

# Chapter 182-504 WAC

## CERTIFICATION PERIODS AND CHANGE OF CIRCUMSTANCE

### WAC

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**WAC 182-504-0005 Washington apple health—Retroactive certification period.** (1) The medicaid agency approves a retroactive Washington apple health (WAH) certification period for the three months immediately before the month of application when an individual:

(a) Requests retroactive WAH on his or her application, within the certification period following the retroactive period, or before the determination of benefits and any appeal process is final;

(b) Would have been eligible for WAH for any or all of the three months if he or she had applied during the retroactive period; and

(c) The individual received covered medical services as described in WAC 182-501-0060 and 182-501-0065.

(2) When an individual is eligible only during the three-month retroactive certification period, that period is the only period of certification, except when:

(a) A pregnant woman is eligible in one of the three months immediately before the month of application, but no earlier than the month of conception. Eligibility continues as described in WAC 182-504-0015(3).

(b) A child is eligible for categorically needy (CN) WAH as described in WAC 182-505-0210 (1) through (5) and (7) in at least one of the three months immediately before the month of application. Eligibility after the retroactive period continues as described in WAC 182-504-0015(11).

(3) An individual applying for the medically needy (MN) spenddown program may be eligible for a retroactive certification period as described in WAC 182-504-0020.

(4) An individual applying for a medicare savings program may be eligible for a retroactive certification period as described in WAC 182-504-0025.

[Statutory Authority: RCW 41.05.021, Patient Protection and Affordable Care Act (Public Law 111-148), 42 C.F.R. §§ 431, 435, and 457, and 45 C.F.R. § 155. WSR 13-14-019, § 182-504-0005, filed 6/24/13, effective 7/25/13.]

(6/24/13)

**WAC 182-504-0015 Certification periods for categorically needy (CN) scope of care medical assistance programs.** (1) A certification period is the period of time a person is determined eligible for a categorically needy (CN) scope of care medical program. Unless otherwise stated in this section, the certification period begins on the first day of the month of application and continues to the last day of the last month of the certification period.

(2) For a child eligible for the newborn medical program, the certification period begins on the child's date of birth and continues through the end of the month of the child's first birthday.

(3) For a woman eligible for a medical program based on pregnancy, the certification period ends the last day of the month that includes the sixtieth day from the day the pregnancy ends.

(4) For families the certification period is twelve months with a six-month report required as a condition of eligibility as described in WAC 388-418-0011.

(5) For children, the certification period is twelve months. Eligibility is continuous without regard to changes in circumstances other than aging out of the program, moving out-of-state, failing to pay a required premium(s), incarceration or death.

(6) When the child turns nineteen the certification period ends even if the twelve-month period is not over. The certification period may be extended past the end of the month the child turns nineteen when:

(a) The child is receiving inpatient services (see WAC 388-505-0230) on the last day of the month the child turns nineteen;

(b) The inpatient stay continues into the following month or months; and

(c) The child remains eligible except for exceeding age nineteen.

(7) For an SSI-related person the certification period is twelve months.

(8) When the medical assistance unit is also receiving benefits under a cash or food assistance program, the medical certification period is updated to begin anew at each:

(a) Approved application for cash or food assistance; or

(b) Completed eligibility review.

(9) A retroactive certification period can begin up to three months immediately before the month of application when:

(a) The client would have been eligible for medical assistance if the client had applied; and

(b) The client received covered medical services as described in WAC 388-501-0060 and 388-501-0065.

(10) If the client is eligible only during the three-month retroactive period, that period is the only period of certification, except when:

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(a) A pregnant woman is eligible in one of the three months preceding the month of application, but no earlier than the month of conception. Eligibility continues as described in subsection (3);

(b) A child is eligible for a CN medical program as described in WAC 388-505-0210 (1) through (5) and (7) in one of the three months preceding the month of application. Eligibility continues for twelve months from the earliest month that the child is determined eligible.

(11) Any months of a retroactive certification period are added to the designated certification periods described in this section.

(12) Coverage under premium-based programs included in apple health for kids as described in WAC 388-505-0210 and chapter 388-542 WAC begins no sooner than the month after creditable coverage ends.

[WSR 11-24-018, recodified as § 182-504-0015, filed 11/29/11, effective 12/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, and 74.08.090, and Apple Health for Kids Act (ESHB 2128); 42 U.S.C. 1305; Public Law 111-3 (Children's Health Insurance Program Reauthorization Act of 2009). WSR 11-03-001, § 388-416-0015, filed 1/5/11, effective 2/5/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.402, 74.09.470, and 2008 session law. WSR 09-07-086, § 388-416-0015, filed 3/17/09, effective 4/17/09. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530, 74.09.700, and 2007 c 5. WSR 08-05-018, § 388-416-0015, filed 2/12/08, effective 3/14/08. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. WSR 06-24-036, § 388-416-0015, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090, 74.09.530, and 74.09.415. WSR 05-19-031, § 388-416-0015, filed 9/12/05, effective 10/13/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.04.510, and 2004 c 54. WSR 04-21-064, § 388-416-0015, filed 10/18/04, effective 11/18/04. Statutory Authority: RCW 74.08.090, 74.09.530, and 2003 c 10. WSR 04-03-019, § 388-416-0015, filed 1/12/04, effective 2/12/04. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, 74.08.090 and 74.09.450. WSR 00-08-002, § 388-416-0015, filed 3/22/00, effective 5/1/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. WSR 98-16-044, § 388-416-0015, filed 7/31/98, effective 9/1/98. Formerly WAC 388-509-0970, 388-521-2105, 388-522-2210 and 388-522-2230.]

**WAC 182-504-0020 Certification periods for the noninstitutional medically needy (MN) program.** (1) The certification period for the noninstitutional medically needy (MN) program for clients with countable income equal to or below the medically needy income level (MNIL):

(a) Begins on the first day of the month in which eligibility is established; and

(b) Is approved for twelve calendar months.

(2) The certification period for the noninstitutional MN program for clients with countable income above the MNIL:

(a) Begins on the day that spenddown is met; and

(b) Continues through the last day of the final month of the base period as described in WAC 388-519-0110.

(3) A retroactive MN certification period may be established for any or all of the three months immediately prior to the month of application.

(4) Expenses used to meet the spenddown liability for the current or the retroactive certification periods are the responsibility of the client. The department is not responsible to pay for any expense or portion of an expense which has been used to meet the spenddown liability. See WAC 388-519-0110.

(5) A new application must be submitted for each subsequent certification period for which medically needy coverage is requested.

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[WSR 11-24-018, recodified as § 182-504-0020, filed 11/29/11, effective 12/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500. WSR 08-21-108, § 388-416-0020, filed 10/16/08, effective 11/16/08. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. WSR 98-16-044, § 388-416-0020, filed 7/31/98, effective 9/1/98. Formerly WAC 388-521-2105 and 388-521-2130.]

**WAC 182-504-0025 Medicare savings program certification periods.** Certification periods for the different kinds of medicare savings programs are not all the same. The chart below explains the differences.

Medicare Savings Program	Certification Period	Start Date
<b>QMB</b> (qualified medicare beneficiary) S03	12 months	On the first day of the month following QMB eligibility determination
<b>SLMB</b> (Special low income medicare beneficiary) S05	12 months	Up to three months prior to the certification period if on the first day of the first month of certification, the person: <ul style="list-style-type: none"> <li>• Is or has been enrolled in medicare Part B; and</li> <li>• Meets SLMB eligibility requirements.</li> </ul>
<b>QDWI</b> (Qualified disabled working individual) S04	12 months	Up to three months prior to the certification period if on the first day of the first month of certification, the person: <ul style="list-style-type: none"> <li>• Is or has been enrolled in medicare Part A; and</li> <li>• Meets QDWI eligibility requirements.</li> </ul>
<b>QI-1</b> (Qualified individual) S06	Thru the end of the calendar year following QI-1 eligibility determination	Up to three months prior to the certification period if on the first day of the first month of certification, the person: <ul style="list-style-type: none"> <li>• Is or has been enrolled in medicare Part B; and</li> <li>• Meets QI-1 eligibility requirements.</li> </ul>

[WSR 11-24-018, recodified as § 182-504-0025, filed 11/29/11, effective 12/1/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.530 and 42 U.S.C. 1396a(a) (Section 1902 (n)(2) of the Social Security Act of 1924). WSR 05-01-126, § 388-416-0035, filed 12/15/04, effective 1/15/05. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. WSR 98-16-044, § 388-416-0035, filed 7/31/98, effective 9/1/98. Formerly WAC 388-521-2150, 388-521-2155 and 388-521-2160.]

**WAC 182-504-0030 Medical certification periods for recipients of medical care services (MCS).** (1) The certification period for medical care services (MCS) begins:

(a) The date the agency or the agency's designee has enough information to make an eligibility decision; or

(b) No later than the forty-fifth day from the date the agency or the agency's designee received the application unless the applicant is confined in a Washington state public institution as defined in WAC 388-406-0005 (6)(a) on the

forty-fifth day, in which case MCS coverage will start on the date of release from confinement.

(2) The certification period may or may not run concurrently with the incapacity review; and

(3) MCS coverage may end before the certification period ends when the incapacity review and financial review do not run concurrently.

[Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. WSR 12-19-051, § 182-504-0030, filed 9/13/12, effective 10/14/12.]

**WAC 182-504-0040 Requirements for a midcertification review for medical care services (MCS).** (1) A **midcertification review (MCR)** is a form sent by the agency or the agency's designee to gather information about the MCS recipient's current circumstances. The answers provided are used to determine if the individual remains eligible for medical coverage.

(2) A recipient of MCS must complete a midcertification review unless the review period is six months or less.

(3) The review form is sent in the fifth month of the MCS certification or review period and must be completed by the tenth day of month six.

(4) If the individual is required to complete a midcertification review, it can be completed in one of the following ways:

(a) **Complete the form and return it to the DSHS office.** The MCR will be considered complete if all of the following steps are taken:

- (i) The form is completed in full and any changes in circumstances for the household are indicated;
- (ii) The form is signed and dated;
- (iii) Proof is provided of any changes that are reported; and

(iv) The form is returned to DSHS by mail or in person along with any required proof by the due date on the review.

(b) **Complete the midcertification review over the phone.** The MCR will be considered complete over the phone if all of the following steps are taken:

- (i) DSHS is contacted at the phone number on the review form and told about any changes in the household's circumstances;
- (ii) Proof is provided of any changes that are reported, and DSHS may be able to verify some information over the phone; and
- (iii) Required proof is returned to DSHS by the due date on the review.

(c) **Complete the application process for another program.** If the agency or the agency's designee approves an application for another program in the month the MCR is due, the application is used to complete the review when the same individual is head of household for the application and the midcertification review.

(5) If eligibility for medical coverage ends because of the information provided in the midcertification review, the change takes effect the next month even if this does not give ten days notice before the effective date of the termination.

(6) If the required midcertification review is not completed, medical coverage under the MCS program stops at the end of the month the review was due.

(7) **Late reviews.** If the midcertification review is completed after the last day of the month the review was due, the

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agency or the agency's designee will process the review as described below based on when the review is received:

(a) **Midcertification reviews that are completed by the last day of the month after the month the review was due:** The agency or the agency's designee determines the MCS recipient's eligibility for ongoing medical coverage. If the individual is determined to be eligible, coverage is reinstated based on the information in the review, unless there is a wait list due to an enrollment cap under WAC 182-508-0150;

(b) **Midcertification reviews completed after the last day of the month after the month the review was due:** The agency or the agency's designee treats the review as a request to send an application. In order to determine eligibility for ongoing MCS medical coverage, the application process as described in chapter 388-406 WAC must be completed.

[Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. WSR 12-19-051, § 182-504-0040, filed 9/13/12, effective 10/14/12.]

**WAC 182-504-0100 Changes of circumstances—Changes that must be reported by a recipient of medical care services (MCS).** (1) An individual who receives medical care services (MCS) coverage must report the following changes:

- (a) A change in address;
- (b) A change in who lives in the home with the individual;

(c) When the individual's total gross monthly income goes over the eligibility standards for MCS and ADATSA as listed in WAC 182-508-0230;

(d) When liquid resources are more than four thousand dollars;

(e) When the individual has a change in employment. The individual must notify the agency or the agency's designee if they:

- (i) Get a job or change employers;
- (ii) Change from part-time to full-time employment or from full-time to part-time employment;
- (iii) Have a change in hourly wage rate or salary; or
- (iv) Stop working.

(2) Changes listed in subsection (1) of this section must be reported to the agency or the agency's designee by the tenth day of the month following the month the change happened.

(3) When the change is a change in income, the date a change happened is the date the individual first received the income, e.g., the date of receipt of the first paycheck for a new job or the date of a paycheck showing a change in the amount of the individual's wage or salary.

(4) Changes that are reported late may result in receiving medical benefits to which the individual is not entitled.

[Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. WSR 12-19-051, § 182-504-0100, filed 9/13/12, effective 10/14/12.]

**WAC 182-504-0125 Effect of changes on medical program eligibility.** (1) An individual continues to be eligible for medical assistance until the agency or the agency's designee completes a review of the individual's case record and determines the individual is ineligible for medical assistance or is eligible for another medical program. This applies to all individuals who, during a certification period, become

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ineligible for, or are terminated from, or request termination from:

- (a) A categorically needy (CN) medicaid program;
- (b) A program included in apple health for kids; or
- (c) Any of the following cash grants:
  - (i) Temporary assistance for needy families (TANF);
  - (ii) Supplemental security income (SSI); or
  - (iii) Aged, blind, disabled (ABD) cash assistance. See

WAC 388-434-0005 for changes reported during eligibility review.

(2) If CN medical coverage ends under one program and the individual meets all the eligibility requirements to be eligible under a different CN medical program, coverage is approved under the new program. If the individual's income exceeds the standard for CN medical coverage, the agency or the agency's designee considers eligibility under the medically needy (MN) program where appropriate.

(3) If CN medical coverage ends and the individual does not meet the eligibility requirements to be eligible under a different medical program, the redetermination process is complete and medical assistance is terminated giving advance and adequate notice with the following exception:

(a) An individual who claims to have a disability is referred to the division of disability determination services for a disability determination if that is the only basis under which the individual is potentially eligible for medical assistance. Pending the outcome of the disability determination, medical eligibility is considered under the SSI-related medical program described in chapter 388-475 WAC.

(b) An individual with countable income in excess of the SSI-related CN medical standard is considered for medically needy (MN) coverage or medically needy (MN) with spend-down pending the final outcome of the disability determination.

(4) An individual who becomes ineligible for refugee cash assistance is eligible for continued refugee medical assistance through the eight-month limit, as described in WAC 182-507-0130.

(5) An individual who receives a TANF cash grant or family medical is eligible for a medical extension, as described under WAC 182-523-0100, when the cash grant or family medical program is terminated as a result of:

- (a) An increase in earned income; or
- (b) Collection of child or spousal support.

(6) Changes in income during a certification period affects eligibility for all medical programs except:

- (a) Pregnant women's CN medical programs;
- (b) A program included in apple health for kids, except as specified in subsection (5) of this section; or

(c) The first six months of the medical extension benefits described under chapter 182-523 WAC.

(7) A child who receives premium-based coverage under a program included in apple health for kids described in WAC 182-505-0210 and chapter 182-505 WAC must be redetermined for a nonpremium-based coverage when the family reports:

- (a) Family income has decreased to less than two hundred percent federal poverty level (FPL);
- (b) The child becomes pregnant;
- (c) A change in family size; or
- (d) The child receives SSI.

(8) An individual who receives SSI-related CN medical coverage and reports a change in earned income which exceeds the substantial gainful activity (SGA) limit set by Social Security Administration no longer meets the definition of a disabled individual as described in WAC 182-512-0050, unless the individual continues to receive a Title 2 cash benefit, e.g., SSDI, DAC, or DWB. The agency or the agency's designee redetermines eligibility for such an individual under the health care for workers with disabilities (HWD) program which waives the SGA income test. The HWD program is a premium-based program and the individual must approve the premium amount before the agency or the agency's designee can authorize ongoing CN medical benefits under this program.

[Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. WSR 12-19-051, § 182-504-0125, filed 9/13/12, effective 10/14/12.]