



# RULE-MAKING ORDER

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

**Agency:** Health Care Authority, Washington Apple Health

**Permanent Rule Only**

**Effective date of rule:**

**Permanent Rules**

31 days after filing.

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

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

Yes  No If Yes, explain:

**Purpose:**

- The agency revised eligibility rules for institutional medical assistance programs, and creating new regulations to implement the Patient Protection and Affordable Care Act established under Public Law 111-148.
- The agency referenced rules that are final January 1, 2014, in the long-term care medical rule in addition to the elimination of the presumptive disability program as an eligibility group.
- The agency added the residential waiver service program as a Home and Community Based (HCB) Waiver in chapter 182-515 WAC
- The agency implemented the Community First Choice option as directed by the Washington State Legislature.
- The agency added clarifying language regarding countable assets for institutional services.
- The agency updated links and references and changing language for readability and clarity.

**Citation of existing rules affected by this order:**

Repealed: WAC 182-513-1300, 182-513-1301, 182-513-1305, 182-513-1364, 182-513-1365, 182-513-1366, 182-515-1500

Amended: WAC 182-507-0125, 182-512-0400, 182-512-0960, 182-513-1315, 182-513-1320, 182-513-1325, 182-513-1330, 182-513-1340, 182-513-1345, 182-513-1350, 182-513-1363, 182-513-1367, 182-513-1380, 182-513-1395, 182-513-1396, 182-513-1397, 182-513-1400, 182-513-1405, 182-513-1410, 182-513-1415, 182-513-1420, 182-513-1425, 182-513-1430, 182-513-1435, 182-513-1440, 182-513-1445, 182-513-1450, 182-513-1455, 182-515-1505, 182-515-1506, 182-515-1507, 182-515-1508, 182-515-1509, 182-515-1510, 182-515-1511, 182-515-1512, 182-515-1513, 182-515-1514

Suspended:

**Statutory authority for adoption:** RCW 41.05.021, 41.05.160

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

**PERMANENT RULE (Including Expedited Rule Making)**

Adopted under notice filed as WSR 16-24-087 on December 7, 2016.

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: \_\_\_\_\_ phone ( ) \_\_\_\_\_  
Address: \_\_\_\_\_ fax ( ) \_\_\_\_\_  
e-mail \_\_\_\_\_

**Date adopted:** January 17, 2017

**NAME (TYPE OR PRINT)**

Wendy Barcus

**SIGNATURE**

**TITLE**

HCA Rules Coordinator

**CODE REVISER USE ONLY**

OFFICE OF THE CODE REVISER  
STATE OF WASHINGTON  
FILED

**DATE: January 17, 2017**

**TIME: 3:07 PM**

**WSR 17-03-116**

**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:**

<b>Federal statute:</b>	New	_____	Amended	_____	Repealed	_____
<b>Federal rules or standards:</b>	New	_____	Amended	_____	Repealed	_____
<b>Recently enacted state statutes:</b>	New	_____	Amended	_____	Repealed	_____

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

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

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

New	<u>17</u>	Amended	<u>38</u>	Repealed	<u>7</u>
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**The number of sections adopted using:**

<b>Negotiated rule making:</b>	New	_____	Amended	_____	Repealed	_____
<b>Pilot rule making:</b>	New	_____	Amended	_____	Repealed	_____
<b>Other alternative rule making:</b>	New	<u>17</u>	Amended	<u>38</u>	Repealed	<u>7</u>

**WAC 182-507-0125 State-funded long-term care services ((program)).** ((1) The state-funded long-term care services program is subject to caseload limits determined by legislative funding. Services cannot be authorized for eligible persons prior to a determination by the aging and disability services administration (ADSA) that caseload limits will not be exceeded as a result of the authorization.

(2) Long-term care services are defined in this section as services provided in one of the following settings:

- (a) In a person's own home, as described in WAC 388-106-0010;
- (b) Nursing facility, as defined in WAC 388-97-0001;
- (c) Adult family home, as defined in RCW 70.128.010;
- (d) Assisted living facility, as described in WAC 388-513-1301;
- (e) Enhanced adult residential care facility, as described in WAC 388-513-1301;

(f) Adult residential care facility, as described in WAC 388-513-1301.

(3) Long-term care services will be provided in one of the facilities listed in subsection (2)(b) through (f) of this section unless nursing facility care is required to sustain life.

(4) To be eligible for the state-funded long-term care services program described in this section, an adult nineteen years of age or older must meet all of the following conditions:

- (a) Meet the general eligibility requirements for medical programs described in WAC 388-503-0505 (2) and (3)(a), (b), (e), and (f);
- (b) Reside in one of the settings described in subsection (2) of this section;
- (c) Attain institutional status as described in WAC 388-513-1320;
- (d) Meet the functional eligibility described in WAC 388-106-0355 for nursing facility level of care;

(e) Not have a penalty period due to a transfer of assets as described in WAC 388-513-1363, 388-513-1364, 388-513-1365, and 388-513-1366;

(f) Not have equity interest in a primary residence more than the amount described in WAC 388-513-1350 (7)(a)(ii); and

(g) Any annuities owned by the adult or spouse must meet the requirements described in chapter 388-561 WAC.

(5) An adult who is related to the supplemental security income (SSI) program as described in WAC 388-475-0050 (1), (2), and (3) must meet the financial requirements described in WAC 388-513-1325, 388-513-1330, and 388-513-1350.

(6) An adult who does not meet the SSI-related criteria in subsection (2) of this section may be eligible under the family institutional medical program rules described in WAC 388-505-0250 or 388-505-0255.

(7) An adult who is not eligible for the state-funded long-term care services program under categorically needy (CN) rules may qualify under medically needy (MN) rules described in:

- (a) WAC 388-513-1395 for adults related to SSI; or
- (b) WAC 388-505-0255 for adults related to family institutional medical.

(8) All adults qualifying for the state-funded long-term care services program will receive CN scope of medical coverage described in WAC 388-501-0060.

~~(9) The department determines how much an individual is required to pay toward the cost of care using the following rules:~~

~~(a) For an SSI-related individual residing in a nursing home, see rules described in WAC 388-513-1380.~~

~~(b) For an SSI-related individual residing in one of the other settings described in subsection (2) of this section, see rules described in WAC 388-515-1505.~~

~~(c) For an individual eligible under the family institutional program, see WAC 388-505-0265.~~

~~(10) A person is not eligible for state-funded long-term care services if that person entered the state specifically to obtain medical care.~~

~~(11) A person eligible for the state-funded long-term care services program is certified for a twelve-month period.)~~ (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 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 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>.

**WAC 182-512-0400 SSI-related medical—Vehicles excluded as resources.** (1) For SSI-related medical programs, a vehicle is defined as anything used for transportation. In addition to cars and trucks, a vehicle can include boats, snowmobiles, and animal-drawn vehicles.

(2) One vehicle is excluded regardless of its value, if it is used to provide transportation for the ((disabled)) SSI-related person or a member of the person's household.

(3) ((For a person receiving SSI-related institutional coverage who has a community spouse, one vehicle is excluded regardless of its value or its use. See WAC 182-513-1350 (7)(b).

(4)) A vehicle used as the person's primary residence is excluded as the home, and does not count as the one excluded vehicle under subsection (2) ((or (3))) of this section.

((5) All other vehicles, except those excluded under WAC 182-512-0350 (11) through (14), are treated as nonliquid resources and the equity value is counted toward the resource limit.))

~~WAC 182-512-0960 SSI-related medical—Allocating income—(How the agency considers income and resources when determining eligibility for a person applying for noninstitutional Washington apple health (WAH) when another household member is receiving institutional WAH))~~  
Determining eligibility for a spouse when the other spouse receives long-term services and supports. ((1) The agency follows rules described in WAC 182-513-1315 for a person considered to be in institutional WAH, which means a person who is either residing in a medical institution, or approved for a home and community based waiver, or approved for the WAH institutional hospice program. The rules in this section describe how the agency considers household income and resources when the household contains both institutional and noninstitutionalized household members.

~~(2) An institutionalized person (adult or child) who is not SSI-related may be considered under the long-term care for families and children programs described in WAC 182-514-0230 through 182-514-0265.~~

~~(3) The agency considers the income and resources of spouses as available to each other through the end of the month in which the spouses stopped living together. See WAC 182-513-1330 and 182-513-1350 when a spouse is institutionalized.~~

~~(4) The agency considers income and resources separately as of the first day of the month following the month of separation when spouses stop living together because of placement into a boarding home (assisted living, enhanced adult residential center, adult residential center), adult family home (AFH), adult residential rehabilitation center/adult residential treatment facility (ARRC/ARTF), or division of developmental disabilities group home (DDD-GH) facility when:~~

~~(a) Only one spouse enters the facility;~~

~~(b) Both spouses enter the same facility but have separate rooms;~~

~~or~~

~~(c) Both spouses enter separate facilities.~~

~~(5) The agency considers income and resources jointly when both spouses are placed in a boarding home, AFH, ARRC/ARTF, or DDD-GH facility and share a room.~~

~~(6) When determining SSI-related WAH categorically needy (CN) or medically needy (MN) eligibility for a community spouse applying for health care coverage, the agency counts:~~

~~(a) The separate income of the community spouse; plus~~

~~(b) One half of any community income received by the community spouse and the institutionalized spouse; plus~~

~~(c) Any amount allocated to the community spouse from the institutionalized spouse. The terms "community spouse" and "institutional spouse" are defined in WAC 182-513-1301.~~

~~(7) For the purposes of determining the countable income of a community spouse applying for health care coverage as described in subsection (6) of this section, it does not matter whether the spouses reside together or not. Income that is allocated and actually available to a community spouse is considered that person's income.~~

~~(8) For the purposes of determining the countable income of a community spouse or children applying for health care coverage under modified adjusted gross income (MAGI)-based family, pregnancy or children's WAH programs, the agency uses the following rules to deter-~~

~~mine if the income of the institutionalized person is considered in the eligibility calculation:~~

~~(a) When the institutionalized spouse or parent lives in the same home with the community spouse and/or children, their income is counted in the determination of household income following the rules for the medical program that is being considered.~~

~~(b) When the institutionalized spouse or parent does not live in the same home as the spouse and/or children, only income that is allocated and available to the household is counted.~~

~~(9) When determining the countable income of a community spouse applying for health care coverage under the WAH MN program, the agency allocates income from the community spouse to the institutionalized spouse in an amount up to the one person effective medically needy income level (MNIL) less the institutionalized spouse's income, when:~~

~~(a) The community spouse is living in the same household as the institutionalized spouse;~~

~~(b) The institutionalized spouse is receiving home and community-based waiver or institutional hospice services described in WAC 182-515-1505; and~~

~~(c) The institutionalized spouse has gross income of less than the MNIL.~~

~~(10) See WAC 182-506-0015 for rules on how to determine medical assistance units for households that include SSI-related persons. A separate medical assistance unit is always established for persons who meet institutional status described in WAC 182-513-1320.) (1) General information.~~

(a) This section describes how the agency determines household income and resources when the household contains both institutional and noninstitutional household members.

(b) A separate medical assistance unit is established for people who meet institutional status under WAC 182-513-1320. See WAC 182-506-0015 for rules on how to determine medical assistance units for households that include people related to the supplemental security income (SSI) program.

(c) Throughout this section, "home" means "own home" as defined in WAC 388-106-0010.

(d) The income and resources of each spouse are available to the other through the end of the month in which the spouses stopped living together, unless subsection (3) of this section applies.

(e) The agency determines income and resources separately starting the first day of the month following the month of separation if spouses stop living together in the same home.

(f) When one, or both members of a couple live in an alternative living facility (ALF), the agency considers the couple to be living:

(i) Apart when:

(A) Only one spouse enters the ALF;

(B) Both spouses enter the same ALF but have separate rooms; or

(C) Both spouses enter separate ALFs.

(ii) Together when both spouses share a room in an ALF.

(2) The agency counts income and resources under this chapter when both members of a couple live in the same house and the community spouse or spousal impoverishment protections community (SIPC) spouse applies for coverage and his or her spouse receives:

(a) Home and community-based (HCB) waiver;

(b) Program for all inclusive care to the elderly (PACE);

(c) Roads to community living (RCL);

(d) Hospice; or



(e) Community first choice (CFC).

(3) When one member of a couple lives apart from their spouse and the community spouse or SIPC spouse applies for coverage, and the spouse who receives long-term services and supports lives:

(a) In an institution:

(i) The agency counts income under this chapter, plus any allocation the institutionalized spouse has made available to the community spouse; and

(ii) The agency counts resources under this chapter, plus any resources allocated to the community spouse when eligibility for the institutionalized spouse was determined, that remain in the name of the institutionalized spouse and are available to the community spouse under WAC 182-512-0250.

(b) In an ALF and receives HCB waiver, PACE, RCL, or hospice:

(i) The agency counts income under this chapter, plus any allocation the institutionalized spouse has made available to the community spouse; and

(ii) The agency counts resources under this chapter, plus any resources allocated to the community spouse when eligibility for the institutionalized spouse was determined, that remain in the name of the institutionalized spouse, and are available to the community spouse under WAC 182-512-0250; and

(c) In an ALF and receives CFC:

(i) The agency counts income under this chapter; and

(ii) The agency counts resources under this chapter, plus any resources allocated to the SIPC spouse when eligibility for the spousal impoverishment protections institutionalized (SIPI) spouse was determined, that remain in the name of the SIPI spouse and are available to the community spouse under WAC 182-512-0250.

(4) Determining household income when the spouse of an HCB waiver recipient is not eligible for categorically needy (CN) coverage.

(a) When the community spouse is not eligible for categorically needy (CN) coverage under subsection (2) of this section, the agency determines eligibility under the medically needy program;

(b) The agency counts income and resources as described under subsection (2) of this section;

(c) The agency allocates income to the institutionalized spouse before comparing the community spouse's income to the medically needy income level (MNIL) if:

(i) The community spouse lives in the same household as the institutionalized spouse;

(ii) The institutionalized spouse is receiving home and community-based waiver services under WAC 182-515-1505 or institutional hospice services under WAC 182-513-1240; and

(iii) The institutionalized spouse has gross income under the MNIL.

(d) The allocation in (c) of this subsection cannot exceed the one-person effective MNIL minus the institutionalized spouse's income.

NEW SECTION

**WAC 182-513-1100 Definitions related to long-term services and supports (LTSS).** This section defines the meaning of certain terms used in chapters 182-513 and 182-515 WAC. Within these chapters, institutional, home and community based (HCB) waiver, program of all-inclusive care for the elderly (PACE), and hospice in a medical institution are referred to collectively as long-term care (LTC). Long-term services and supports (LTSS) is a broader definition which includes institutional, HCB waiver, and other services such as medicaid personal care (MPC), community first choice (CFC), PACE, and hospice in the community. See chapter 182-500 WAC for additional definitions.

**"Adequate consideration"** means that the fair market value (FMV) of the property or services received, in exchange for transferred property, approximates the FMV of the property transferred.

**"Administrative costs" or "costs"** means necessary costs paid by the guardian including attorney fees.

**"Aging and long-term support administration (ALTSA)"** means the administration within the Washington state department of social and health services (DSHS).

**"Alternate living facility (ALF)"** is not an institution under WAC 182-500-0050; it is one of the following community residential facilities:

- (a) An adult family home (AFH) licensed under chapter 70.128 RCW.
- (b) An adult residential care facility (ARC) licensed under chapter 18.20 RCW.
- (c) A mental health adult residential treatment facility under chapter 246-337 WAC.
- (d) An assisted living facility (AL) licensed under chapter 18.20 RCW.
- (e) A developmental disabilities administration (DDA) group home (GH) licensed as an adult family home under chapter 70.128 RCW or an assisted living facility under chapter 18.20 RCW.
- (f) An enhanced adult residential care facility (EARC) licensed as an assisted living facility under chapter 18.20 RCW.
- (g) An enhanced service facility (ESF) licensed under chapter 70.97 RCW.

**"Assets"** means all income and resources of a person and of the person's spouse, including any income or resources which that person or that person's spouse would otherwise currently be entitled to but does not receive because of action:

- (a) By that person or that person's spouse;
- (b) By another person, including a court or administrative body, with legal authority to act in place of or on behalf of the person or the person's spouse; or
- (c) By any other person, including any court or administrative body, acting at the direction or upon the request of the person or the person's spouse.

**"Authorization date"** means the date payment begins for long-term services and supports (LTSS) under WAC 388-106-0045.

**"Clothing and personal incidentals (CPI)"** means the cash payment (under WAC 388-478-0090, 388-478-0006, and 388-478-0033) issued by the department for clothing and personal items for people living in an ALF or medical institution.

**"Community first choice (CFC)"** means a medicaid state plan home and community based service developed under the authority of section 1915(k) of the Social Security Act under chapter 388-106 WAC.

**"Community options program entry system (COPES)"** means a medicaid HCB waiver program developed under the authority of section 1915(c) of the Social Security Act under chapter 388-106 WAC.

**"Community spouse (CS)"** means the spouse of an institutionalized spouse.

**"Community spouse resource allocation (CSRA)"** means the resource amount that may be transferred without penalty from:

(a) The institutionalized spouse (IS) to the community spouse (CS); or

(b) The spousal impoverishment protections institutionalized (SIPI) spouse to the spousal impoverishment protections community (SIPC) spouse.

**"Community spouse resource evaluation"** means the calculation of the total value of the resources owned by a married couple on the first day of the first month of the institutionalized spouse's most recent continuous period of institutionalization.

**"Comprehensive assessment reporting evaluation (CARE) assessment"** means the evaluation process defined under chapter 388-106 WAC used by a department designated social services worker or a case manager to determine a person's need for long-term services and supports (LTSS).

**"Continuing care contract"** means a contract to provide a person, for the duration of that person's life or for a term in excess of one year, shelter along with nursing, medical, health-related, or personal care services, which is conditioned upon the transfer of property, the payment of an entrance fee to the provider of such services, or the payment of periodic charges for the care and services involved.

**"Continuing care retirement community"** means an entity which provides shelter and services under continuing care contracts with its members and which sponsors or includes a health care facility or a health service.

**"Dependent"** means a minor child, or one of the following who meets the definition of a tax dependent under WAC 182-500-0105: Adult child, parent, or sibling.

**"Developmental disabilities administration (DDA)"** means an administration within the Washington state department of social and health services (DSHS).

**"Developmental disabilities administration (DDA) home and community based (HCB) waiver"** means a medicaid HCB waiver program developed under the authority of section 1915(c) of the Social Security Act under chapter 388-845 WAC authorized by DDA. There are five DDA HCB waivers:

(a) Basic Plus;

(b) Core;

(c) Community protection;

(d) Children's intensive in-home behavioral support (CIIBS); and

(e) Individual and family services (IFS).

**"Equity"** means the fair market value of real or personal property less any encumbrances (mortgages, liens, or judgments) on the property.

**"Fair market value (FMV)"** means the price an asset may reasonably be expected to sell for on the open market in an agreement, made by two parties freely and independently of each other, in pursuit of their own self-interest, without pressure or duress, and without some

special relationship (arm's length transaction), at the time of transfer or assignment.

**"Guardianship fees"** or **"fees"** means necessary fees charged by a guardian for services rendered on behalf of a client.

**"Home and community based (HCB) waiver programs authorized by home and community services (HCS)"** means medicaid HCB waiver programs developed under the authority of Section 1915(c) of the Social Security Act under chapter 388-106 WAC authorized by HCS. There are three HCS HCB waivers: Community options program entry system (COPES), new freedom consumer directed services (New Freedom), and residential support waiver (RSW).

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

**"Institutional services"** means services paid for by Washington apple health, and provided:

(a) In a medical institution;

(b) Through an HCB waiver; or

(c) Through programs based on HCB waiver rules for post-eligibility treatment of income under chapter 182-515 WAC.

**"Institutionalized individual"** means a person who has attained institutional status under WAC 182-513-1320.

**"Institutionalized spouse"** means a person who, regardless of legal or physical separation:

(a) Has attained institutional status under WAC 182-513-1320; and

(b) Is legally married to a person who is not in a medical institution.

**"Life care community"** see continuing care community.

**"Likely to reside"** means the agency or its designee reasonably expects a person will remain in a medical institution for thirty consecutive days. Once made, the determination stands, even if the person does not actually remain in the facility for that length of time.

**"Long-term care services"** see "Institutional services."

**"Long-term services and supports (LTSS)"** includes institutional and noninstitutional services authorized by the department.

**"Medicaid personal care (MPC)"** means a medicaid state plan home and community based service under chapter 388-106 WAC.

**"Most recent continuous period of institutionalization (MRCPI)"** means the current period an institutionalized spouse has maintained uninterrupted institutional status when the request for a community spouse resource evaluation is made. Institutional status is determined under WAC 182-513-1320.

**"Noninstitutional medicaid"** means any apple health program not based on HCB waiver rules under chapter 182-515 WAC, or rules based on a person residing in an institution for thirty days or more under chapter 182-513 WAC.

**"Nursing facility level of care (NFLOC)"** is under WAC 388-106-0355.

**"Participation"** means the amount a person must pay each month toward the cost of long-term care services received each month; it is the amount remaining after the post-eligibility process under WAC 182-513-1380, 182-515-1509, or 182-515-1514. Participation is not room and board.

**"Penalty period"** or **"period of ineligibility"** means the period of time during which a person is not eligible to receive services that are subject to transfer of asset penalties.

**"Personal needs allowance (PNA)"** means an amount set aside from a person's income that is intended for personal needs. The amount a person is allowed to keep as a PNA depends on whether the person lives in a medical institution, ALF, or at home.

**"Room and board"** means the amount a person must pay each month for food, shelter, and household maintenance requirements when that person resides in an ALF. Room and board is not participation.

**"Short stay"** means residing in a medical institution for a period of twenty-nine days or fewer.

**"Special income level (SIL)"** means the monthly income standard that is three hundred percent of the supplemental security income (SSI) federal benefit rate.

**"Spousal impoverishment protections"** means the financial provisions within Section 1924 of the Social Security Act that protect income and assets of the community spouse through income and resource allocation. The allocation process is used to discourage the impoverishment of a spouse due to the other spouse's need for LTSS. This includes services provided in a medical institution, HCB waivers authorized under 1915(c) of the Social Security Act, and through December 31, 2018, services authorized under 1115 and 1915(k) of the Social Security Act.

**"Spousal impoverishment protections community (SIPC) spouse"** means the spouse of a SIPI spouse.

**"Spousal impoverishment protections institutionalized (SIPI) spouse"** means a legally married person who qualifies for the noninstitutional categorically needy (CN) Washington apple health SSI-related program only because of the spousal impoverishment protections under WAC 182-513-1220.

**"State spousal resource standard"** means the minimum CSRA standard for a CS or SIPC spouse.

**"Third-party resource (TPR)"** means funds paid to or on behalf of a person by a third party, where the purpose of the funds is for payment of activities of daily living, medical services, or personal care. The agency does not pay for these services if there is a third-party resource available.

**"Transfer"** means, in the context of long-term care eligibility, the changing of ownership or title of an asset, such as income, real property, or personal property, by one of the following:

- (a) An intentional act that changes ownership or title; or
- (b) A failure to act that results in a change of ownership or title.

**"Uncompensated value"** means the fair market value (FMV) of an asset on the date of transfer, minus the FMV of the consideration the person receives in exchange for the asset.

**"Undue hardship"** means a person is not able to meet shelter, food, clothing, or health needs. A person may apply for an undue hardship waiver based on criteria under WAC 182-513-1367.

#### NEW SECTION

**WAC 182-513-1200 Long-term services and supports (LTSS) authorized under Washington apple health programs.** (1) Long-term services and supports (LTSS) programs available to people eligible for nonin-

stitutional Washington apple health coverage who meet the functional requirements.

(a) Noninstitutional apple health coverage in an alternate living facility (ALF) under WAC 182-513-1205.

(b) Community first choice (CFC) under WAC 182-513-1210.

(c) Medicaid personal care (MPC) under WAC 182-513-1225.

(d) For people who do not meet institutional status under WAC 182-513-1320, skilled nursing or rehabilitation is available under the CN, medically needy (MN) or alternative benefits plan (ABP) scope of care if enrolled into a managed care plan.

(2) Non-HCB waiver LTSS programs that use institutional rules under WAC 182-513-1315 and 182-513-1380 or HCB waiver rules under chapter 182-515 WAC, depending on the person's living arrangement:

(a) Program of all-inclusive care for the elderly (PACE) under WAC 182-513-1230.

(b) Roads to community living (RCL) under WAC 182-513-1235.

(c) Hospice under WAC 182-513-1240.

## NEW SECTION

**WAC 182-513-1205 Determining eligibility for noninstitutional coverage in an alternate living facility (ALF).** (1) This section describes the eligibility determination for noninstitutional coverage for a person who lives in a department-contracted alternate living facility (ALF) defined under WAC 182-513-1100.

(2) The eligibility criteria for noninstitutional Washington apple health in an ALF follows SSI-related rules under WAC 182-512-0050 through 182-512-0960 with the exception of the higher income standard under subsection (3) of this section.

(3) A person is eligible for noninstitutional coverage under the categorically needy (CN) program if the person's monthly income after allowable exclusions under chapter 182-512 WAC:

(a) Does not exceed the special income level (SIL) defined under WAC 182-513-1100; and

(b) Is less than or equal to the person's assessed state rate at a department-contracted facility. To determine the CN standard:  $((y \times 31) + \$38.84)$ , where "y" is the state daily rate. \$38.84 is based on the cash payment standard for a person living in an ALF setting under WAC 388-478-0006.

(4) A person is eligible for noninstitutional coverage under the medically needy (MN) program if the person's monthly income after allowable exclusions under chapter 182-512 WAC is less than or equal to the person's private rate at a department-contracted facility. To determine the MN standard:  $((z \times 31) + \$38.84)$ , where "z" is the facility's private daily rate. To determine MN spenddown liability, see chapter 182-519 WAC.

(5) For both CN and MN coverage, a person's countable resources cannot exceed the standard under WAC 182-512-0010.

(6) The agency or its designee approves CN noninstitutional coverage for twelve months.

(7) The agency or its designee approves MN noninstitutional coverage for a period of months under chapter 182-504 WAC for an SSI-related person, provided the person satisfies any spenddown liability under chapter 182-519 WAC.

(8) People who receive medicaid personal care (MPC) or community first choice (CFC) pay all of their income to the ALF except a personal needs allowance of \$62.79.

(9) A person may have to pay third-party resources as defined under WAC 182-513-1100 in addition to the payment under this subsection.

#### NEW SECTION

**WAC 182-513-1210 Community first choice (CFC)—Overview.** (1) Community first choice (CFC) is a Washington apple health state plan benefit authorized under Section 1915(k) of the Social Security Act.

(2) CFC enables the agency and its contracted entities to deliver person-centered home and community based long-term services and supports (LTSS) to medicaid-eligible people who meet the institutional level of care under WAC 388-106-0355. See:

(a) WAC 388-106-0270 through 388-106-0295 for services included within the CFC benefit package.

(b) WAC 182-513-1215 for financial eligibility for CFC services.

#### NEW SECTION

**WAC 182-513-1215 Community first choice (CFC)—Eligibility.** (1) An applicant 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 applicant is:

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

(b) 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) An applicant 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 applicant 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 person is eligible under subsection (1)(a) or (b) of this section. People who reside in an alternate living facility (ALF) do pay up to the room and board standard. The room and board amount is based on the effective one-person medically needy income level (MNIL) minus the residential personal needs allowance (PNA) except when eligibility is based on the rules under WAC 182-513-1205.

(6) A person who receives CFC and aged, blind, disabled (ABD) cash assistance in an AFH keeps a clothing and personal incidentals (CPI) amount of \$38.84 and pays the remainder of the cash grant and other available income towards room and board.

(7) A person 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, if residing in a residential setting.

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

(9) A person 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 <http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources>.

#### NEW SECTION

**WAC 182-513-1220 Community first choice (CFC)—Spousal impoverishment protections for noninstitutional Washington apple health clients.** (1) 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.

(2) 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.

(3) 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 (8) of this section applies.

(4) 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.

(5) A redetermination of the couple's resources under subsection (3) of this section is required if:

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

(b) The SIPI spouse's countable resources exceed the standard under subsection (3)(a) of this section; or

(c) The SIPI spouse does not transfer the amount under subsection (4) of this section to the SIPC spouse by the end of the month of the first regularly scheduled eligibility review.

(6) 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.

(7) 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.

(8) 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.

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

(10) If the applicant's separate countable income is above the standards under subsections (6), (7), and (8) of this section, the applicant is not eligible for CFC services under this section.

(11) The spousal impoverishment protections under this section expire on December 31, 2018.

(12) Standards are found at <http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources>.

## NEW SECTION

**WAC 182-513-1225 Medicaid personal care (MPC).** (1) Medicaid personal care (MPC) is a state-plan benefit available to a person 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 program.

(2) MPC services may be provided to a person 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 person who resides in an alternate living facility (ALF) listed in subsection (2) of this section:

(a) Keeps a personal needs allowance (PNA) of \$62.79; and

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

(4) A person who receives MPC and aged, blind, disabled (ABD) cash assistance in an AFH keeps a clothing and personal incidentals (CPI) amount of \$38.84 and pays the rest of the cash grant and other available income towards room and board.

(5) A person 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, if residing in a residential setting.

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

(7) Current PNA and room and board standards are found at <http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources>.

## NEW SECTION

**WAC 182-513-1230 Program of all-inclusive care for the elderly (PACE).** (1) The program of all-inclusive care for the elderly (PACE) provides long-term services and supports (LTSS), medical, mental health, and chemical dependency treatment through a department-contracted managed care plan using a personalized plan of care for each enrollee.

(2) Program rules governing functional eligibility for PACE are listed under WAC 388-106-0700, 388-106-0705, 388-106-0710, and 388-106-0715.

(3) A person is financially eligible for PACE if the person:

(a) Is age:

(i) Fifty-five or older and disabled under WAC 182-512-0050; or

(ii) Sixty-five or older;

(b) Meets nursing facility level of care under WAC 388-106-0355;

(c) Lives in a designated PACE service area;

(d) Meets financial eligibility requirements under this section;

and

(e) Agrees to receive services exclusively through the PACE provider and the PACE provider's network of contracted providers.

(4) Although PACE is not a home and community based (HCB) waiver program, financial eligibility is determined using the HCB waiver rules under WAC 182-515-1505 when a person is living at home or in an alternate living facility (ALF), with the following exceptions:

(a) PACE enrollees are not subject to the transfer of asset rules under WAC 182-513-1363; and

(b) PACE enrollees may reside in a medical institution thirty days or longer and still remain eligible for PACE services. The eligibility rules for institutional coverage are under WAC 182-513-1315 and 182-513-1380.

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

#### NEW SECTION

**WAC 182-513-1235 Roads to community living (RCL).** (1) Roads to community living (RCL) is a demonstration project authorized under Section 6071 of the Deficit Reduction Act of 2005 (P.L. 109-171) and extended through the Patient Protection and Affordable Care Act (P.L. 111-148).

(2) Program rules governing functional eligibility for RCL are described in WAC 388-106-0250 through 388-106-0265. RCL services are authorized by the department.

(3) A person must have a stay of at least ninety consecutive days in a qualified institutional setting such as a hospital, nursing home, or residential habilitation center, to be eligible for RCL. The ninety-day count excludes days paid solely by medicare, must include at least one day of medicaid paid inpatient services immediately prior to discharge, and the person must be eligible to receive any categorically needy (CN), medically needy (MN), or alternate benefit plan (ABP) medicaid program on the day of discharge. In addition to meeting the ninety-day criteria, a person who is being discharged from a state psychiatric hospital must be under age twenty-two or over age sixty-four.

(4) Once a person is discharged to home or to a residential setting under RCL, the person remains continuously eligible for medical coverage for three hundred sixty-five days unless the person:

- (a) Returns to an institution for thirty days or longer;
- (b) Is incarcerated in a public jail or prison;
- (c) No longer wants RCL services;
- (d) Moves out-of-state; or
- (e) Dies.

(5) Changes in income or resources during the continuous eligibility period do not affect eligibility for RCL services. Changes in income or deductions may affect the amount a person must pay toward the cost of care.

(6) A person approved for RCL is not subject to transfer of asset provisions under WAC 182-513-1363 during the continuous eligibility period, but transfer penalties may apply if the person needs HCB waiver or institutional services once the continuous eligibility period has ended.

(7) A person who is not otherwise eligible for a noninstitutional medical program must have eligibility determined using the same rules used to determine eligibility for HCB waivers. If HCB rules are used to establish eligibility, the person must pay participation toward the cost of RCL services. HCB waiver eligibility and cost of care calculations are under:

(a) WAC 182-515-1508 and 182-515-1509 for home and community services (HCS); and

(b) WAC 182-515-1513 and 182-515-1514 for development disabilities administration (DDA) services.

(8) At the end of the continuous eligibility period, the agency or its designee redetermines a person's eligibility for other programs under WAC 182-504-0125.

#### NEW SECTION

##### **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 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 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>.

#### NEW SECTION

**WAC 182-513-1245 Medically needy hospice program in a medical institution.** (1) General information.

(a) When living in a medical institution, a person may be eligible for medically needy coverage under the hospice program. A person must:

(i) Meet program requirements under WAC 182-513-1315;

(ii) Have available income that exceeds the special income level (SIL), defined under WAC 182-513-1100, but is below the institution's monthly state-contracted rate;

(iii) Meet the financial requirements of subsection (4) or (5) of this section; and

(b) Elect hospice services under chapter 182-551 WAC.

(2) Financial eligibility.

(a) The agency or its designee determines a person's resource eligibility, excess resources, and medical expense deductions using WAC 182-513-1350.

(b) The agency or its designee determines a person's countable income by:

(i) Excluding income under WAC 182-513-1340;

(ii) Determining available income under WAC 182-513-1325 or 182-513-1330;

(iii) Disregarding income under WAC 182-513-1345; and

(iv) Deducting medical expenses that were not used to reduce excess resources under WAC 182-513-1350.

(3) Determining the state-contracted daily rate in an institution, and the institutional medically needy income level (MNIL).

(a) The agency or its designee determines the state-contracted daily rate in an institution and the institutional MNIL based on the living arrangement, and whether the person is entitled to receive hospice services under medicare.

(b) When the person resides in a hospice care center:

(i) If entitled to medicare, the state-contracted daily rate is the state-contracted daily hospice care center rate. The institutional MNIL is calculated by multiplying the state-contracted daily rate by 30.42.

(ii) If not entitled to medicare, the state-contracted daily rate is the state-contracted daily hospice care center rate, plus the state-contracted daily hospice rate. To calculate the institutional MNIL, multiply the state-contracted daily rate by 30.42.

(c) When the person resides in a nursing facility:

(i) If entitled to medicare, the state-contracted daily rate is ninety-five percent of the nursing facility's state-contracted daily rate. The institutional MNIL is calculated by multiplying the state-contracted daily rate by 30.42.

(ii) If not entitled to medicare, the state-contracted daily rate is ninety-five percent of the nursing facility's state-contracted daily rate, plus the state-contracted daily hospice rate. The institutional MNIL is calculated by multiplying the state-contracted daily rate by 30.42.

(4) Eligibility for agency payment to the facility for institutional hospice services and the MN program.

(a) If a person's countable income plus excess resources is less than or equal to the state-contracted daily rate under subsection (3) of this section times the number of days the person has resided in the medical institution, the person:

(i) Is eligible for agency payment to the facility for institutional hospice services;

(ii) Is approved for MN coverage for a twelve-month certification period;

(b) Pays excess resources under WAC 182-513-1350; and

(c) Pays income towards the cost of care under WAC 182-513-1380.

(5) Eligibility for institutional MN spenddown.

(a) If a person's countable income is more than the state-contracted daily rate times the number of days the person has resided in the medical institution, but less than the institution's private rate for the same period, the person:

(i) Is not eligible for agency payment to the facility for institutional hospice services; and

(ii) Is eligible for the MN spenddown program for a three-month or six-month base period when qualifying medical expenses meet a person's spenddown liability.

(b) Spenddown liability is calculated by subtracting the institutional MNIL from the person's countable income for each month in the base period. The values from each month are added together to determine the spenddown liability.

(c) Qualifying medical expenses used to meet the spenddown liability are described in WAC 182-519-0110, except that only costs for hospice services not included within the state-contracted daily rate are qualifying medical expenses.

(6) Eligibility for MN spenddown.

(a) If a person's countable income is more than the institution's private rate times the number of days the person has resided in the medical institution, the person is not eligible for agency payment to

the facility for institutional hospice services and institutional MN spenddown; and

(b) The agency or its designee determines eligibility for MN spenddown under chapter 182-519 WAC.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(d) Receive home and community waiver (HCS) or DDD waiver services in addition to hospice services. The client's responsibility to pay toward the cost of care (participation) is applied to the waiver service provider first; or~~

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~WAC 182-514-0260 and must be preapproved for coverage by ADSA as described in WAC 182-507-0125.~~

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

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

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

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

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

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

~~(18) Clients not living in a medical institution who are considered to be receiving SSI benefits for the purposes of medicaid do not pay service participation toward their cost of care. Clients living in a residential setting do pay room and board as described in WAC 388-515-1505 through 388-515-1509 or WAC 388-515-1514. Groups deemed to be receiving SSI and for medicaid purposes are eligible to receive CN medicaid. These groups are described in WAC 182-512-0880.) This section lists the sections in this chapter that describe how the agency determines a person's eligibility for long-term care services. These sections are:~~

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

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

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

~~(4) WAC 182-513-1319 State-funded programs for noncitizens who are not eligible for a federally funded program.~~

## NEW SECTION

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

(a) Meet the general eligibility requirements for medical programs under WAC 182-503-0505, except:

(i) An adult age nineteen or older must meet citizenship and immigration status requirements under WAC 182-503-0535 (2)(a) or (b);

(ii) A person under age nineteen must meet citizenship and immigration status requirements under WAC 182-503-0535 (2)(a), (b), (c), or (d); and

(iii) If a person does not meet the requirements in (a)(i) or (ii) of this subsection, the person is not eligible for medicaid and must have eligibility determined under WAC 182-513-1319.

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

(c) Meet the functional eligibility under:

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

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

(d) Meet either:

(i) SSI-related criteria under WAC 182-512-0050; or

(ii) MAGI-based criteria under WAC 182-503-0510(2), if residing in a medical institution. A person who is eligible for MAGI-based coverage is not subject to the provisions under subsection (2) of this section.

(2) A supplemental security income (SSI) recipient or a person meeting SSI-related criteria who needs LTC services must also:

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

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

(c) Disclose to the agency or its designee any interest the applicant or spouse has in an annuity, which must meet annuity requirements under chapter 182-516 WAC.

(3) A person who receives SSI must submit a signed health care coverage application form attesting to the provisions under subsection (2) of this section. A signed and completed eligibility review for LTC benefits can be accepted for people receiving SSI who are applying for long-term care services.

(4) To be eligible for HCB waiver services, a person must also meet the program requirements under:

(a) WAC 182-515-1505 through 182-515-1509 for HCS HCB waivers; or

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

#### NEW SECTION

**WAC 182-513-1317 Income and resource criteria for an institutionalized person.** (1) This section provides an overview of the income and resource eligibility rules for a person who lives in an institutional setting.

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

(a) Determines available income under WAC 182-513-1325 and 182-513-1330;

(b) Excludes income under WAC 182-513-1340; and

(c) Compares remaining available income to the special income level (SIL) defined under WAC 182-513-1100. A person's available income must be equal to or less than the SIL to be eligible for CN coverage.

(3) To determine income eligibility for an SSI-related LTC client under the medically needy (MN) program, the agency or its designee follows the income standards and eligibility rules under WAC 182-513-1395.

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

(a) Meet the resource eligibility requirements under WAC 182-513-1350;

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

(c) Disclose to the state any interest the person or the person's spouse has in an annuity, which must meet the annuity requirements under chapter 182-516 WAC.

(5) A resident of eastern or western state hospital is eligible for medicaid if the person:

(a) Has attained institutional status under WAC 182-513-1320; and

(b) Is under age twenty-one; or

(c) Applies for or receives inpatient psychiatric treatment in the month of the person's twenty-first birthday that will likely continue through the person's twenty-first birthday, and can receive coverage until:

(i) The facility discharges the person; or

(ii) The end of the month in which the person turns age twenty-two, whichever occurs first; or

(d) Is at least age sixty-five.

(6) To determine long-term care CN or MN income eligibility for a person eligible under a MAGI-based program, the agency or its designee follows the rules under chapter 182-514 WAC.

(7) There is no asset test for MAGI-based LTC programs under WAC 182-514-0245.

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

(a) For an SSI-related person residing in a medical institution, see WAC 182-513-1380;

(b) For an SSI-related person on a home and community based waiver, see chapter 182-515 WAC.

#### NEW SECTION

**WAC 182-513-1318 Income and resource criteria for home and community based (HCB) waiver programs and hospice.** (1) This section provides an overview of the income and resource eligibility rules for a person to be eligible for a categorically needy (CN) home and community based (HCB) waiver program under chapter 182-515 WAC or the hospice program under WAC 182-513-1240 and 182-513-1245.

(2) To determine income eligibility for an SSI-related long-term care (LTC) HCB waiver, the agency or its designee:

(a) Determines income available under WAC 182-513-1325 and 182-513-1330;

(b) Excludes income under WAC 182-513-1340;

(c) Compares remaining gross nonexcluded income to:

(i) The special income level (SIL) defined under WAC 182-513-1100; or

(ii) For HCB service programs authorized by the aging and long-term supports administration (ALTSA), a higher standard is determined following the rules under WAC 182-515-1508 if a client's income is above the SIL but net income is below the medically needy income level (MNIL).

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

(4) To be resource eligible under the HCB waiver program, the person must:

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

(b) Not be in a period of ineligibility due to a transfer of asset penalty under WAC 182-513-1363;

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

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

(a) For people receiving HCS HCB waiver services, see WAC 182-515-1509;

(b) For people receiving DDA HCB waiver services, see WAC 182-515-1514.

(6) To be eligible for the CN hospice program, see WAC 182-513-1240.

(7) To be eligible for the MN hospice program in a medical institution, see WAC 182-513-1245.

#### NEW SECTION

**WAC 182-513-1319 State-funded programs for noncitizens who are not eligible for a federally funded program.** (1) This section describes the state-funded programs available to a person who does not meet the citizenship and immigration status criteria under WAC 182-513-1316 for federally funded coverage.

(2) If a person meets the eligibility and incapacity criteria of the medical care services (MCS) program under WAC 182-508-0005, the person may receive nursing facility care or state-funded residential services in an alternate living facility (ALF).

(3) Noncitizens age nineteen or older may be eligible for the state-funded long-term care services program under WAC 182-507-0125. A person must be preapproved by the aging and long-term support administration (AL TSA) for this program due to enrollment limits.

(4) Noncitizens under age nineteen who meet citizenship and immigration status under WAC 182-503-0535 (2)(e) are eligible for:

(a) Nursing facility services if the person meets nursing facility level of care; or

(b) State-funded personal care services if functionally eligible based on a department assessment under chapter 388-106 or 388-845 WAC.

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

**WAC 182-513-1320 Determining institutional status for long-term care (LTC) services.** ~~((1) Institutional status is an eligibility requirement for long term care services (LTC) and institutional medical programs. To attain institutional status, you must:~~

~~(a) Be approved for and receiving home and community based waiver services or hospice services; or~~

~~(b) Reside or based on a department assessment is likely to reside in a medical institution, institution for mental diseases (IMD) or inpatient psychiatric facility for a continuous period of:~~

~~(i) Thirty days if you are an adult eighteen and older;~~

~~(ii) Thirty days if you are a child seventeen years of age or younger admitted to a medical institution; or~~

~~(iii) Ninety days if you are a child seventeen years of age or younger receiving inpatient chemical dependency or inpatient psychiatric treatment.~~

~~(2) Once the department has determined that you meet institutional status, your status is not affected by:~~

~~(a) Transfers between medical facilities; or~~

~~(b) Changes from one kind of long term care services (waiver, hospice or medical institutional services) to another.~~

~~(3) If you are absent from the medical institution or you do not receive waiver or hospice services for at least thirty consecutive days, you lose institutional status.) (1) To attain institutional status outside a medical institution, a person must be approved for and receive:~~

~~(a) Home and community based (HCB) waiver services under chapter 182-515 WAC;~~

~~(b) Roads to community living (RCL) services under WAC 182-513-1235;~~

~~(c) Program of all-inclusive care for the elderly (PACE) under WAC 182-513-1230;~~

~~(d) Hospice services under WAC 182-513-1240(3); or~~

~~(e) State-funded long-term care service under WAC 182-507-0125.~~

~~(2) To attain institutional status in a medical institution, a person must reside in a medical institution thirty consecutive days or more, or based on a department assessment, be likely to reside in a medical institution thirty consecutive days or more.~~

~~(3) Once a person meets institutional status, the person's status is not affected if the person:~~

~~(a) Transfers between medical facilities; or~~

~~(b) Changes between any of the following programs: HCB waiver, RCL, PACE, hospice or services in a medical institution.~~

~~(4) A person loses institutional status if the person is absent from a medical institution, or does not receive HCB waiver, RCL, PACE, or hospice services, for more than twenty-nine consecutive days.~~

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

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

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

(2) The ~~((department must apply))~~ agency or its designee applies the following rules when determining income eligibility for SSI-related LTC services:

- (a) WAC 182-512-0600 SSI-related medical—Definition of income;
- (b) WAC 182-512-0650 SSI-related medical—Available income;
- (c) WAC 182-512-0700 SSI-related medical—Income eligibility;
- (d) WAC 182-512-0750 SSI-related medical—Countable unearned income;
- (e) WAC ~~((182-514-0840(3)))~~ 182-512-0840(3) self-employment income-allowable expenses(~~(+~~
  - ~~((f) WAC 388-513-1315(15), Eligibility for long term care (institutional, waiver, and hospice) services))~~; and
  - ~~((g) WAC 388-450-0155, 388-450-0156, 388-450-0160 and 182-509-0155))~~ (f) WAC 182-512-0785, 182-512-0790, and 182-512-0795 for sponsored immigrants and how to determine if sponsors' income counts in determining benefits.
- (3) In initial categorically needy income eligibility for LTC, the agency does not allow any deductions listed in 1612(b) of the Social Security Act, for example:
  - (a) Twenty dollars per month income exclusion under WAC 182-512-0800;
  - (b) The first \$65 and the remaining one-half earned income work incentive under WAC 182-512-0840; and
  - (c) Impairment related work expense or blind work expense under WAC 182-512-0840.

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

**WAC 182-513-1330 Determining available income for legally married couples for long-term care (LTC) services.** This section describes income the ~~((department considers))~~ agency or its designee determines available when ~~((determining))~~ evaluating a legally married ~~((client's))~~ person's eligibility for LTC services.

(1) The ~~((department must apply))~~ agency or its designee applies the following rules when determining income eligibility for LTC services:

- (a) WAC 182-512-0600 SSI-related medical—Definition of income (~~SSI-related medical~~);
- (b) WAC 182-512-0650 SSI-related medical—Available income;
- (c) WAC 182-512-0700 SSI-related medical—Income eligibility;
- (d) WAC 182-512-0750 SSI-related medical—Countable unearned income;
- (e) WAC 182-512-0840(3), self-employment income-allowance expenses;
- (f) WAC 182-512-0960(~~(7)~~) SSI-related medical (~~clients; and~~
  - ~~(g) WAC 388-513-1315, Eligibility for long term care (institutional, waiver, and hospice) services.~~

~~(2) For~~)—Allocating income—Determining eligibility for a spouse when the other spouse receives long-term services and supports (LTSS).

(2) In initial categorically needy income eligibility for LTC, the agency does not allow any deductions listed in 1612(b) of the Social Security Act, for example:

- (a) Twenty dollars per month income exclusion under WAC 182-512-0800;

(b) The first \$65 and the remaining one-half earned income work incentive under WAC 182-512-0840; and

(c) Impairment related work expense or blind work expense under WAC 182-512-0840.

(3) The following income is available to an institutionalized ((client married to a community spouse who is not applying or approved for LTC services, the department considers the following income available)) spouse, unless subsections ((+4) applies) (5) and (6) apply:

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

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

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

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

((+3)) (4) The ((department considers the)) following income is unavailable to an institutionalized ((client)) spouse:

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

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

((+4)) (5) For the determination of eligibility only, if available income ((described in)) under subsection((s-(+2)) (3)(a) through ((+d)) (c) of this section, minus income exclusions ((described in WAC 388-513-1340)) under WAC 182-513-1340, exceeds the special income level (SIL), ((then)) defined under WAC 182-513-1100, the agency or its designee:

(a) ((The department)) Follows Washington state community property law when determining ownership of income;

(b) Presumes all income received after the marriage by either ((or both)) spouse((s)) to be community income; ((and))

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

((+d)) (6) If the total of subsection ((+4)) (5)(c) of this section plus the ((client's own)) institutionalized spouse's separate income is over the SIL, ((follow)) determine available income using subsection ((+2)) (3) of this section.

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

(6) The department considers)) (7) A stream of income, not generated by a transferred resource, is available to the ((client not generated by a transferred resource available to the client)) institutionalized spouse, even ((when the client)) if the institutionalized spouse transfers or assigns the rights to the stream of income to one of the following:

(a) The community spouse; or

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

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



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

(1) When determining a person's eligibility and participation in the cost of care for LTC services, the agency excludes:

(a) Crime victim's compensation;

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

~~((3) Native))~~ (c) American Indian/Alaskan native benefits excluded by federal statute (refer to WAC ~~((388-450-0040))~~ 182-512-0770);

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~((31))~~ (2) The agency or its designee treats Department of Veterans Affairs (VA) benefits ~~((designated for))~~ as follows:

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

(b) ~~((Unusual medical expenses))~~ UME, aid and attendance allowance, special monthly compensation (SMC) and housebound allowance ~~((with the exception described in subsection (32)))~~ are third-party resources;

~~((32))~~ (c) Benefits ~~((described in subsection (31)(b)))~~ in subsection (2)(b) of this section for a ~~((client))~~ person who receives long-term care services are excluded when determining eligibility, but are ~~((considered))~~ available as a third-party resource (TPR) as defined under WAC 182-513-1100 when determining the amount the ~~((client))~~ institutionalized individual contributes in the cost of care.

(3) Any other income excluded by federal law is excluded.

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

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

(1) The ~~((department))~~ agency or its designee disregards the following income amounts in the following order:

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

(i) Twenty dollars per month if unearned; or

(ii) Ten dollars per month if earned.

(b) The first ~~((twenty dollars))~~ \$20 per month of earned or unearned income, unless the sole source of income paid to a ~~((client))~~ person is:

(i) Based on need; and

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

(2) For a ~~((client))~~ person who is related to the supplemental security income (SSI) program ~~((as described in))~~ under WAC 182-512-0050(1), the first ~~((sixty five dollars))~~ \$65 per month of earned income not excluded under WAC ~~((388-513-1340))~~ 182-513-1340, plus one-half of the remainder.

(3) Department of Veterans Affairs benefits designated for:

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

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

(4) Benefits ~~((described in))~~ under subsection (3)(b) of this section for a ~~((client))~~ person who receives long-term care services are excluded when determining eligibility, but are considered available as a third-party resource (TPR) defined under WAC 182-513-1100 when determining the amount the ~~((client))~~ person contributes in the cost of care.

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

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

**WAC 182-513-1350 Defining the resource standard and determining resource eligibility for SSI-related long-term care (LTC) services.** ~~((This section describes how the department defines the resource standard and countable or excluded resources when determining a client's eligibility for LTC services. The department uses the term "re-~~

source standard" to describe the maximum amount of resources a client can have and still be resource eligible for program benefits.

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

~~(a) Two thousand dollars for:~~

~~(i) A single client; or~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(ii) WAC 182 512 0350 (1)(b) clients who have submitted an application for LTC services on or after May 1, 2006 and have an equity interest greater than five hundred thousand dollars in their primary residence are ineligible for LTC services. This exception does not apply if a spouse or blind, disabled or dependent child under age twenty one is lawfully residing in the primary residence. Clients denied~~

~~or terminated LTC services due to excess home equity may apply for an undue hardship waiver described in WAC 388-513-1367. Effective January 1, 2011, the excess home equity limits increase to five hundred six thousand dollars. On January 1, 2012 and on January 1 of each year thereafter, this standard may be increased or decreased by the percentage increased or decreased in the consumer price index urban (CPIU). For current excess home equity standard starting January 1, 2011 and each year thereafter, see <http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml>.~~

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

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

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

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

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

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

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

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

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

~~(ii) As long as the incurred medical expenses:~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(i) The institutionalized spouse; or~~

~~(ii) Both spouses.~~

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

~~(i) Either spouse; or~~

~~(ii) Both spouses.~~

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

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

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

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

~~(ii) The state spousal resource standard of forty eight thousand six hundred thirty nine dollars (this standard may change every odd year on July 1st). This standard is based on the consumer price index published by the federal bureau of labor statistics. For the current~~

standard starting July 2009 and each year thereafter, see long term care standards at <http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml>.

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

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

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

~~(b) The determination of the spousal share is completed as part of the application for LTC services if the client was institutionalized prior to the month of application, and declares the spousal share exceeds the state spousal resource standard. The client is required to provide verification of the couple's combined countable resources held at the beginning of the current period of institutional status.~~

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

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

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

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

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

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

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

~~(c) The institutionalized spouse does not transfer the amount described in subsections (10) or (12) to the community spouse by either:~~

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

~~(ii) The reasonable amount of additional time necessary to obtain a court order for the support of the community spouse.)) (1) General information.~~

~~(a) This section describes how the agency or its 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 its 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 its designee determines the eligibility of each spouse as a single person the month following the month of separation.

(iii) If the agency or its 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 its 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 thirty 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 its 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 its 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 its 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 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 twenty-one, blind child, or disabled child.

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

(c) Effective January 1, 2016, the excess home equity limit is \$552,000. On January 1, 2017, and on January 1st of each year thereafter, this standard may change by the percentage in the consumer price index-urban.

(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 <http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources>.

## NEW SECTION

**WAC 182-513-1355 Allocating resources to a community spouse when determining resource eligibility for SSI-related long-term care serv-**

**ices.** (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>.

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

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

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

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

(1) When evaluating the effect of the transfer of asset made on or after May 1, 2006 on the client's eligibility for LTC services the department counts sixty months before the month of application to establish what is referred to as the "look back" period.

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

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

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

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

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

market value as well as evidence to support the value (if any) of the disposed asset.

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

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

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

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

(i) Spouse; or

(ii) Child, who:

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

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

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

(iii) Brother or sister, who has:

(A) Equity in the home, and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) When determining a person's eligibility for long-term care (LTC) services, the agency or its designee evaluates the effect of an asset transfer made within the sixty-month period before the month that the person:

(a) Attained institutional status, or would have attained institutional status but for a period of ineligibility; and

(b) Applied for LTC services.

(2) The agency or its designee evaluates all transfers for recipients of LTC services made on or after the month the recipient attained institutional status.

(3) The agency or its designee establishes a period of ineligibility during which the person is not eligible for LTC services if the person, the person's spouse, or someone acting on behalf of either:

(a) Transfers an asset within the time period under subsection (1) or (2) of this section; and

(b) Does not receive adequate consideration for the asset, unless the transfer meets one of the conditions in subsection (4)(a) through (g) of this section.

(4) The agency or its designee does not apply a period of ineligibility for uncompensated value if:

(a) The total of all transfers in a month does not exceed the average daily private nursing facility rate in that month;

(b) The transferred resource was an excluded resource under WAC 182-513-1350 except a home, unless the transfer of the home meets the conditions under (d) of this subsection;

(c) The asset was transferred for less than fair market value (FMV), and the person can establish one of the following:

(i) An intent to transfer the asset at FMV. To establish such an intent, the agency or its designee must be provided with convincing evidence of the attempt to dispose the asset for FMV;

(ii) The transfer was not made to qualify for medicaid, continue to qualify for medicaid, or avoid estate recovery. Convincing evidence must be presented regarding the specific purpose of the transfer;

(iii) All assets transferred for less than FMV have been returned to the person or the person's spouse; or

(iv) The denial of eligibility would result in an undue hardship under WAC 182-513-1367;

(d) The transferred asset was a home, if the home was transferred to the person's:

(i) Spouse;

(ii) Child who meets the disability criteria under WAC 182-512-0050 (1)(b) or (c);

(iii) Child who was under age twenty-one; or

(iv) Child who lived in the home and provided care, but only if:

(A) The child lived in the person's home for at least two years;

(B) The child provided verifiable care during the time period in (d)(iv)(A) of this subsection for at least two years;

(C) The period of care under (d)(iv)(B) of this subsection was immediately before the person's current period of institutional status;

(D) The care was not paid for by medicaid;

(E) The care enabled the person to remain at home; and

(F) The person provided physician's documentation that the in-home care was necessary to prevent the person's current period of institutional status; or

(v) Sibling, who has lived in and has had an equity interest in the home for at least one year immediately before the date the person attained institutional status;

(e) The asset was transferred to the person's spouse; or to the person's child, if the child meets the disability criteria under WAC 182-512-0050 (1)(b) or (c);

(f) The transfer was to a family member before the current period of institutional status, and all the following conditions are met. If all the following conditions are not met, the transfer is an uncompensated transfer, regardless of consideration received:

(i) The transfer is in exchange for care services the family member provided to the person;

(ii) The person had a documented need for the care services provided by the family member;

(iii) The care services provided by the family member are allowed under the medicaid state plan or the department's home and community based waiver services;

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

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

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

(vii) The assets were transferred as the care services were performed, or with no more time delay than one calendar month between the provision of the service and the transfer.



(g) The transfer meets the conditions under subsection (5) of this section, and the asset is transferred; or

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

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

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

(iv) To a trust established for the sole benefit of a person who is under age sixty-five who meets the disability criteria under WAC 182-512-0050 (1)(b) or (c).

(5) An asset transfer or establishment of a trust is for the sole benefit of a person under subsection (4)(g) of this section if the document transferring the asset:

(a) Was made in writing;

(b) Is irrevocable;

(c) States that the person's spouse, blind or disabled child, or another disabled person can benefit from the transferred assets; and

(d) States that all assets involved must be spent for the sole benefit of the person over an actuarially sound period, based on the life expectancy of that person or the term of the document, whichever is less, unless the document is a trust that meets the conditions of a trust established under Section 42 U.S.C. 1396p(d)(4)(A) or Section 42 U.S.C. 1396(d)(4)(C) as described under chapter 182-516 WAC.

(6) To calculate the period of ineligibility under subsection (3) of this section:

(a) Add together the total uncompensated value of all transfers under subsection (3) of this section; and

(b) Divide the total in (a) of this subsection by the statewide average daily private cost for nursing facilities at the time of application or the date of transfer, whichever is later. The result is the length, in days rounded down to the nearest whole day, of the period of ineligibility;

(7) The period of ineligibility under subsection (6) of this section begins:

(a) For an LTC services applicant: The date the person would be otherwise eligible for LTC services, but for the transfer, based on an approved application for LTC services or the first day after any previous period of ineligibility has ended; or

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

(8) The period of ineligibility ends after the number of whole days, calculated in subsection (6) of this section, pass from the date the period of ineligibility began in subsection (7) of this section.

(9) If the transfer was to the person's spouse, and it includes the right to receive an income stream, the agency or its designee determines availability of the income stream under WAC 182-513-1330.

(10) If the transferred asset for which adequate consideration was not received was made to someone other than the person's spouse and included the right to receive a stream of income not generated by the transferred asset, the length of the period of ineligibility is calculated and applied in the following way:

(a) The amount of reasonably anticipated future monthly income, after the transfer, is multiplied by the actuarial life expectancy in

months of the person who owned the income. The actuarial life expectancy is based on age of the person in the month the transfer occurs;

(b) The amount in (a) of this subsection is divided by the state-wide average daily private cost for nursing facilities at the time of application or the date of transfer, whichever is later. The result is the length, in days rounded down to the nearest whole day, of the period of ineligibility; and

(c) The period of ineligibility begins under subsection (7) of this section and ends under subsection (8) of this section.

(11) A period of ineligibility for the transfer of an asset that is applied to one spouse is not applied to the other spouse, unless both spouses have attained institutional status. When both spouses are institutionalized, the agency or its designee divides the penalty equally between the two spouses. If one spouse is no longer subject to a period of ineligibility, the remaining period of ineligibility that applied to both spouses will be applied to the other spouse.

(12) Throughout this section, the date of an asset transfer is:

(a) For real property:

(i) The day the deed is signed by the grantor if the deed is recorded; or

(ii) The day the signed deed is delivered to the grantee;

(b) For all other assets, the day the intentional act or the failure to act resulted in the change of ownership or title.

(13) If a person or the person's spouse disagrees with the determination or application of a period of ineligibility, a hearing may be requested under chapter 182-526 WAC.

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

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

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

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

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

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

**WAC 182-513-1367 Hardship waivers ((for long-term care (LTC) services)).** ((Clients)) (1) People who are denied or terminated from ((LTC)) long-term services and supports (LTSS) due to a transfer of asset penalty ((described in WAC 388-513-1363, 388-513-1364 and 388-513-1365)) under WAC 182-513-1363, or having excess home equity ((described in WAC 388-513-1350)) under WAC 182-513-1350 may apply for an undue hardship waiver. The agency or its designee gives notice of the right to apply for an undue hardship waiver ((will be given)) whenever there is a denial or termination based on an asset transfer or excess home equity. This section:

((\*) (a) Defines undue hardship;

~~((\*) (b) Specifies the approval criteria for an undue hardship request;~~

~~((\*) (c) Establishes the process the ((department)) agency or its designee follows for determining undue hardship; and~~

~~((\*) (d) Establishes the appeal process for a client whose request for an undue hardship is denied.~~

~~((1) When does undue hardship exist?~~

~~(a)) (2) Undue hardship ((may exist)) exists:~~

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

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

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

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

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

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

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

~~((v)) (c) When, without ((LTC)) LTSS benefits, the ((client)) person is unable to obtain:~~

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

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

~~((b)) (3) Undue hardship can be approved for an interim period while the client is pursuing recovery of the assets or income.~~

~~((2)) (4) Undue hardship does not exist:~~

~~(a) When the transfer of asset penalty period or excess home equity provision inconveniences a ((client)) person or restricts ((their)) the person's lifestyle but does not seriously deprive ((him or her)) the person as defined in subsection ((1)(a)(iii)) (2)(c)(i) and (ii) of this section;~~

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

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

~~((d)) (5) Undue hardship may exist under subsection (4)(b) and (c) of this section if ((DSHS)) the department has found evidence of financial exploitation.~~

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

~~(a)) (6) An undue hardship waiver may be requested by:~~

~~((i)) (a) The ((client)) person;~~

~~((ii)) (b) The ((client's)) person's spouse;~~

~~((iii)) (c) The ((client's)) person's authorized representative( (+~~

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

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

~~((b))~~ (7) The hardship waiver request must:

~~((i))~~ (a) Be in writing;

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

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

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

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

~~((4) What if additional information is needed to determine a hardship waiver?~~

~~((a))~~ (8) If additional information is needed to determine a hardship waiver, the agency or its designee sends a written notice to the ~~((client is sent))~~ person requesting additional information within fifteen days of the request for an undue hardship waiver. The person may request additional time to provide the information ~~((can be requested by the client.~~

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

(9) If the hardship is approved:

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

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

~~((6) What happens if my))~~ (10) If the hardship waiver is denied~~((?))~~:

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

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

~~((7) What statute or rules govern administrative hearings?~~

~~((a) An administrative hearing held under this section is governed by chapters 34.05 RCW and chapter 388-02 WAC and this section. If a provision in this section conflicts with a provision in chapter 388-02 WAC, the provision in this section governs.~~

~~((8) Can the department revoke an approved undue hardship waiver?~~

~~((a) The department))~~ (11) If there is a conflict between this section and chapter 182-526 WAC, this section prevails.

(12) The agency or its designee may revoke approval of an undue hardship waiver if any of the following occur:

~~((i))~~ (a) A ~~((client))~~ person, or ~~((his or her))~~ the person's authorized representative, fails to provide timely information ~~((and/or))~~ or resource verifications as it applies to the hardship waiver when requested by the ~~((department))~~ agency or its designee per

WAC (~~388-490-0005 and 388-418-0007 or 182-504-0125~~) 182-503-0050 and 182-504-0105;

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

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

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

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

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

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

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

~~(4) The department) in a medical institution.~~

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

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

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

(i) ~~((Seventy dollars))~~ For the following ~~((clients))~~ people who receive a needs-based veteran's pension in excess of \$90 and live in a state veteran's home ~~((and receive a needs-based veteran's pension in excess of ninety dollars))~~, \$70:

(A) A veteran without a spouse or dependent child~~((-))~~; or

(B) A veteran's surviving spouse with no dependent children~~((-))~~;

(ii) For people who live in a state veteran's home and receive a pension of less than \$90, the difference between ~~((one hundred sixty dollars))~~ \$160 and the needs-based veteran's pension amount ~~((for persons specified in subsection (4)(a)(i) of this section who receive a veteran's pension less than ninety dollars.))~~;

(iii) ~~((One hundred sixty dollars))~~ For a ~~((client))~~ person living in a state veterans' home who does not receive a needs-based veteran's pension, \$160;

(iv) ~~((Forty one dollars and sixty two cents))~~ For all ~~((clients))~~ people in a medical institution receiving aged, blind, disabled, (ABD) or temporary assistance for needy families (TANF) cash assistance ~~((-))~~, \$41.62; or

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

~~(vi) Current PNA and long term care standards can be found at <http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml>),~~ \$57.28.

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

(c) Wages for a ~~((client))~~ person who:

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

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

(d) Guardianship fees and administrative costs, including any attorney fees paid by the guardian, ~~((after June 15, 1998, only))~~ as allowed ~~((by chapter 388 79 WAC))~~ under WAC 182-513-1505 through 182-513-1525.

~~((5) The department))~~ (3) The agency or its designee allocates nonexcluded income after deducting amounts ((described in)) under subsection ((4)) (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 ~~((+ (i)))~~;

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

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

(b) A monthly maintenance needs allowance for the community spouse ~~((not to exceed, effective January 1, 2008, two thousand six hundred ten dollars, unless a greater amount is allocated as described in subsection (7) of this section. The community spouse maintenance allowance may change each January based on the consumer price index. Starting January 1, 2008 and each year thereafter the community spouse maintenance allocation can be found in the long term care standards chart at <http://www1.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml>. The monthly maintenance needs allowance:~~

~~(i) Consists of a combined total of both:~~

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

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

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

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

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

~~(i) Resides with the community spouse:~~

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

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

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

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

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

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

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

(ii) Limited to a six-month period;

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

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

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

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

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

~~(i) Rent;~~

~~(ii) Mortgage;~~

~~(iii) Taxes and insurance;~~

~~(iv) Any maintenance care for a condominium or cooperative; and~~

~~(v) The food stamp standard utility allowance described in WAC 388-450-0195, provided the utilities are not included in the maintenance charges for a condominium or cooperative.~~

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

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

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

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

~~(9)) (4) A person may have to pay third-party resources as defined under WAC 182-513-1100 in addition to the participation.~~

(5) A person 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 person pays only the difference up to the state rate cost of care.

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

(7) Standards ((described in)) under this section for long-term care ((can be)) are found at ((: http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml)) <http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/standards-ltc>.

#### NEW SECTION

**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>, 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 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 percent of one hundred fifty 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 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 13-01-017, filed 12/7/12, effective 1/1/13)

**WAC 182-513-1395 Determining eligibility for institutional (~~or hospice~~) services for ((individuals)) people living in a medical in-**

stitution under the SSI-related medically needy (~~((MN))~~) program. ((This section describes how the department determines a client's eligibility for institutional or hospice services in a medical institution and for facility care only under the MN program. In addition, this section describes rules used by the department to determine whether a client approved for these benefits is also eligible for non-institutional medical assistance in a medical institution under the MN program.

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

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

(b) Be a child not described in subsection (1)(a) with countable income as described in subsection (4)(b) that exceeds the categorically needy (CN) standard for the children's medical program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Is approved for twelve months; and

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

(6) If the income remaining after the allowed deductions described in WAC 388-513-1380 plus countable resources in excess of the standard described in WAC 388-513-1350(1) is more than the department-

~~contracted rate times the number of days residing in the facility the client:~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(b) Eligibility is determined for medical assistance only as described in chapter 182-519 WAC.) (1) For the purposes of this section only, "remaining income" means all gross nonexcluded income remaining after the post-eligibility calculation under WAC 182-513-1380.~~

~~(2) General information. To be eligible for institutional services when living in a medical institution under the SSI-related medically needy (MN) program, a person must:~~

~~(a) Meet program requirements under WAC 182-513-1315;~~

~~(b) Have gross nonexcluded income in excess of the special income level (SIL) defined under WAC 182-513-1100; and~~

~~(c) Meet the financial requirements of subsection (3) or (4) of this section.~~

~~(3) Financial eligibility.~~

~~(a) The agency or its designee determines a person's resource eligibility, excess resources, and medical expense deductions using WAC 182-513-1350.~~

~~(b) The agency or its designee determines a person's countable income by:~~

~~(i) Excluding income under WAC 182-513-1340;~~

(ii) Determining available income under WAC 182-513-1325 or 182-513-1330;

(iii) Disregarding income under WAC 182-513-1345; and

(iv) Deducting medical expenses that were not used to reduce excess resources under WAC 182-513-1350.

(4) Eligibility for agency payment to the facility for institutional services and the MN program.

(a) If a person's remaining income plus excess resources is less than, or equal to, the state-contracted daily rate times the number of days the person has resided in the facility, the person:

(i) Is eligible for agency payment to the facility for institutional services and the MN program; and

(ii) Is approved for a twelve-month certification period.

(b) The person must pay income and excess resources towards the cost of care under WAC 182-513-1380.

(5) Eligibility for agency payment to the facility for institutional services and MN spenddown. If a person's remaining income is more than the state-contracted daily rate times the number of days the person has resided in the facility, but less than the private nursing facility rate for the same period, the person:

(a) Is eligible to receive institutional services at the state-contracted rate; and

(i) Is approved for a three-month or six-month base period;

(ii) Pays income and excess resources towards the state-contracted cost of care under WAC 182-513-1380; and

(b) Is eligible for the MN program for the same three-month or six-month base period when the total of additional medical expenses incurred during the base period exceeds:

(i) The total remaining income for all months of the base period;

(ii) Minus the total state-contracted rate for all months of the base period.

(6) If a person has excess resources and the person's remaining income is more than the state-contracted daily rate times the number of days the person has resided in the facility, the person is not eligible to receive institutional services and the MN program.

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

**WAC 182-513-1396 ((Clients)) People living in a fraternal, religious, or benevolent nursing facility.** ~~((This section describes how the department determines eligibility for institutional services and noninstitutional medical assistance for a client living in a fraternal, religious, or benevolent nursing facility.~~

~~(1) For a client living in a licensed nursing facility operated by a fraternal, religious, or benevolent organization who meets all other eligibility requirements, the department approves institutional services and noninstitutional medical assistance, if:~~

~~(a) Any contract between the client and the facility excludes such benefits on a free or prepaid basis for life; or~~

~~(b) The facility is unable to fulfill the terms of the contract and has:~~

~~(i) Voided the contract; and~~

~~(ii) Refunded any of the client's existing assets to the client.~~

~~(2) For a client described in subsection (1), the department denies institutional services and noninstitutional medical assistance, if the client:~~

~~(a) Signs a contract with the organization that includes such benefits on a free or prepaid basis for life; and~~

~~(b) Surrenders income and/or resources to the organization in exchange for such benefits.)~~ (1) The agency or its designee determines apple health coverage under noninstitutional rules for a person who meets all other eligibility requirements and lives in a licensed, but nonmedicaid-contracted facility operated by a fraternal, religious, or benevolent organization.

(2) Nothing in subsection (1) of this section prevents the agency or its designee from evaluating contracts with facilities not described in subsection (1) of this section.

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

**WAC 182-513-1397 Treatment of entrance fees ((of individuals)) for people residing in a continuing care retirement ((communities)) community or a life care community.** ~~((The following rule applies to long-term care medicaid applicants who reside in a continuing care retirement communities or life care communities that collect an entrance fee on admission from residents:~~

~~(1) Treatment of entrance fee. An individual's))~~ (1) A person's entrance fee in a continuing care retirement community or life care community is ((considered a)) an available resource ((available)) to the ((individual)) person, to the extent that:

~~(a) The ((individual)) person has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the ((individual)) person be insufficient to pay for care((-));~~

~~(b) The ((individual)) person is eligible for a refund of any remaining entrance ((free)) fee when the ((individual)) person dies or when the person terminates the continuing care retirement community or life care community contract and leaves the community; and~~

~~(c) The entrance ((free)) fee does not confer an ownership interest in the continuing care retirement community or life care community.~~

(2) Nothing in subsection (1) of this section prevents the agency or its designee from evaluating contracts with facilities not described in subsection (1) of this section.

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

**WAC 182-513-1400 Long-term care (LTC) partnership program (index).** Under the long-term care (LTC) partnership program, ~~((individuals))~~ people who purchase qualified long-term care partnership insurance policies can apply for long-term care medicaid under special rules for determining financial eligibility. These special rules gen-

erally allow the ~~((individual))~~ person to protect assets up to the insurance benefits received from a partnership policy so that such assets will not be taken into account in determining financial eligibility for long-term care medicaid and will not subsequently be subject to estate recovery for medicaid and long-term care services paid. The Washington long-term care partnership program is effective on December 1, 2011.

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

- (1) WAC ~~((388-513-1405))~~ 182-513-1405 Definitions.
- (2) WAC ~~((388-513-1410 What qualifies as a))~~ 182-513-1410 LTC partnership policy((?)) qualifications.
- (3) WAC ~~((388-513-1415 What))~~ 182-513-1415 Assets that can't be protected under the LTC partnership provisions((?)).
- (4) WAC ~~((388-513-1420 Who is eligible))~~ 182-513-1420 Eligibility for asset protection under a ((LTC)) partnership policy((?)).
- (5) WAC ~~((388-513-1425 When would I not qualify))~~ 182-513-1425 Not qualifying for LTC medicaid if ((I have a)) an LTC partnership policy ((that does not have exhausted benefits?)) is in pay status.
- (6) WAC ~~((388-513-1430 What))~~ 182-513-1430 Change of circumstances that must ((I report when I have a)) be reported when there is an LTC partnership policy paying a portion of ((my)) care((?)).
- (7) WAC ~~((388-513-1435 Will))~~ 182-513-1435 When Washington recognizes ((a)) an LTC partnership policy purchased in another state((?)).
- (8) WAC ~~((388-513-1440))~~ 182-513-1440 Determining how many ((of my)) assets can be protected((?)).
- (9) WAC ~~((388-513-1445 How do I designate))~~ 182-513-1445 Designating a protected asset and ((what)) required proof ((is required?)).
- (10) WAC ~~((388-513-1450))~~ 182-513-1450 How ((does)) the transfer of assets affects LTC partnership and medicaid eligibility((?)).
- (11) WAC ~~((388-513-1455 If I have))~~ 182-513-1455 Protected assets under ((a)) an LTC partnership policy((, what happens)) after ((my)) death((?)).

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

**WAC 182-513-1405 Definitions.** For purposes of ~~((this section))~~ WAC 182-513-1400 through 182-513-1455, the following terms have the meanings ~~((given them. Additional definitions can be found at))~~ stated. See chapter ((388-500)) 182-500 WAC and WAC ((388-513-1301)) 182-513-1100 for additional definitions.

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

**"Long-term care (LTC) insurance"** means a policy ~~((described in))~~ under chapter 284-83 WAC.

~~((**"Long-term care services"** means services received in a medical institution, or under a home and community based waiver authorized by home and community services or division of developmental disabilities.~~

Hospice services are considered long term care services for the purposes of the long term care partnership when medicaid eligibility is determined under chapter 388-513 or 388-515 WAC.)

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

**"Qualified long-term care insurance partnership"** means an agreement between the Centers for Medicare and Medicaid Services (CMS), and the health care authority (HCA) which allows for the disregard of any assets or resources in an amount equal to the insurance benefit payments that are made to or on behalf of ((an individual)) a person who is a beneficiary under a long-term care insurance policy that has been determined by the Washington state insurance commission to meet the requirements of section 1917 (b)(1)(c)(iii) of the act. These policies are described in chapter 284-83 WAC.

**"Reciprocity Agreement"** means an agreement between states approved under section 6021(b) of the Deficit Reduction Act of 2005, Public Law 109-171 (DRA) under which the states agree to provide the same asset protections for qualified partnership policies purchased by ((an individual)) a person while residing in another state and that state has a reciprocity agreement with the state of Washington.

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

**WAC 182-513-1410 ((What qualifies as a)) LTC partnership policy((?)) qualifications.** A LTC partnership policy is a LTC policy that has been approved by the office of insurance commissioner as a LTC partnership policy described in chapter 284-83 WAC.

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

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

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

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

(3) Home equity in excess of the standard ((described in WAC 388-513-1350)) under WAC 182-513-1350. Individuals who have excess

home equity interest are not eligible for long-term care medicaid services.

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

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

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

**WAC 182-513-1420 (~~(Who is eligible)~~) Eligibility for asset protection under a partnership policy(?).** (1) The LTC partnership policy must meet all the requirements in chapter 284-83 WAC. For existing LTC policies which are converted to a LTC partnership policy via an exchange or through the addition of a policy rider or endorsement, the conversion must take place on or after December 1, 2011 unless the policy is paying out benefits at the time the policy is exchanged.

(2) You meet all applicable eligible requirements for LTC medicaid and:

(a) Your LTC partnership policy benefits have been exhausted and you are in need of LTC services.

(b) Your LTC partnership policy is not exhausted and is:

(i) Covering all costs in a medical institution and you are still in need for medicaid; or

(ii) Covering a portion of the LTC costs under your LTC partnership policy but does not meet all of your LTC needs.

(c) At the time of your LTC partnership policy has paid out more benefits than you have designated as protected. In this situation your estate can designate additional assets to be excluded from the estate recovery process up to the dollar amount the LTC partnership policy has paid out.

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

**WAC 182-513-1425 (~~(When would I not qualify)~~) Not qualifying for LTC medicaid if (~~(I have a))~~ an LTC partnership policy is in pay status(?).** You are not eligible for long-term care (LTC) medicaid when the following applies:

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

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

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



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

**WAC 182-513-1430 ((What)) Change of circumstances that must ((I report)) be reported when ((I have a)) there is an LTC partnership policy paying a portion of ((my)) care((?)).** You must report changes described in WAC ((388-418-0005)) 182-504-0105 plus the following:

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

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

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

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

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

**WAC 182-513-1435 ((Will)) When Washington recognizes ((a)) an LTC partnership policy purchased in another state((?)).** The Washington long term care partnership program provides reciprocity with respect to qualifying long-term care insurance policies covered under other state long-term care insurance partnerships. This allows you to purchase a partnership policy in one state and move to Washington without losing your asset protection. If your LTC policy is in pay status at the time you move to Washington and you are otherwise eligible for LTC medicaid, Washington will recognize the amount of protection you accumulated in the other state.

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

**WAC 182-513-1440 Determining how many of my assets can be protected((?)).** You can protect assets based on the amount paid by your LTC partnership policy. Assets are protected in both LTC eligibility and estate recovery. If the partnership for long-term care program is discontinued, an individual who purchased an approved plan before the date the program is discontinued remains eligible to receive dollar-for-dollar asset disregard and asset protection under the long-term care (LTC) medicaid program.

**WAC 182-513-1445 (~~(How do I designate)~~) Designating a protected asset and (~~(what)~~) required proof (~~(is required?)~~).** (1) Complete a (~~(DSHS)~~) department of social and health services (DSHS) 10-438 long-term care partnership (LTCP) asset designation form listing assets and the full fair market value that are earmarked as protected at the time of initial application for (~~(LTC)~~) long-term services and supports under medicaid.

(a) The full fair market value (FMV) of real property or interests in real property will be based on the current assessed value for property tax purposes for real property. A professional appraisal by a licensed appraiser can establish the current value if the assessed value is disputed.

(b) The value of a life estate in real property is determined using the life estate tables found (~~(in: <http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCOappendix2.shtml>)~~) at <http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/determining-value-life-estates>.

(c) If you own an asset with others, you can designate the value of your (~~(pro-rata)~~) pro rata equity share.

(d) If the dollar amount of the benefits paid under a LTCP policy is greater than the fair market value of all assets protected at the time of the application for long-term care medicaid, you may designate additional assets for protection under this section. The DSHS LTCP asset designation form must be submitted with the updated assets indicated along with proof of the current value of designated assets.

(e) The value of your assets protected for you under your LTC partnership policy do not carry over to your spouse should (~~(they)~~) the spouse need medicaid (~~(long-term care)~~) LTC services during or after your lifetime (~~(or after your death)~~). If your surviving spouse has (~~(their own)~~) an LTC partnership policy (~~(he or she)~~) the spouse may designate assets based on the dollar amount paid under (~~(his or her)~~) the spouse's own policy.

(f) Assets designated as protected under this subsection will not be subject to transfer penalties (~~(described in WAC 388-513-1363)~~) under WAC 182-513-1363.

(2) Proof of the current fair market value of all protected assets is required at the initial application and each annual review.

(3) Submit current verification from the issuer of the LTCP policy of the current dollar value paid toward (~~(long-term care)~~) LTC benefits. This verification is required at application and each annual eligibility review.

(4) Any (~~(individual)~~) person or the personal representative of the (~~(individual's)~~) person's estate who asserts that an asset is protected has the initial burden of:

(a) Documenting and proving by (~~(clear and)~~) convincing evidence that the asset or source of funds for the asset in question was designated as protected;

(b) Demonstrating the value of the asset and the proceeds of the asset beginning from the time period the LTC partnership has paid out benefits to the present; and

(c) Documenting that the asset or proceeds of the asset remained protected at all times.

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

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

(a) You have already been receiving institutional services;  
(b) Your LTC partnership policy has paid toward institutional services for you; and  
(c) The value of the transferred assets has been protected under the LTC partnership policy.

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

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

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

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

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

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

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

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

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

REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 182-513-1300 Payment standard for persons in medical institutions.

WAC 182-513-1301 Definitions related to long-term care (LTC) services.

WAC 182-513-1305 Determining eligibility for noninstitutional medical assistance in an alternate living facility (ALF).

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

WAC 182-513-1365 Evaluating the transfer of an asset made on or after March 1, 1997 and before April 1, 2003 for long-term care (LTC) services.

WAC 182-513-1366 Evaluating the transfer of an asset made before March 1, 1997 for long-term care (LTC) services.

**WAC 182-515-1505** (~~Long-term care~~) Home and community based (HCB) waiver services authorized by home and community services (HCS) ((and hospice)). ~~((1))~~ This chapter describes the general and financial eligibility requirements for categorically needy (CN) home and community based (HCB) waiver services ~~((administered))~~ authorized by home and community services (HCS) ~~((and hospice services administered by the health care authority (HCA)))).~~ The definitions in WAC 182-513-1100 and chapter 182-500 WAC apply throughout this chapter.

~~((2))~~ (1) The ~~((HCB service programs))~~ HCS waivers are:  
(a) Community options program entry system (COPEs);  
(b) ~~((Program of all inclusive care for the elderly (PACE));~~  
~~(c) Washington medicaid integration partnership (WMIP); or~~  
~~(d))~~ New Freedom consumer-directed services (New Freedom)~~((~~  
(3) ~~Roads to community living (RCL) services. For RCL services this chapter is used only to determine your cost of care. Medicaid eligibility is guaranteed for three hundred sixty five days upon discharge from a medical institution.~~

~~(4) Hospice services if you don't reside in a medical institution and:~~

~~(a) Have gross income at or below the special income level (SIL); and~~

~~(b) Aren't eligible for another CN or medically needy (MN) medicaid program.~~

~~(5) WAC 388-515-1506 describes the general eligibility requirements for HCS CN waivers.~~

~~(6) WAC 388-515-1507 describes eligibility for waiver services when you are eligible for medicaid using noninstitutional CN rules.~~

~~(7) WAC 388-515-1508 describes the initial financial eligibility requirements for waiver services when you are not eligible for noninstitutional CN medicaid described in WAC 388-515-1507(1).~~

~~(8) WAC 388-515-1509 describes the rules used to determine your responsibility in the cost of care for waiver services if you are not eligible for medicaid under a CN program listed in WAC 388-515-1507(1). This is also called client participation or post eligibility); and~~

(c) Residential support waiver (RSW).

(2) WAC 182-515-1506 describes the general eligibility requirements for HCB waiver services authorized by HCS.

(3) WAC 182-515-1507 describes financial requirements for eligibility for HCB waiver services authorized by HCS when a person is eligible for a noninstitutional SSI-related categorically needy (CN) medicaid program.

(4) WAC 182-515-1508 describes the financial eligibility requirements for HCB waiver services authorized by HCS when a person is not eligible for SSI-related noninstitutional CN medicaid under WAC 182-515-1507.

(5) WAC 182-515-1509 describes the rules used to determine a person's responsibility for the cost of care and room and board for HCB waiver services if the person is eligible under WAC 182-515-1508.

~~WAC 182-515-1506 ((What are the general eligibility requirements for)) Home and community based (HCB) waiver services authorized by home and community services (HCS) ((and hospice?))—General eligibility.~~ (1) To be eligible for home and community based (HCB) waiver services ~~((and hospice you))~~ a person must:

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

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

~~(ii) ((PACE, per WAC 388-106-0705;~~

~~(iii) WMIP waiver services, per WAC 388-106-0750;~~

~~(iv)) Residential support waiver (RSW), under WAC 388-106-0310;~~

or

~~(iii) New Freedom, ((per)) under WAC ((388-106-1410;~~

~~(v) Hospice, per chapter 182-551 WAC; or~~

~~(vi) Roads to community living (RCL), per WAC 388-106-0250, 388-106-0255 and 388-106-0260)) 388-106-0338.~~

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

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

(d) ~~((Be residing))~~ Reside in a medical institution as defined in WAC 182-500-0050, or be likely to be placed in one within the next thirty days without HCB waiver services provided under one of the programs listed in ~~((subsection (1)))~~ (a) of this subsection;

(e) ~~((Have attained))~~ Attain institutional status ~~((as described in WAC 388-513-1320))~~ under WAC 182-513-1320;

(f) ~~((Be determined in need of))~~ Assessed for HCB waiver services ~~((and)),~~ be approved for a plan of care ~~((as described in subsection (1)(a))~~, 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 ~~((+~~

~~(i) Enhanced adult residential care (EARC) facility;~~

~~(ii) Licensed adult family home (AFH); or~~

~~(iii) Assisted living (AL) facility.~~

~~(h) Not be subject to a penalty period of ineligibility for the transfer of an asset as described in WAC 388-513-1363 through 388-513-1365;~~

~~(i) Not have a home with equity in excess of the requirements described in WAC 388-513-1350.~~

~~(2) Refer to WAC 388-513-1315 for rules used to determine countable resources, income, and eligibility standards for long term care services)) 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.

~~((3))~~ (4) Current income and resource standards ((charts)) are ((located)) found at((:—http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.html)) http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources.

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

~~WAC 182-515-1507 ((What are the financial requirements for))~~  
~~Home and community based (HCB) waiver services authorized by home and community services (HCS) ((when you are))—Financial eligibility if a person is eligible for ((a)) an SSI-related noninstitutional categorically needy (CN) medicaid program((?)).~~ ~~((1) You are eligible for medicaid under one of the following programs:~~

~~(a) Supplemental security income (SSI) eligibility described in WAC 388-474-0001. This includes SSI clients under 1619B status;~~

~~(b) SSI-related CN medicaid described in WAC 182-512-0100 (2)(a) and (b);~~

~~(c) SSI-related health care for workers with disabilities program (HWD) described in WAC 182-511-1000. If you are receiving HWD, you are responsible to pay your HWD premium as described in WAC 182-511-1250;~~

~~(d) Aged, blind, or disabled (ABD) cash assistance described in WAC 388-400-0060 and are receiving CN medicaid.~~

~~(2) You do not have a penalty period of ineligibility for the transfer of an asset as described in WAC 388-513-1363 through 388-513-1365. This does not apply to PACE or hospice services.~~

~~(3) You do not have a home with equity in excess of the requirements described in WAC 388-513-1350.~~

~~(4) You do not have to meet the initial eligibility income test of having gross income at or below the special income level (SIL).~~

~~(5) You do not pay (participate) toward the cost of your personal care services.~~

~~(6) If you live in a department contracted facility listed in WAC 388-515-1506 (1)(g), you pay room and board up to the ADSA room and board standard. The ADSA room and board standard is based on the federal benefit rate (FBR) minus the current personal needs allowance (PNA) for HCS CN waivers in an alternate living facility.~~

~~(a) If you live in an assisted living (AL) facility, enhanced adult residential center (EARC), or adult family home (AFH) you keep a PNA of sixty two dollars and seventy nine cents and use your income to pay up to the room and board standard.~~

~~(b) If subsection (6)(a) applies and you are receiving HWD described in WAC 182-511-1000, you are responsible to pay your HWD premium as described in WAC 182-511-1250, in addition to the ADSA room and board standard.~~

~~(7) If you are eligible for aged, blind or disabled (ABD) cash assistance program described in WAC 388-400-0060 you do not participate in the cost of personal care and you may keep the following:~~

~~(a) When you live at home, you keep the cash grant amount authorized under WAC 388-478-0033;~~

~~(b) When you live in an AFH, you keep a PNA of thirty eight dollars and eighty four cents, and pay any remaining income and ABD cash grant to the facility for the cost of room and board up to the ADSA room and board standard; or~~

~~(c) When you live in an assisted living facility or enhanced adult residential center, you are only eligible to receive an ABD cash grant of thirty eight dollars and eighty four cents as described in WAC 388-478-0045, which you keep for your PNA.~~

~~(8) Current resource and income standards are located at: <http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml>.~~

~~(9)) (1) A person is financially eligible for home and community based (HCB) waiver services if:~~

~~(a) The person is receiving coverage under one of the following supplemental security income (SSI)-related 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) The person does not have a penalty period of ineligibility for the transfer of an asset under WAC 182-513-1363; and~~

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

~~(2) A person 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 person eligible under this section who lives in a department-contracted ALF described under WAC 182-513-1100 and does not receive a cash grant from the department of social and health services under WAC 388-400-0060:~~

~~(a) Keeps a personal needs allowance (PNA) of \$62.79; and~~

~~(b) Pays towards room and board up to the room and board standard with the remaining income. The room and board standard is the federal benefit rate (FBR) minus \$62.79.~~

~~(4) A person 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) A person who is eligible for the aged, blind, disabled (ABD) cash assistance program under WAC 388-400-0060 does not pay toward the cost of care and keeps:~~

~~(a) The cash grant amount authorized under WAC 388-478-0033 if living at home;~~

~~(b) A PNA of \$38.84, but must pay towards room and board with the remaining income and ABD cash grant up to the room and board standard if living in an adult family home (AFH). The room and board standard is the federal benefit rate (FBR) minus \$62.79; or~~

~~(c) The cash grant of \$38.84 under WAC 388-478-0006 if living in an assisted living facility.~~

~~(6) Current resource, income, PNA, and ((ADSA)) room and board standards are ((located)) found at((:—<http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/ltestandardsPNAchartsufile.shtml>))~~



<http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources>.

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

~~WAC 182-515-1508 ((How does the department determine if you are financially eligible for)) Home and community based (HCB) waiver services authorized by home and community services (HCS) ((and hospice if you are not eligible for medicaid under a categorically needy (CN) program listed in WAC 388-515-1507(1)?)) Financial eligibility using SSI-related institutional rules. (1) If ((you are)) a person is not eligible for ((medicaid under)) a categorically needy (CN) program ((listed in)) under WAC ((388-515-1507(1)) 182-515-1507, the ((department must)) agency determines ((your)) eligibility for home and community based (HCB) waiver services authorized by home and community services (HCS) using institutional medicaid rules. This section explains how ((you)) a person may qualify using institutional ((medicaid)) rules.~~

~~(2) ((You)) A person must meet ((the)):~~

~~(a) General eligibility requirements ((described in WAC 388-513-1315 and 388-515-1506.~~

~~(3) You must meet the following resource requirements:~~

~~(a) Resource limits described in WAC 388-513-1350.~~

~~(b) If you have resources over the standard allowed in WAC 388-513-1350, the department reduces resources over the standard by your unpaid medical expenses described in WAC 388-513-1350 if you verify these expenses.~~

~~(4) You must meet)) under WAC 182-513-1315 and 182-515-1506;~~

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

~~(c) The following income requirements:~~

~~((a) Your gross nonexcluded)) (i) Available income must be at or below the special income level (SIL) ((which is three hundred percent of the federal benefit rate (FBR))), defined under WAC 182-513-1100; or~~

~~((b) For home and community based (HCB) service programs authorized by HCS your gross nonexcluded income is:~~

~~(i) Above the special income level (SIL) which is three hundred percent of the federal benefit rate (FBR); and))~~

~~(ii) ((Net)) 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 ((gross nonexcluded)) available income by:~~

~~(A) Medically needy (MN) disregards found ((in WAC 388-513-1345)) under WAC 182-513-1345; ((and))~~

~~(B) The average monthly nursing facility state rate ((is five thousand six hundred and twenty six dollars. This rate will be updated annually starting October 1, 2012 and each year thereafter on October 1. This standard will be updated annually in the long term care standard section of the EAZ manual described at <http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml>.~~

~~(5) The department follows the rules in WAC 388-515-1325, 388-513-1330, and 388-513-1340 to determine available income and income exclusions.~~

~~(6));~~

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

(D) Outstanding medical bills, prorated monthly over a twelve-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 ((and)), income standards ((including the SIL, MNIL and FBR)), and the average state nursing facility rate for long-term care are found at(~~:-~~ <http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml>) <http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources>.

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

**WAC 182-515-1509 ((How does the department determine how much of my income I must pay towards the cost of my care if I am only eligible for home and community based (HCB) services under WAC 388-515-1508?)) Home and community based (HCB) waiver services authorized by home and community services (HCS)—Client financial responsibility.** ~~((If you are only eligible for medicaid under WAC 388-515-1508, the department determines how much you must pay based upon the following:~~

~~(1) If you are))~~ (1) A person 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 person's responsibility towards cost of care.

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

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

(a) A single ((and living)) person who lives at home (as defined in WAC 388-106-0010)((, you)) keeps ((all your income up to the federal poverty level (FPL) for your personal needs allowance (PNA))) a personal needs allowance (PNA) of up to the federal poverty level (FPL) and must pay the remaining available income toward cost of care after allowable deductions described in subsection (4) of this section.

~~((2) If you are))~~ (b) A married ((living)) person who lives with the person's spouse at home ((as defined in WAC 388-106-0010, you keep all your income up to the effective one person medically needy income level (MNIL) for your PNA if your spouse lives at home with you. If

~~you are married and living apart from your spouse, you're allowed to keep your income up to the FPL for your PNA.~~

~~(3) If you live in an assisted living (AL) facility, enhanced adult residential center (EARC), or adult family home (AFH), you:~~

~~(a) Keep a PNA from your gross nonexcluded income. The PNA is sixty two dollars and seventy nine cents effective July 1, 2008; and~~

~~(b) Pay for your room and board up to the ADSA room and board standard.~~

~~(4) In addition to paying room and board, you may also have to pay toward the cost of personal care. This is called your participation. Income that remains after the PNA and any room and board deduction)) (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 person's available income toward cost of care after allowable deductions under subsection (4) of this section.~~

~~(c) A married person who lives at home and apart from the person's spouse keeps a PNA of up to the FPL 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 at home where each person receives HCB waiver services is each allowed to keep a PNA of up to the FPL but must pay remaining available income toward cost of care after allowable deductions under subsection (4) of this section.~~

~~(e) A married couple living at home where each person receives HCB waiver services, one person authorized by the developmental disabilities administration (DDA) and the other authorized by HCS, is allowed the following:~~

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

~~(ii) The person authorized by HCS retains the federal poverty level (FPL) 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 person 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 person:~~

~~(a) Keeps a PNA of \$62.79;~~

~~(b) Pays room and board up to the room and board standard. The room and board standard is the federal benefit rate (FBR) minus \$62.79; 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) ((If you are working, the department allows)) An earned income deduction of the first ((sixty five dollars)) \$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 ((by chapter 388-79 WAC)) under WAC 182-513-1505 through 182-513-1525;~~

~~(c) Current or back child support garnished or withheld from ((you)) the person's income according to a child support order in the month of the garnishment if it is for the current month. If the ((department)) agency allows this as a deduction from ((you)) income, the~~

~~((department will)) agency does not count it as ~~((your)) the~~ child's income when determining the family allocation amount in WAC 182-513-1385;~~

~~(d) A monthly maintenance-needs allowance for ~~((your)) the~~ community spouse ~~((not to exceed that in WAC 388-513-1380 (5)(b) unless a greater amount is allocated as described in subsection (e) of this section. This amount:~~~~

~~(i) Is allowed only to the extent that your income is made available to your community spouse; and~~

~~(ii) Consists of a combined total of both:~~

~~(A) One hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st and can be found at: <http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml>; and~~

~~(B) Excess shelter expenses. For the purposes of this section, excess shelter expenses are the actual required maintenance expenses for your community spouse's principal residence. These expenses are determined in the following manner:~~

~~(I) Rent, including space rent for mobile homes, plus;~~

~~(II) Mortgage, plus;~~

~~(III) Taxes and insurance, plus;~~

~~(IV) Any required payments for maintenance care for a condominium or cooperative, plus;~~

~~(V) The food assistance standard utility allowance (SUA) described in WAC 388-450-0195 provided the utilities are not included in the maintenance charges for a condominium or cooperative, minus;~~

~~(VI) The standard shelter allocation. This standard is based on thirty percent of one hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st and can be found at: <http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml>; and~~

~~(VII) Is reduced by your community spouse's gross countable income.~~

~~(iii) The amount allocated to the community spouse may be greater than the amount in subsection (d)(ii) only when:~~

~~(A) There is a court order approving a higher amount for the support of your community spouse; or~~

~~(B) A hearing officer determines a greater amount is needed because of exceptional circumstances resulting in extreme financial distress.) 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 person's income to the person's PNA, as calculated under WAC 182-513-1385;~~

~~(e) A monthly maintenance-needs ~~((amount)) allowance~~ for each ~~((minor or dependent child, dependent parent, or dependent sibling of your community or institutionalized spouse. The amount the department allows is based on the living arrangement of the dependent. If the dependent:~~~~

~~(i) Resides with your community spouse, for each child, one hundred fifty percent of the two person FPL minus that child's income and divided by three (child support received from a noncustodial parent is considered the child's income);~~

~~(ii) Does not reside with the community spouse, the amount is equal to the effective one person MNIL based on the number of dependent family members in the home less their separate income (child support received from a noncustodial parent is considered the child's in-~~

~~come).~~) dependent of the institutionalized person, or the person's spouse, as calculated under WAC 182-513-1385;

~~(f) ((Your unpaid))~~ Incurring medical expenses which have not been used to reduce excess resources. Allowable medical expenses are ~~((described in WAC 388-513-1350))~~ under WAC 182-513-1350.

~~((g))~~ (5) The total of the following deductions cannot exceed the ((SIL (three hundred percent of the FBR)) special income level (SIL) defined under WAC 182-513-1100:

~~((i) Personal needs allowance))~~ (a) The PNA allowed in subsection((s (1), (2) and (3)(a) and (b))) (2) or (3) of this section, including room and board; ((and

~~(ii))~~

(b) The earned income deduction ((of the first sixty five dollars plus one half of the remaining earned income)) in subsection (4)(a) of this section; and

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

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

~~((5) You))~~ (7) A person must pay ((your provider the combination)) the person's provider the sum of the room and board amount, and the cost of ((personal)) care ((services)) after all allowable deductions, and any third-party resources defined under WAC 182-513-1100.

~~((6) You may have to pay third party resources described in WAC 182-501-0200 in addition to the room and board and participation. The combination of room and board, participation, and third party resources is the total amount you must pay.~~

~~(7) Current income and resource standards for long term care (including SIL, MNIL, FPL, FBR) are located at: <http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml>.)~~

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

(9) When a person lives in multiple living arrangements in a month ((an example is a move from an adult family home to a home setting on HCB services)), the ((department)) agency allows ((you)) the highest PNA available based on all the living arrangements and services ((you have)) the person has received in a month.

~~((9) Current PNA and ADSA room and board))~~ (10) Standards described in this section are ((located)) found at((: <http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/ltestandardsPNA-ehartsubfile.shtml>)) <http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources>.

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

**WAC 182-515-1510 ((Division of)) Home and community based (HCB) waiver services authorized by the developmental disabilities ((DDD) home and community based services waivers) administration (DDA).** ((The four sections that follow)) This chapter describes the general and financial eligibility requirements for categorically needy (CN) home and community based (HCB) waivers authorized by the ((division of)) developmental disabilities ((DDD) home and community based serv-

ices (HCBS) waivers)) administration (DDA). The definitions in WAC 182-513-1100 and chapter 182-500 WAC apply throughout this chapter.

(1) The DDA waiver programs are:

(a) Basic Plus;

(b) Core;

(c) Community protection;

(d) Children's intensive in-home behavioral support (CIIBS); and

(e) Individual and family services (IFS).

((~~(1) WAC 388-515-1511~~)) (2) WAC 182-515-1511 describes the general eligibility requirements ((under the DDD HCBS)) for HCB waiver((s)) services authorized by DDA.

((~~(2) WAC 388-515-1512~~)) (3) WAC 182-515-1512 describes the financial requirements for ((the DDD waivers if you are)) eligibility for HCB waiver services authorized by DDA if a person is eligible for ((medicaid under the noninstitutional categorically needy)) a noninstitutional SSI-related CN program ((CN)).

((~~(3) WAC 388-515-1513~~)) (4) WAC 182-515-1513 describes the ((initial)) financial eligibility requirements for ((the DDD)) HCB waiver((s if you are)) services authorized by DDA when a person is not eligible for ((medicaid under a categorically needy)) an SSI-related noninstitutional CN program ((CN) listed in)) under WAC ((~~388-515-1512(1)~~)) 182-515-1512.

((~~(4) WAC 388-515-1514~~)) (5) WAC 182-515-1514 describes the ((post eligibility financial requirements for the DDD waivers if you are not eligible for medicaid under a categorically needy program CN listed in)) rules used to determine a person's responsibility in the cost of care and room and board for HCB waiver services authorized by DDA if the person is eligible under WAC ((~~388-515-1512(1)~~)) 182-515-1512.

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

**WAC 182-515-1511 ((What are the general eligibility requirements for)) Home and community based (HCB) waiver services ((under the division of)) authorized by the developmental disabilities ((DDD) home and community based services (HCBS) waivers?) administration (DDA) — General eligibility.** ((~~(1) This section describes the general eligibility requirements for waiver services under the DDD home and community based services (HCBS) waivers.~~

((~~(2) The requirements for services for DDD HCBS waivers are described in chapter 388-845 WAC. The department establishes eligibility for DDD HCBS waivers.~~)) (1) To be eligible((, you)) 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 ((division of developmental disabilities (DDD))) DDA;

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

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

~~((d))~~ (e) Have attained institutional status ((as described in WAC 388-513-1320)) under WAC 182-513-1320;

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

~~((f) Need waiver services as determined by your plan of care or individual support plan))~~ (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((, which includes)) 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 ((your)) 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((+ and

~~(g) Be both medicaid eligible under the categorically needy program (CN) and be approved for services by the division of developmental disabilities)).~~

(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>.

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

**WAC 182-515-1512** ~~((What are the financial requirements for the DDD waiver services if I am eligible for medicaid under the noninstitutional categorically needy program (CN)?))~~ **Home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA)—Financial eligibility if a person is eligible for a noninstitutional SSI-related categorically needy (CN) program.** ~~((1) You automatically meet income and resource eligibility for DDD waiver services if you are eligible for medicaid under a categorically needy program (CN) under one of the following programs:~~

~~(a) Supplemental security income (SSI) eligibility described in WAC 388-474-0001. This includes SSI clients under 1619B status. These clients have medicaid eligibility determined and maintained by the Social Security Administration;~~

~~(b) Health care for workers with disabilities (HWD) described in WAC 182-511-1000 through 182-511-1250;~~

~~(c) SSI-related (CN) medicaid described in WAC 182-512-0100 (2)(a) and (b) or meets the requirements in WAC 182-512-0880 and is (CN) eligible after the income disregards have been applied;~~

~~(d) CN medicaid for a child as described in WAC 182-505-0210 (1), (2), (7) or (8); or~~

~~(e) Aged, blind or disabled (ABD) cash assistance described in WAC 388-400-0060.~~

~~(2) If you are eligible for a CN medicaid program listed in subsection (1) above, you do not have to pay (participate) toward the cost of your personal care and/or habilitation services.~~

~~(3) If you are eligible for a CN medicaid program listed in subsection (1) above, you do not need to meet the initial eligibility income test of gross income at or below the special income level (SIL), which is three hundred percent of the federal benefit rate (FBR).~~

~~(4) If you are eligible for a CN medicaid program listed in subsection (1), you pay up to the ADSA room and board standard described in WAC 388-515-1507. Room and board and long term care standards are located at <http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml>.~~

~~(a) If you live in an ARC, AFH or DDD group home, you keep a personal needs allowance (PNA) and use your income to pay up to the ADSA room and board standard. Effective January 1, 2009 the PNA is sixty-two dollars and seventy nine cents.~~

~~(5) If you are eligible for a premium based medicaid program such as health care for workers with disabilities (HWD), you must continue to pay the medicaid premium to remain eligible for that CN P program.)~~ (1) A person is financially eligible for home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA) if:

(a) The person is receiving coverage under one of the following SSI-related 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 person meets disability requirements under WAC 182-512-0050.

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

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

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

(a) Keeps a personal needs allowance (PNA) of \$62.79; and

(b) Pays towards room and board up to the room and board standard with remaining income. The room and board standard is the federal benefit rate (FBR) minus \$62.79.

(4) A person 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) A person who is eligible for the aged, blind, disabled (ABD) cash assistance program under WAC 388-400-0060 does not pay participation toward the cost of care and keeps the following:

(a) The cash grant amount authorized under WAC 388-478-0033 if living at home;

(b) A PNA of \$38.84, but must pay towards room and board with the remaining income and ABD cash grant for the cost of room and board up to the room and board standard if living in an adult family home (AFH). The room and board standard is the federal benefit rate (FBR) minus \$62.79; or

(c) The cash grant of \$38.84 authorized under WAC 388-478-0006 when living in an assisted living or DDA group home.

(6) 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/program-standard-income-and-resources>.

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

~~WAC 182-515-1513 ((How does the department determine if I am financially eligible for DDD waiver service medical coverage if I am not eligible for medicaid under a categorically needy program (CN) listed in WAC 388-515-1512(1)?) Home and community based (HCB) waiver services authorized by the developmental disabilities administration (DDA) —Financial eligibility using SSI-related institutional rules. ((If you are not eligible for medicaid under a categorically needy program (CN) listed in WAC 388-515-1512(1), we must determine your eligibility using institutional medicaid rules. This section explains how you may qualify under this program. You may be required to pay towards the cost of your care if you are eligible under this program. The rules explaining how much you have to pay are listed in WAC 388-515-1514. To qualify, you must meet both the resource and income requirements.~~

~~(1) Resource limits are described in WAC 388-513-1350. If you have resources which are higher than the standard allowed, we may be able to reduce resources by your unpaid medical expenses described in WAC 388-513-1350.~~

~~(2) You are not subject to a transfer of asset penalty described in WAC 388-513-1363 through 388-513-1365.~~

~~(d) Not have a home with equity in excess of the requirements described in WAC 388-513-1350.~~

~~(3) Your gross nonexcluded income must be at or below the special income level (SIL) which is three hundred percent of the federal benefit level. The department follows the rules in WAC 388-515-1325, 388-513-1330 and 388-513-1340 to determine available income and income exclusions.~~

~~(4) Refer to WAC 388-513-1315 for rules used to determine countable resources, income and eligibility standards for long term care services.~~

~~(5) Current income and resources standards are located at: <http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml>.~~

(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>.

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

~~WAC 182-515-1514 ((How does the department determine how much of my income I must pay towards the cost of my DDD waiver services if I am not eligible for medicaid under a categorically needy program (CN) listed in WAC 388-515-1512(1)?)) Home and community based (HCB) services authorized by the developmental disabilities administration (DDA) —Client financial responsibility. ((If you are not eligible for medicaid under a categorically needy program (CN) listed in WAC 388-515-1512(1), the department determines how much you must pay based upon the following:~~

~~(1) If you are an SSI-related client living at home as defined in WAC 388-106-0010, you keep all your income up to the SIL (three hundred percent of the FBR) for your personal needs allowance (PNA).~~

~~(2) If you are an SSI-related client and you live in an ARC, AFH or DDD group home, you:~~

~~(a) Keep a personal needs allowance (PNA) from your gross nonexcluded income. Effective January 1, 2009 the PNA is sixty two dollars and seventy nine cents; and~~

~~(b) Pay for your room and board up to the ADSA room and board rate described in <http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml>.~~

~~(3) In addition to paying room and board, you may also have to pay toward the cost of personal care. This is called your participation. Income that remains after the PNA and any room and board deduction described in (2) above, is reduced by allowable deductions in the following order:~~

~~(a) If you are working, we allow an earned income deduction of the first sixty five dollars plus one-half of the remaining earned income;~~

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

~~(c) Current or back child support garnished or withheld from your income according to a child support order in the month of the garnishment if it is for the current month. If we allow this as deduction from your income, we will not count it as your child's income when determining the family allocation amount;~~

~~(d) A monthly maintenance needs allowance for your community spouse not to exceed that in WAC 388-513-1380 (5)(b) unless a greater amount is allocated as described in subsection (e) of this section. This amount:~~

~~(i) Is allowed only to the extent that your income is made available to your community spouse; and~~

~~(ii) Consists of a combined total of both:~~

~~(A) One hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st and can be found at: <http://www.dshs.wa.gov/manuals/ez/sections/LongTermCare/LTCstandardspna.shtml>; and~~

~~(B) Excess shelter expenses. For the purposes of this section, excess shelter expenses are the actual required maintenance expenses for your community spouse's principal residence. These expenses are determined in the following manner:~~

~~(I) Rent, including space rent for mobile homes, plus;~~

~~(II) Mortgage, plus;~~

~~(III) Taxes and insurance, plus;~~

~~(IV) Any required payments for maintenance care for a condominium or cooperative plus;~~

~~(V) The food assistance standard utility allowance (SUA) provided the utilities are not included in the maintenance charges for a condominium or cooperative, minus;~~

~~(VI) The standard shelter allocation. This standard is based on thirty percent of one hundred fifty percent of the two person federal poverty level. This standard may change annually on July 1st and can be found at: <http://www.dshs.wa.gov/manuals/ez/sections/LongTermCare/LTCstandardspna.shtml>; and~~

~~(VII) Is reduced by your community spouse's gross countable income.~~

~~(iii) May be greater than the amount in subsection (d)(ii) only when:~~

~~(A) There is a court order approving a higher amount for the support of your community spouse; or~~

~~(B) A hearing officer determines a greater amount is needed because of exceptional circumstances resulting in extreme financial distress.~~

~~(e) A monthly maintenance needs amount for each minor or dependent child, dependent parent or dependent sibling of your community or institutionalized spouse. The amount we allow is based on the living arrangement of the dependent. If the dependent:~~

~~(i) Resides with your community spouse, for each child, one hundred fifty percent of the two person FPL minus that child's income and divided by three (child support received from a noncustodial parent is considered the child's income);~~

~~(ii) Does not reside with the community spouse, the amount is equal to the effective one person MNIL based on the number of dependent family members in the home less their separate income (child support received from a noncustodial parent is considered the child's income).~~

~~(f) Your unpaid medical expenses which have not been used to reduce excess resources. Allowable medical expenses are described in WAC 388-513-1350.~~

~~(g) The total of the following deductions cannot exceed the SIL (three hundred percent of the FBR):~~

~~(i) Personal needs allowances in subsection (1) for in-home or subsection (2)(a) in a residential setting; and~~

~~(ii) Earned income deduction of the first sixty five dollars plus one half of the remaining earned income in subsection (3)(a); and~~

~~(iii) Guardianship fees and administrative costs in subsection (3)(b).~~

~~(4) If you are eligible for aged, blind or disabled (ABD) cash assistance described in WAC 388-400-0060 you do not participate in the cost of personal care and you may keep the following:~~

~~(a) When you live at home, you keep the cash grant amount authorized under the ABD cash program;~~

~~(b) When you live in an AFH, you keep a PNA of thirty eight dollars and eighty four cents, and pay any remaining income and ABD cash grant to the facility for the cost of room and board up to the ADSA room and board standard described in <http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml>; or~~

~~(c) When you live in an ARC or DDD group home, you are only eligible to receive a cash grant of thirty eight dollars and eighty four cents which you keep for your PNA.~~

~~(5) You may have to pay third party resources (TPR) described in WAC 182-501-0200 in addition to room and board and the cost of personal care and/or habilitation services (participation) after all allowable deductions have been considered is called your total responsibility. You pay this amount to the ARC, AFH or DDD group home provider.))~~

(1) A person 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 person's responsibility towards cost of care.

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

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

(a) A single person 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 person 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 person who lives with the person'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 person receives HCB waiver services, one authorized by DDA and the other authorized by home and community services (HCS) is allowed the following:

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

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

(a) Keeps a PNA of \$62.79;

(b) Pays room and board up to the room and board standard. The room and board standard is the federal benefit rate (FBR) minus \$62.79; 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 WAC 182-513-1505 through 182-513-1525;

(c) Current or back child support garnished or withheld from the person'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 person's income to the person's PNA;

(e) A monthly maintenance-needs allowance for each dependent of the institutionalized person, or the person'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 person may have to pay third-party resources defined under WAC 182-513-1100 in addition to the room and board and participation.

(7) A person must pay the person'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 person on HCB waiver services does not pay more than the state rate for cost of care.

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

(10) Standards described in this section are found at <http://www.hca.wa.gov/free-or-low-cost-health-care/program-administration/program-standard-income-and-resources>.

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 182-515-1500      Payment standard for persons in certain group living facilities.