

# Medicaid State Plan - Attachment 2

## Groups Covered and Eligibility Determinations

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*NOTE: Most of Attachment 2 has been superseded and moved to "[Eligibility and Enrollment](#)." This Attachment 2 contains only the sections/pages that have not been superseded by the sections in "Eligibility and Enrollment"*

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## 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).

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Citation(s)

Groups Covered

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The following groups are covered under this plan.

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

1902(e)(6)  
of the Act

11. b. A pregnant woman who would otherwise lose eligibility because of an increase in income (of the family in which she is a member) during the pregnancy or the postpartum period which extends through the end of the month in which the 60-day period (beginning on the last day of pregnancy) ends.

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Citation(s)

Groups Covered

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

42 CFR 435.212 &  
1902l(2) of the  
Act, P.L. 99-272  
(section 9517) P.L.  
101-508 (section  
4732)

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

X The State elects not to guarantee eligibility.

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

The State measures the minimum enrollment period from:

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

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

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Citation(s)

Groups Covered

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1932(a)(4) of  
the Act

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

The Medicaid Agency may elect to restrict the disenrollment rights of Medicaid enrollees of MCOs, PIHPs, PAHPs, and PCCMs in accordance with the regulations at 42 CFR 438.56. This requirements applies unless a recipient can demonstrate good cause for disenrolling or if he/she moves out of the entity's service area or becomes ineligible.

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

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

  X   No restrictions upon disenrollment rights.

1903(m)(2)(H),  
1902 (a)(52) of  
the Act  
P.L. 101-508  
42 CFR 438.56(g)

In the case of individuals who have become ineligible for Medicaid for the brief period described in section 1903(m)(2)(H) and who were enrolled with an MCO, PIHP, PAHP, or PCCM when they became ineligible, the Medicaid agency may elect to reenroll those individuals in the same entity if that entity still has a contract.

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

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

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

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Citation(s)

Groups Covered

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

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.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Citation(s)

Groups Covered

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C. Optional Coverage of the Medically Needy (Continued)

1906 of the  
Act

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

Citation	Groups Covered
1935(a) and 1920(a)(66) 42 CFR 423.774 And 423.904	<p>The agency provides for making Medicare prescription drug Low Income Subsidy determinations under Section 1935I of the Social Security Act.</p> <ol style="list-style-type: none"><li>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.</li><li>2. The agency provides for informing the Secretary of such determinations in cases in which such eligibility is established or redetermined.</li><li>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.</li></ol>

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Citation	Condition or Requirement
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A. General Conditions of Eligibility (cont)

Each individual covered under the plan (cont):

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Citation	Condition or Requirement
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A. General Conditions of Eligibility (cont)

Each individual covered under the plan (cont):

An applicant or recipient must also cooperate in establishing the paternity of any eligible child and in obtaining medical support and payments for himself or herself and any other person who is eligible for Medicaid and on whose behalf the individual can make an assignment; except that individuals described in §1902(1)(1)(A) of the Social Security Act (pregnant women and women in the postpartum period) are exempt from these requirements involving paternity and obtaining support. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.

An applicant or recipient must also cooperate in identifying any third party who may be liable to pay for care that is covered under the State plan and providing information to assist in pursuing these third parties. Any individual may be exempt from the cooperation requirements by demonstrating good cause for refusing to cooperate.

/ / Assignment of rights is automatic because of State law.

42 CFR 435.910

7. Is required, as a condition of eligibility, to furnish his/her social security account number (or numbers, if he/she has more than one number). Exception, aliens seeking medical assistance for the treatment of an emergency medical condition under Section 1903(v)(2) of the Social Security Act (Section 1137(f)).

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Citation	Condition or Requirement
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A. General Conditions of Eligibility (cont)

Each individual covered under the plan (cont):

- |                                                                                                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         |
|----------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 1906 of the Act                                                                                          | 10. Is required to apply for enrollment in an employer-based cost-effective group health plan, if such plan is available to the individual. Enrollment is a condition of eligibility except for the individual who is unable to enroll on his/her own behalf (failure of a parent to enroll a child does not affect a child's eligibility).                                                                                                                                                                                                                                                                             |
| U.S. Supreme Court case<br>New York State Department<br>Of Social Services v. Dublino<br>413 U.S. (1973) | 11. Is required to apply for coverage under Medicare Parts A, B and/or D if it is likely that the individual would meet the eligibility criteria for any or all 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. |

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Citation

Condition or Requirement

1924 of the Act  
435.725  
435.733  
435.832

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

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

- a. Aged, blind, disabled:  
*Individuals* \$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.

- c. 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.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Citation	Condition or Requirement
1924 of the Act	<p>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:</p> <p>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)I. The maintenance needs standard consists of a poverty level component plus an excess shelter allowance.</p> <p><u>X</u> The poverty level component is calculated using the applicable percentage (set out §1924(d)(3)(B) of the Act) of the official poverty level.</p> <p>— 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).</p> <p>— The maintenance needs standard for all community spouses is set at the maximum permitted by §1924(d)(3)I.</p> <p>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.</p>

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Citation

Condition or Requirement

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

X the standard utility allowance under §51 of the Food Stamp Act of 1977 or

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

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

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

a greater 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.)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Citation	Condition or Requirement
435.725 435.733 435.832	<p>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:</p> <p>a. An amount for the maintenance needs of each member of a family living in the institutionalized individual's home with no community spouse living in the home. The amount must be based on a reasonable assessment of need but must not exceed the higher of the:</p> <ul style="list-style-type: none"><li>• AFDC level or</li><li>• Medically needy level:</li></ul> <p>(Check one)</p> <p><input type="checkbox"/> AFDC levels in Supplement 1</p> <p><input checked="" type="checkbox"/> Medically needy level in Supplement 1</p> <p><input type="checkbox"/> Other: \$</p> <p>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:</p> <p>(i) Medicaid, Medicare, and other health insurance premiums, deductibles, or coinsurance charges, or copayments.</p> <p>(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.)</p>
435.725 435.733 435.832	<p>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:</p> <p>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:</p> <p><input type="checkbox"/> No</p> <p><input checked="" type="checkbox"/> Yes (the applicable amount is shown on page 5a.)</p>

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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Citation

Condition or Requirement

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X Amount for maintenance of home is:  
100% FPL

\_\_\_ Amount for maintenance of home is the actual maintenance costs not to exceed \$\_\_\_\_\_.

\_\_\_ Amount for maintenance of home is deductible when countable income is determined under §1924(d)(1) of the Act only if the individual's home and the community spouse's home are different.

\_\_\_ Amount for maintenance of home is not deductible when countable income is determined under §1924 (d)(1) of the Act.

6. SSI benefits paid under section 1611I(1)I and (G) of the Act to individuals who receive care in a hospital or nursing facility.
7. Except as provided under Section 1924 of the Act, the policies reflected in C. apply. See Supplement 13 for additional policies related to Section 1924.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Citation

Condition or Requirement

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C. Financial Eligibility (cont)

1902I(2)  
of the Act

C.1. Methods of Determining Income

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

1902I(6)  
the Act

- (3) Agency continues to treat women eligible under the provisions of sections 1902(a)(10) of the Act as eligible, without regard to any changes in income of the family of which she is a member, for the 60-day period after her pregnancy ends and any remaining days in the month in which the 60<sup>th</sup> day falls.

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

State WASHINGTON

Citation

Condition or Requirement

## C.1. Methods of Determining Income (cont)

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

State WASHINGTON

Citation

Condition or Requirement

## C.1. Methods of Determining Income (cont)

1902(a)(10)(A)(ii)(XIII),  
(XV), (XVI), and 1916(g)  
of the Act (cont.)

For individuals eligible under the Basic Coverage  
Group described in No. 24 on page 23e of  
Attachments 2.2-A, and the Medical Improvement  
Group described in No. 25 on page 23e of Attachment  
2.2-A:

NOTE: Regardless of the option selected below, the  
agency MUST require that individuals whose annual  
adjusted gross income, as defined under IRS statute,  
exceeds \$75,000 pay 100 percent of premiums.

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

The premiums or other cost-sharing charges, and  
how they are applied, are described on page 12o.

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

State WASHINGTON

Citation

Condition or Requirement

## C.1. Methods of Determining Income (cont)

Sections 1902(a)(10)(A)  
(ii)(XV), (XVI), and 1916(g)  
of the Act (cont.)

## Premiums and Other Cost-Sharing Charges

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

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

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

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Citation(s)	Condition or Requirement
1902(k) of the Act	<p>C.2. Medicaid Qualifying Trusts</p> <p>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.</p> <p>/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.</p>

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Citation(s)

Condition or Requirement

C. Financial Eligibility (cont)

42 CFR  
435.914

12. Effective Date of Eligibility

a. Groups Other Than Qualified Medicare Beneficiaries

(1) For the prospective period.

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

  X   Aged, blind, disabled.  
  X   AFDC-related

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

       Aged, blind, disabled.  
       AFDC-related.

(2) For the retroactive period.

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

       Aged, blind, disabled.  
       AFDC-related.

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

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

Citation	Condition or Requirement
C. Financial Eligibility (cont)	
1902 (a) (18) and 1902 (f) of the Act	<p>12. Pre-OBRA 93 Transfer of Resources – Categorically and Medically Needy, Qualified Medicare Beneficiaries and Qualified Disabled and Working Individuals.</p> <p>The agency complies with the provisions of section 1917 of the Act with respect to the transfer of resources.</p> <p>Disposal of resources at less than fair market value affects eligibility for certain services as detailed in Supplement 9 to Attachment 2.6-A.</p>
1917I	<p>13. Transfer of Assets – All eligibility groups</p> <p>The agency complies with the provisions of section. 1917 I of the Act, as enacted by OBRA 93, with regard to the transfer of assets.</p> <p>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.</p>
1917(d)	<p>14. Treatment of Trusts – All eligibility groups</p> <p>The agency complies with the provisions of section 1917 (d) of the Act, as amended by OBRA 93, with regard to trusts.</p> <p>— The agency uses more restrictive methodologies under section 1902 (f) of the Act, and applies those methodologies in dealing with trusts;</p> <p>— The agency meets the requirements in section 1917(d)(f)(B) of the Act for use of Miller trusts.</p> <p>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.</p>

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

State WASHINGTON

Citation

Condition or Requirement

## C. Financial Eligibility (cont)

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

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

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

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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TRANSFER OF ASSETS

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

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

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

Nursing facility services

Nursing facility level of care provided in a medical institution

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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TRANSFER OF ASSETS (cont.)

2. Non-institutionalized individuals

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

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

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

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

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

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

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

Program of All Inclusive Care for the Elderly (PACE)

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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TRANSFER OF ASSETS (cont.)

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

or

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

and

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

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TRANSFER OF ASSETS (cont.)

4. Penalty Period - Institutionalized Individuals

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

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

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

5. Penalty Period - Non-institutionalized Individuals

-

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

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

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

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

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

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

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

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

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TRANSFER OF ASSETS (cont.)

8. Treatment of a transfer of income

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

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

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

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

9. Imposition of a penalty would work an undue hardship

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

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

- (a) Of medical care such that the individual's health or life would be endangered; or
- (b) Of food, clothing, shelter, or other necessities of life.

10. Procedures for Undue Hardship Waivers

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

- (a) Notice to a recipient subject to a penalty that an undue hardship exception exists;
- (b) A timely process for determining whether an undue hardship waiver will be granted; and
- (c) A process, which is described in the notice, under which an adverse determination can be appealed.

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

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TRANSFER OF ASSETS (cont.)

11. Bed Hold Waivers For Hardship Applicants

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

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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CONSIDERATION OF MEDICAID QUALIFYING TRUSTS – UNDUE HARDSHIP

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

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

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

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

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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Citation

Condition or Requirement

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COST EFFECTIVENESS METHODOLOGY FOR  
COBRA CONTINUATION BENEFICIARIES

1902(u) of the  
Act

Premium payments are made by the agency only if such payments are likely to be cost-effective. The agency specifies the guidelines used in determining cost effectiveness by selecting one of the following methods.

- ☐ The methodology as described in SMM section 3598.
- ☐ Another cost-effective methodology as described below.

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

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## VARIATIONS FROM THE BASIC PERSONAL NEEDS ALLOWANCE (PNA)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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VARIATIONS FROM THE BASIC PERSONAL NEEDS ALLOWANCE

## Disclosure Statement for Post-Eligibility Preprint

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

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

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

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

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

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

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

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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Citation

Condition or Requirement

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Section 1924 Provisions

- A. Income and resource eligibility policies used to determine eligibility for institutionalized individuals who have spouses living in the community are consistent with Section 1924.
- B. In the determination of resource eligibility the State resource standard is the maximum resource allowance permissible under section 1924 of the Social Security Act.
- C. The definition of undue hardship for purposes of determining if institutionalized spouses receive Medicaid in spite of having excess countable resources is described below.

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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ELIGIBILITY CONDITIONS AND REQUIREMENTS

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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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ELIGIBILITY CONDITIONS AND REQUIREMENTS

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Personal Needs Allowance, cont.

INCOME TAX DEDUCTION.

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

1. Withholdings from earned and unearned income necessary to meet expected Federal, State or local tax liability.
2. Federal, State or local income taxes that are not covered by earned or unearned income withholding but are owed or have been paid.

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

State WASHINGTON

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PERSONAL NEEDS ALLOWANCE - NURSING FACILITY RESIDENTS WITH HIGHER NEEDS

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

1. Guardianship Fees

Guardianship fees will be allowed under a court order, including an order that establishes or continues a legal guardianship and the order requires a future review or accounting in an amount not to exceed \$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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## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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PERSONAL NEEDS ALLOWANCE - NURSING FACILITY RESIDENTS WITH HIGHER NEEDS

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

The individual is a resident of a nursing facility that:

1. Is located in excess of 50 miles from the individual's last community residence, prior to Institutionalization, resulting in additional expenses for transportation and communication.
2. Provides regular access, at resident's expense, to long-distance phone services and cable television.
3. In addition to providing nursing care, provides co-located, less intensive services for higher functioning individuals, including integrated social activities for both groups, promoting an active lifestyle that necessitates a higher PNA.
4. Provides on campus access to goods and services, including, but not limited to, a barber shop, commissary and snack bar that allows for normal activities of daily living that necessitates a higher PNA.
5. Provides opportunity for resident's involvement in governance of programs for a multiple facility organization. This requires additional funds for inter-facility travel and additional expenses.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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ASSET VERIFICATION SYSTEM

- 1940(a) 1. of the Act      The agency will provide for the verification of assets for purposes of determining or re-determining Medicaid eligibility for aged, blind and disabled Medicaid applicants and recipients using an Asset Verification System (AVS) that meets the following minimum requirements.
- The request and response system must be electronic:
    - Verification inquiries must be sent electronically via the internet or similar means from the agency to the financial institution (FI).
    - The system cannot be based on mailing paper-based requests.
    - The system must have the capability to accept responses electronically.
  - The system must be secure, based on a recognized industry standard of security (e.g., as defined by the U.S. Commerce Department's National Institute of Standards and Technology, or NIST).
  - The system must establish and maintain a database of FIs that participate in the agency's AVS.
  - Verification requests also must be sent to FIs other than those identified by applicants and recipients, based on some logic such as geographic proximity to the applicant's home address, or other reasonable factors whenever the agency determines that such requests are needed to determine or re-determine the individual's eligibility.
  - The verification requests must include a request for information on both open and closed accounts, going back up to 5 years as determined by the State.

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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ASSET VERIFICATION SYSTEM

- System Development

☐ A. The agency itself will develop an AVS.

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

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

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

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

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

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

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

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

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

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

State WASHINGTON

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ASSET VERIFICATION SYSTEM

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

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

- (i) An electronic process for asset verification.
- (ii) A database of financial institutions that provide data to the entity, meeting the geographic requirements of the consortium.
- (iii) A 5-year "look-back" of the assets on individual applicants, recipients, spouses, and partners.
- (iv) A secure system based on a recognized industry standard as defined by the U.S Commerce Department's National Institute.
- (v) Verification requests will include both open and closed asset account information.
- (vi) The acceptable asset verification entity will provide adequate data for the generation of all required reports expected to meet federal reporting requirements, such as the number of requests, number of responses, and amounts of undisclosed assets found.

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

- 1917(f) The State agency denies reimbursement for nursing facility services and other long-term care services covered under the State Plan for an individual who does not have a spouse, child under 21, or adult disabled child residing in the individual's home, when the individual's equity interest in the home exceeds the following amount:
- X   \$500,000 (increased by the annual percentage increase in the urban component of the consumer price index beginning with 2011, rounded to the nearest \$1,000).
- An amount that exceeds \$500,000 but does not exceed \$750,000 (increased by the annual percentage increase in urban component of the consumer price index beginning with 2011, rounded to the nearest \$1,000).

The amount chosen by the State is \_\_\_\_\_

- This higher standard applies statewide.
- This higher standard does not apply statewide. It only applies in the following areas of the State:
- This higher standard applies to all eligibility groups.
- This higher standard only applies to the following eligibility groups:

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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METHODOLOGY FOR IDENTIFICATION OF APPLICABLE FMAP RATES

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

Part 1 – Adult Group Individual Income-Based Determinations

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

2) approved by CMS on March 31, 2014. In general, and subject to any adjustments described in this SPA, under the adult group FMAP methodology, the expenditures of individuals with incomes below the relevant converted income standards for the applicable subgroup are considered as those for which the newly eligible FMAP is not available. The relevant MAGI-converted standards for each population group in the new adult group are described in Table 1.

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**Table 1: Adult Group Eligibility Standards and FMAP Methodology Features**

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

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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

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

The state:

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

☒ 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).

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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2. Attachment C describes any enrollment caps authorized in section 1115 demonstrations as of December 1, 2009 that are applicable to populations that the state covers in the eligibility group described at 42 CFR 435.119 and received full benefits, benchmark benefits, or benchmark equivalent benefits as determined by CMS. The enrollment cap or caps are as specified in the applicable section 1115 demonstration special terms and conditions as confirmed by CMS, or in alternative authorized cap or caps as confirmed by CMS. Attach CMS correspondence confirming the applicable enrollment cap(s).
4. The state applies a combined enrollment cap adjustment for purposes of claiming FMAP in the adult group:
- ☐ Yes. The combined enrollment cap adjustment is described in Attachment C
- ☐ No.
5. Enrollment Cap Methodology: Attachment C describes the methodology for calculating the enrollment cap adjustment, including the use of combined enrollment caps, if applicable.
6. Special Circumstances (42 CFR 433.206(g)) and Other Adjustments to the Adult Group FMAP Methodology

The state:

- ☒ Applies a special circumstances adjustment(s).
- ☐ Does not apply a special circumstances adjustment.

The state:

- ☒ Applies additional adjustment(s) to the adult group FMAP methodology (complete item 3).
- ☐ Does not apply any additional adjustment(s) to the adult group FMAP methodology (skip item 3 and go to Part 3).

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

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

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

- ☒ 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)
- ☒ 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:

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

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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State WASHINGTON

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Part 5 - State Attestations

The State attests to the following:

10. The application of the adult group FMAP methodology will not affect the timing or approval of any individual's eligibility for Medicaid.
11. The application of the adult group FMAP methodology will not be biased in such a manner as to inappropriately establish the numbers of, or medical assistance expenditures for, individuals determined to be newly or not newly eligible.

ATTACHMENTS

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

- ☒ 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

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## 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\*

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

n/a: Not applicable

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

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ATTACHMENT D

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

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

12. Obtain the client IDs for these presumptive SSI clients from the Automated Client Eligibility System (ACES) maintained by DSHS, by identifying those that are in the Adult Blind/Disabled (ABD) cash assistance program.
13. Match these clients to the medical eligibility data in Provider One to obtain a list of ABD clients that are also eligible for Medicaid in the newly eligible population segment at the same time.
14. On a monthly basis, HCA Budget pulls all expenses for these clients. Medicaid claims data for clients is obtained from various Washington State systems, including Provider One, SSPS (Social Service Payment System), etc. The Journal Voucher data is then provided to HCA Accounting to ensure federal match for these clients is exactly 75% (or updated annual figure).

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

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

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

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

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

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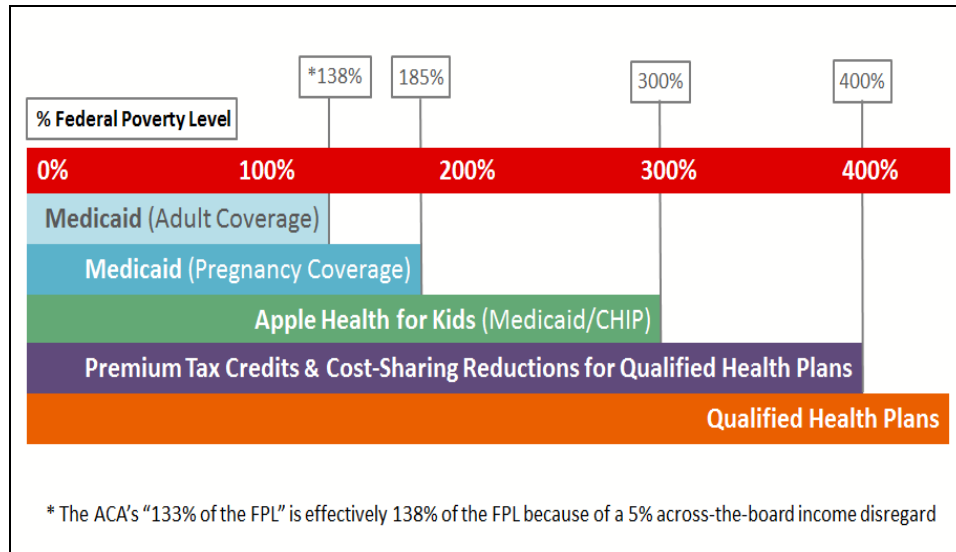
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Attachment E

Washington State Revised 2014 Transition Plan

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



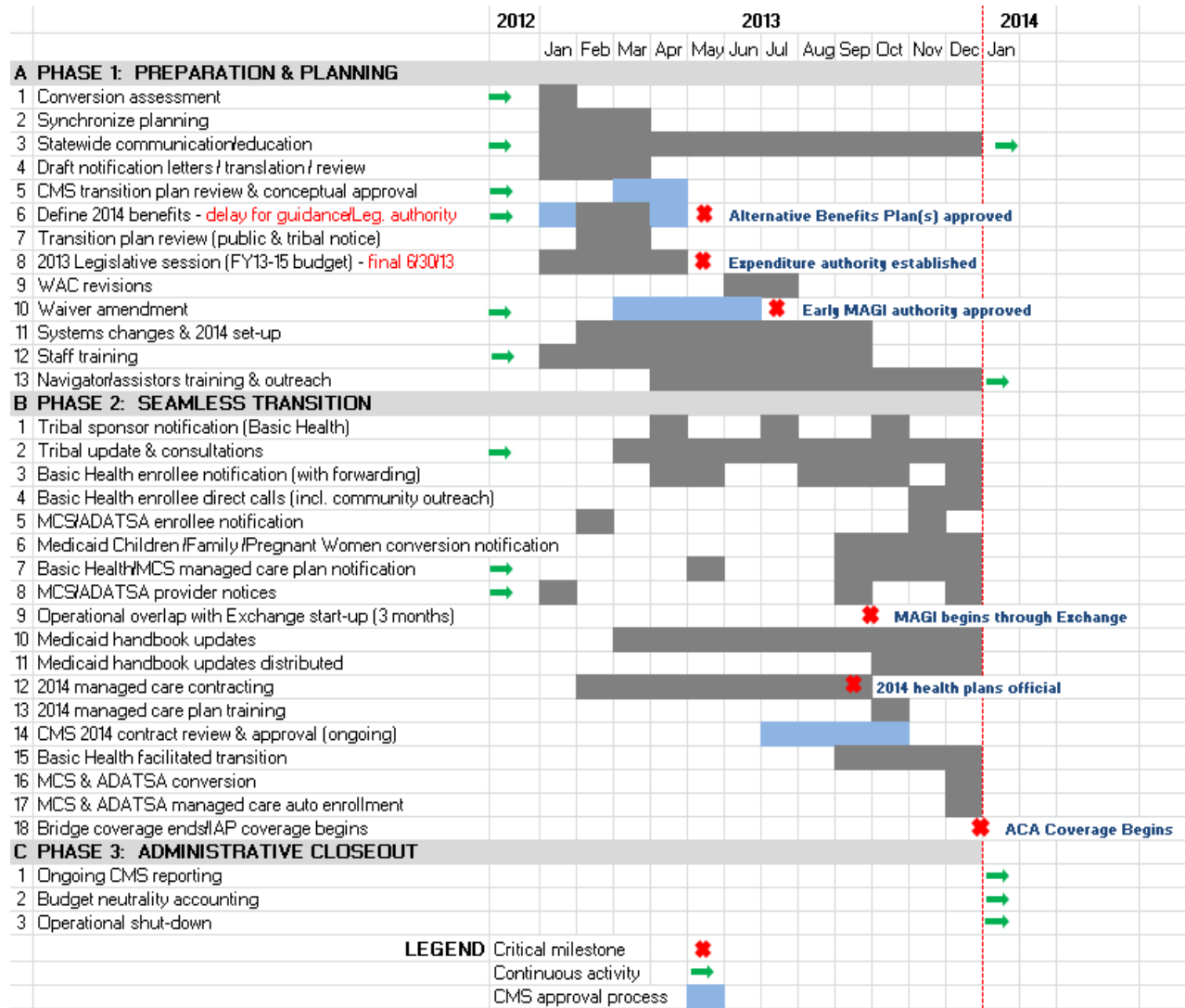
A broad range of discussions, presentations and webinars has been hosted to clarify general Medicaid expansion and transition details for Tribes, stakeholders, health plans and others interested. The timeline and critical milestones for preparation/planning, seamless transition and administrative closeout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

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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](http://www.hca.wa.gov/hcr/me/documents/ME2014_Changes_Comparison_Fact_Sheet.pdf). Populations covered through current 1115 Demonstrations will transition to 2014 coverage as follows.

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

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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](http://www.wahealthplanfinder.org).)

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

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

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

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

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## C. Notification/Notices

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

As required, notices comply with the notice requirements in 42 CFR 431.206, 431.210 and 431.213 and where applicable, information on appeal and hearing rights as outlined in 42 CFR 431.220 and 431.221 is included. In general, the terms and conditions of the Transitional Bridge waiver which expires December 31, 2013, make the need for hearing and appeal rights not relevant since the programs will not continue for Transition Eligibles. A full list and sample of actual notices is included in Attachment 1. Multiple versions of these notices have been reviewed through email, webinar, teleconference and verbal interactions with State agency staff, advocates, Tribal representatives and others. The notification process is as follows:

Population	Timing and Delivery of Beneficiary Notices	Support for Questions
Basic Health	<b>Letter # a: Member alert</b> Preliminary announcement mailed early July 2013 along with the monthly notice for premium payment (September coverage)	19. Online at <a href="http://www.wahealthplanfinder.org">www.wahealthplanfinder.org</a> .
	<b>Letter # b: 90-day first notice</b> 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 21. Mail to PO Box 946, Olympia, WA 98507 22. Email at <a href="mailto:CustomerSupport@wahbexchange.org">CustomerSupport@wahbexchange.org</a>
	<b>Letter # c: 60-day second notice</b> 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 <u>for those who have not already completed 2014 coverage action</u>	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

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Attachment E (cont)

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

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Medicaid Furnished Out of State

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

1. Medical services are required because of a medical emergency and a Canadian provider is the closest source of care or
2. Needed medical services are more readily available in Canada and the aggregate cost of care is equal to or less than the aggregate cost of the same care when provided within the state.

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

1. Have a signed agreement with the department and bill at U.S. exchange rate in effect at the time the service was provided.
2. Satisfy all Medicaid conditions of participation,
3. Meet functionally equivalent licensing requirements, and
4. Be subject to the same utilization control standards as in-state providers.

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