Chapter 182-519 WAC
MEDICALLY NEEDY 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.

(2) Medically needy (MN) standards for people who meet institutional status requirements are in WAC 182-513-1395. The standard for a client who lives in an alternate living facility is in WAC 182-513-1305.

(3) The resource standards for institutional programs are in WAC 182-513-1350. The institutional standard chart is 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) People who do not meet institutional status requirements use the "effective" MNIL income standard to determine eligibility for the MN program. 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 and 41.05.160. WSR 15-17-012, § 182-519-0050, filed 8/7/15, effective 9/7/15. 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 388-507-0710, 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) A person who meets the following conditions may be eligible for medically needy (MN) coverage under the special rules in chapters 182-513 and 182-515 WAC:

(a) Meets the institutional status requirements of WAC 182-513-1320;

(b) Resides in a medical institution as described in WAC 182-513-1395; or

(c) Receives waiver services under a medically needy in-home waiver (MNIW) under WAC 182-515-1550 or a medically needy residential waiver (MNRW) under WAC 182-515-1540.

(2) A supplemental security income (SSI)-related person who lives in a medicaid agency-contracted alternate living facility may be eligible for MN coverage under WAC 182-513-1305.

(3) A person 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 person is:

(a) A child;

(b) A pregnant woman;

(c) A refugee;

(d) An SSI-related person, including an aged, blind, or disabled person, 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 above the special income level (SIL).

(5) A person who is not eligible for CN medical who applies for MN coverage has the right to income deductions in addition to, or instead of, those used to calculate CN countable income. These deductions to income are applied to each month of the base period to calculate MN countable income:

(a) The agency disregards the difference between the medically needy income level (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 SSI payment standard;

(b) All health insurance premiums, except for medicare Part A through Part D premiums, expected to be paid by the person or family member during the base period or periods;

(c) Any allocations to a spouse or to dependents for an SSI-related person 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 person who is married and lives in the same home as his or her spouse who receives home and community-based waiver services under chapter 182-515 WAC, an income deduction equal to the MNIL, minus the nonapplying spouse's income; and

(e) A child or pregnant woman applying for MN coverage is eligible for income deductions allowed under temporary assistance for needy families (TANF) and state family assistance (SFA) rules and not under the rules for CN programs based on the federal poverty level. See WAC 182-509-0001(4) for exceptions to the TANF and SFA rules that apply to medical programs and not to the cash assistance program.

(6) The MNIL for a person who qualifies for MN coverage under subsection (1) of this section is based on rules in chapters 182-513 and 182-515 WAC.

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

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

(9) A person with "excess income" is not eligible for MN coverage until the person gives the agency or its designee evidence of medical expenses incurred by that person, their spouse, or family members living in the home for whom they are financially responsible. See WAC 182-519-0110(8). An expense is incurred when:

(a) The person receives medical treatment or medical supplies, is financially liable for the medical expense, and has not paid the bill; or

(b) The person pays for the expense within the current or retroactive base period under 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 a person's spenddown by multiplying the monthly excess income amount by the number of months in the certification period under WAC 182-519-0110. The qualifying medical expenses must be greater than or equal to the total calculated spenddown amount.

(12) A person who is considered for MN coverage under this chapter may not spenddown excess resources to become eligible for the MN program. Under this chapter, a person is ineligible for MN coverage if the person's resources exceed the program standard in WAC 182-519-0050. A person who is considered for MN coverage under WAC 182-513-1395, 182-514-0250 or 182-514-0255 is allowed to spenddown excess resources.

(13) There is no automatic redetermination process for MN coverage. A person must apply for each eligibility period under the MN program.

(14) A person who requests a timely administrative hearing under WAC 182-518-0025(5) is not eligible for continued benefits beyond the end of the original certification date under the MN program.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 19-02-046, § 182-519-0100, filed 12/27/18, effective 1/27/19; WSR 15-17-012, § 182-519-0100, filed 8/7/15, effective 9/7/15. 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) A person who applies for Washington apple health (WAH) 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, unless a condition in subsection (4) of this section applies.

(3) A person may request a separate base period to cover up to three 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 subsections (1), (2), or (3) of this section if:

(a) A three-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 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 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 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-month retroactive base period if eligibility for WAH 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 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 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-month retroactive base period if eligibility for WAH 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 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 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 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 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 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 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 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 months of the current application, and the agency or its designee could not establish WAH 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 designee within thirty 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 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 designee include, but are not limited to:

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

(b) The person has medical issues that prevent him or her 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 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 designee. See WAC 182-502-0160, Billing a client.

(19) The agency or its 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, the agency or its designee does not pay any portion of the bill.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 19-02-046, § 182-519-0110, filed 12/27/18, effective 1/27/19; WSR 15-17-012, § 182-519-0110, filed 8/7/15, effective 9/7/15. 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.]