

# Chapter 182-519 WAC

## MEDICALLY NEEEDY AND SPENDDOWN

### WAC

182-519-0050	Monthly income and countable resource standards for medically needy (MN).
182-519-0100	Eligibility for the medically needy program.
182-519-0110	Spenddown of excess income for the medically needy program.

**WAC 182-519-0050 Monthly income and countable resource standards for medically needy (MN).** (1) Changes to the medically needy income level (MNIL) occur on January 1st of each calendar year when the Social Security Administration (SSA) issues a cost-of-living adjustment for that year.

(2) Medically needy (MN) standards for persons who meet institutional status requirements are in WAC 388-513-1395. The standard for a client who lives in an alternate living facility can be found in WAC 388-513-1305.

(3) The resource standards for institutional programs are found in WAC 388-513-1350. The institutional standard chart can be found at <http://www.dshs.wa.gov/manuals/eaz/sections/LongTermCare/LTCstandardspna.shtml>.

(4) Countable resource standards for the noninstitutional MN program are:

(a) One person	\$2,000
(b) A legally married couple	\$3,000
(c) For each additional family member add	\$50

(5) For individuals who do not meet institutional status requirements, the income standard used to determine eligibility for the medically needy program is the "effective" MNIL. The "effective" MNIL is the one-person federal benefit rate (FBR) established by SSA each year, or the MNIL listed below, whichever amount is higher. The FBR is the supplemental security income (SSI) payment standard. For example, in 2012 the FBR is six hundred ninety-eight dollars.

1	2	3	4	5	6	7	8	9	10
467	592	667	742	858	975	1125	1242	1358	1483

[Statutory Authority: RCW 41.05.021. WSR 12-20-001, § 182-519-0050, filed 9/19/12, effective 10/20/12. WSR 11-23-091, recodified as § 182-519-0050, filed 11/17/11, effective 11/21/11. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, and 74.09.500. WSR 08-11-098, § 388-478-0070, filed 5/20/08, effective 6/20/08. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530, and Section 1924 of the Social Security Act (42 U.S.C. 1396r-5). WSR 06-06-013, § 388-478-0070, filed 2/17/06, effective 3/20/06. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 42 U.S.C. 9902(2). WSR 05-06-090, § 388-478-0070, filed 3/1/05, effective 4/1/05. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 42 U.S.C. 1396r-5. WSR 02-10-116, § 388-478-0070, filed 4/30/02, effective 5/31/02. Statutory Authority: RCW 74.04.050, 74.04.057, 74.08.090, 74.09.500, and Section 1924 (42 U.S.C. 1396r-5). WSR 01-12-073, § 388-478-0070, filed 6/4/01, effective 7/5/01. Statutory Authority: RCW 74.08.090, 74.04.050, 74.04.057, and 74.09.575. WSR 00-10-095, § 388-478-0070, filed 5/2/00, effective 5/2/00; WSR 99-11-054, § 388-478-0070, filed 5/17/99, effective 6/17/99. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. WSR 98-16-044, § 388-478-0070, filed 7/31/98, effective 9/1/98. Formerly WAC 388-507-

(9/19/12)

0710, 388-507-0720, 388-511-1115, 388-518-1820, 388-518-1830, 388-518-1840 and 388-518-1850.]

**WAC 182-519-0100 Eligibility for the medically needy program.** (1) An individual who meets the following conditions may be eligible for medically needy (MN) coverage under the special rules in chapters 388-513 WAC and 388-515 WAC:

(a) Meets the institutional status requirements of WAC 388-513-1320;

(b) Resides in a medical institution as described in WAC 388-513-1395; or

(c) Receives waiver services under a medically needy in-home waiver (MNIW) according to WAC 388-515-1550 or a medically needy residential waiver (MNRW) according to WAC 388-515-1540.

(2) An SSI-related individual who lives in a department contracted alternate living facility may be eligible for MN coverage under the rules described in WAC 388-513-1305.

(3) An individual may be eligible for MN coverage under this chapter when he or she is:

(a) Not covered under subsection (1) and (2) of this section; and

(b) Eligible for categorically needy (CN) medical coverage in all other respects except that his or her CN countable income is above the CN income standard.

(4) MN coverage may be available if the individual is:

(a) A child;

(b) A pregnant woman;

(c) A refugee;

(d) An SSI-related individual including an aged, blind or disabled individual with countable income under the CN income standard, who is an ineligible spouse of an SSI recipient; or

(e) A hospice client with countable income which is above the special income level (SIL).

(5) An individual who is not eligible for CN medical and who is applying for MN coverage has the right to income deductions in addition to, or instead of, those used to arrive at CN countable income. Deductions to income are applied to each month of the base period to determine MN countable income. The following deductions are used to calculate countable income for MN:

(a) The agency disregards the difference between the MNIL described in WAC 182-519-0050 and the federal benefit rate (FBR) established by the Social Security Administration each year. The FBR is the one person Supplemental Security Income (SSI) payment standard;

(b) All health insurance premiums, with the exception of medicare Part A, Part B, Part C and Part D premiums expected to be paid by the individual or family member during the base period(s);

(c) Any allocations to a spouse or to dependents for an SSI-related individual who is married or who has dependent

children. Rules for allocating income are described in WAC 182-512-0900 through 182-512-0960;

(d) For an SSI-related individual who is married and lives in the same home as his or her spouse who receives home and community based waiver services under chapter 388-515 WAC, an income deduction equal to the medically needy income level (MNIL) minus the nonapplying spouse's income; and

(e) A child or pregnant woman who is applying for MN coverage is eligible for income deductions allowed under TANF/SFA rules and not under the rules for CN programs based on the federal poverty level. See WAC 182-109-0001(4) for exceptions to the TANF/SFA rules which apply to medical programs and not to the cash assistance program.

(6) The MNIL for individuals who qualify for MN coverage under subsection (1) of this section is based on rules in chapter 388-513 and 388-515 WAC.

(7) The MNIL for all other individuals is described in WAC 182-519-0050. If an individual has countable income which is at or below the MNIL, he or she is certified as eligible for up to twelve months of MN medical coverage.

(8) If an individual has countable income which is over the MNIL, the countable income that exceeds the agency's MNIL standards is called "excess income."

(9) When individuals have "excess income" they are not eligible for MN coverage until they provide evidence to the agency or its designee of medical expenses incurred by themselves, their spouse or family members who live in the home for whom they are financially responsible. See WAC 182-519-0110(8). An expense has been incurred when:

(a) The individual has received the medical treatment or medical supplies, is financially liable for the medical expense but has not yet paid the bill; or

(b) The individual has paid for the expense within the current or retroactive base period described in WAC 182-519-0110.

(10) Incurred medical expenses or obligations may be used to offset any portion of countable income that is over the MNIL. This is the process of meeting "spenddown."

(11) The agency or its designee calculates the amount of an individual's spenddown by multiplying the monthly excess income amount by the number of months in the certification period as described in WAC 182-519-0110. The qualifying medical expenses must be greater than or equal to the total calculated spenddown amount.

(12) An individual who is considered for MN coverage under this chapter may not spenddown excess resources to become eligible for the MN program. Under this chapter individuals are ineligible for MN coverage if their resources exceed the program standard in WAC 182-519-0050. An individual who is considered for MN coverage under WAC 388-513-1395, 182-514-0250 or 182-514-0255 is allowed to spenddown excess resources.

(13) There is no automatic redetermination process for MN coverage. An individual must submit an application for each eligibility period under the MN program.

(14) An individual who requests a timely administrative hearing under WAC 388-458-0040 is not eligible for continued benefits beyond the end of the original certification date under the MN program.

[Statutory Authority: RCW 41.05.021. WSR 12-20-001, amended and recodified as § 182-519-0100, filed 9/19/12, effective 10/20/12. Statutory Authority: RCW 74.04.055, 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 42 C.F.R. 435.831 (3)(e) and (f). WSR 09-08-003, § 388-519-0100, filed 3/19/09, effective 4/19/09. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. WSR 98-16-044, § 388-519-0100, filed 7/31/98, effective 9/1/98. Formerly WAC 388-503-0320, 388-518-1840, 388-519-1930 and 388-522-2230.]

**WAC 182-519-0110 Spenddown of excess income for the medically needy program.** (1) An individual who applies for medical assistance 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 amount of the spenddown liability. The months must be consecutive calendar months unless one of the conditions in subsection (4) of this section applies.

(2) A base period begins on the first day of the month, in which an individual applies for medical assistance, subject to the exceptions in subsection (4) of this section.

(3) An individual may request a separate base period to cover the time period up to three calendar months immediately prior to the month of application. This is called a retroactive base period.

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

(a) A three month base period would overlap a previous eligibility period; or

(b) The individual has countable resources that are over the applicable standard for any part of the required base period; or

(c) The individual is not or will not be able to meet the TANF-related or SSI-related requirement for the required base period; or

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

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

(5) An individual's spenddown liability is calculated by the agency or its designee. The MN countable income from each month of the base period is compared to the effective medically needy income level (MNIL) described in WAC 182-519-0050. Income which is over the effective MNIL standard (based on the individual'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 an individual's MN countable income falls below the effective MNIL for one or more months, the difference is used to offset the excess income in other months of the base period. If this results in a spenddown amount of zero dollars and cents, see WAC 182-519-0100(7).

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

(8) Once an individual's spenddown amount has been determined, qualifying medical expenses are deducted. To be considered a qualifying medical expense, the expense must:

(a) Be an expense for which the individual 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 designee allows the entire expense if the 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 individual:

(i) The individual's spouse;

(ii) A family member, residing in the home of the individual, for whom the individual is financially responsible; or

(iii) A relative, residing in the home of the individual, who is financially responsible for the individual.

(e) Meet one of the following conditions:

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

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

(iii) Be for medical services incurred and paid during the three month retroactive base period if eligibility for medical assistance 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 and either unpaid or paid for, if it was necessary for the individual to make a payment due to delays in the certification for that base period.

(9) An exception to the provisions in subsection (8) of this section exists for qualifying medical expenses that have been paid on behalf of the individual by a publicly administered program during the current or the retroactive base period. The agency or its 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 the payments from federally matched funds;

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

(c) Provide proof of the expenses paid on behalf of the individual.

(10) Once the agency or its designee has determined that the expenses meet the definition of a qualified expense as defined in subsection (8) or (9) of this section, the expenses are subtracted from the spenddown liability to determine the date the individual is eligible for medical coverage to begin. 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 individual's responsibility under medicare Part A, Part B, Part C and Part D. (Health insurance premiums are income deductions under WAC 182-519-0100 (5));

(b) Second, medical expenses incurred and paid by the individual during the three month retroactive base period if

eligibility for medical assistance was not established in that base period;

(c) Third, current payments on, or unpaid balance of, medical expenses incurred prior to the current base period which have not been used to establish eligibility for medical coverage in any other base period. The agency or its designee sets no limit on the age of an unpaid expense; however, the expense must still be a current liability and be unpaid at the beginning of the base period;

(d) Fourth, other medical expenses that would not be covered by the agency's or its designee's medical programs, minus any third party payments which apply to the charges. The items or services allowed as a medical expense must have been provided or prescribed by a licensed health care provider;

(e) Fifth, other medical expenses which have been incurred by the individual during the base period that are potentially payable by the MN program (minus any confirmed third party payments that apply to the charges), even if payment is denied for these services because they exceed the agency's or its 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 that have been incurred by the individual 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 designee's limits on amount, duration or scope of care.

(11) If an individual submits verification of qualifying medical expenses with his or her application that meets or exceeds the spenddown liability, he or she is eligible for MN medical coverage for the remainder of the base period unless their circumstances change. See WAC 388-418-0005 to determine which changes must be reported to the agency or its designee. The beginning of eligibility is determined as described in WAC 182-504-0020.

(12) If an individual cannot meet the spenddown amount at the time the application is submitted, the individual is not eligible until he or she 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 under the following circumstances:

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

(b) The medical expense was a bill incurred and paid within three months of the current application and the agency or its designee could not establish eligibility for medical assistance for the individual in the retroactive base period.

(14) The individual must provide the proof of qualifying medical expenses to the agency or its designee. The deadline for providing medical expense information is thirty days after the base period ends unless there is a good reason for delay.

(15) Once an individual meets the spenddown requirement and the certification begin date has been established, newly identified expenses cannot be considered toward that spenddown unless there is a good reason for the delay in sub-

mitting the expense or there was an error by the agency or its designee in determining the correct begin date.

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

(a) The individual did not receive a timely bill from his or her medical provider or insurance company;

(b) The individual has medical issues that prevents him or her from submitting proof in a timely manner; or

(c) The individual meets the criteria for needing a supplemental accommodation under chapter 388-472 WAC.

(17) The agency or its designee is not responsible to pay for any expense or portion of an expense that has been used to meet an individual's spenddown liability. If an expense is potentially payable under the MN program, and only a portion of the medical expense has been assigned to meet spenddown, the medical provider may not bill the individual for more than the amount which was assigned to the remaining spenddown liability, or accept or retain any additional amount for the covered service from the individual. Any additional amount may be billed to the agency or its designee. See WAC 182-502-0160, Billing a client.

(18) The agency or its designee determines whether any payment is due to the medical provider on medical expenses that have been partially assigned to meet a spenddown liability, according to WAC 182-502-0100.

(19) If the medical expense assigned to spenddown was incurred outside of a period of MN eligibility, or if the expense is not the type that is covered by the agency's or its designee's medical assistance programs, the agency or its designee is not responsible for any portion of the bill.

[Statutory Authority: RCW 41.05.021. WSR 12-20-001, amended and recodified as § 182-519-0110, filed 9/19/12, effective 10/20/12. Statutory Authority: RCW 74.04.055, 74.04.050, 74.04.057, 74.08.090, 74.09.500, and 42 C.F.R. 435.831 (3)(e) and (f). WSR 09-08-003, § 388-519-0110, filed 3/19/09, effective 4/19/09. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. WSR 06-24-036, § 388-519-0110, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 71.05.560, 74.04.050, 74.04.057, 74.08.090, 74.09.500, 74.09.530. WSR 06-13-042, § 388-519-0110, filed 6/15/06, effective 7/16/06. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057, and 74.08.090. WSR 05-08-093, § 388-519-0110, filed 4/1/05, effective 5/2/05; WSR 98-16-044, § 388-519-0110, filed 7/31/98, effective 9/1/98. Formerly WAC 388-518-1830, 388-518-1840, 388-519-1905, 388-519-1910, 388-519-1930 and 388-522-2230.]