WSR 26-19-026
PERMANENT RULES
HEALTH CARE AUTHORITY

[Filed September 8, 2026, 1:48 p.m., effective January 1, 2027]

Effective Date of Rule: January 1, 2027.

Purpose: Effective January 1, 2027, federal law (42 U.S.C. Section 1396a (e)(14)(L)) requires that states conduct eligibility redeterminations for certain federally funded medical assistance every six months. Also effective January 1, 2027, federal law (P.L. 119-21, Section 71112) shortens the retroactive coverage period for federally-funded medical assistance. The health care authority is amending its rules to comply with these changes in federal law.

Citation of Rules Affected by this Order: Amending WAC 182-503-0070, 182-504-0005, 182-504-0015, 182-504-0020, 182-504-0025, 182-504-0035, 182-505-0250, 182-511-1100, 182-512-0150, 182-513-1350, and 182-519-0110.

Statutory Authority for Adoption: RCW 41.05.021 and 41.05.160.

Other Authority: P.L. 119-21, Sections 71107 and 71112.

Adopted under notice filed as WSR 26-15-024 on July 7, 2026.

Changes Other than Editing from Proposed to Adopted Version:

Proposed/Adopted	WAC Subsection	Reason
WAC 182-504-0005 (2)(a)		
Proposed	(a) One month when the individual is eligible for apple health for adults; or	As a result of stakeholder comment, added "under WAC 182-505-0250" to clarify the apple health for adults coverage to which this subsection refers
Adopted	(a) One month when the individual is eligible for apple health for adults under WAC 182-505-0250; or	

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 11, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 11, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 11, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: September 8, 2026.

Wendy Barcus
Rules Coordinator

RDS-7077.1

AMENDATORY SECTION (Amending WSR 25-11-007, filed 5/8/25, effective 7/1/25)

WAC 182-503-0070 Washington apple health—When coverage begins.

(1) Your Washington apple health coverage starts on the first day of

the month you applied for and we decided you are eligible to receive coverage, unless one of the exceptions in subsection (4) of this section applies to you.

(2) Sometimes we can start your coverage up to ((~~three~~)) two months before the month you applied (see WAC 182-504-0005).

(3) If you are confined or incarcerated as described in WAC 182-503-0010, your coverage cannot start before the day you are discharged, except when:

(a) You are hospitalized during your confinement and the hospital requires you to stay overnight; or

(b) You are determined to be eligible for prerelease reentry services.

(4) Your apple health coverage may not begin on the first day of the month if:

(a) Subsection (3) of this section applies to you. In that case, your coverage would start on:

(i) The first day of your hospital stay; or

(ii) When you are determined to be eligible for prerelease reentry services;

(b) You must meet a medically needy spenddown liability (see WAC 182-519-0110). In that case, your coverage would start on the day your spenddown is met; or

(c) You are eligible under the apple health alien emergency medical program (see WAC 182-507-0115). In that case, your coverage would start on the day your ((~~emergent~~)) emergency hospital stay begins.

(5) For long-term care, the date your services start is described in WAC 388-106-0045.

RDS-7078.2

AMENDATORY SECTION (Amending WSR 22-21-086, filed 10/14/22, effective 11/14/22)

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

(a) Requests retroactive ((~~WAH on his or her~~)) apple health on their 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~~)) apple health for any or all of the ((~~three~~)) months if ((~~he or she~~)) they 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) A retroactive apple health certification period is:

(a) One month when the individual is eligible for apple health for adults under WAC 182-505-0250; or

(b) Two months for all other apple health programs.

(3) 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 individual is eligible in one of the ((~~three~~)) two 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) An individual who is applying within 12 months of their last pregnancy end date is eligible for after-pregnancy coverage in any of the ((~~three~~)) two months immediately before the month of application. Continuous eligibility begins from the earliest month the individual is found eligible as described in WAC 182-504-0015 (3) and (4).

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

((~~(3)~~)) (4) 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)~~)) (5) An individual applying for a medicare savings program may be eligible for a retroactive certification period as described in WAC 182-504-0025.

AMENDATORY SECTION (Amending WSR 15-13-053, filed 6/10/15, effective 7/11/15)

WAC 182-504-0020 Certification periods for the noninstitutional medically needy 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~~)) 12 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 182-519-0110.

(3) A retroactive MN certification period may be established for up to ((~~three~~)) two months preceding 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 agency is not responsible for paying any expense or portion of an expense which has been used to meet the spenddown liability. See WAC 182-519-0110.

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

AMENDATORY SECTION (Amending WSR 11-24-018, filed 11/29/11, effective 12/1/11)

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
QMB (qualified medicare beneficiary) S03	12 months	On the first day of the month following QMB eligibility determination
SLMB (Special low income medicare beneficiary) S05	12 months	Up to ((~~three~~)) two months prior to the certification period if on the first day of the first month of certification, the person: • Is or has been enrolled in medicare Part B; and • Meets SLMB eligibility requirements.
QDWI (Qualified disabled working individual) S04	12 months	Up to ((~~three~~)) two months prior to the certification period if on the first day of the first month of certification, the person: • Is or has been enrolled in medicare Part A; and • Meets QDWI eligibility requirements.
QI-1 (Qualified individual) S06	Thru the end of the calendar year following QI-1 eligibility determination	Up to ((~~three~~)) two months prior to the certification period if on the first day of the first month of certification, the person: • Is or has been enrolled in medicare Part B; and • Meets QI-1 eligibility requirements.

RDS-7121.2

AMENDATORY SECTION (Amending WSR 25-16-101, filed 8/6/25, effective 9/6/25)

WAC 182-504-0015 Washington apple health—Certification periods for categorically needy programs. (1) A certification period is the period of time we determine that you are eligible for a categorically needy (CN) Washington apple health program. Unless otherwise stated in this section, the certification period begins on the first day of the month of application and continues through the end of the last month of the certification period.

(2) Newborn coverage begins on the child's date of birth and continues through the end of the month of the child's first birthday.

(3) If you are eligible for apple health based on pregnancy, the certification period continues through the last day of the month the pregnancy ends. After-pregnancy coverage begins the first day of the month, following the end of the pregnancy, and ends the last day of the 12th month from the time after-pregnancy coverage began.

(4) If you are newly eligible for apple health coverage and had a pregnancy end within the last 12 months, your certification period for after-pregnancy coverage:

(a) Begins the first day of the month you are eligible; and

(b) Ends the last day of the 12th month following the end of your pregnancy.

(5) If you are eligible for the refugee program, the certification period ends at the end of the fourth month following your date of entry to the United States.

(6) If you are a child under age six receiving apple health for kids, with or without premiums, your certification period ends the last day of the month of your sixth birthday.

(7) If you are eligible for newborn coverage, your coverage continues through the last day of the month of your first birthday. Apple health for kids coverage begins automatically on the first day of the month after your newborn coverage ends and the certification period ends the last day of the month of your sixth birthday.

(8) If you are eligible for apple health for adults under WAC 182-505-0250, the certification period begins the first day of the month of application and continues for six months. If you are American Indian or Alaska native and eligible for apple health for adults under WAC 182-505-0250, the certification period begins the first day of the month of application and continues for 12 months.

(9) For all other CN coverage, the certification period is 12 months.

((~~(9)~~)) (10) If you are a child, eligibility is continuous throughout the certification period regardless of a change in circumstances, unless you:

(a) Turn age 19;

(b) Move out-of-state; or

(c) Die.

((~~(10)~~)) (11) When you turn 19, the certification period ends after the redetermination process described in WAC 182-504-0125 is completed, even if the 12-month period is not over, unless:

(a) You are receiving inpatient services (described in WAC 182-514-0230) on the last day of the month you turn 19;

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

(c) You remain eligible except for turning age 19.

((~~(11)~~)) (12) A retroactive certification period is described in WAC 182-504-0005.

((~~(12)~~)) (13) Coverage under premium-based programs included in apple health for kids as described in chapter 182-505 WAC begins no sooner than the month after creditable coverage ends.

AMENDATORY SECTION (Amending WSR 25-16-101, filed 8/6/25, effective 9/6/25)

WAC 182-504-0035 Washington apple health—Renewals. (1) For all Washington apple health programs, the following applies:

(a) You are required to complete a renewal of eligibility at least every 12 months with the following exceptions:

(i) If you are eligible for apple health medically needy with spenddown, then you must complete a new application at the end of each three- or six-month base period;

(ii) If you are eligible for apple health alien emergency medical, then you are certified for a specific period of time to cover emergency inpatient hospitalization costs only (see WAC 182-507-0115(8));

(iii) If you are eligible for apple health refugee coverage, you must complete a renewal of eligibility after four months; ((~~or~~))

(iv) If you are a child under age six on apple health for kids, with or without premiums, your first renewal is due the month of your sixth birthday; or

(v) If you are eligible for apple health for adults under WAC 182-505-0250, you must complete a renewal of eligibility every six months. If you are American Indian or Alaska native and eligible for apple health for adults under WAC 182-505-0250, you must complete a renewal of eligibility every 12 months.

(b) You may complete renewals online, by phone, or by paper application that you mail or fax to us (the agency or the agency's designee).

(c) If your apple health is renewed, we decide the certification period according to WAC 182-504-0015.

(d) We review all eligibility factors subject to change during the renewal process.

(e) We redetermine eligibility as described in WAC 182-504-0125 and send you written notice as described in WAC 182-518-0005 before apple health is terminated.

(f) If you need help meeting the requirements of this section, we provide equal access services as described in WAC 182-503-0120.

(2) For programs based on modified adjusted gross income (MAGI) as described in WAC 182-503-0510:

(a) Sixty days prior to the end of the certification period:

(i) When information from electronic sources shows income is reasonably compatible (as defined in WAC 182-500-0095), we administratively renew your coverage (as defined in WAC 182-500-0010) for a new certification period and send you a notice of renewal with the information used. You are required to inform us if any of the information we used is wrong.

(ii) If we are unable to complete an administrative renewal (as defined in WAC 182-500-0010), you must give us a signed renewal in order for us to decide if you will continue to get apple health coverage beyond the current certification period.

(iii) We follow the requirements described in WAC 182-518-0015 to request any additional information needed to complete the renewal process or to terminate coverage for failure to renew.

(b) If your apple health coverage is terminated because you did not renew, you have 90 days from the termination date to give us a completed renewal without requiring a new application. ((~~If we decide~~

~~you are still eligible to get apple health coverage, we will restore your apple health without a gap in coverage.~~))

(3) For non-MAGI based programs (as described in WAC 182-503-0510):

(a) Forty-five days prior to the end of the certification period, we send notice with a renewal form. You must renew before the end of the certification period by either calling the department of social and health services at the number listed on the form to renew by telephone, renew online at www.washingtonconnection.org, or mailing or delivering to the department of social and health services a signed renewal form with the information required by WAC 182-503-0005.

(b) We follow the requirements in WAC 182-518-0015 to request any additional information needed to complete the renewal process or to terminate coverage for failure to renew.

(c) To complete your renewal, you must give us all the other information requested on the application that is needed to determine your eligibility.

(d) If you are terminated for failure to renew, you have 30 days from the termination date to submit a completed renewal. If still eligible, we will restore your apple health without a gap in coverage.

(4) If we determine that you are not eligible for renewal of your apple health coverage, we:

(a) Consider your eligibility for all other apple health programs before ending your apple health coverage; and

(b) Coordinate with the health benefit exchange any request for information that is necessary to determine your eligibility for:

(i) Other apple health programs; and

(ii) With respect to qualified health plans, health insurance premium tax credits (as defined in WAC 182-500-0045) and cost-sharing reductions (as defined in WAC 182-500-0020).

(5) We reconsider our decision that you are not eligible for apple health coverage without a new application from you when:

(a) We receive the information that we need to decide if you are eligible within 30 days of the date on the termination notice; or

(b) You request a hearing within 90 days of the date on the renewal denial letter and an administrative law judge (ALJ) or HCA review judge decides our decision was wrong (per chapter 182-526 WAC).

(6) If you disagree with our decision, you can ask for a hearing. If we decided that you are not eligible for renewal because we do not have enough information, the ALJ will consider the information we already have and anymore information you give us. The ALJ does not consider the previous absence of information or failure to respond in determining if you are eligible.

RDS-7122.1

AMENDATORY SECTION (Amending WSR 14-16-052, filed 7/29/14, effective 8/29/14)

WAC 182-505-0250 Washington apple health—MAGI-based adult medical. (1) Effective on or after January 1, 2014, a person is eligible for Washington apple health ((~~(WAH)~~)) modified adjusted gross income

(MAGI)-based adult coverage when ((~~he or she~~)) the person meets the following requirements:

(a) Is age ((~~nineteen~~)) 19 or older and under the age of ((~~sixty-five~~)) 65;

(b) Is not entitled to, or enrolled in, medicare benefits under Part A or B of Title XVIII of the Social Security Act;

(c) Is not otherwise eligible for and enrolled in mandatory coverage under one of the following programs:

(i) ((~~WAH~~)) Apple health SSI-related categorically needy (CN);

(ii) ((~~WAH~~)) Apple health foster care program; or

(iii) ((~~WAH~~)) Apple health adoption support program;

(d) Meets citizenship and immigration status requirements described in WAC 182-503-0535;

(e) Meets general eligibility requirements described in WAC 182-503-0505; and

(f) Has net countable income that is at or below ((~~one hundred thirty-three~~)) 133 percent of the federal poverty level for a household of the applicable size.

(2) Parents or caretaker relatives of an eligible dependent child as described in WAC 182-503-0565 are first considered for ((~~WAH~~)) apple health for families as described in WAC 182-505-0240. A person whose countable income exceeds the standard to qualify for family coverage is considered for coverage under this section.

(3) Persons who are eligible under this section are eligible for ((~~WAH~~)) apple health alternative benefit plan as defined in WAC 182-500-0010 coverage. A person described in this section is not eligible for medically needy ((~~WAH~~)) apple health.

(4) For persons eligible under this section, a certification period begins the first day of the month of application and continues for six months. For American Indians or Alaska natives eligible under this section, a certification period begins the first day of the month of application and continues for 12 months.

(5) Other coverage options for adults not eligible under this section are described in WAC 182-508-0001.

RDS-7079.1

AMENDATORY SECTION (Amending WSR 19-23-063, filed 11/15/19, effective 1/1/20)

WAC 182-511-1100 Apple health for workers with disabilities (HWD)—Retroactive coverage. This section describes requirements for retroactive coverage provided under the apple health for workers with disabilities (HWD) program.

(1) Retroactive coverage refers to the period of up to ((~~three~~)) two months before the month in which a person applies for the HWD program.

(2) To qualify for retroactive coverage under the HWD program, a person must first:

(a) Meet all program requirements described in WAC 182-511-1050 for each month of the retroactive period; and

(b) Pay the premium amount for each month requested within ((~~one hundred twenty~~)) 120 days of being billed for such coverage.

(3) Payment must be received for each month of requested ((~~of~~)) retroactive coverage before such coverage is approved.

RDS-7080.1

AMENDATORY SECTION (Amending WSR 22-12-056, filed 5/26/22, effective 6/26/22)

WAC 182-512-0150 SSI-related medical—Medically needy (MN) medical eligibility. (1) Washington apple health (((~~WAH~~)) medicaid) medically needy (MN) health care coverage is available for any of the following:

(a) A person who is SSI-related and not eligible for ((~~WAH~~)) apple health categorically needy (CN) medical coverage because the person has countable income that is above the ((~~WAH~~)) apple health CN income level (CNIL) (or for long-term care (LTC) recipients, above the special income limit (SIL)):

(i) The person's countable income is at or below ((~~WAH~~)) apple health MN standards, leaving no spenddown requirement; or

(ii) The person's countable income is above ((~~WAH~~)) apple health MN standards requiring the person to spenddown their excess income (see subsection (4) of this section). See WAC 182-512-0500 through 182-512-0800 for rules on determining countable income, and WAC 182-519-0050 for program standards or chapter 182-513 WAC for institutional standards.

(b) An SSI-related ineligible spouse of an SSI recipient;

(c) A person who meets SSI program criteria but is not eligible for the SSI cash grant due to immigration status or sponsor deeming. See WAC 182-503-0535 for limits on eligibility for aliens;

(d) A person who meets the ((~~WAH~~)) apple health MN LTC services requirements of chapter 182-513 WAC;

(e) A person who lives in an alternate living facility and meets the requirements of WAC 182-513-1205; or

(f) A person who meets resource requirements as described in chapter 182-512 WAC, elects and is certified for hospice services per chapter 182-551 WAC.

(2) A person whose countable resources are above the SSI resource standards is not eligible for ((~~WAH~~)) apple health MN noninstitutional health care coverage. See WAC 182-512-0200 through 182-512-0550 to determine countable resources.

(3) A person who qualifies for services under ((~~WAH~~)) apple health long-term care programs has different criteria and may spend down excess resources to become eligible for ((~~WAH~~)) apple health LTC institutional or waiver health care coverage. Refer to WAC 182-513-1315 and 182-513-1395.

(4) A person with income over the effective ((~~WAH~~)) apple health MN income limit (MNIL) described in WAC 182-519-0050 may become eligible for ((~~WAH~~)) apple health MN coverage when the person has incurred medical expenses that are equal to the excess income. This is the

process of meeting spenddown. Refer to chapter 182-519 WAC for spenddown information.

(5) A person may be eligible for health care coverage for any or all of the ((~~three~~)) two months immediately prior to the month of application, if the person has:

(a) Met all eligibility requirements for the months being considered; and

(b) Received medical services covered by medicaid during that time.

(6) A person who is eligible for ((~~WAH~~)) apple health MN without a spenddown is certified for up to 12 months. For a person who must meet a spenddown, refer to WAC 182-519-0110. For a person who is eligible for a ((~~WAH~~)) apple health long-term care MN program, refer to WAC 182-513-1395 and 182-513-1315.

(7) A person must reapply for each certification period. There is no continuous eligibility for ((~~WAH~~)) apple health MN.

RDS-7094.1

AMENDATORY SECTION (Amending WSR 26-06-050, filed 2/25/26, effective 3/28/26)

WAC 182-513-1350 Defining the resource standard and determining resource eligibility for SSI-related long-term care (LTC) services.

(1) General information.

(a) This section describes how the agency or the agency's designee defines the resource standard and countable or excluded resources when determining a person's eligibility for SSI-related long-term care (LTC) services.

(b) "Resource standard" means the maximum amount of resources a person can have and still be resource eligible for program benefits.

(c) For a person not SSI-related, the agency applies program specific resource rules to determine eligibility.

(2) Resource standards.

(a) The resource standard for the following people is $2000:

(i) A single person; or

(ii) An institutionalized spouse.

(b) The resource standard for a legally married couple is $3000, unless subsection (3)(b)(ii) of this section applies.

(c) The resource standard for a person with a qualified long-term care partnership policy under WAC 182-513-1400 may be higher based on the dollar amount paid out by a partnership policy.

(d) Determining the amount of resources that can be allocated to the community spouse when determining resource eligibility is under WAC 182-513-1355.

(3) Availability of resources.

(a) General. The agency or the agency's designee applies the following rules when determining available resources for LTC services:

(i) WAC 182-512-0300 SSI-related medical—Resources eligibility;

(ii) WAC 182-512-0250 SSI-related medical—Ownership and availability of resources; and

(iii) WAC 182-512-0260 SSI-related medical—How to count a sponsor's resources.

(b) Married couples.

(i) When both spouses apply for LTC services, the resources of both spouses are available to each other through the month in which the spouses stopped living together.

(ii) When both spouses are institutionalized, the agency or the agency's designee determines the eligibility of each spouse as a single person the month following the month of separation.

(iii) If the agency or the agency's designee has already established eligibility and authorized services for one spouse, and the community spouse needs LTC services in the same month, but after eligibility has been established and services authorized for the institutionalized spouse, then the agency applies the standard under subsection (2)(a) of this section to each spouse. If doing this would make one of the spouses ineligible, then the agency applies subsection (2)(b) of this section for the couple.

(iv) The resources of the community spouse are unavailable to the institutionalized spouse the month after eligibility for LTC services is established, unless (v) or (vi) of this subsection applies.

(v) When a single institutionalized individual marries, the agency or the agency's designee redetermines eligibility applying the resource and income rules for a legally married couple.

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

(A) The institutionalized spouse has a break of at least 30 consecutive days in a period of institutional status;

(B) The institutionalized spouse's countable resources exceed the standard under subsection (2)(a) of this section, and WAC 182-513-1355 (2)(b) applies; or

(C) The institutionalized spouse does not transfer the amount, under WAC 182-513-1355 (3) or (5), to the community spouse by either:

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

(II) A reasonable amount of time necessary to obtain a court order for the support of the community spouse.

(4) Countable resources.

(a) The agency or the agency's designee determines countable resources using the following sections:

(i) WAC 182-512-0200 SSI-related medical—Definition of resources.

(ii) WAC 182-512-0250 SSI-related medical—Ownership and availability of resources.

(iii) WAC 182-512-0260 SSI-related medical—How to count a sponsor's resources.

(iv) WAC 182-512-0300 SSI-related medical—Resources eligibility.

(v) WAC 182-512-0350 SSI-related medical—Property and contracts excluded as resources;

(vi) WAC 182-512-0400 SSI-related medical—Vehicles excluded as resources;

(vii) WAC 182-512-0450 SSI-related medical—Life insurance excluded as a resource; and

(viii) WAC 182-512-0500 SSI-related medical—Burial funds, contracts and spaces excluded as resources.

(ix) Chapter 182-516 WAC, Trusts, annuities, life estates, and promissory notes—Effect on medical programs.

(b) The agency or the agency's designee determines excluded resources based on federal law and WAC 182-512-0550, except:

(i) For institutional and HCB waiver programs, pension funds owned by a nonapplying spouse are counted toward the resource standard.

(ii) For institutional and HCB waiver programs, one home is excluded only if it meets the home equity limits of subsection (8) of this section. See WAC 182-512-0350 (1)(b).

(c) The agency or the agency's designee adds together the countable resources of both spouses if subsections (3)(b)(i) and (iv) apply, but not if subsection (3)(b)(ii) or (iii) apply. For a person with a community spouse, see WAC 182-513-1355.

(5) Excess resources.

(a) For LTC programs, a person may reduce excess resources by deducting incurred medical expenses under subsection (6) of this section;

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

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

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

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

(ii) For LTC services provided under the medically needy (MN) program, see:

(A) WAC 182-513-1395 for LTC programs; and

(B) WAC 182-513-1245 for hospice.

(c) Excess resources not otherwise applied to medical expenses will be applied to the projected cost of care for services in a medical institution under WAC 182-513-1380.

(6) Allowable medical expenses.

(a) The following incurred medical expenses may be used to reduce excess resources:

(i) Premiums, deductibles, coinsurance, or copayment charges for health insurance and medicare;

(ii) Medically necessary care defined under WAC 182-500-0070, but not covered under the state's medicaid plan. Information regarding covered services is under chapter 182-501 WAC;

(iii) Medically necessary care defined under WAC 182-500-0070 incurred prior to medicaid eligibility. Expenses for nursing facility care are reduced at the state rate for the specific facility that provided the services.

(b) To be allowed, the medical expense must:

(i) Have been incurred no more than ((~~three~~)) two months before the month of the medicaid application;

(ii) Not be subject to third-party payment or reimbursement;

(iii) Not have been used to satisfy a previous spenddown liability;

(iv) Not have been previously used to reduce excess resources;

(v) Not have been used to reduce participation;

(vi) Not have been incurred during a transfer of asset penalty under WAC 182-513-1363; and

(vii) Be an amount for which the person remains liable.

(7) Nonallowable expenses. The following expenses are not allowed to reduce excess resources:

(a) Unpaid adult family home (AFH) or assisted living facility expenses incurred prior to medicaid eligibility;

(b) Personal care cost more than approved hours determined by the CARE assessment under chapter 388-106 WAC; and

(c) Expenses excluded by federal law.

(8) Excess home equity.

(a) A person with an equity interest in a primary residence more than the home equity limit is ineligible for institutional and HCB waiver programs, unless one of the following persons lawfully resides in the home:

(i) That person's spouse; or

(ii) That person's dependent child under age 21, blind child, or disabled child.

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

(c) The excess home equity limit is the federal maximum allowed. On January 1st of each year, this standard may change by the percentage in the consumer price index for all consumers (CPI-U). The current maximum home equity limit is posted by the Centers for Medicare and Medicaid Services. (See subsection (9) of this section for institutional resource standards.)

(d) A person who is denied or terminated LTC services due to excess home equity may apply for an undue hardship waiver under WAC 182-513-1367.

(9) Institutional resource standards are found at: www.hca.wa.gov/free-or-low-cost-health-care/i-help-others-apply-and-access-apple-health/program-standard-income-and-resources

RDS-7081.1

AMENDATORY SECTION (Amending WSR 19-02-046, filed 12/27/18, effective 1/27/19)

WAC 182-519-0110 Spenddown of excess income for the medically needy program. (1) A person who applies for Washington apple health (((~~WAH~~)) medicaid) and is eligible for medically needy (MN) coverage with a spenddown may choose a three-month or a six-month base period. A base period is a time period used to compute the spenddown liability amount. The months must be consecutive calendar months, unless a condition in subsection (4) of this section applies.

(2) A base period begins on the first day of the month a person applies for ((~~WAH~~)) apple health, unless a condition in subsection (4) of this section applies.

(3) A person may request a separate base period to cover up to ((~~three~~)) two calendar months immediately before the month of application. This is called a retroactive base period.

(4) A base period may vary from the terms in subsection((~~s~~)) (1), (2), or (3) of this section if:

(a) A ((~~three~~)) two-month base period would overlap a previous eligibility period;

(b) The person has countable resources over the applicable standard for any part of the required base period;

(c) The person is not or will not be able to meet the temporary assistance to needy families (TANF)-related or supplemental security income (SSI)-related requirement for the required base period;

(d) The person is eligible for categorically needy (CN) coverage for part of the required base period; or

(e) The person was not otherwise eligible for MN coverage for each month of the retroactive base period.

(5) The medicaid agency or ((~~its~~)) the agency's designee calculates a person's spenddown liability. The MN countable income from each month of the base period is compared to the effective medically needy income level (MNIL) under WAC 182-519-0050. Income over the effective MNIL standard (based on the person's household size) in each month in the base period is added together to determine the total spenddown amount.

(6) If household income varies and a person's MN countable income falls below the effective MNIL for one or more months, the difference offsets the excess income in other months of the base period. See WAC 182-519-0100(7) if a spenddown amount results in zero dollars and cents.

(7) If a person's income decreases, the agency or ((~~its~~)) the agency's designee approves CN coverage for each month in the base period when the person's countable income and resources are equal to or below the applicable CN standards. Children age eighteen and younger and pregnant women who become CN eligible in any month of the base period are continuously eligible for CN coverage for the remainder of the certification, even if there is a subsequent increase in income.

(8) Once a person's spenddown amount is determined, qualifying medical expenses are deducted. A qualifying medical expense must:

(a) Be an expense for which the person is financially liable;

(b) Not have been used to meet another spenddown;

(c) Not be the confirmed responsibility of a third party. The agency or ((~~its~~)) the agency's designee allows the entire expense if a third party has not confirmed its coverage of the expense within:

(i) Forty-five days of the date of service; or

(ii) Thirty days after the base period ends.

(d) Be an incurred expense for the person:

(i) The person's spouse;

(ii) A family member residing in the person's home for whom the person is financially responsible; or

(iii) A relative residing in the person's home who is financially responsible for the person.

(e) Meet one of the following conditions:

(i) Be an unpaid liability at the beginning of the base period;

(ii) Be for paid or unpaid medical services incurred during the base period;

(iii) Be for medical services incurred and paid during the ((~~three~~)) two-month retroactive base period if eligibility for ((~~WAH~~)) apple health was not established in that base period. Paid expenses that meet this requirement may be applied towards the current base period; or

(iv) Be for medical services incurred during a previous base period, either unpaid or paid, if it was necessary for the person to make a payment due to delays in the certification for that base period.

(9) An exception to subsection (8) of this section exists for qualifying medical expenses paid on the person's behalf by a publicly administered program during the current or the retroactive base period. The agency or ((~~its~~)) the agency's designee uses the qualifying medical expenses to meet the spenddown liability. To qualify for this exception, the program must:

(a) Not be federally funded or make payments from federally matched funds;

(b) Not pay the expenses before the first day of the retroactive base period; and

(c) Provide proof of the expenses paid on the person's behalf.

(10) Once the agency or ((~~its~~)) the agency's designee determines the expenses are a qualified medical expense under subsection (8) or (9) of this section, the expenses are subtracted from the spenddown liability to determine the date the person's eligibility for medical coverage begins. Qualifying medical expenses are deducted in the following order:

(a) First, medicare and other health insurance deductibles, coinsurance charges, enrollment fees, copayments, and premiums that are the person's responsibility under medicare Part A through Part D. (Health insurance premiums are income deductions under WAC 182-519-0100(5));

(b) Second, medical expenses incurred and paid by the person during the ((~~three~~)) two-month retroactive base period if eligibility for ((~~WAH~~)) apple health was not established in that base period;

(c) Third, current payments on, or unpaid balance of, medical expenses incurred before the current base period that were not used to establish eligibility for medical coverage in another base period. The agency or ((~~its~~)) the agency's designee sets no limit on the age of an unpaid expense; however, the expense must be a current liability and be unpaid at the beginning of the base period;

(d) Fourth, other medical expenses that are not covered by the agency's or ((~~its~~)) the agency's designee's medical programs, minus any third-party payments that apply to the charges. A licensed health care provider must provide or prescribe the items or services allowed as a medical expense;

(e) Fifth, other medical expenses incurred by the person during the base period that are potentially payable by the MN program (minus any confirmed third-party payments that apply to the charges). This deduction is allowed even if payment is denied for these services because they exceed the agency's or ((~~its~~)) the agency's designee's limits on amount, duration, or scope of care. Scope of care is described in WAC 182-501-0060 and 182-501-0065; and

(f) Sixth, other medical expenses incurred by the person during the base period that are potentially payable by the MN program (minus any confirmed third-party payments that apply to the charges) and that are within the agency's or ((~~its~~)) the agency's designee's limits on amount, duration, or scope of care.

(11) If a person submits verification of qualifying medical expenses with his or her application that meet or exceed the spenddown liability, the person is eligible for MN medical coverage for the remainder of the base period unless their circumstances change. See WAC 182-504-0105 to determine which changes must be reported to the agency or ((~~its~~)) the agency's designee. The beginning of eligibility is determined under WAC 182-504-0020.

(12) If a person cannot meet the spenddown amount when the application is submitted, the person is not eligible until ((~~he or she~~))

the person provides proof of additional qualifying expenses that meet the spenddown liability.

(13) Each dollar of a qualifying medical expense may count once against a spenddown period that leads to eligibility for MN coverage. However, medical expenses may be used more than once if:

(a) The person did not meet ((~~his or her~~)) the person's total spenddown liability and become eligible in a previous base period and the bill remains unpaid; or

(b) The medical expense was incurred and paid within ((~~three~~)) two months of the current application, and the agency or ((~~its~~)) the agency's designee could not establish ((~~WAH~~)) apple health eligibility for the person in the retroactive base period.

(14) The person must provide the proof of qualifying medical expense information to the agency or ((~~its~~)) the agency's designee within ((~~thirty~~)) 30 days after the base period ends, unless there is a good reason for delay.

(15) Once a person meets the spenddown requirement and the certification begin date is established, newly identified expenses are not considered toward that spenddown unless:

(a) There is a good reason for the delay in submitting the expense; or

(b) The agency or ((~~its~~)) the agency's designee made an error when determining the correct begin date.

(16) Good reasons for delay in providing medical expense information to the agency or ((~~its~~)) the agency's designee include, but are not limited to:

(a) The person did not receive a timely bill from ((~~his or her~~)) the person's medical provider or insurance company;

(b) The person has medical issues that prevent ((~~him or her~~)) the person from submitting proof on time; or

(c) The person meets the criteria for needing equal access under WAC 182-503-0120.

(17) The agency or ((~~its~~)) the agency's designee does not pay for any expense or portion of an expense used to meet a person's spenddown liability.

(18) If an expense is potentially payable under the MN program, and only a portion of the medical expense is assigned to meet spenddown, the medical provider must not:

(a) Bill the person for more than the amount assigned to the remaining spenddown liability; or

(b) Accept or retain any additional amount for the covered service from the person. Any additional amount may be billed to the agency or ((~~its~~)) the agency's designee. See WAC 182-502-0160, Billing a client.

(19) The agency or ((~~its~~)) the agency's designee determines whether any payment is due to the medical provider on medical expenses partially assigned to meet a spenddown liability under WAC 182-502-0100.

(20) If the medical expense assigned to spenddown was incurred outside of a period of MN eligibility, or if the expense is not covered by ((~~WAH~~)) apple health, the agency or ((~~its~~)) the agency's designee does not pay any portion of the bill.