Medicaid State Plan - Attachment 2

Groups Covered and Eligibility Determinations

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2.7-A Medicaid Furnished Out of State
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

State Definition of a Health Maintenance Organization:

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

An Health Maintenance Organization also meets the requirements of 42 CFR 434.20 (c)(2).
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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GROUPS COVERED AND AGENCIES RESPONSIBLE FOR ELIGIBILITY DETERMINATIONS

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_PAGE 1 SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS_

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

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<td>IV-A</td>
<td>A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</td>
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### 2. Deemed Recipients of AFDC.

1902(a)(10)(A)(i)(I) Of the Act


406(h) and 1902(a)(10)(A)(i)(I) of the Act

d. An assistance unit deemed to be receiving AFDC for a period of four calendar months because the family becomes ineligible for AFDC as a result of collection or increased collection of support and meets the requirements of section 406(h) of the Act.

1902(a) of the Act
e. Individuals deemed to be receiving AFDC who meet the requirements of section 473(b)(1) or (2) for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made under title IV-E of the Act.

*Agency that determines eligibility for coverage.

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<td>407(b), 1902 (a)(10)(A)(i) And 1905(m)(l)</td>
<td>3. Qualified Family Members SUPERSEDED BY MEDICAID MAGI ELIGIBILITY &amp; BENEFITS SEE S14, S25, S28, S30, S51, S53, S54, S55</td>
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<td></td>
<td>1902(a)(52) and 1925 of the Act</td>
<td>4. Families terminated from AFDC solely because of earnings, hours of employment, or loss of earned income disregards entitled up to twelve months of extended benefits in accordance with section 1925 of the Act. (This provision expires on September 30, 1998.)</td>
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*Agency that determines eligibility for coverage.

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**PAGE 3 SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS**

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

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SEE S14, S25, S28, S30, S51, S53, S54, S55
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Citation(s) Groups Covered

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PAGE 4a SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

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Citation(s) Groups Covered

A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1902(a)(10) (A)(i)(V) and 1905(m) of the Act

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

1902(e)(5) of the Act

11. a. A woman who, while pregnant, was eligible for, applied for, and receives Medicaid under the approved State plan on the day her pregnancy ends. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and postpartum medical assistance under the plan for a 60-day period (beginning on the last day of her pregnancy) and for any remaining days in the month in which the 60th day falls.

1902(e)(6) of the Act

b. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.
## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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### COVERAGE AND CONDITIONS OF ELIGIBILITY

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<td>42 CFR 435.117 1902(e)(4) of the Act</td>
<td>12. A child born in the United States to a woman who was eligible for and receiving Medicaid (including coverage of an alien for labor and delivery as emergency medical services) for the date of the child’s birth, including retroactively. The child is deemed eligible for one year from birth.</td>
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<td>42 CPR 435.120</td>
<td>13. Aged, Blind and Disabled Individuals Receiving Cash Assistance</td>
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<td><em>X</em> A. Individuals receiving SSI.</td>
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<tr>
<td>This includes beneficiaries' eligible spouses and persons receiving SSI benefits pending a final determination of blindness or disability or pending disposal of excess resources under an agreement with the Social Security Administration; and beginning January 1, 1981 persons receiving SSI under section 1619(a) of the Act or considered to be receiving SSI under section 1619(b) of the Act.</td>
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<tr>
<td><em>X</em> Aged</td>
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<tr>
<td><em>X</em> Blind</td>
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<tr>
<td><em>X</em> Disabled</td>
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## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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### A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

#### 435.121

13. / / b. **Individuals who meet more restrictive requirements for Medicaid than the SSI requirements.** (This includes persons who qualify for benefits under section 1619(a) of the Act or who meet the requirements for SSI status under section 1619(b)(1) of the Act and who met the State's more restrictive requirements for Medicaid in the month before the month they qualified for SSI under section 1619(a) or met the requirements under section 1619(b)(1) of the Act. Medicaid eligibility for these individuals continues as long as they continue to meet the 1619(a) eligibility standard or the requirements of section 1619(b) of the Act.)

- Aged
- Blind
- Disabled

The more restrictive categorical eligibility criteria are described below:

(Financial criteria are described in ATTACHMENT 2.6-A).

*Agency that determines eligibility for coverage.

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## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

*Agency that determines eligibility for coverage.

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<td>(4) Be seriously inhibited by the lack of Medicaid coverage in their ability to continue to work or obtain employment; and</td>
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<td>(5) Have earnings that are not sufficient to provide for himself or herself a reasonable equivalent of the Medicaid, SSI (including any Federally administered SSP), or public funded attendant care services that would be available if he or she did have such earnings.</td>
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<td></td>
<td>/ / Not applicable with respect to individuals receiving only SSP because the State either does not make SSP payments or does not provide Medicaid to SSP-only recipients.</td>
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* Agency that determines eligibility for coverage.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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1619(b)(3) of the Act / /

The state applies more restrictive eligibility requirements for Medicaid than under SSI and under 42 CFR 435.121. Individuals who qualify for benefits under section 1619(a) of the Act or individuals described above who meet the eligibility requirements for SSI benefits under section 1619(b)(1) of the Act and who met the State's more restrictive requirements in the month before the month they qualified for SSI under section 1619(a) or met the requirements of section 1619(b)(1) of the Act are covered. Eligibility for these individuals continues as long as they continue to qualify for benefits under section 1619(a) of the Act or meet the SSI requirements under section 1619(b)(1) of the Act.

*Agency that determines eligibility for coverage.

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<td>1634(c) of the Act</td>
<td>15. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, blind or disabled individuals who--</td>
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<td>a. Are at least 18 years of age;</td>
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<td>b. Lose SSI eligibility because they become entitled to OASDI child's benefits under section 202(d) of the Act or an increase in these benefits based on their disability. Medicaid eligibility for these individuals continues for as long as they would be eligible for SSI, absent their OASDI eligibility.</td>
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<td></td>
<td>c. The State applies more restrictive eligibility requirements than those under SSI, and part or all of the amount of the OASDI benefit that caused SSI/SSP ineligibility and subsequent increases are deducted when determining the amount of countable income for categorically needy eligibility.</td>
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<td>d. The State applies more restrictive requirements than those under SSI, and none of the OASDI benefit is deducted in determining the amount of countable income for categorically needy eligibility.</td>
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<td>42 CFR 435.122</td>
<td>16. Except in States that apply more restrictive eligibility requirements for Medicaid than under SSI, individuals who are ineligible for SSI or optional State supplements (if the agency provides Medicaid under S435.230), because of requirements that do not apply under title XIX of the Act.</td>
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<tr>
<td>42 CFR 435.130</td>
<td>17. Individuals receiving mandatory State supplements.</td>
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<tr>
<td>42 CFR 435.131</td>
<td>18. Individuals who in December 1973 were eligible for Medicaid as an essential spouse and who have continued, as spouse, to live with and be essential to the well-being of a recipient of cash assistance. The recipient with whom the essential spouse is living continues to meet the December 1973 eligibility requirements of the State's approved plan for OAA, AB, APTD, or AABD and the spouse continues to meet the December 1973 requirements for having his or her needs included in computing the cash payment.</td>
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/ X/ In December 1973, Medicaid coverage of the essential spouse was limited to the following group(s):

- X Aged
- X Blind
- X Disabled

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

*Agency that determines eligibility for coverage.
## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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19. Institutionalized individuals who were eligible for Medicaid in December 1973 as inpatients of title XIX medical institutions or residents of title XIX intermediate care facilities, if, for each consecutive month after December 1973, they--

- a. Continue to meet the December 1973 Medicaid State plan eligibility requirements; and
- b. Remain institutionalized; and
- c. Continue to need institutional care.

20. Blind and disabled individuals who-

- a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria; and
- b. Were eligible for Medicaid in December 1973 as blind or disabled; and
- c. For each consecutive month after December 1973 continue to meet December 1973 eligibility criteria.

*Agency that determines eligibility for coverage.

[Back to TOC](#)
#### Agency* | Citation(s) | Groups Covered
--- | --- | ---
SSI | A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued) | 42 CFR 435.134

21. Individuals who would be SSI/SSP eligible except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), who were entitled to OASDI in August 1972, and who were receiving cash assistance in August 1972.

/X/ Includes persons who would have been eligible for cash assistance but had not applied in August 1972 (this group was included in this State's August 1972 plan).

/X/ Includes persons who would have been eligible for cash assistance in August 1972 if not in a medical institution or intermediate care facility (this group was included in this State's August 1972 plan).

/ / Not applicable with respect to intermediate care facilities; the State did or does not cover this service.

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

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<td>1634 of the Act</td>
<td>Disabled widows and widowers who would be eligible for SSI or SSP except for the increase in their OASDI benefits as a result of the elimination of the reduction factor required by section 134 of Pub. L. 98-21. and who are deemed, for purposes of title XIX, to be SSI beneficiaries or SSP beneficiaries for individuals who would be eligible for SSP only, under section 1634(b) of the Act.</td>
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<td>23. / / Not applicable with respect to individuals receiving only SSP because the State either does not make these payments or does not provide Medicaid to SSP-only recipients.</td>
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<td>23. / / The State applies more restrictive eligibility standards than those under SSI and considers these individuals to have income equaling the SSI Federal benefit rate, or the SSP benefit rate for individuals who would be eligible for SSP only, when determining countable income for Medicaid categorically needy eligibility.</td>
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<td>1634(d) of the Act</td>
<td>24. Disabled widows, disabled widowers, and disabled unarmed divorced spouses who had been married to the insured individual for a period of at least ten years before the divorce became effective, who have attained the age of 50, who are receiving title II payments, and who because of the receipt of title II income lost eligibility for SSI or SSP which they received in the month prior to the month in which they began to receive title II payments, who would be eligible for SSI or SSP if the amount of the title II benefit were not counted as income, and who are not entitled to Medicare Part A.</td>
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<td>The State applies more restrictive eligibility requirements for its blind or disabled than those of the SSI program.</td>
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<td>In determining eligibility as categorically needy, the State disregards the amount of the title II benefits identified in §1634(d)(1)(A) in determining the income of the individual, but does not disregard any more of this income than would reduce the individual's income to the SSI income standard.</td>
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<td>In determining eligibility as categorically needy, the State disregards only part of the amount of the benefits identified in §1634(d)(1)(A) in determining the income of the individual, which amount would not reduce the individual's income below the SSI income standard. The amount of these benefits to disregarded is specified in Supplement 4 to Attachment 2.6-A.</td>
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<td>In determining eligibility as categorically needy, the State chooses not to deduct any of the benefit identified in §1634(d)(1)(A) in determining the income of the individual.</td>
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A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)

1902(a)(10)(E)(i), 1905(p) and 1860D-14(a)(3)(D) of the Act

25. Qualified Medicare beneficiaries-
   a. Who are entitled to hospital insurance benefits under Medicare Part A, (but not pursuant to an enrollment under section 1818A of the Act);
   b. Whose income does not exceed 100 percent of the Federal poverty level; and
   c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer index.

(Medical assistance for this group is limited to Medicare cost-sharing as defined in item 3.2 of this plan.)

1902(a)(10)(E)(ii), 1905(p)(3)(A)(i) And 1905(s) of the Act

26. Qualified disabled and working individuals-
   a. Who are entitled to hospital insurance benefits under Medicare Part A under section 1818A of the Act;
   b. Whose income does not exceed 200 percent of the Federal poverty level; and

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<td>A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</td>
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<td></td>
<td>a. Whose resources do not exceed two times the SSI resource limit.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Who are not otherwise eligible for medical assistance under Title XIX of the Act.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Medical assistance for this group is limited to Medicare Part A premiums under section 1818A of the Act.)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);</td>
</tr>
<tr>
<td></td>
<td></td>
<td>b. whose income is greater than 100 percent but less than 120 percent of the Federal poverty level; and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Medical assistance for this group is limited to Medicare Part B premiums under section 1839 of the Act.)</td>
</tr>
</tbody>
</table>

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### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State _______________ WASHINGTON ___________

<table>
<thead>
<tr>
<th>Agency*</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>1902(a)(10)(E)(iv) and 1905(p)(3)(A)(ii) and 1860D-14(a)(3)(D) of the Act</td>
<td>Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)</td>
</tr>
</tbody>
</table>

28. Qualifying Individuals --
   a. Who are entitled to hospital insurance benefits under Medicare Part A (but not pursuant to an enrollment under section 1818A of the Act);
   b. whose income is at least 120 percent but less than 135 percent of the Federal poverty level;
   c. Whose resources do not exceed three times the SSI resource limit, adjusted annually by the increase in the consumer price index.
### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

**State** WASHINGTON

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>IV-A</td>
<td>B. Optional Groups Other Than the Medically Needy</td>
<td></td>
</tr>
<tr>
<td>42 CFR</td>
<td>/X/ 1. Individuals described below who meet the income and resources requirements of AFDC, SSI, or an optional state supplement as specified in 42 CFR 435.230, but who do not receive cash assistance.</td>
<td></td>
</tr>
<tr>
<td>435.210</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1902 (a)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(10)(A)(ii) and 1905(a) of the Act</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[X] The plan covers all individuals as described above.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>[ ] The plan covers only the following group or groups of individuals:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>___ Aged</td>
<td></td>
<td></td>
</tr>
<tr>
<td>___ Blind</td>
<td></td>
<td></td>
</tr>
<tr>
<td>___ Disabled</td>
<td></td>
<td></td>
</tr>
<tr>
<td>___ Caretaker relatives Removed per SPA 13-0030 eff. 1/1/14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>___ Pregnant women Removed per SPA 13-0030 eff. 1/1/14</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Section 1902</td>
<td>[X] The plan covers individuals not receiving SSI who the State finds blind or disabled and who are determined otherwise eligible for assistance during the period of time prior to which a final determination of disability or blindness is made by Social Security Administration. The State applies the definitions of disability and blindness found in Section 1614 (a) of the Social Security Act.</td>
<td></td>
</tr>
<tr>
<td>(V)(1) (42 U.S.C. 1396a)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>42 CFR</td>
<td>/X/ 2. Individuals who would be eligible for AFDC, SSI or an optional State supplement as specified in 42 CFR 435.230, if they were not in a medical institution.</td>
<td></td>
</tr>
</tbody>
</table>

*Agency that determines eligibility for coverage

---

**Back to TOC**
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Agency* Citation(s) Groups Covered

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


3. The State deems as eligible those individuals who became otherwise ineligible for Medicaid while enrolled in an HMO qualified under Title XIII of the Public Health Service Act, or a managed care organization (MCO), or a primary care case management organization (PCCM) program, but who have enrolled in the entity for less than the minimum enrollment period listed below. Coverage under this section is limited to HMO or PCCM services and family planning services described in section 1905(a)(4)(C) of the Act.

X The State elects not to guarantee eligibility.

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

The State measures the minimum enrollment period from:

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

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

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

*Agency that determines eligibility for coverage.

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TN# 03-015 Approval Date: 10/17/03 Effective Date: 8/11/03
Supersedes TN# 92-06
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State ___________________ WASHINGTON ___________________

<table>
<thead>
<tr>
<th>Agency*</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
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<tbody>
<tr>
<td>1932(a)(4) of the Act</td>
<td>B. Optional Groups Other Than the Medically Needy (Continued)</td>
<td></td>
</tr>
<tr>
<td>1903(m)(2)(H), 1902 (a)(52) of the Act, P.L. 101-508, 42 CFR 438.56(g)</td>
<td>In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with an MCO, PIHP, PAHP, or PCCM when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract.</td>
<td></td>
</tr>
</tbody>
</table>

— Disenrollment rights are restricted for a period of ___ months (not to exceed 12 months).

  During the first three months of each enrollment period the recipient may disenroll without cause. The State will provide notification, at least once per year, to recipients enrolled with such organization of their right to and restrictions of terminating such enrollment.

— The agency elects to reenroll the above individuals who are ineligible in a month but in the succeeding two months become eligible, into the same entity in which they were enrolled at the time eligibility was lost.

— The agency elects not to reenroll above individuals into the same entity in which they were previously enrolled.

*Agency that determines eligibility for coverage.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

*Agency that determines eligibility for coverage.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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<tr>
<td>IV-A</td>
<td>B. Optional Groups Other Than the Medically Needy (Continued)</td>
<td></td>
</tr>
<tr>
<td>1902(a)(10) (A)(ii)(VII) of the Act</td>
<td>/X/ 5. Individuals who would be eligible for Medicaid under the plan if they were in a medical institution, who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.</td>
<td></td>
</tr>
</tbody>
</table>

/X/ The State covers all individuals as described above.

/ / The State covers only the following group or groups of individuals:

- Aged
- Blind
- Disabled
- Individuals under the age of--
  - 21
  - 20
  - 19
  - 18
- Caretaker relatives
- Pregnant women

*Agency that determines eligibility for coverage.
## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: Washington

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**PAGE 12 SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS**

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

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PAGE 13 SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

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

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PAGE 13a SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

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

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Agency* Citation(s) Groups Covered

PAGE 14 SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

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

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# STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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**PAGE 14a SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS**

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

[Back to TOC](#)
B. Optional Groups Other Than the Medically Needy (Continued)

SSI

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

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

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

c. Available to all individuals in the State.

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

X (1) All aged individuals.

X (2) All blind individuals.

X (3) All disabled individuals.

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### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

**State**  
WASHINGTON  

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<th>Agency*</th>
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<tr>
<td>B. Optional Groups Other Than the Medically Needy (Continued)</td>
<td></td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>(4) Aged individuals in domiciliary facilities or other group living arrangements as defined under SSI.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(5) Blind individuals in domiciliary facilities or other group living arrangements as refined under SSI.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(6) Disabled individuals in domiciliary facilities or other group living arrangements as defined under SSI.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(7) Individuals receiving a Federally administered optional State supplement that meets the conditions specified in 42 CFR 435.230.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(8) Individuals receiving a State administered optional State supplement that meets the conditions specified in 42 CFR 435.230.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(9) Individuals in additional classifications approved by the Secretary as follows:</td>
</tr>
</tbody>
</table>

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

<table>
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<tr>
<th>Agency*</th>
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<tbody>
<tr>
<td>B. Optional Groups Other Than the Medically Needy (Continued)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

SSI

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

- Yes.
- No.

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

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

42 CFR 435.121  / /  11. Section 1902(8 States and SSI criteria States
435.230
1902(a)(10)
(A)(ii)(XI)
without agreements under section 1616 or 1634
of the Act.

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

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

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

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

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

    ____ (1)  All aged individuals.

    ____ (2)  All blind individuals.

    ____ (3)  All disabled individuals.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Agency* Citation(s) Groups Covered

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

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

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

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

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

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

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

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

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

___ Yes

___ No

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

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## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

State WASHINGTON

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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*PAGE 21 SUPERSED BY MEDICAID MAGI ELIGIBILITY & BENEFITS*

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

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### Optional Groups Other Than the Medically Needy (Continued)

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

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PAGE 1 SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS12

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

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<tbody>
<tr>
<td>B. Optional Groups Other Than the Medically Needy (Continued)</td>
</tr>
</tbody>
</table>

1906 of the Act

18. Individuals required to enroll in cost-effective employer-based group health plans remain eligible for a minimum enrollment period of _______ months.

1902(a)(10)(F) and 1902(u)(1) of the Act

19. Individuals entitled to elect COBRA continuation coverage and whose income as determined under Section 1612 of the Act for purposes of the SSI program, is no more than 100 percent of the Federal poverty level, whose resources are no more than twice the SSI resource limit for an individual, and for whom the State determines that the cost of COBRA premiums is likely to be less than the Medicaid expenditures for an equivalent set of services. See Supplement 11 to Attachment 2.6-A.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Citation

Groups Covered

PAGE 23b SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

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

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

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

X 21. A child under age 19 who has been determined eligible for a total of 12 months regardless of changes in circumstances other than the attainment of the maximum age stated above.
### Citation

<table>
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<tr>
<th>Groups Covered</th>
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<tbody>
<tr>
<td>B. Optional Groups Other Than the Medically Needy (Continued)</td>
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</table>

#### 1902(a)(10)(A) (ii)(XVIII) of the Act

<table>
<thead>
<tr>
<th>(24) Women who:</th>
</tr>
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<tbody>
<tr>
<td>(a) Have been screened for breast cancer under the Centers for Disease Control and Prevention and Cervical Cancer Early Detection Program established under title XV of the Public Health Service Act in accordance with the requirements of section 1504 of that Act and need treatment for breast or cervical cancer, including a precancerous condition of the breast or cervix;</td>
</tr>
<tr>
<td>(b) Are not otherwise covered under creditable coverage, as defined in section 2701(c) of the Public Health Service Act;</td>
</tr>
<tr>
<td>(c) Are not eligible for Medicaid under any mandatory categorically needy eligibility group; and</td>
</tr>
<tr>
<td>(d) Have not attained age 65.</td>
</tr>
</tbody>
</table>

#### 1920B of the Act

| (25) Women who are determined by a “qualified entity” (as defined in 1920B (b) based on preliminary information, to be a woman described in 1902 (aa) the Act related to certain breast and cervical cancer patients. |

The presumptive period begins on the day that the determination is made. The period ends on the date that the State makes a determination with respect to the woman’s eligibility for Medicaid, or if the woman does not apply for Medicaid (or a Medicaid application was not made on her behalf) by the last day of the month following the month in which the determination of presumptive eligibility was made, the presumptive period ends on that last day.
## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

### Citation | Groups Covered
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**B. Optional Groups Other Than the Medically Needy**  
(Continued)

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<thead>
<tr>
<th>Citation</th>
<th>Groups Covered</th>
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<tbody>
<tr>
<td>1902(a)(10)(A) (ii)(XIII) of the Act / /</td>
<td>23. BBA Work Incentives Eligibility Group - Individuals with a disability whose net family income is below 250 percent of the Federal poverty level for a family of the size involved and who, except for earned income, meet all criteria for receiving benefits under the SSI program. See page 12c of Attachment 2.6-A.</td>
</tr>
<tr>
<td>1902(a)(10)(A) (ii)(XV) of the Act /X/</td>
<td>24. TWWIIA Basic Coverage Group - Individuals with a disability at least 16 but less than 65 years of age whose income and resources do not exceed a standard established by the State. See page 12d of Attachment 2.6-A.</td>
</tr>
<tr>
<td>1902(a)(10)(A) (ii)(XVI) of the Act /X/</td>
<td>25. TWWIIA Medical Improvement Group - Employed individuals at least 16 but less than 65 years of age with a medically improved disability whose income and resources do not exceed a standard established by the State. See page 12h of Attachment 2.6-A.</td>
</tr>
</tbody>
</table>

**NOTE:** If the State elects to cover this group, it MUST also cover the Basic Coverage Group described in no. 24 above.

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## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

**State**

WASHINGTON

<table>
<thead>
<tr>
<th>Agency*</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>IV-A</td>
<td>C. Optional Coverage of the Medically Needy</td>
<td></td>
</tr>
</tbody>
</table>

### 42 CFR 435.301

This plan includes the medically needy.

/ / No.

/X/ Yes. This plan covers:

1. Pregnant women who, except for income and/or resources, would be eligible as categorically needy under title XIX of the Act.

2. Women who, while pregnant, were eligible for and have applied for Medicaid and receive Medicaid as medically needy under the approved State plan on the date the pregnancy ends. These women continue to be eligible, as though they were pregnant, for all pregnancy-related and postpartum services under the plan for a 60-day period, beginning with the date the pregnancy ends, and any remaining days in the month in which the 60th day falls.

3. Individuals under age 18 who, but for income and/or resources, would be eligible under section 1902(a)(10)(A)(i) of the Act.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State _______________ WASHINGTON _______________

<table>
<thead>
<tr>
<th>Agency*</th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
</table>

C. Optional Coverage of the Medically Needy (Continued)

4. RESERVED

42 CFR 435.308

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

<p>| | | |</p>
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<thead>
<tr>
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<tbody>
<tr>
<td></td>
<td>21</td>
<td></td>
</tr>
<tr>
<td></td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>X</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td></td>
<td>18 or under age 19 who are full-time students in a secondary school or in the equivalent level of vocational or technical training</td>
<td></td>
</tr>
</tbody>
</table>

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

<p>| | | |</p>
<table>
<thead>
<tr>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>(1)</td>
<td>Individuals for whom public agencies are assuming full or partial financial responsibility and who are:</td>
</tr>
<tr>
<td></td>
<td>(a)</td>
<td>In foster homes (and are under the age of <strong>21</strong>).</td>
</tr>
<tr>
<td>X</td>
<td>(b)</td>
<td>In private institutions (and are the age of <strong>21</strong>).</td>
</tr>
</tbody>
</table>

Back to TOC
### C. Optional Coverage of the Medically Needy (Continued)

<table>
<thead>
<tr>
<th></th>
<th>Citation(s)</th>
<th>Groups Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>(c)</td>
<td>In addition to the group under b.(1)(a) and (b), individuals placed in foster homes or private institutions by private, nonprofit agencies (and are under the age of 21).</td>
</tr>
<tr>
<td>X</td>
<td>(2)</td>
<td>Individuals in adoptions subsidized in full or part by a public agency (who are under the age of 21),</td>
</tr>
<tr>
<td>X</td>
<td>(3)</td>
<td>Individuals in NFs (who are under the age of 21). NF services are provided under this plan.</td>
</tr>
<tr>
<td>X</td>
<td>(4)</td>
<td>In addition to the group under (b)(3), individuals in ICFs/MR (who are under the age of 21).</td>
</tr>
<tr>
<td>X</td>
<td>(5)</td>
<td>Individuals receiving active treatment as inpatients in psychiatric facilities or programs (who are under the age of 21). Inpatient psychiatric services for individuals under age 21 are provided under this plan.</td>
</tr>
<tr>
<td></td>
<td>(6)</td>
<td>Other defined groups (and ages), as specified in Supplement 1 of ATTACHMENT 2.2-A.</td>
</tr>
</tbody>
</table>

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C. Optional Coverage of the Medically Needy (Continued)

IV - A 42 CFR 435.310  6. Caretaker Relatives

IV – A 42 CFR 435.320  
and 42 CFR 435.330  XX  7. Aged Individuals

IV - A 42 CFR 435.322  
and 42 CFR 435.330  XX  8. Blind individuals

IV - A 42 CFR 435.324  
and 42 CFR 435.330  XX  9. Disabled individuals

42 CFR 435.326  10. Individuals who would be eligible if they were not enrolled in an HMO. Categorically needy individuals are covered under 42 CFR 435.212 and the same rules apply to medically needy individuals.

42 CFR 435.326  11. Blind and disabled individuals who:

a. Meet all current requirements for Medicaid eligibility except the blindness or disability criteria;

b. Were eligible as medically needy in December 1973 as blind or disabled; and

c. For each consecutive month after December 1973 continue to meet the December 1973 eligibility criteria.
C. Optional Coverage of the Medically Needy (Continued)

1906 of the Act

12. Individuals required to enroll in cost effective employer-based group health plans remain eligible for a minimum enrollment period of ________ months.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

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

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SUPPLEMENT 1 TO ATTACHMENT 2.2-A

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

PAGE SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

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

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THERE IS NO SUPPLEMENT 2 TO ATTACHMENT 2.2-A
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State _______________________ WASHINGTON _______________________

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State ______________________ WASHINGTON ______________________

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation(s) Condition or Requirement

A. General Conditions of Eligibility

Each individual covered under the plan:

42 CFR Part 435, Subpart G

1. Is financially eligible (using the methods and standards described in Parts B and C of this Attachment) to receive services.

42 CFR Part 435, Subpart F

2. Meets the applicable non-financial eligibility conditions.

a. For the categorically needy:

   (i) Superseded by Medicaid MAGI Eligibility & Benefits 
       See S14, S25, S28, S30, S51, S53, S54, S55

   (ii) For SSI-related individuals, meets the non-financial criteria of the SSI program or more restrictive SSI-related categorically needy criteria.

1902(m) of the Act

(iii) Superseded by Medicaid MAGI Eligibility & Benefits 
       See S14, S25, S28, S30, S51, S53, S54, S55

(iv) For financially eligible aged and disabled individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, meets the non-financial criteria of section 1902(m) of the Act.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>b. 1905(p) of the Act</td>
<td>For the medically needy, meets the non-financial eligibility conditions of 42 CFR Part 435.</td>
</tr>
<tr>
<td>c. 1905(p) of the Act</td>
<td>For financially eligible qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, meets the non-financial criteria of section 1905(p) of the Act.</td>
</tr>
<tr>
<td>d. 1905(s) of the Act</td>
<td>For financially eligible qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, meets the non-financial criteria of section 1905(s).</td>
</tr>
</tbody>
</table>

42 CFR 435.406 3. a - f Superseded by Medicaid MAGI Eligibility & Benefits
See S14, S25, S28, S30, S51, S53, S54, S55

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State _______________ WASHINGTON _______________

Citation                        Condition or Requirement

PAGE 2a SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

SEE S89
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State __________________ WASHINGTON ____________________

PAGE 2B SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

SEE S14, S25, S28, S30, S51, S53, S54, S55
# STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

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<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
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## PAGE 3 SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

SEE S88

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# STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State _______________ WASHINGTON _______________

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

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

State

WASHINGTON

Citation | Condition or Requirement
---|---

**PAGE 3B SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS**

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

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

1. The following items are not considered in the post-eligibility process:

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

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2. The following monthly amounts for personal needs are deducted from total monthly income in the application of an institutionalized individual's or couple's income to the cost of institutionalized care:

Personal Needs Allowance (PNA) of not less than $30 For Individuals and $60 For Couples For All Institutionalized Persons.

   a. Aged, blind, disabled:
      Individuals $70.00
      Couples $140.00

      Effective January 1, 2018, and each calendar year thereafter, the PNA described under a and b will be increased, subject to state legislative funding, by the percentage of the annual cost of living allowance adjustment under 215(i) of the Act, if there is such an adjustment that year.

      For the following persons with greater need:
      Supplement 12 to Attachment 2.6-A describes the greater need and describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.

   b. AFDC related:
      Children $70.00
      Adults $70.00

      Effective January 1, 2018, and each calendar year thereafter, the PNA described under a and b will be increased, subject to state legislative funding, by the percentage of the annual cost of living allowance adjustment under 215(i) of the Act, if there is such an adjustment that year.

      For the following persons with greater need:
      Supplement 12 to Attachment 2.6-A describes the greater need and describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.
For the following persons with greater need:

Supplement 12 to Attachment 2.6-A describes the greater need describes the basis or formula for determining the deductible amount when a specific amount is not listed above; lists the criteria to be met; and, where appropriate, identifies the organizational unit which determines that a criterion is met.

1924 of the Act

3. In addition to the amounts under item 2., the following monthly amounts are deducted from the remaining income of an institutionalized individual with a community spouse:

a. The monthly income allowance for the community spouse, calculated using the formula in §1924(d)(2), is the amount by which the maintenance needs standard exceeds the community spouse's income. The maintenance needs standard cannot exceed the maximum prescribed in §1924 (d)(3)(C). The maintenance needs standard consists of a poverty level component plus an excess shelter allowance.

   X The poverty level component is calculated using the applicable percentage (set out §1924(d)(3)(B) of the Act) of the official poverty level.

   ___ The poverty level component is calculated using a percentage greater than the applicable percentage, equal to %, of the official poverty level (still subject to maximum maintenance needs standard).

   ___ The maintenance needs standard for all community spouses is set at the maximum permitted by §1924(d)(3)(C).

Except that, when applicable, the State will set the community spouse's monthly income allowance at the amount by which exceptional maintenance needs, established at a fair hearing; exceed the community spouse's income, or at the amount of any court-ordered support.
In determining any excess shelter allowance, utility expenses are calculated using:

- the standard utility allowance under §5(e) of the Food Stamp Act of 1977 or
- the actual unreimbursable amount of the community spouse's utility expenses less any portion of such amount included in condominium or cooperative charges.

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

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

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

N/A

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

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

(ii) Necessary medical or remedial care recognized under State law but not covered under the State, plan. (Reasonable limits on amounts are described in Supplement-3 to ATTACHMENT 2.6-A.)
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State  WASHINGTON

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

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>X</td>
<td>Amount for maintenance of home is: 100% FPL</td>
</tr>
<tr>
<td>___</td>
<td>Amount for maintenance of home is the actual maintenance costs not to exceed $_________.</td>
</tr>
<tr>
<td>___</td>
<td>Amount for maintenance of home is deductible when countable income is determined under §1924(d)(1) of the Act only if the individual's home and the community spouse's home are different.</td>
</tr>
<tr>
<td>___</td>
<td>Amount for maintenance of home is not deductible when countable income is determined under §1924(d)(1) of the Act.</td>
</tr>
</tbody>
</table>

6. SSI benefits paid under section 1611(e)(1)(E) and (G) of the Act to individuals who receive care in a hospital or nursing facility.

7. Except as provided under Section 1924 of the Act, the policies reflected in C. apply. See Supplement 13 for additional policies related to Section 1924.
## State Plan Under Title XIX of the Social Security Act

### State

**WASHINGTON**

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.711, 435.721, 435.831</td>
<td>C. <strong>Financial Eligibility</strong></td>
</tr>
</tbody>
</table>

For individuals who are AFDC or SSI recipients, the income and resource levels and methods for determining countable income and resources of the AFDC and SSI program apply, unless the plan provides for more restrictive levels and methods than SSI for SSI recipients under section 1902(f) of the Act, or more liberal methods under section 1902(r)(2) of the Act, as specified below.

For individuals who are not AFDC or SSI recipients in a non-section 1902(f) State and those who are deemed to be cash assistance recipients, the financial eligibility requirements specified in this section C apply.

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

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### ELIGIBILITY CONDITIONS AND REQUIREMENTS

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

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

| / / | For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A. |
| / / | For institutional couples, the methods specified under section 1611(e)(5) of the Act. |
| / / | For optional State supplement recipients under section 435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A. |
| / / | For optional State supplement, recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements – |
| [ ] | SSI methods only |
| [ ] | SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A. |
| [ ] | Methods more restrictive an/or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A. |

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses.

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<thead>
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<tbody>
<tr>
<td>42 CFR 435.721 and 435.831 1902(m)(1)(B), (m)(4), and 1902(r)(2) of the Act</td>
<td>c. Blind individuals. In determining countable income for blind individuals, the following methods are used:</td>
</tr>
<tr>
<td></td>
<td>_____ The methods of the SSI program only.</td>
</tr>
<tr>
<td></td>
<td>X SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>_____ For individuals other than optional State supplement recipients, more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A, and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>_____ For institutional couples, the methods specified under section 1611(e)(5) of the Act.</td>
</tr>
<tr>
<td></td>
<td>_____ For optional State supplement recipients under §435.230, income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>_____ For optional State supplement recipients in section 1902(f) States and SSI criteria States without section 1616 or 1634 agreements-</td>
</tr>
<tr>
<td></td>
<td>_____ SSI methods only.</td>
</tr>
<tr>
<td></td>
<td>_____ SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>_____ Methods more restrictive and/ or more liberal than SSI. More restrictive methods are described in Supplement 4 to ATTACHMENT 2.6-A and more liberal methods are described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
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**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

State  
WASHINGTON  

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<thead>
<tr>
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<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>42 CFR 435.721, and 435.831</td>
<td>In determining relative responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.</td>
</tr>
<tr>
<td>1902(m)(1)(B), (m)(4), and</td>
<td>d. Disabled individuals. In determining countable income of disabled individuals, including individuals with incomes up to the Federal poverty level described in section 1902(m) of the Act the following methods are used:</td>
</tr>
<tr>
<td>1902(r)(2) of the Act</td>
<td>__ The methods of the SSI program.</td>
</tr>
<tr>
<td></td>
<td>X SSI methods and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>___ For institutional couples: the methods specified under section 1611(e)(5) of the Act.</td>
</tr>
<tr>
<td></td>
<td>___ For optional State supplement recipients under §435.230: income methods more liberal than SSI, as specified in Supplement 4 to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>___ For individuals other than optional State supplement recipients (except aged and disabled individuals described in section 1903(m)(1) of the Act): more restrictive methods than SSI, applied under the provisions of section 1902(f) of the Act, as specified in Supplement 4 to ATTACHMENT 2.6-A; and any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
</tbody>
</table>
### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State  WASHINGTON  

<table>
<thead>
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<th>Citation</th>
<th>Condition or Requirement</th>
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</thead>
<tbody>
<tr>
<td>____</td>
<td><strong>For optional State supplement recipients in section 1902(f) States and SSI criteria</strong> States without section 1616 or 1634 Agreements--</td>
</tr>
<tr>
<td>____</td>
<td>SSI methods only.</td>
</tr>
<tr>
<td>____</td>
<td>SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>____</td>
<td>Methods more restrictive and/or more liberal than SSI, except for aged and disabled individuals described in section 1902(m)(1) of the Act. More restrictive methods are described in Supplement-4-to ATTACHMENT 2.6-A and more liberal methods are specified in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
</tbody>
</table>

In determining relative financial responsibility, the agency considers only the income of spouses living in the same household as available to spouses and the income of parents as available to children living with parents until the children become 21.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Citation(s)                     Condition or Requirement

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PAGE 11A SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

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

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## ELIGIBILITY CONDITIONS AND REQUIREMENTS

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<tr>
<th>Citation(s)</th>
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</thead>
<tbody>
<tr>
<td>(3) 1905(p)(1), 1902(m)(4), and 1902(r)(2) of the Act</td>
<td>The agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60th day falls.</td>
</tr>
<tr>
<td>f.</td>
<td>Qualified Medicare beneficiaries. In determining countable income for qualified Medicare beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, the following methods are used:</td>
</tr>
<tr>
<td>X</td>
<td>The methods of the SSI program only.</td>
</tr>
<tr>
<td>___</td>
<td>SSI methods and/or any more liberal methods than SSI described in Supplement 8a to ATTACHMENT 2.6-A.</td>
</tr>
<tr>
<td>___</td>
<td>For institutional couples, the methods specified under section 1611(e)(5) of the Act.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>1905(s) of the Act</td>
<td>g. (1) Qualified disabled and working individuals.</td>
</tr>
<tr>
<td>1905(p) of the Act</td>
<td>(2) Specified low-income Medicare beneficiaries.</td>
</tr>
</tbody>
</table>

If an individual receives a title II benefit, any amounts attributable to the most recent increase in the monthly insurance benefit as a result of a title II COLA is not counted as income during a "transition period" beginning with January, when the title II benefit for December is received, and ending with the last day of the month following the month of publication of the revised annual Federal poverty level.

For individuals with title II income, the revised poverty levels are not effective until the first day of the month following the end of the transition period.

For individuals not receiving title II income, the revised poverty levels are effective no later than the date of publication.

In determining countable income for qualified disabled and working individuals covered under 1902(a)(10)(E)(ii) of the Act, the methods of the SSI program are used.

In determining countable income for specified low-income Medicare beneficiaries covered under 1902(a)(10)(E)(iii) of the Act, the same method as in f. is used.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(u) of the Act</td>
<td><strong>(h) COBRA Continuation Beneficiaries</strong></td>
</tr>
<tr>
<td></td>
<td>In determining countable income for COBRA continuation beneficiaries, the following disregards are applied:</td>
</tr>
<tr>
<td></td>
<td>___ The disregards of the SSI program;</td>
</tr>
<tr>
<td></td>
<td>___ The agency uses methodologies for treatment income more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6.</td>
</tr>
<tr>
<td></td>
<td><strong>NOTE:</strong> For COBRA continuation beneficiaries specific at 1902(u)(4), costs incurred from medical care or for any other type of remedial care shall not be taken into account in determining income, except as provided in section 1612(b)(4)(B)(ii).</td>
</tr>
</tbody>
</table>

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## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(10)(A) (ii)(XIII) of the Act</td>
<td>(i) Working Individuals with Disabilities - BBA</td>
</tr>
</tbody>
</table>

In determining countable income and resources for working individuals with disabilities under the BBA, the following methodologies are applied:

___ The methodologies of the SSI program.

___ The agency uses methodologies for treatment of income and resources more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 (income) and/or Supplement 5 (resources) to Attachment 2.6-A.

___ The agency uses more liberal income and/or resource methodologies than the SSI program. More liberal methodologies are described in Supplement 8a to Attachment 2.6-A. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A.

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<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
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</thead>
<tbody>
<tr>
<td>1902(a)(10)(A) (ii)(XV) of the Act</td>
<td>Working Individuals with Disabilities - Basic Coverage Group – TWWIIA</td>
</tr>
</tbody>
</table>

In determining financial eligibility for working individuals with disabilities under this provision, the following standards and methodologies are applied:

- The agency does not apply any income or resource standard.

  NOTE: If the above option is chosen, no further eligibility-related options should be elected.

- The agency applies the following income and/or resource standards):

  220% FPL - income standard

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### Citation | Condition or Requirement
--- | ---
1902(a)(10)(A) (ii)(XV) of the Act (cont.) | Income Methodologies

In determining whether an individual meets the income standard described above, the agency uses the following methodologies.

- **X** The income methodologies of the SSI program.
- ___ The agency uses methodologies for treatment of income that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A.
- ___ The agency uses more liberal income methodologies than the SSI program. More liberal income methodologies are described in Supplement 8a to Attachment 2.6-A.

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### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

**State** WASHINGTON

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

Citation | Condition or Requirement
---|---
1902(a)(10)(A) (ii)(XV) of the Act (cont.) | The agency does not disregard funds in retirement accounts.

| | The agency uses resource methodologies in addition to any indicated above that are more liberal than those used by the SSI program. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A.

| | The agency uses the resource methodologies of the SSI program.

| | The agency uses methodologies for treatment of resources that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 5 to Attachment 2.6-A.

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<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
</table>
| 1902(a)(10)(A) (ii)(XVI) of the Act (iii) Working Individuals with Disabilities - Employed Medically Improved Individuals - TWWIIA | In determining financial eligibility for employed medically improved individuals under this provision, the following standards and methodologies are applied:  
  ___ The agency does not apply any income or resource standard.  
  NOTE: If the above option is chosen, no further eligibility-related options should be elected.  
  X The agency applies the following income and/or resource standard(s):  
    220% FPL - income standard |
### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

<table>
<thead>
<tr>
<th>Citation</th>
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</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(10)(A)(ii)(XVI) of the Act (cont.)</td>
<td>Income Methodologies</td>
</tr>
<tr>
<td></td>
<td>In determining whether an individual meets the income standard described above, the agency uses the following methodologies.</td>
</tr>
<tr>
<td></td>
<td><strong>X</strong> The income methodologies of the SSI program.</td>
</tr>
<tr>
<td></td>
<td>The agency uses methodologies for treatment of income that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 4 to Attachment 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>The agency uses more liberal income methodologies than the SSI program. More liberal methodologies are described in Supplement 8a to Attachment 2.6-A.</td>
</tr>
</tbody>
</table>

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### Citation | Condition or Requirement
--- | ---
1902(a)(10)(A) (ii)(XVI) of the Act (cont.) | Resource Methodologies

In determining whether the individual meets the resource standard described above, the agency uses the following methodologies.

Unless one of the following items is checked the agency, under the authority of section 1902(r)(2) of the Act, disregards all funds held in retirement funds and accounts, including private retirement accounts such as IRAs and other individual accounts, and employer-sponsored retirement plans such as 401(k) plans, Keogh plans, and employer pension plans. Any disregard involving retirement accounts is separately described in Supplement 8b to Attachment 2.6-A.

- The agency disregards funds held in employer-sponsored retirement plans, but not private retirement plans.
- The agency disregards funds in retirement accounts in a manner other than those listed above. The agency's disregards are specified in Supplement 8b to Attachment 2.6-A.
# STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(10)(A) (ii)(XVI) of the Act (cont.)</td>
<td>The agency does not disregard funds in retirement accounts.</td>
</tr>
<tr>
<td></td>
<td>The agency uses resource methodologies in addition to any indicated above that are more liberal than those used by the SSI program. More liberal resource methodologies are described in Supplement 8b to Attachment 2.6-A.</td>
</tr>
<tr>
<td></td>
<td>The agency uses the resource methodologies of the SSI program.</td>
</tr>
<tr>
<td></td>
<td>The agency uses methodologies for treatment of resources that are more restrictive than the SSI program. These more restrictive methodologies are described in Supplement 5 to Attachment 2.6-A.</td>
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</tr>
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<tbody>
<tr>
<td>1902(a)(10)(A) (ii)(XVI) and 1905(v)(2) of the Act</td>
<td>Definition of Employed – Employed Medically Improved Individuals - TWWIIA</td>
</tr>
<tr>
<td></td>
<td>X The agency uses the statutory definition of &quot;employed&quot;, i.e., earning at least the minimum wage, and working at least 40 hours per month.</td>
</tr>
<tr>
<td></td>
<td>___ The agency uses an alternative definition of &quot;employed&quot; that provides for substantial and reasonable threshold criteria for hours of work, wages, or other measures. The agency's threshold criteria are described below:</td>
</tr>
</tbody>
</table>
Citation | Condition or Requirement
---|---
1902(a)(10)(A)(ii)(XIII), (XV), (XVI), and 1916(g) of the Act | Payment of Premiums or Other Cost Sharing Charges

For individuals eligible under the BBA eligibility group described in No. 23 on page 23e of Attachment 2.2-A:

X The agency requires payment of premiums or other cost-sharing charges on a sliding scale based on income. The premiums or other cost-sharing charges, and how they are applied, are described below:

The agency requires individuals to pay premiums or other cost sharing charges on a sliding scale based on income. For individuals with net annual income below 450 percent of the Federal poverty level for a family of the size involved, the amount of premiums cannot exceed 7.5 percent of the individual's income.

The premiums or other cost sharing charges, and how they are applied, are described in Attachment 2.6-A page 12o.

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

For the Basic Coverage Group and the Medical Improvement Group, the agency's premium or other cost-sharing charges, and how they are applied, are described below.

Individuals pay a monthly premium equal to a total of the following:

- 50 percent of unearned income in excess of the medically needy income level
- 5 percent of all unearned income
- 2.5 percent of earned income after deducting $65

Except that the premium amount shall not exceed 7.5 percent of total income.

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### Citation(s) | Condition or Requirement
--- | ---
1902(k) of the Act | 2. Medicaid Qualifying Trusts

In the case of a Medicaid qualifying trust described in section 1902(k)(2) of the Act, the amount from the trust that is deemed available to the individual who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted under the trust to distribute to the individual. This amount is deemed available to the individual, whether or not the distribution is actually made. This provision does not apply to any trust or initial trust decree established before April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded.

/X/ The agency does not count the funds in a trust as described above in any instance where the State determines that it would work an undue hardship. Supplement 10 of ATTACHMENT 2.6-A specifies what constitutes an undue hardship.

1902(a)(10) of the Act | 3. Medically needy income levels (MNILs) are based on family size.

Supplement 1 to ATTACHMENT 2.6-A specifies the MNILs for all covered medically needy groups. If the agency chooses more restrictive levels under section 1902(f) of the Act, Supplement 1 so indicates.

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Handling of Excess Income - Spend-down for the Medically Needy in All States and the Categorically Needy in 1902(f) States only

a. Medically Needy
   (1) Income in excess of the MNIL is considered as available for payment of medical care and services. The Medicaid agency measures available income for periods of either 3 or 6 month(s) (not to exceed 6 months) to determine the amount of excess countable income applicable to the cost of medical care and services.

   (2) If countable income exceeds the MNIL standard, the agency deducts the following incurred expenses in the following order:

      (a) Health insurance premiums, deductibles and coinsurance charges.

      (b) Expenses for necessary medical and remedial care not included in the plan.

      (c) Expenses for necessary medical and remedial care included in the plan.

      ___ Reasonable limits on amounts of expense deducted from income under a.(2)(a) and (b) above are listed below.

      * In determining countable income for the medically needy, costs of health insurance premiums, except Medicare are deducted from monthly income.

1902(a)(17) of the Act

Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State _______________ WASHINGTON ________________

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1903(f)(2) of the Act</td>
<td>a. Medically Needy (Continued)</td>
</tr>
<tr>
<td>___ (3)</td>
<td>If countable income exceeds the MNIL standard, the agency deducts spenddown payments made to the State by the individual.</td>
</tr>
</tbody>
</table>

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Citation(s) | Condition or Requirement
--- | ---
42 CFR 435.732 | b. Categorically Needy - Section 1902 (f) States

The agency applies the following policy under the provisions of section 1902(f) of the Act. The following amounts are deducted from income to determine the individual's countable income:

1. Any SSI benefit received.

2. Any State supplement received that is within the scope of an agreement described in section 1616 or 1634 of the Act, or a State supplement within the scope of section 1902(a)(10)(A)(ii)(XI) of the Act.

3. Increases in OASDI that are deducted under §§435.134 and 435.135 for individuals specified in that section, in the manner elected by the State under that section.

4. Other deductions from income described in this plan at Attachment 2.6-A. Supplement 4.

5. Incurred expenses for necessary medical and remedial services recognized under State law.

1902(a)(17) of the Act, P.L. 100-203 | Incurred expenses that are subject to payment by a third party are not deducted unless the expenses are subject to payment by a third party that is a publicly funded program (other than Medicaid) of a State or local government.

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TN# 91-22 | Approval Date: 1/21/92 | Effective Date: 11/1/91
Supersedes TN# 89-11 | HCFA ID: 7985E
### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

**State**  
WASHINGTON

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>4. b.</td>
<td><strong>Categorically Needy - Section 1902(f) States (contd)</strong></td>
</tr>
<tr>
<td>1903(f)(2) of the Act</td>
<td>(6) <strong>Spenddown payments made to the State by the individual.</strong></td>
</tr>
</tbody>
</table>

**NOTE:** FFP will be reduced to the extent a State is paid a spenddown payment by the individual.

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**TN# 91-29**  
Approval Date: 2/4/92  
Effective Date: 12/1/91  
HCFA ID: 7985E

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5. Methods for Determining Resources
   
a. AFDC-related individuals (for poverty level related pregnant women, infants, and children).
   
   (1) In determining countable resources for AFDC-related individuals, the following methods are used:

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

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

   (2) In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
## 5. Methods for Determining Resources

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B) and (C), and 1902(r) of the Act</td>
<td>b. Aged individuals. For aged individuals covered under section 1902(a)(10)(A)(ii)(X) of the Act, the agency used the following methods for treatment of resources:</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Back to TOC
In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses.

1902(a)(10)(A), 1902(a)(10)(C), 1902(m)(1)(B), and 1902(r) of the Act

c. Blind individuals. For blind individuals the agency uses the following methods for treatment of resources:

___ The methods of the SSI program.

X SSI methods and/or any more liberal methods described in Supplement 8b to ATTACHMENT 2.6-A.

___ Methods that are more restrictive and/or more liberal than those of the SSI program. Supplement 5 to ATTACHMENT 2.6-A describe the more restrictive methods and Supplement 8b to ATTACHMENT 2.6-A specify the more liberal methods.

In determining relative financial responsibility, the agency considers only the resources of spouses living in the same household as available to spouses and the resources of parents as available to children living with parents until the children become 21.
## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

**State** WASHINGTON

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

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State WASHINGTON

Citation Condition or Requirement

PAGE SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

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

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<table>
<thead>
<tr>
<th>Citation</th>
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</thead>
</table>

PAGE SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Citation   Condition or Requirement

PAGE SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(a)(10)(E)(iii) of the Act</td>
<td>k. Specified low-income Medicare beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act: The agency uses the same method as in 5.h. of Attachment 2.6-A.</td>
</tr>
</tbody>
</table>

6. Resource Standard - Categorically Needy

a. 1902(f) States (except as specified under items 6.c. and d. below) for aged, blind and disabled individuals:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Same as SSI resource standards.</td>
<td>More restrictive.</td>
</tr>
</tbody>
</table>

The resource standards for other individuals are the same as those in the related cash assistance program.

b. Non-1902(f) States (except as specified under items 6.c. and d. below)

The resource standards are the same as those in the related cash assistance program.

Supplement 8 to ATTACHMENT 2.6-A specifies for 1902(f) States the categorically needy resource levels for all covered categorically needy groups.

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## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State _______________ WASHINGTON _______________

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
</table>

PAGE SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

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

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### ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(m)(1)(C) and (m)(2)(B) of the Act e.</td>
<td>For aged and disabled individuals described in section 1902(m)(1) of the Act who are covered under section 1902(a)(10)(A)(ii)(X) of the Act, the resource standard is:</td>
</tr>
<tr>
<td></td>
<td>___ Same as SSI resource standards.</td>
</tr>
<tr>
<td></td>
<td>___ Same as the medically needy resource standards, which are higher than the SSI resource standards (if the State covers the medically needy).</td>
</tr>
</tbody>
</table>

Supplement 2 to ATTACHMENT 2.6-A specifies the resource levels for these individuals.
7. Resource Standard - Medically Needy
   a. Resource standards are based on family size.

   1902(a)(10)(C)(i) of the Act
   b. A single standard is employed in determining resource eligibility for all groups.

   _ c. In 1902(f) States, the resource standards are more restrictive than in 7.b. above for--
   ____ Aged
   ____ Blind
   ____ Disabled

   Supplement 2 to ATTACHMENT 2.6-A specifies the resource standards for all covered medically needy groups. If the agency chooses more restrictive levels under 7.c., Supplement 2 to ATTACHMENT 2.6-A so indicates.

8. Resource Standard - Qualified Medicare Beneficiaries, Specified Low-Income Medicare Beneficiaries and Qualifying Individuals

   For Qualified Medicare Beneficiaries covered under section 1902(a)(10)(E)(i) of the Act, Specified Low-Income Medicare Beneficiaries covered under section 1902(a)(10)(E)(iii) of the Act, and Qualifying Individuals covered under 1902(a)(10)(E)(iv) of the Act, the resource standard is three times the SSI resource limit, adjusted annually since 1996 by the increase in the consumer price index.
### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State ________________  WASHINGTON ________________

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>For qualified disabled and working individuals covered under section 1902(a)(10)(E)(ii) of the Act, the resource standard for an individual or a couple (in the case of an individual with a spouse) is two times the SSI resource limit.</td>
</tr>
<tr>
<td>1902(u) of the Act</td>
<td>10. For COBRA continuation beneficiaries, the resource standard is:</td>
</tr>
<tr>
<td></td>
<td>____ Twice the SSI resource standard for an individual.</td>
</tr>
<tr>
<td></td>
<td>____ More restrictive standard as applied under section 1902(f) of the Act as described in Supplement 8 to Attachment 2.6-A.</td>
</tr>
</tbody>
</table>

[Back to TOC]
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: WASHINGTON

Citation | Condition or Requirement
--- | ---
1902(u) of the Act | Excess Resources

10. Categorically Needy, Qualified Medicare Beneficiaries, Qualified Disabled and Working Individuals, and Specified Low-Income Medicare Beneficiaries

Any excess resources make the individual ineligible.

b. Categorically Needy Only

This State has a section 1634 agreement with SSI. Receipt of SSI is provided for individuals while disposing of excess resources.

c. Medically Needy

Any excess resources make the individual ineligible.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State ___________________ WASHINGTON ____________________

Citation(s)                                                                 Condition or Requirement

42 CFR 435.914

11. Effective Date of Eligibility

   a. Groups Other Than Qualified Medicare Beneficiaries

      (1) For the prospective period.

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

      X Aged, blind, disabled.
      X AFDC-related

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

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

      (2) For the retroactive period.

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

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

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

      X Aged, blind, disabled.
      X AFDC-related.
## ELIGIBILITY CONDITIONS AND REQUIREMENTS

<table>
<thead>
<tr>
<th>Citation(s)</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>(3)</td>
<td>Superseded by Medicaid MAGI Eligibility &amp; Benefits. See S14, S25, S28, S30, S51, S53, S54, S55</td>
</tr>
</tbody>
</table>

1902(e)(8) and 1905(a) of the Act

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
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<td></td>
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<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

b. For qualified Medicare beneficiaries defined in section 1905(p)(1) of the Act coverage is available beginning with the first day of the month after the month in which the individual is first determined to be a qualified Medicare beneficiary under section 1905(p)(1). The eligibility determination is valid for--

- 12 months
- 6 months
- ___ months (no less than 6 months and no more than 12 months)
## Citation | Condition or Requirement
--- | ---
1902 (a) (18) and 1902 (f) of the Act | Pre-OBRA 93 Transfer of Resources - Categorically and Medically Needy, Qualified Medicare Beneficiaries and Qualified Disabled and Working Individuals.

The agency complies with the provisions of section 1917 of the Act with respect to the transfer of resources.

Disposal of resources at less than fair market value affects eligibility for certain services as detailed in Supplement 9 to Attachment 2.6-A.

1917(c) | Transfer of Assets - All eligibility groups

The agency complies with the provisions of section 1917 (c) of the Act, as enacted by OBRA 93, with regard to the transfer of assets.

Disposal of assets at less than fair market value affects eligibility for certain services as detailed in Supplement 9(a) to ATTACHMENT 2.6-A, except in instances where the agency determines that the transfer rules would work an undue hardship.

1917(d) | Treatment of Trusts - All eligibility groups

The agency complies with the provisions of section 1917 (d) of the Act, as amended by OBRA 93, with regard to trusts.

___ The agency uses more restrictive methodologies under section 1902 (f) of the Act, and applies those methodologies in dealing with trusts;

___ The agency meets the requirements in section 1917(d)(f)(B) of the Act for use of Miller trusts.

The agency does not count the funds in a trust in any instance where the agency determines that the transfer would work an undue hardship, as described in Supplement 10 to ATTACHMENT 2.6-A.
## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State ___________________________ WASHINGTON ___________________________

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

INCOME ELIGIBILITY LEVELS

PAGE SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

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

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INCOME ELIGIBILITY LEVELS

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Supplement 1 to Attachment 2.6-A
Page 3

State Plan Under Title XIX of the Social Security Act

State WASHINGTON

__________________________________________________________

Income Eligibility Levels

Page Superseded by Medicaid MAGI Eligibility & Benefits

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

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TN# 05-003  Approval Date: 4/22/05  Effective Date: 4/1/05
Supersedes
TN# 04-005
INCOME ELIGIBILITY LEVELS (Continued)

3. Aged and Disabled Individuals

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

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

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Income Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$___________</td>
</tr>
<tr>
<td>2</td>
<td>$___________</td>
</tr>
<tr>
<td>3</td>
<td>$___________</td>
</tr>
<tr>
<td>4</td>
<td>$___________</td>
</tr>
<tr>
<td>5</td>
<td>$___________</td>
</tr>
</tbody>
</table>

4. Special Income Level for Institutionalized Individuals

300 percent of the SSI Federal Benefit Level for an individual in his or her own home who has no income.
**STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT**

**WASHINGTON**

---

**INCOME LEVELS (Continued)**

**D. MEDICALLY NEEDY**

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Net income level protected for maintenance for 3 or 6 months</th>
<th>Amount by which Column (2) exceeds limits specified in CFR 435.1007</th>
<th>Net income level for persons living in rural areas for _____ months</th>
<th>Amount by which Column (4) exceeds limits specified in 42 CFR 435.1007</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$467</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>2</td>
<td>$592</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>3</td>
<td>$667</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>4</td>
<td>$742</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

For each Additional Person, Add: 

|                | $ | $ | $ | $ |

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

---

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D. MEDICALLY NEEDY

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Net income level protected for maintenance for 3 or 6 months</th>
<th>Amount by which Column (2) exceeds limits specified in CFR 435.1007(\frac{1}{\frac{1}{2}})</th>
<th>Net income level for persons living in rural areas for ___ months</th>
<th>Amount by which Column (4) exceeds limits specified in 42 CFR 435.1007(\frac{1}{\frac{1}{2}})</th>
</tr>
</thead>
<tbody>
<tr>
<td>5</td>
<td>$ 858</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>6</td>
<td>$ 975</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>7</td>
<td>$ 1,125</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>8</td>
<td>$ 1,242</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>9</td>
<td>$ 1,358</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
<tr>
<td>10</td>
<td>$ 1,483</td>
<td>$</td>
<td>$</td>
<td>$</td>
</tr>
</tbody>
</table>

For each Additional Person, Add:

|                                     | 0 | $ | $ | $ |

\(\frac{1}{\frac{1}{2}}\) The agency has methods for excluding from its claim for FFP payments made on behalf of individuals whose income exceeds these limits.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

RESOURCE LEVELS

PAGE SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

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

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

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4. Aged and Disabled Individuals

/X/ Same as SSI resource levels.

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

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Resource Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2,000</td>
</tr>
<tr>
<td>2</td>
<td>3,000</td>
</tr>
<tr>
<td>3</td>
<td>3,050</td>
</tr>
<tr>
<td>4</td>
<td>3,100</td>
</tr>
<tr>
<td>5</td>
<td>3,150</td>
</tr>
</tbody>
</table>

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

B. MEDICALLY NEEDY

Applicable to all groups—

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

<table>
<thead>
<tr>
<th>Family Size</th>
<th>Resource Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2,000</td>
</tr>
<tr>
<td>2</td>
<td>3,000</td>
</tr>
<tr>
<td>3</td>
<td>3,050</td>
</tr>
<tr>
<td>4</td>
<td>3,100</td>
</tr>
<tr>
<td>5</td>
<td>3,150</td>
</tr>
<tr>
<td>6</td>
<td>3,200</td>
</tr>
<tr>
<td>7</td>
<td>3,250</td>
</tr>
<tr>
<td>8</td>
<td>3,300</td>
</tr>
<tr>
<td>9</td>
<td>3,350</td>
</tr>
<tr>
<td>10</td>
<td>3,400</td>
</tr>
</tbody>
</table>

For each additional person 50
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

__________________________________________________________

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

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

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

State ________________ WASHINGTON ________________

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

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

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

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Back to TOC
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

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

Back to TOC
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

FEDERALLY ADMINISTERED OPTIONAL STATE SUPPLEMENT:
PAYMENT GROUPS/INCOME LEVELS

<table>
<thead>
<tr>
<th>Gross Income Level</th>
<th>SSI Standard</th>
<th>SSI Benefit</th>
<th>State Supplement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Statewide Standard – Living Alone/1</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individuals:</td>
<td>$2,250</td>
<td>$750</td>
<td>$750</td>
</tr>
<tr>
<td></td>
<td>790</td>
<td>750</td>
<td></td>
</tr>
<tr>
<td>Couples:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Both individuals eligible:</td>
<td>3,375</td>
<td>1125</td>
<td>1125</td>
</tr>
<tr>
<td>2. Eligible individual w/one Essential person on Rolls before 1/1/74: <strong>No individuals identified in this category in November 2003</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Eligible individual with Ineligible spouse Enrolled after 1/1/74:</td>
<td>2250</td>
<td>790</td>
<td>750</td>
</tr>
</tbody>
</table>

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

**Statewide Standard – Shared Living (Supplied Housing):**

<table>
<thead>
<tr>
<th>Gross Income Level</th>
<th>SSI Standard</th>
<th>SSI Benefit</th>
<th>State Supplement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individuals:</td>
<td>1,500</td>
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<tr>
<td></td>
<td>540</td>
<td>500</td>
<td></td>
</tr>
<tr>
<td>Couples:</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>1. Both individuals eligible:</td>
<td>2,250</td>
<td>750</td>
<td>750</td>
</tr>
<tr>
<td>2. Eligible individual w/one Essential person on Rolls before 1/1/74: <strong>No individuals identified in this category in November 2003</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>3. Eligible individual with Ineligible spouse Enrolled after 1/1/74:</td>
<td>1,500</td>
<td>540</td>
<td>500</td>
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</tbody>
</table>

**Over age 65 or blind**

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TN# 18-0001 Approval Date 1/23/18 Effective Date 1/1/18
Supersedes
TN# 17-0001
FEDERALLY ADMINISTRATED OPTIONAL STATE SUPPLEMENT:
PAYMENT GROUPS/INCOME LEVELS

<table>
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<th>Gross Income Level</th>
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<th>SSI Benefit</th>
<th>State Supplement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statewide Standard – Other Living/1:</td>
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<td></td>
</tr>
<tr>
<td>Individuals:</td>
<td>$2,250</td>
<td>2,250</td>
<td>750</td>
</tr>
</tbody>
</table>

Includes individuals in a Congregate Care Facility, Adult Residential Treatment Facility, Adult Family Home, or Group Home. (These are non-Title XIX facilities).
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State ______________ WASHINGTON ____________

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

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RESOURCE STANDARDS FOR 1902 (f) STATES – CATEGORICALLY NEEDY

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Back to TOC
More Liberal Methods of Treating Income
Under Section 1902(r)(2) of the Act*

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

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


Back to TOC
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

PAGE SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS
SEE S14, S25, S28, S30, S51, S53, S54, S55
4. The following income regulation applies to individuals described in subclauses (A) (i) (III), (A) (i) (IV), (A) (i) (VI), (A) (i) (VII)*, (A) (ii), and (C) (i) (III) of subsection 1902(a) (10), and section 1905(p) of the Social Security Act.

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

* Superseded by Medicaid MAGI Eligibility & Benefits. See S14, S25, S28, S30, S51, S53, S54, S55
5. The following income regulation applies to individuals described in sub clause (C)(i)(III) of subsection 1902(a)(10) of the Social Security Act.

Effective July 1, 1992, income of an individual is exempt in an amount equal to the maintenance allowance of the individual’s spouse, living in the same household, who is eligible under clause (VI) of section 1902 (a) (10) (A) (ii) of the Act, less the income of the spouse.
6. The following applies to individuals covered under Section 1902 (a)(10)(A)(ii)(IV) of the Act, who are defined in 1905 (a) (iii) and (vii).

Disregard income equal to the difference between the Federal Benefit Rate and the Categorically Needy Income Level for individuals and couples as in effect on January 1, 2002 and as described in supplement 6 to Attachment 2.6-A, Page 1.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

PAGE SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

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

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

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

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

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

When determining the available income of an individual for the above Medicare Cost-sharing programs, the department shall exclude from countable income an amount equal to that expended on medical expenses.
MORE LIBERAL METHOD OF TREATING INCOME UNDER SECTION 1902(r)(2) OF THE ACT

9. Effective January 1, 2005, disregard the difference between the medically needy standard described on Supplement 1 to Attachment 2.6-A, page 8 and the SSI benefit for an individual described on Supplement 6 to Attachment 2.6-A, page 1. This applies to all medically needy groups: children, pregnant women, and the aged, blind and persons with disabilities.
MORE LIBERAL METHODS OF TREATING INCOME UNDER SECTION 1902(r)(2) OF THE ACT

10. Effective July 1, 2008, disregard the difference between the TANF payment standard by family size, and the AFDC payment standard by family size, as described in Supplement 1 to Attachment 2.6-A, Page 1, of the Medicaid State Plan for institutionalized AFDC-related eligibility groups under 1902(a)(10)(A)(ii)(IV) of the Act.
MORE LIBERAL METHODS OF TREATING INCOME UNDER SECTION 1902(r)(2) OF THE ACT

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

- X - Poverty level pregnant women and infants (133 – 185% FPL) under 1902(a)(10)(A)(i)(IV)
- X - Poverty level children under age 6 (133 – 185% FPL) under 1902(a)(10)(A)(i)(VI)
- X - Poverty level children under age 19 (100% FPL) under 1902(a)(10)(A)(i)(VII)
- X - Optional categorically needy groups under 1902(a)(10)(A)(ii) as listed below.
  - 1902(a)(10)(A)(ii)(XI) - recipients of optional State supplemental payments
  - 1902(a)(10)(A)(ii)(XV)
  - 1902(a)(10)(A)(ii)(XVI)

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

- X - Medically Needy under 1902(a)(10)(C)(i)(III)

- All aged, blind or disabled groups in 209(b) states under 1902(f).
- X - QMBs, SLMBs and QIs under 1905(p).

* Removed by Medicaid MAGI Eligibility & Benefits. See S14, S25, S28, S30, S51, S53, S54, S55
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State ___________________ WASHINGTON ___________________

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

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

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

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

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

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

For all eligibility groups subject to 1902(r)(2) and not subject to the limitations on payment explained in 1903(f) of the Act: All interest earned on an IDA account funded under the Assets for Independence Act is excluded.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State ______________ WASHINGTON ______________

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

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

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

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

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

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

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

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

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

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

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

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

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

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

   Effective October 1, 1991, non-exempt resources in excess of the Medically Needy resource levels found in SUPPLEMENT 2 TO ATTACHMENT 2.6-A, Page 7, can, at the individuals option, be reduced by incurred expenses listed in C. 4. a. (2) of ATTACHMENT 2.6-A (Page 14) as long as such expenses have not been used to reduce excess income. (TN 90-17, Approved 10/4/91)
7. (Removed by Medicaid Eligibility and Benefits. See S14, S25, S28, S30, S51, S52, S53, & S54)

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

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

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

Furnishings, clothing, and ordinary household and personal items which provide the essentials of living, basic comfort, and convenience are excluded without limit when determining eligibility.
MORE LIBERAL METHODS OF TREATING RESOURCES UNDER SECTION 1902 (r) (2) OF THE ACT.

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

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

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

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

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

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

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

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

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

When determining the countable resources for a Holocaust survivor, exclude recoveries of insurance proceeds or other assets.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State  WASHINGTON

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

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

Back to TOC
STATE LONG-TERM CARE INSURANCE PARTNERSHIP

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

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

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

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

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

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

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

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

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

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

(3) The policy was issued no earlier than the effective date of this State plan amendment.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

STATE LONG-TERM CARE INSURANCE PARTNERSHIP (cont)

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


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

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

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

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

1902(f) and 1917 of the Act

The agency provides for the denial of eligibility by reason of disposal of resources for less than fair market value.

The criteria specified in Sections 1613(a), 1917(c) and 1924(f) of the Social Security Act are followed.
b. / / The period of ineligibility is less than 24 months, as specified below:

c. / / The agency has provisions for waiver of denial of eligibility in any instance where the State determines that a denial would work an undue hardship.
2. Transfer of the home of an individual who is an inpatient in a medical institution.

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

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

Back to TOC
b. 

Subject to the exceptions on page 2 of this supplement, if the uncompensated value of the home is more than the average amount payable under this plan as medical assistance for 24 months of care in an SNF, the period of ineligibility is more than 24 months after the date on which he disposed of the home. The period of ineligibility bears a reasonable relationship (based upon the average amount payable under this plan as medical assistance for care in an SNF) to the uncompensated value of the home as follows:
No individual is ineligible by reason of item A.2 if-

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

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

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

(iv) The agency determines that denial of eligibility would work an undue hardship.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

3. 1902(f) States

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

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

1. If the uncompensated value of the transfer is $12,000 or less:
2. If the uncompensated value of the transfer is more than $12,000:
3. If the agency sets a period of ineligibility of less than 24 months and applies it to all transfers of resources (regardless of uncompensated value):

4. Other procedures:

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

TRANSFER OF RESOURCES

1902(f) and 1917
Of the Act

<table>
<thead>
<tr>
<th>Dollar Amount of Uncompensated Value</th>
<th>Months of Ineligibility</th>
</tr>
</thead>
<tbody>
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</tr>
<tr>
<td>1,001 - 2,000</td>
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<tr>
<td>2,001 - 3,000</td>
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<tr>
<td>48,334 - 50,000</td>
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TRANSFER OF ASSETS

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

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

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

   - Payments based on a level of care in a nursing facility;
   - Payments based on a nursing facility level of care in a medical institution;
   - Home and community-based services under a 1915 waiver.

2. Non-institutionalized individuals:

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

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

   - Home health services (section 1905(a)(7);
   - Home and community care for functionally disabled and elderly adults (section 1905(a) 22);
   - Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

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

3. Penalty Date-The beginning date of each penalty period imposed for an uncompensated transfer of assets is:
   - X the first day of the month in which transferred;
   - ___ the first day of the month following the month of transfer.

4. Penalty Period - Institutionalized Individuals-
   In determining the penalty for an institutionalized individual, the agency uses:
   - X the average monthly cost to a private patient of nursing facility services in the agency;
   - ___ the average monthly cost to a private patient of nursing facility services in the community in which the individual is institutionalized.

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

Back to TOC
TRANSFER OF ASSETS

6. Penalty period for amounts of transfer less than cost of nursing facility care
   a. Where the amount of the transfer is less than the monthly
cost of nursing facility care, the agency:
      ___ Does not impose a penalty;
      X Imposes a penalty for less than a full month, based on the
       proportion of the agency’s private nursing facility rate that
       was transferred.

   b. Where an individual makes a series of transfers, each less
      than the private nursing facility rate for a month, the
      agency:
      ___ Does not impose a penalty;
      X Imposes a series of penalties, each for less that a full month.

7. Transfers made so that penalty periods would overlap
   The agency:
      ___ Totals the value of all assets transferred to produce a single
         penalty period;
      X Calculates the individual penalty periods and imposes them
         sequentially.

8. Transfers made so that penalty periods would not overlap
   The agency:
      X Assigns each transfer its own penalty period;
      ___ Uses the method outlined below:

Back to TOC
TRANSFER OF ASSETS

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

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

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

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

10. Treatment of income as an asset:

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

       The agency will impose partial month penalty periods.

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

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

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

       The agency uses an alternate method to calculate penalty periods, as described below:
11. Imposition of a penalty would work an undue hardship:
The agency does not apply the transfer of assets provisions in any case in
which the agency determines that such an application would work an undue
hardship. The agency will use the following procedures in making undue
hardship determinations:

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

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

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

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

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

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

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

- Nursing facility services
- Nursing facility level of care provided in a medical institution
- Home and community-based services under a 1915(c) or (d) waiver
2. Non-institutionalized individuals

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

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

- Home health services (section 1905(a)(7));
- Home and community care for functionally disabled elderly adults (section 1905(a)(22));
- Personal care services furnished to individuals who are not inpatients in certain medical institutions, as recognized under agency law and specified in section 1905(a)(24).

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

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

Program of All Inclusive Care for the Elderly (PACE)
TRANSFER OF ASSETS (cont.)

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

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

      or

   2. For individuals receiving Medicaid payment for long-term care services, the first day of the month following advance notice of the penalty period, but no later than the first day of the month that follows three full calendar months from the date of the report or discovery of the transfer:

      and

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

Back to TOC
TRANSFER OF ASSETS (cont.)

4. Penalty Period - Institutionalized Individuals

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

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

5. Penalty Period - Non-institutionalized Individuals

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

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

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

- Where the amount of the transfer is less than the monthly cost of nursing facility care, the agency imposes a penalty for less than a full month, based on the option selected in item 4.
- The state adds together all transfers for less than fair market value made during the look-back period in more than one month and calculates a single period of ineligibility, that begins on the earliest date that would otherwise apply if the transfer had been made in a single lump sum.

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

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

(b) If one spouse is no longer subject to a penalty, the remaining penalty period must be served by the remaining spouse.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State _______ WASHINGTON ________

TRANSFER OF ASSETS (cont.)

8. Treatment of a transfer of income

When income has been transferred as a lump sum, the agency will calculate the penalty period on the lump sum value. When a stream of income or the right to a stream of income has been transferred, the agency will impose a penalty period for each income payment.

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

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

9. Imposition of a penalty would work an undue hardship

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

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

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

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

10. Procedures for Undue Hardship Waivers

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

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

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

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

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

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

___ Payments to the nursing facility to hold the bed for the individual will be made for a period not to exceed_____ days (may not be greater than 30).
CONSIDERATION OF MEDICAID QUALIFYING TRUSTS – UNDUE HARDSHIP

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

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

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

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

The maximum value of the exemption for an irrevocable burial trust is $____________.
<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1902(u) of the Act</td>
<td>Premium payments are made by the agency only if such payments are likely to be cost-effective. The agency specifies the guidelines used in determining cost effectiveness by selecting one of the following methods.</td>
</tr>
<tr>
<td>___</td>
<td>The methodology as described in SMM section 3598.</td>
</tr>
<tr>
<td>___</td>
<td>Another cost-effective methodology as described below.</td>
</tr>
</tbody>
</table>
VARIATIONS FROM THE BASIC PERSONAL NEEDS ALLOWANCE (PNA)

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

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

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

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

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

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

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

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

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

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

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

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

   The person’s income tax deduction plus the usual PNA may not exceed the one-person MNIL.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State ________________ WASHINGTON ________________

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

VARIATIONS FROM THE BASIC PERSONAL NEEDS ALLOWANCE

Disclosure Statement for Post-Eligibility Preprint

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is #0938-0673. The time required to complete this information collection is estimated at 3 hours per response, including the time to review instructions, searching existing data resources, gathering the date needed and completing and reviewing the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestion for improving this form, please write to: CMS, 7500 Security Boulevard, N2-14-26, Baltimore, Maryland, 21244-1850 and to the Office of Information and Regulatory Affairs, Office of Management and Budget, Washington, D.C., 20503.
The following resource regulation applies to individuals described in clause (A)(ii), and subclause (C)(i)(III) of subsection 1-02(a)(10) of the Social Security Act.

Effective July 1, 1990, individuals, non-cash resources, that cannot be expected to be converted into cash within 20 working days, are not considered available to the extent that an ongoing bona fide effort to convert them into cash is unsuccessful.
LESS RESTRICTIVE RESOURCE METHODS ALLOWED UNDER 1902(r) OF THE SOCIAL SECURITY ACT.

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

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

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

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

PAGE SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

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

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ELIGIBILITY UNDER SECTION 1931 OF THE ACT

PAGE SUPERSEDED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State ____________ WASHINGTON ____________

ELIGIBILITY UNDER SECTION 1931 OF THE ACT

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

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### STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

**State**

WASHINGTON

<table>
<thead>
<tr>
<th>Citation</th>
<th>Condition or Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Section 1924 Provisions</strong></td>
<td></td>
</tr>
</tbody>
</table>

**A.** Income and resource eligibility policies used to determine eligibility for institutionalized individuals who have spouses living in the community are consistent with Section 1924.

**B.** In the determination of resource eligibility the State resource standard is the maximum resource allowance permissible under section 1924 of the Social Security Act.

**C.** The definition of undue hardship for purposes of determining if institutionalized spouses receive Medicaid in spite of having excess countable resources is described below.

Undue hardship means the client’s inability to meet shelter, food, clothing, and health care needs.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

ELIGIBILITY CONDITIONS AND REQUIREMENTS

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

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

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

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

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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INCOME AND RESOURCE REQUIREMENTS FOR TUBERCULOSIS (TB) INFECTED INDIVIDUALS

PAGE REMOVED BY MEDICAID MAGI ELIGIBILITY & BENEFITS

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

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

Personal Needs Allowance, cont.

INCOME TAX DEDUCTION.

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

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

2. Federal, State or local income taxes that are not covered by earned or unearned income withholding but are owed or have been paid.
PERSONAL NEEDS ALLOWANCE - NURSING FACILITY RESIDENTS WITH HIGHER NEEDS

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

1. **Guardianship Fees**
   Guardianship fees will be allowed under a court order, including an order that establishes or continues a legal guardianship and the order requires a future review or accounting in an amount not to exceed $235 per month.

2. **Guardianship-related Costs (including Attorney’s Fees)**
   Costs are limited to an amount not to exceed $1850 for the initial establishment of a guardianship.
   Costs are limited to an amount not to exceed $1200 during any three year period for the review of a guardianship.

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

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PERSONAL NEEDS ALLOWANCE - NURSING FACILITY RESIDENTS WITH HIGHER NEEDS

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

The individual is a resident of a nursing facility that:

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

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

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

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

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

1940(a) 1. of the Act

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

- The request and response system must be electronic:
  - Verification inquiries must be sent electronically via the internet or similar means from the agency to the financial institution (FI).
  - The system cannot be based on mailing paper-based requests.
  - The system must have the capability to accept responses electronically.

- The system must be secure, based on a recognized industry standard of security (e.g., as defined by the U.S. Commerce Department's National Institute of Standards and Technology, or NIST).

- The system must establish and maintain a database of FIs that participate in the agency's AVS.

- Verification requests also must be sent to FIs other than those identified by applicants and recipients, based on some logic such as geographic proximity to the applicant's home address, or other reasonable factors whenever the agency determines that such requests are needed to determine or re-determine the individual's eligibility.

- The verification requests must include a request for information on both open and closed accounts, going back up to 5 years as determined by the State.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

ASSET VERIFICATION SYSTEM

- System Development

  ___ A. The agency itself will develop an AVS.
  
  In 3 below, provide any additional information the agency wants to include.

  ___ B. The agency will hire a contractor to develop an AVS.
  
  In 3 below provide any additional information the agency wants to include.

  ___ X C. The agency will be joining a consortium to develop an AVS.
  
  In 3 below, identify the States participating in the consortium. Also, provide any other information the agency wants to include pertaining to how the consortium will implement the AVS requirements.

  ___ D. The agency already has a system in place that meets the requirements for an acceptable AVS.
  
  In 3 below, describe how the existing system meets the requirements in Section 1.

  ___ E. Other alternative not included in A. – D. above.
  
  In 3 below, describe this alternative approach and how it will meet the requirements in Section 1.
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

ASSET VERIFICATION SYSTEM

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

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

(i) An electronic process for asset verification.

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

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

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

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

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

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

\[
\begin{array}{ll}
1 & \text{X} \quad \text{\$500,000} \\
\end{array}
\]

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

\[
\begin{array}{ll}
2 & \text{\text{An amount that exceeds \$500,000 but does not exceed \$750,000}} \\
\end{array}
\]

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

The amount chosen by the State is __________________________

\[
\begin{array}{ll}
3 & \text{This higher standard applies statewide.} \\
\end{array}
\]

\[
\begin{array}{ll}
4 & \text{This higher standard does not apply statewide. It only applies in the following areas of the State:} \\
\end{array}
\]

\[
\begin{array}{ll}
5 & \text{This higher standard applies to all eligibility groups.} \\
6 & \text{This higher standard only applies to the following eligibility groups:} \\
\end{array}
\]

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

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

Part 1 – Adult Group Individual Income-Based Determinations

For individuals eligible in the adult group, the state will make an individual income-based determination for purposes of the adult group FMAP methodology by comparing individual income to the relevant converted income eligibility standards in effect on December 1, 2009, and included in the MAGI Conversion Plan (Part 2) approved by CMS on March 31, 2014. In general, and subject to any adjustments described in this SPA, under the adult group FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the newly eligible FMAP is not available. The relevant MAGI-converted standards for each population group in the new adult group are described in Table 1.
Table 1: Adult Group Eligibility Standards and FMAP Methodology Features

<table>
<thead>
<tr>
<th>Covered Populations Within New Adult Group</th>
<th>Applicable Population Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population Group</td>
<td>Relevant Population Group Income Standard</td>
</tr>
<tr>
<td></td>
<td>For each population group, indicate the lower of:</td>
</tr>
<tr>
<td>Parents/Caretaker Relatives</td>
<td>1. The reference in the MAGI Conversion Plan (Part 2) to the relevant income standard and the appropriate cross-reference, or • 133% EPI</td>
</tr>
<tr>
<td>Disabled Persons, non-institutionalized</td>
<td>Attachment A, Column C, Line 1 of Part 2 of the CMS-approved MAGI Conversion Plan, including any subsequent CMS-approved modifications to the MAGI Conversion Plan</td>
</tr>
<tr>
<td>Disabled Persons, institutionalized</td>
<td>Attachment A, Column C, Line 2 of Part 2 of the CMS-approved MAGI Conversion Plan, including any subsequent CMS-approved modifications to the MAGI Conversion Plan</td>
</tr>
<tr>
<td>Children Age 19 or 20</td>
<td>Attachment A, Column C, Line 3 of Part 2 of the CMS-approved Conversion Plan, including any subsequent CMS-approved modifications to the MAGI Conversion Plan</td>
</tr>
<tr>
<td>Childless Adults</td>
<td>Attachment A, Column C, Line 4 of Part 2 of the CMS-approved MAGI Conversion Plan, including any subsequent CMS-approved modifications to the MAGI Conversion Plan</td>
</tr>
</tbody>
</table>

Enter “Y” (Yes), “N” (No), or “NA” (Not Applicable) in the appropriate column to indicate if the population adjustment will apply to each population group. Provide additional information in corresponding attachments.
Part 2 – Population-based Adjustments to the Newly Eligible Population Based on Resource Test, Enrollment Cap or Special Circumstances

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

The state:

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

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

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

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

Data source used for resource proxy adjustments:

The state:

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

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

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

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

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

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

X  An enrollment cap adjustment is not applied by the state (skip items 2 through 4 and go to Section C).
2. Attachment C describes any enrollment caps authorized in section 1115 demonstrations as of December 1, 2009 that are applicable to populations that the state covers in the eligibility group described at 42 CFR 435.119 and received full benefits, benchmark benefits, or benchmark equivalent benefits as determined by CMS. The enrollment cap or caps are as specified in the applicable section 1115 demonstration special terms and conditions as confirmed by CMS, or in alternative authorized cap or caps as confirmed by CMS. Attach CMS correspondence confirming the applicable enrollment cap(s).

4. The state applies a combined enrollment cap adjustment for purposes of claiming FMAP in the adult group:
   __ Yes. The combined enrollment cap adjustment is described in Attachment C
   __ No.

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

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

The state:

  X  Applies a special circumstances adjustment(s).

  __ Does not apply a special circumstances adjustment.

The state:

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

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

Attachment D describes the special circumstances and other proxy adjustment(s) that are applied, including the population groups to which the adjustments apply and the methodology for calculating the adjustments.
Part 3 – One-Time Transitions of Previously Covered Populations into the New Adult Group

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

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

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

Part 4 - Applicability of Special FMAP Rates

8. Expansion State Designation

The state:

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

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

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

The state:

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

__ Qualifies for temporary 2.2 percentage point increase in FMAP under 42 CFR 433.10(c)(7), determined in accordance with the CMS letter confirming eligibility for the temporary FMAP increase, dated . The state will not claim any federal funding for individuals determined eligible under 42 CFR 435.119 at the FMAP rate described in 42 CFR 433.10(c)(6).
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Part 5 - State Attestations

The State attests to the following:

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

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

ATTACHMENTS

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

- Attachment A – Conversion Plan Standards Referenced in Table 1
- Attachment B – Resource Criteria Proxy Methodology
- Attachment C – Enrollment Cap Methodology
- Attachment D – Special Circumstances Adjustment and Other Adjustments to the Adult Group FMAP Methodology
- Attachment E – Transition Methodologies
STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State ____________________ WASHINGTON __________________

Attachment A

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

<table>
<thead>
<tr>
<th>Population Group</th>
<th>Net Standard as of 12/1/09</th>
<th>Converted Standard for FMAP Claiming</th>
<th>Same as converted eligibility standard? (yes, no, or n/a/)</th>
<th>Source of information in column C (New SIPP conversion or Part 1 of approved state MAGI conversion plan)</th>
<th>Data source for Conversion (SIPP or state data)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Parents/Caretaker Relatives</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dollar standards by family size</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
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<tr>
<td>3</td>
<td></td>
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<td></td>
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<tr>
<td>4</td>
<td></td>
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<td></td>
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<tr>
<td>5</td>
<td></td>
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<tr>
<td>6</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>7</td>
<td></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>8</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 or higher</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Add-on</td>
<td>$359</td>
<td>$511</td>
<td>Yes</td>
<td>Part 1 of approved state MAGI conversion plan</td>
<td>State data</td>
</tr>
<tr>
<td>2</td>
<td>Noninstitutionalized Disabled persons</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSI FBR%</td>
<td>100%</td>
<td>103%</td>
<td>n/a</td>
<td>New SIPP conversion</td>
<td>SIPP</td>
</tr>
<tr>
<td>3</td>
<td>Institutionalized Disabled persons</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSI FBR%</td>
<td>300%</td>
<td>300%</td>
<td>n/a</td>
<td>ABD conversion template</td>
<td>n/a</td>
</tr>
<tr>
<td>4</td>
<td>Children age 19 – 20</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
<tr>
<td>5</td>
<td>Childless adults</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
</tr>
</tbody>
</table>

n/a: Not applicable

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

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

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

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

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

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

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

With respect to the CMS 64, the monthly JV process ensures a “true-up” of the expenditures so that on a quarterly basis, the actual dollars for the Presumptive SSI are claimed appropriately at exactly 75% federal match.
Washington State administered a Presumptive SSI program (PSSI) until January 1, 2014. PSSI benefits included expedited Medicaid coverage and a state-funded cash benefit under the Aged Blind or Disabled (ABD) program for qualifying adults.

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

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

Washington State Revised 2014 Transition Plan

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

[Diagram showing Medicaid coverage levels and premium tax credits]

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

State WASHINGTON

### Attachment E (cont)

<table>
<thead>
<tr>
<th>2012</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jan</td>
<td>Feb</td>
<td>Mar</td>
</tr>
</tbody>
</table>

#### A PHASE 1: PREPARATION & PLANNING
1. Conversion assessment
2. Synchronization planning
3. Statewide communication/education
4. Draft notification letters/translation/revision
5. CMS transition plan review & conceptual approval
6. Define 2014 benefits - delay for guidance/Leg. authority
7. Transition plan review (public & initial notice)
8. 2013 Legislative session (FY2014 budget) - final 03/13
9. WAC revisions
10. Waiver amendment
11. Systems changes & 2014 set-up
12. Staff training
13. Navigators/staff training & outreach

#### B PHASE 2: SEAMLESS TRANSITION
1. Tribal sponsor notification (Basic Health)
2. Tribal update & consultations
3. Basic Health enrollee notice notification (with forwarding)
4. Basic Health enrollee direct calls (incl. community outreach)
5. MCHIP/ADATSA enrollee notification
6. Medicaid/Children/parent/infant enrollee conversion notification
7. Basic Health/MCHIP managed care plan notification
8. MCHIP/ADATSA provider notices
9. Operational overlap with Exchange start-up (3 months)
10. Medical handbook update
11. Medical handbook updates distributed
12. 2014 managed care contracting
13. 2014 managed care plan training
14. CMS 2014 contract review & approval (ongoing)
15. Basic health facilitator transition
16. MCHIP & ADATSA transition
17. MCHIP & ADATSA managed care auto enrollment
18. Bridge coverage end/AIAP coverage begins

#### C PHASE 3: ADMINISTRATIVE CLOSEOUT
1. On-going CMS reporting
2. Budget neutrality accounting
3. Operational shutdown

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TN# 15-0036 Approval Date 11/23/15 Effective Date: 8/1/15
Supersedes
TN# NEW
A. Coverage in 2014
Through the authority of the Transitional Bridge waiver Washington State will adopt MAGI-based eligibility determination methods beginning on October 1, 2013 to help facilitate a streamlined enrollment process for 2014 for all IAPs. (A general fact sheet on 2014 eligibility for Medicaid/CHIP is available at: http://www.hca.wa.gov/hcr/me/documents/ME2014_Changes_Comparison_Fact_Sheet.pdf. Populations covered through current 1115 Demonstrations will transition to 2014 coverage as follows.

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

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

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

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

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

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

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

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

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

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

TN# 14-0011
Supersedes
TN# -----

Approval Date 7/31/14  
Effective Date 1/1/14
Attachment E (cont)

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

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

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

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

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

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

2. Satisfy all Medicaid conditions of participation,

3. Meet functionally equivalent licensing requirements, and

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