the dependent allocation amount under WAC 182-513-1385.

(b) A monthly maintenance needs allowance for the community spouse as determined using the calculation under WAC 182-513-1385. If the community spouse is also receiving long-term care services, the allocation is limited to an amount that brings the community spouse's income up to the PNA.

(c) A dependent allowance for each dependent of the institutionalized client or the client's spouse, as determined using the calculation under WAC 182-513-1385.

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

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

(i) Up to ((~~one hundred~~)) 100 percent of the one-person federal poverty level per month;

(ii) Limited to a six-month period;

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

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

(4) A client may have to pay third-party resources as defined under WAC 182-513-1100 in addition to the participation.

(5) A client is responsible to pay only up to the state rate for the cost of care. If long-term care insurance pays a portion of the state rate cost of care, a client pays only the difference up to the state rate cost of care.

(6) When a client lives in multiple living arrangements in a month, the agency allows the highest PNA available based on all the living arrangements and services the client has in a month.

(7) Standards under this section for long-term care are found at ((~~https://www.hca.wa.gov/health-care-services-supports/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

AMENDATORY SECTION (Amending WSR 17-03-116, filed 1/17/17, effective 2/17/17)

WAC 182-513-1385 Determining the community spouse monthly maintenance needs allowance and dependent allowance in post-eligibility treatment of income for long-term care (LTC) programs. (1) This section describes how to calculate the monthly maintenance needs allowance (MMNA) in post-eligibility treatment of income for long-term care (LTC) programs for a community spouse or dependent of the institutionalized individual.

(2) The community spouse MMNA standards are found at ((~~http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/standards-ltc~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources, unless a greater amount is calculated under subsection (5) of this section. The MMNA standards may change each January and July based on the consumer price index.

(3) The community spouse MMNA is allowed only to the extent that the institutionalized spouse's income is made available to the community spouse, and is calculated as follows:

(a) The minimum MMNA as calculated in subsection (4)(a) of this section plus excess shelter expenses as calculated in subsection (4)(b) of this section;

(i) The total under (a) of this subsection cannot be less than the minimum MMNA; and

(ii) If the total under subsection (4)(a) of this section exceeds the maximum MMNA, the maximum MMNA is the result under subsection (4)(a) of this section; and

(b) The total under subsection (4)(a) of this section is reduced by the community spouse's gross income. The result is the MMNA.

(4) The minimum MMNA and excess shelter expense values are calculated as follows:

(a) The minimum MMNA is ((~~one hundred fifty~~)) 150 percent of the two-person federal poverty level (FPL); and

(b) If excess shelter expenses are less than zero, the result is zero. Excess shelter expenses are calculated as follows:

(i) Add:

(A) Mortgage or rent, which includes space rent for mobile homes;

(B) Real property taxes;

(C) Homeowner's insurance;

(D) Required maintenance fees for a condominium, cooperative, or homeowner's association that are recorded in a covenant; and

(E) The food assistance standard utility allowance (SUA) under WAC 388-450-0195 minus the cost of any utilities that are included in (b)(i)(D) of this subsection.

(ii) Subtract the standard shelter allocation from the total in (b)(i) of this subsection. The standard shelter allocation is ((~~thirty~~)) 30 percent of ((~~one hundred fifty~~)) 150 percent of the two-person FPL. The result is the value of excess shelter expenses.

(5) The amount allocated to the community spouse may be greater than the amount determined in subsection (3) of this section, but only if:

(a) A court order has been entered against the institutionalized spouse approving a higher MMNA for the support of the community spouse; or

(b) A final order has been entered after an administrative hearing has been held under chapter 182-526 WAC ruling the institutionalized spouse or the community spouse established the community spouse needs income, above the level otherwise provided by the MMNA, due to exceptional circumstances causing significant financial duress.

(6) If a final order establishes that the conditions identified in subsection (5)(b) of this section have been met, then an amount of allocated resources under subsection (3) of this section will be substituted by an amount adequate to provide such an MMNA.

(7) The agency or its designee determines the dependent allowance for dependents of the institutionalized individual or the institutionalized individual's spouse. The amount the agency allows depends on whether the dependent resides with the community spouse.

(a) For each dependent who resides with the community spouse:

(i) Subtract the dependent's income from ((~~one hundred fifty~~)) 150 percent of the two-person FPL;

(ii) Divide the amount determined in (a)(i) of this subsection by three;

(iii) The result is the dependent allowance for that dependent.

(b) For each dependent who does not reside with the community spouse:

(i) The agency determines the effective MNIL standard based on the number of dependent family members in the home;

(ii) Subtracts each dependent's separate income;

(iii) The result is the dependent allowance for the dependents.

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

AMENDATORY SECTION (Amending WSR 21-10-051, filed 4/29/21, effective 5/30/21)

WAC 182-513-1660 Medicaid alternative care (MAC) and tailored supports for older adults (TSOA)—Spousal impoverishment. (1) The medicaid agency or the agency's designee determines financial eligibility for medicaid alternative care (MAC) or tailored supports for older adults (TSOA) using spousal impoverishment protections under this section, when an applicant or recipient:

(a) Is married to, or marries, a person who is not in a medical institution; and

(b) Is ineligible for a noninstitutional categorically needy (CN) SSI-related program or the TSOA program due to:

(i) Spousal deeming rules under WAC 182-512-0920 for MAC;

(ii) Exceeding the resource limit in WAC 182-512-0010 for MAC, or the limit under WAC 182-513-1640 for TSOA; or

(iii) Both (b)(i) and (ii) of this subsection.

(2) When a resource test applies, the agency or the agency's designee determines countable resources using the SSI-related resource rules under chapter 182-512 WAC, except pension funds owned by the spousal impoverishment protections community (SIPC) spouse are not excluded as described under WAC 182-512-0550:

(a) Resource standards:

(i) For MAC, the resource standard is $2,000; or

(ii) For TSOA, the resource standard is $53,100.

(b) Before determining countable resources used to establish eligibility for the applicant, the agency or the agency's designee allocates the state spousal resource standard to the SIPC spouse.

(c) The resources of the SIPC spouse are unavailable to the spousal impoverishment protections institutionalized (SIPI) spouse the month after eligibility for MAC or TSOA services is established.

(3) The SIPI spouse has until the end of the month of the first regularly scheduled eligibility review to transfer countable resources in excess of $2,000 (for MAC) or $53,100 (for TSOA) to the SIPC spouse.

(4) Income eligibility:

(a) For MAC:

(i) The agency or the agency's designee determines countable income using the SSI-related income rules under chapter 182-512 WAC, but uses only the applicant or recipient's income;

(ii) If the applicant's or recipient's countable income is at or below the SSI categorically needy income level (CNIL), the applicant or recipient is considered a SIPI spouse and is income eligible for noninstitutional CN coverage and MAC services;

(iii) If the applicant is employed and the applicant's countable income is at or below the standard under WAC 182-511-1060, the applicant is considered a SIPI spouse and is income eligible for noninstitutional CN coverage under the health care for workers with disabilities (HWD) program and MAC services.

(b) For TSOA, see WAC 182-513-1635.

(5) Once a person no longer receives MAC services, eligibility is redetermined without using spousal impoverishment protections under WAC 182-504-0125.

(6) If the applicant's separate countable income is above the standards described in subsection (4) of this section, the applicant is not income eligible for MAC or TSOA services.

(7) The spousal impoverishment protections described in this section are time-limited and expire on September 30, 2023.

(8) Standards described in this chapter are located at ((~~www.hca.wa.gov/health-care-services-supports/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

AMENDATORY SECTION (Amending WSR 22-21-043, filed 10/11/22, effective 1/1/23)

WAC 182-517-0100 Federal medicare savings programs. (1) Available programs. The medicaid agency offers eligible clients the following medicare savings programs (MSPs):

(a) The qualified medicare beneficiary (QMB) program;

(b) The specified low-income medicare beneficiary (SLMB) program;

(c) The qualified individual (QI-1) program; and

(d) The qualified disabled and working individuals (QDWI) program.

(2) Eligibility requirements.

(a) To be eligible for an MSP, a client must:

(i) Be entitled to medicare Part A; and

(ii) Meet the general eligibility requirements under WAC 182-503-0505.

(b) To be eligible for QDWI, a client must be under age 65.

(c) Income limits.

(i) Income limits for all MSPs are found at ((~~https://www.hca.wa.gov/health-care-services-and-supports/program-administration/program-standard-income-and-resources~~)) www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources.

(ii) If a client's countable income is less than or equal to 100 percent of the federal poverty level (FPL), the client is income eligible for the QMB program.

(iii) If a client's countable income is over 100 percent of the FPL, but does not exceed 120 percent of the FPL, the client is income eligible for the SLMB program.

(iv) If a client's countable income is over 120 percent of the FPL, but does not exceed 135 percent of the FPL, the client is income eligible for the QI-1 program.

(v) If a client's countable income is over 135 percent of the FPL, but does not exceed 200 percent of the FPL, the client is income eligible for the QDWI program if the client is employed and meets disability requirements described in WAC 182-512-0050.

(d) The federal MSPs do not require a resource test.

(3) MSP income eligibility determinations.

(a) The agency has two methods for determining if a client is eligible for an MSP:

(i) The agency first determines if the client is eligible based on SSI-rated methodologies under chapter 182-512 WAC. Under this method, the agency calculates the household's net countable income and compares the result to the one-person standard. However, if the spouse's income is deemed to the client, or if both spouses are applying, the household's net countable income is compared to the two-person standard.

(ii) If the client is not eligible under the methodology described in (a)(i) of this subsection, the agency compares the same countable income, as determined under (a)(i) of this subsection, to the appropriate FPL standard based on family size. The number of individuals that count for family size include:

(A) The client;

(B) The client's spouse who lives with the client;

(C) The client's dependents who live with the client;

(D) The spouse's dependents who live with the spouse, if the spouse lives with the client; and

(E) Any unborn children of the client, or of the spouse if the spouse lives with the client.

(b) Under both eligibility determinations, the agency follows the rules for SSI-related people under chapter 182-512 WAC for determining:

(i) Countable income;

(ii) Availability of income;

(iii) Allowable income deductions and exclusions; and

(iv) Deemed income from and allocated income to a nonapplying spouse and dependents.

(c) The agency uses the eligibility determination that provides the client with the highest level of coverage.

(i) If the MSP applicant is eligible for QMB coverage under (a)(i) of this subsection, the agency approves the coverage.

(ii) If the MSP applicant is not eligible for QMB coverage, the agency determines if the applicant is eligible under (a)(ii) of this subsection.

(iii) If neither eligibility determination results in QMB coverage, the agency uses the same process to determine if the client is eligible under any other MSP.

(d) When calculating income under this section:

(i) The agency subtracts client participation from a long-term care client's countable income under WAC 182-513-1380, 182-515-1509, or 182-515-1514.

(ii) The agency counts the annual Social Security cost-of-living increase beginning April 1st each year.

(4) Covered costs.

(a) The QMB program pays:

(i) Medicare Part A and Part B premiums using the start date in WAC 182-504-0025; and

(ii) Medicare coinsurance, copayments, and deductibles for Part A, Part B, and Part C, subject to the limitations in WAC 182-502-0110.

(b) If the client is eligible for both SLMB and another medicaid program:

(i) The SLMB program pays the Part B premiums using the start date in WAC 182-504-0025; and

(ii) The medicaid program pays medicare coinsurance, copayments, and deductibles for Part A, Part B, and Part C subject to the limitations in WAC 182-502-0110.

(c) If the client is only eligible for SLMB, the SLMB program covers medicare Part B premiums using the start date in WAC 182-504-0025.

(d) The QI-1 program pays medicare Part B premiums using the start date in WAC 182-504-0025 until the agency's federal funding allotment is spent. The agency resumes QI-1 benefit payments the beginning of the next calendar year.

(e) The QDWI program covers medicare Part A premiums using the start date in WAC 182-504-0025.

(5) MSP eligibility. Medicaid eligibility may affect MSP eligibility:

(a) QMB and SLMB clients may receive medicaid and still be eligible to receive QMB or SLMB benefits.

(b) QI-1 and QDWI clients who begin receiving medicaid are no longer eligible for QI-1 or QDWI benefits, but may be eligible for the state-funded medicare buy-in program under WAC 182-517-0300.

(6) Right to request administrative hearing. A person who disagrees with agency action under this section may request an administrative hearing under chapter 182-526 WAC.