# Chapter 182-507 WAC
# MEDICAL ASSISTANCE PROGRAMS FOR NONCITIZENS

**WAC**


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**WAC 182-507-0110 Alien medical programs.** (1) To qualify for an alien medical program (AMP) a person must:

(a) Be ineligible for medicaid or other medicaid agency medical program due to the citizenship/alien status requirements described in WAC 388-424-0010;

(b) Meet the requirements described in WAC 182-507-0115, 182-507-0120, or 182-507-0125; and

(c) Meet categorical eligibility criteria for one of the following programs, except for the Social Security number or citizenship/alien status requirements:

(i) WAC 388-475-0050, for an SSI-related person;

(ii) WAC 182-505-0240, for family medical programs;

(iii) WAC 182-505-0210, for a child under the age of nineteen;

(iv) WAC 182-505-0115, for a pregnant woman;

(v) WAC 388-462-0020, for the breast and cervical cancer treatment program for women; or

(vi) WAC 182-523-0100, for medical extensions.

(2) AMP medically needy (MN) coverage is available for children, adults age sixty-five or over, or persons who meet SSI disability criteria. See WAC 388-519-0100 for MN eligibility and 388-519-0110 for spending down excess income under the MN program.

(3) The agency or its designee does not consider a person's date of arrival in the United States when determining eligibility for AMP.

(4) The agency or its designee does not consider a sponsor's income and resources when determining eligibility for AMP, unless the sponsor makes the income or resources available.

(5) A person is not eligible for AMP if that person entered the state specifically to obtain medical care.

(6) A person who the agency or its designee determines is eligible for AMP may be eligible for retroactive coverage as described in WAC 388-416-0015.

(7) Once the agency or its designee determines financial and categorical eligibility for AMP, the agency or its designee then determines whether a person meets the requirements described in WAC 182-507-0115, 182-507-0120, or 182-507-0125.

[Statutory Authority: RCW 41.05.021. 12-24-038, § 182-507-0110, filed 11/29/12, effective 12/30/12. 12-13-056, recodified as WAC 182-507-0110, filed 6/15/12, effective 7/1/12. Statutory Authority: RCW 74.04.050, 74.08.090, and 2009 c 564 §§ 1109, 201, 209. 10-19-085, § 388-438-0110, filed 9/17/10, effective 10/18/10. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530. 07-07-024, § 388-438-0110, filed 3/9/07, effective 4/9/07; 06-04-047, § 388-438-0110, filed 1/26/06, effective 2/26/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090. 04-15-057, § 388-438-0110, filed 7/13/04, effective 8/13/04. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530, and Section 1903 (v)(2)(c) of the Social Security Act. 03-24-058, § 388-438-0110, filed 12/1/03, effective 1/1/04. Statutory Authority: RCW 74.08.090, 74.08A.100, 74.09.080, and 74.09.415. 02-17-030, § 388-438-0110, filed 8/12/02, effective 9/12/02. Statutory Authority: RCW 74.08.090 and C.F.R. 436.128, 436.406(c) and 440.255. 01-05-041, § 388-438-0110, filed 2/14/01, effective 3/17/01. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, 74.09.530, 42 C.F.R. 435.139 and 42 C.F.R. 440.255. 99-23-082, § 388-438-0110, filed 11/16/99, effective 12/17/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-438-0110, filed 7/31/98, effective 9/1/98.]

**WAC 182-507-0115 Alien emergency medical program (AEM).** (1) A person nineteen years of age or older who is not pregnant and meets the eligibility criteria under WAC 182-507-0110 is eligible for the alien emergency medical program's scope of covered services described in this section if the person meets (a) and (b) or (c) of this subsection:

(a) The medicaid agency determines that the primary condition requiring treatment meets the definition of an emergency medical condition as defined in WAC 182-500-0030, and the condition is confirmed through review of clinical records; and

(b) The person's qualifying emergency medical condition is treated in one of the following hospital settings:

(i) Inpatient;

(ii) Outpatient surgery;

(iii) Emergency room services, which must include an evaluation and management (E&M) visit by a physician; or

(c) Involuntary Treatment Act (ITA) and voluntary inpatient admissions to a hospital psychiatric setting that are authorized by the agency's inpatient mental health designee (see subsection (5) of this section).

(2) If a person meets the criteria in subsection (1) of this section, the agency will cover and pay for all related medically necessary health care services and professional services provided:

(a) By physicians in their office or in a clinic setting immediately prior to the transfer to the hospital, resulting in a direct admission to the hospital; and

(b) During the specific emergency room visit, outpatient surgery or inpatient admission. These services include, but are not limited to:

(i) Medications;

(ii) Laboratory, X ray, and other diagnostics and the professional interpretations;

(iii) Medical equipment and supplies;

(iv) Anesthesia, surgical, and recovery services;

(v) Physician consultation, treatment, surgery, or evaluation services;

(vi) Therapy services;

(vii) Emergency medical transportation; and

(viii) Nonemergency ambulance transportation to transfer the person from a hospital to a long term acute care (LTAC) or an inpatient physical medicine and rehabilitation (PM&R) unit, if that admission is prior authorized by the agency or its designee as described in subsection (3) of this section.

(3) The agency will cover admissions to an LTAC facility or an inpatient PM&R unit if:

(a) The original admission to the hospital meets the criteria as described in subsection (1) of this section;

(b) The person is transferred directly to this facility from the hospital; and

(c) The admission is prior authorized according to LTAC and PM&R program rules (see WAC 182-550-2590 for LTAC and WAC 182-550-2561 for PM&R).

(4) The agency does not cover any services, regardless of setting, once the person is discharged from the hospital after being treated for a qualifying emergency medical condition authorized by the agency or its designee under this program. Exception: Pharmacy services, drugs, devices, and drug-related supplies listed in WAC 182-530-2000, prescribed on the same day and associated with the qualifying visit or service (as described in subsection (1) of this section) will be covered for a one-time fill and retrospectively reimbursed according to pharmacy program rules.

(5) Medical necessity of inpatient psychiatric care in the hospital setting must be determined, and any admission must be authorized by the agency's inpatient mental health designee according to the requirements in WAC 182-550-2600.

(6) There is no precertification or prior authorization for eligibility under this program. Eligibility for the AEM program does not have to be established before an individual begins receiving emergency treatment.

(7) Under this program, certification is only valid for the period of time the person is receiving services under the criteria described in subsection (1) of this section. The exception for pharmacy services is also applicable as described in subsection (4) of this section.

(a) For inpatient care, the certification is only for the period of time the person is in the hospital, LTAC, or PM&R facility - The admission date through the discharge date. Upon discharge the person is no longer eligible for coverage.

(b) For an outpatient surgery or emergency room service the certification is only for the date of service. If the person is in the hospital overnight, the certification will be the admission date through the discharge date. Upon release from the hospital, the person is no longer eligible for coverage.

(8) Under this program, any visit or service not meeting the criteria described in subsection (1) of this section is considered not within the scope of service categories as described in WAC 182-501-0060. This includes, but is not limited to:

(a) Hospital services, care, surgeries, or inpatient admissions to treat any condition which is not considered by the agency to be a qualifying emergency medical condition, including but not limited to:

(i) Laboratory X ray, or other diagnostic procedures;

(ii) Physical, occupational, speech therapy, or audiology services;

(iii) Hospital clinic services; or

(iv) Emergency room visits, surgery, or hospital admissions.

(b) Any services provided during a hospital admission or visit (meeting the criteria described in subsection (1) of this section), which are not related to the treatment of the qualifying emergency medical condition;

(c) Organ transplants, including preevaluations, post operative care, and anti-rejection medication;

(d) Services provided outside the hospital settings described in subsection (1) of this section including, but not limited to:

(i) Office or clinic-based services rendered by a physician, an ARNP, or any other licensed practitioner;

(ii) Prenatal care, except labor and delivery;

(iii) Laboratory, radiology, and any other diagnostic testing;

(iv) School-based services;

(v) Personal care services;

(vi) Physical, respiratory, occupational, and speech therapy services;

(vii) Waiver services;

(viii) Nursing facility services;

(ix) Home health services;

(x) Hospice services;

(xi) Vision services;

(xii) Hearing services;

(xiii) Dental services;

(xiv) Durable and nondurable medical supplies;

(xv) Nonemergency medical transportation;

(xvi) Interpreter services; and

(xvii) Pharmacy services, except as described in subsection (4) of this section.

(9) The services listed in subsection (8) of this section are not within the scope of service categories for this program and therefore the exception to rule process is not available.

(10) Providers must not bill the agency for visits or services that do not meet the qualifying criteria described in this section. The agency will identify and recover payment for claims paid in error.

[Statutory Authority: RCW 41.05.021. 12-24-038, § 182-507-0115, filed 11/29/12, effective 12/30/12. 12-13-056, recodified as WAC 182-507-0115, filed 6/15/12, effective 7/1/12. Statutory Authority: RCW 74.04.050, 74.08.090, and 2009 c 564 §§ 1109, 201, 209. 10-19-085, § 388-438-0115, filed 9/17/10, effective 10/18/10.]

**WAC 182-507-0120 Alien medical for dialysis and cancer treatment.** In addition to the provisions for emergency care described in WAC 182-507-0115, the medicaid agency also considers the conditions in this section as an emergency, as defined in WAC 182-500-0030.

(1) A person nineteen years of age or older who is not pregnant and meets the eligibility criteria under WAC 182-507-0110 may be eligible for the scope of service categories under this program if the condition requires:

(a) Surgery, chemotherapy, and/or radiation therapy to treat cancer;

(b) Dialysis to treat acute renal failure or end stage renal disease (ESRD); or

(c) Anti-rejection medication, if the person has had an organ transplant.

(2) When related to treating the qualifying medical condition, covered services include but are not limited to:

(a) Physician and ARNP services, except when providing a service that is not within the scope of this medical program (as described in subsection (7) of this section);

(b) Inpatient and outpatient hospital care;

(c) Dialysis;

(d) Surgical procedures and care;

(e) Office or clinic based care;

(f) Pharmacy services;

(g) Laboratory, X ray, or other diagnostic studies;

(h) Oxygen services;

(i) Respiratory and intravenous (IV) therapy;

(j) Anesthesia services;

(k) Hospice services;

(l) Home health services, limited to two visits;

(m) Durable and nondurable medical equipment;

(n) Nonemergency transportation; and

(o) Interpreter services.

(3) All hospice, home health, durable and nondurable medical equipment, oxygen and respiratory, IV therapy, and dialysis for acute renal disease services require prior authorization. Any prior authorization requirements applicable to the other services listed above must also be met according to specific program rules.

(4) To be qualified and eligible for coverage for cancer treatment under this program, the diagnosis must be already established or confirmed. There is no coverage for cancer screening or diagnostics for a workup to establish the presence of cancer.

(5) Coverage for dialysis under this program starts the date the person begins dialysis treatment, which includes fistula placement and other required access. There is no coverage for diagnostics or predialysis intervention, such as surgery for fistula placement anticipating the need for dialysis, or any services related to preparing for dialysis.

(6) Certification for eligibility will range between one to twelve months depending on the qualifying condition, the proposed treatment plan, and whether the client is required to meet a spenddown liability.

(7) The following are not within the scope of service categories for this program:

(a) Cancer screening or work-ups to detect or diagnose the presence of cancer;

(b) Fistula placement while the person waits to see if dialysis will be required;

(c) Services provided by any health care professional to treat a condition not related to, or medically necessary to, treat the qualifying condition;

(d) Organ transplants, including preevaluations and post operative care;

(e) Health department services;

(f) School-based services;

(g) Personal care services;

(h) Physical, occupational, and speech therapy services;

(i) Audiology services;

(j) Neurodevelopmental services;

(k) Waiver services;

(l) Nursing facility services;

(m) Home health services, more than two visits;

(n) Vision services;

(o) Hearing services;

(p) Dental services, unless prior authorized and directly related to dialysis or cancer treatment;

(q) Mental health services;

(r) Podiatry services;

(s) Substance abuse services; and

(t) Smoking cessation services.

(8) The services listed in subsection (7) of this section are not within the scope of service categories for this program. The exception to rule process is not available.

(9) Providers must not bill the agency for visits or services that do not meet the qualifying criteria described in this section.

[Statutory Authority: RCW 41.05.021. 12-24-038, § 182-507-0120, filed 11/29/12, effective 12/30/12. 12-13-056, recodified as WAC 182-507-0120, filed 6/15/12, effective 7/1/12. Statutory Authority: RCW 74.04.050, 74.08.090, and 2009 c 564 §§ 1109, 201, 209. 10-19-085, § 388-438-0120, filed 9/17/10, effective 10/18/10.]

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

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

(a) In a person's own home, as described in WAC 388-106-0010;

(b) Nursing facility, as defined in WAC 388-97-0001;

(c) Adult family home, as defined in RCW 70.128.010;

(d) Assisted living facility, as described in WAC 388-513-1301;

(e) Enhanced adult residential care facility, as described in WAC 388-513-1301;

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

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

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

(a) Meet the general eligibility requirements for medical programs described in WAC 388-503-0505 (2) and (3)(a),(b), (e), and(f);

(b) Reside in one of the settings described in subsection (2) of this section;

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

(d) Meet the functional eligibility described in WAC 388-106-0355 for nursing facility level of care;

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

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

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

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

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

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

(a) WAC 388-513-1395 for adults related to SSI; or

(b) WAC 388-505-0255 for adults related to family institutional medical.

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

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

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

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

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

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

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

[12-13-056, recodified as WAC 182-507-0125, filed 6/15/12, effective 7/1/12. Statutory Authority: 2011 c 5, RCW 74.04.057, 74.08.090, and 74.09.510. 11-19-070, § 388-438-0125, filed 9/15/11, effective 10/16/11. Statutory Authority: RCW 74.04.050, 74.08.090, and 2009 c 564 §§ 1109, 201, 209. 10-19-085, § 388-438-0125, filed 9/17/10, effective 10/18/10.]

**WAC 182-507-0130 Refugee medical assistance (RMA).** (1) An individual is eligible for refugee medical assistance (RMA) if the following conditions are met. The individual:

(a) Meets immigration status requirements of WAC 182-507-0135;

(b) Has countable resources below one thousand dollars on the date of application;

(c) Has countable income equal to or below two hundred percent of the federal poverty level (FPL) on the date of application. The following income is not considered when determining eligibility for RMA:

(i) Resettlement cash payments made by the voluntary agency (VOLAG);

(ii) Income of a sponsor is not counted unless the sponsor is also part of the individual's assistance unit; and

(iii) Income received after the date of application.

(d) Provides the name of the VOLAG which helped bring the individual to the United States so that the department of social and health services (DSHS) can promptly notify the VOLAG (or sponsor) about the medical application.

(2) An individual who receives refugee cash assistance (RCA) is eligible for RMA as long as the individual is not otherwise eligible for medicaid or a children's health care program as described in WAC 182-505-0210. An individual does not have to apply for or receive RCA in order to qualify for RMA.

(3) An individual is not eligible to receive RMA if the individual is:

(a) Already eligible for medicaid or a children's health care program as described in WAC 182-505-0210;

(b) A full-time student in an institution of higher education unless the educational activity is part of a DSHS-approved individual responsibility plan (IRP); or

(c) A nonrefugee spouse of a refugee.

(4) If approved for RMA, the agency or its designee issues an approval letter in both English and the individual's primary language. The agency or its designee also sends a notice every time there are any changes or actions taken which affect the individual's eligibility for RMA.

(5) An individual may be eligible for RMA coverage of medical expenses incurred during the three months prior to the first day of the month of the application. Eligibility determination will be made according to medicaid rules.

(6) A victim of human trafficking must provide the following documentation and meet the eligibility requirements in subsections (1) and (2) of this section to be eligible for RMA:

(a) Adults, eighteen years of age or older, must provide the original certification letter from the United States Department of Health and Human Services (DHHS). No other documentation is needed. The eight-month eligibility period will be determined based on the entry date on the individual's certification letter;

(b) A child victim under the age of eighteen does not need to be certified. DHHS issues a special letter for children. Children also have to meet income eligibility requirements;

(c) A family member of a certified victim of human trafficking must have a T-2, T-3, T-4, or T-5 visa (derivative T-Visas), and the family member must meet eligibility requirements in subsections (1) and (2) of this section.

(7) The entry date for an asylee is the date that the individual's asylum status is granted. For example, an individual entered the United States on December 1, 1999, as a tourist, then applied for asylum on April 1, 2000, interviewed with the asylum office on July 1, 2000, and was granted asylum on September 1, 2000. The date of entry is September 1, 2000, and that is the date used to establish eligibility for RMA.

(8) RMA ends on the last day of the eighth month from the month the individual entered the United States. For example, an individual who entered the United States on May 28, 2011, is eligible through the end of December 2011.

(9) An individual approved for RMA is continuously eligible through the end of the eighth month after the individual's entry to the United States, regardless of an increase in income.

(10) The agency, or its designee, determines eligibility for medicaid and other medical programs for an individual's spouse when the spouse arrives in the United States. If the

spouse is not eligible for medicaid due to the countable income of the individual, the spouse is still eligible for RMA for eight months following the spouse's entry into the United States.

(11) An individual who disagrees with a decision or action taken on the case by the agency, or its designee, has the right to request a review of the case action(s) or request an administrative hearing (see chapter 182-526 WAC). The request must be received by the agency, or its designee, within ninety days of the date of the decision or action.

[Statutory Authority: RCW 41.05.021 and 2011 1st sp.s. c 15. 12-19-001, § 182-507-0130, filed 9/5/12, effective 10/6/12. 12-02-034, recodified as § 182-507-0130, filed 12/29/11, effective 1/1/12. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090, 74.08A.320, Pub. L. No. 110-181, National Defense Authorization Act for Fiscal Year 2008, Pub. L. No. 111-08, the Omnibus Appropriations Act of 2009, Division F, Title VI, Section 602; Office of Refugee Resettlement State Letter 09-17 from April 9, 2009; and federal guidance issued on May 15, 2009, by the Food and Nutrition Service, United States Department of Agriculture. 09-21-046, § 388-466-0130, filed 10/14/09, effective 11/4/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08A.320, 74.08.090, and Public Law 110-161 Section 525; Public Law 110-181 Section 1244; FNS Admin Notice 08-17; State Letter 04-12 from the Office of Refugee Resettlement. 08-14-116, § 388-466-0130, filed 6/30/08, effective 8/1/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057. 04-05-010, § 388-466-0130, filed 2/6/04, effective 3/8/04. Statutory Authority: RCW 74.08.090, 74.08A.320. 00-21-065, § 388-466-0130, filed 10/16/00, effective 11/1/00.]

**WAC 182-507-0135 Immigration status requirement for refugee medical assistance (RMA).** (1) An individual is eligible for refugee medical assistance (RMA) if the individual provides documentation issued by the United States Citizenship and Immigration Services (USCIS) to show that the individual is:

(a) Admitted as a refugee under section 207 of the Immigration and Nationalities Act (INA);

(b) Paroled into the United States as a refugee or asylee under section 212 (d)(5) of the INA;

(c) Granted conditional entry under section 203 (a)(7) of the INA;

(d) Granted asylum under section 208 of the INA;

(e) Admitted as an Amerasian immigrant from Vietnam through the orderly departure program, under section 584 of the Foreign Operations Appropriations Act, incorporated in the FY88 continuing resolution P.L. 100-212;

(f) A Cuban-Haitian entrant who was admitted as a public interest parolee under section 212 (d)(5) of the INA;

(g) Certified as a victim of human trafficking by the federal Office of Refugee Resettlement (ORR);

(h) An eligible family member of a victim of human trafficking certified by ORR who has a T-2, T-3, T-4, or T-5 visa; or

(i) Admitted as special immigrant from Iraq or Afghanistan under section 101 (a)(27) of the INA.

(2) A permanent resident alien meets the immigration status requirements for RCA and RMA if the individual was previously in one of the statuses described in subsection (1)(a) through (g) of this section.

[Statutory Authority: RCW 41.05.021 and 2011 1st sp.s. c 15. 12-19-001, § 182-507-0135, filed 9/5/12, effective 10/6/12.]