State of Washington
Joint Legislative Audit and Review Committee (JLARC)

State Health Care Coverage Eligibility

Report 08-8

October 22, 2008

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Committee Approval

On October 22, 2008, this report was approved for distribution by the Joint Legislative Audit and Review Committee.

Acknowledgements

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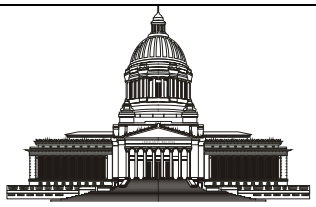
STATE HEALTH CARE COVERAGE ELIGIBILITY

REPORT 08-8

OCTOBER 22, 2008



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REPORT SUMMARY

How Does the State Provide Health Care Coverage to Individuals?

The state determines eligibility and participates in funding 73 health care coverage programs in three main categories:

1. The state provides **employment-related** health care coverage to public employees, retirees, their dependents, and certain non-employees.
2. The state provides health care coverage as a **social service** for low-income persons who are members of qualified classes, for example, children, families on assistance, and disabled adults. To receive this health coverage, individuals must fit within specific eligibility criteria related to age, income, and family or disability status. These health care coverage programs are known collectively as Medical Assistance. Federal law establishes boundaries within which many Medical Assistance programs must operate, both in terms of who must be included and the limits beyond which the state may not use federal funds to provide coverage. Most Medical Assistance programs for which federal law provides funding are known as Medicaid.
3. The state provides health care coverage related to **expansion** of the number of persons able to obtain health care coverage, primarily through insurance products, including the Basic Health Plan and the Washington State Health Insurance Pool.

A New Tool for Comparing Health Care Coverage Programs

This report provides information on 73 different health care coverage programs across these three categories. For the first time, legislators and other interested parties have information consolidated into one report on health care coverage program eligibility criteria and the eligibility determination processes. The program information also identifies which criteria are established by federal law or regulation, which by state law or rule, and which by some other process, usually a negotiation or contract.

Each program is summarized on a "Program Summary Page." The report also includes information about how eligibility criteria and eligibility determination processes compare across programs.

What Did JLARC Learn?

In many cases, broad classes of eligibility are similar across programs within a category. For example, public employees must work at least half time, and home care providers must work at least 86 hours per month, which is approximately half of the working hours in a month. Within Social Services programs, enrollees must be low-income and meet age, family, or disability criteria to obtain coverage. In most cases, the enrollee must also be a citizen or eligible non-citizen. Eligibility for non-citizens is illustrated in Appendix 4.

Although income level is typically an eligibility requirement for Social Services programs, the specific criteria and how income is calculated differ among the programs. Each Program Summary Page lists the income limitations, if any, for that program.

The Social Services programs are collectively known as "Medical Assistance" and most of those that have federal matching funds are collectively known as "Medicaid." However, despite the convention of referring to these two categories, they comprise many programs. Medical Assistance includes 54 programs and, among these, neither the eligibility criteria nor the benefits are identical.

The eligibility criteria and the benefits available for social service programs are primarily established in federal and state law. Because these criteria and benefits differ for each program, there is little duplication. Because most criteria are established by federal law, or through negotiation with the federal government, there are large areas where the state has little ability to make changes. In the Employment-Related and Expansion programs, however, the state has more, but not complete, control.

In general, the processes for determining eligibility share similar characteristics across coverage categories. Applicants are required to provide documentation of facts that determine eligibility. Once the application is entered into a computerized system, the determination process is generally automated. The effect of the automation means that, in most cases, applicants are not required to fill out multiple applications or understand the nuances of eligibility requirements—they simply provide one application and receive coverage based on the program(s) for which they qualify.

Opportunities for Improvement

The focus of this report is the compilation of information on the 73 health care coverage programs. However, in the course of assembling this information, JLARC identified an area for needed improvements. It is reflected in the following recommendation:

Recommendation 1

The Department of Social and Health Services (DSHS) should update its administrative rules that relate to the scope of coverage, income limits and eligibility to ensure that they reflect current criteria and are understandable to the general public. DSHS should also ensure that its administrative manuals are consistent with each other and the administrative rules and that its publicly available information is up to date.

REPORT DETAIL

Mandate and Approach

The Legislature asked JLARC to "conduct a review of the eligibility requirements and eligibility review processes that apply to any state program that offers individual health care coverage for qualified recipients." The differences between these programs, notably in the Social Services category, can be very confusing and, collectively, these programs account for a significant portion of the state budget. The inventory of health care coverage programs in this report provides, for the first time, a tool for legislators and others to compare programs side-by-side.

In order to review the criteria, JLARC examined the Revised Code of Washington, the Washington Administrative Code, federal laws, publicly available information on state agency websites, and the manuals used to administer programs. We also conducted interviews and reviewed internal policy and procedure documents at the administering agencies.

About Health Care Coverage Programs

Before looking at the comparisons among programs, this first section of the report clarifies what health care coverage programs are included in this report and which programs are excluded. This first section also provides a sense of the relative size of the three categories of programs and explains the seven different scopes of coverage included within the Social Services category.

What is a Health Care Coverage Program?

Health care coverage is a means by which a person can obtain health treatment from a provider of his or her choice. The coverage documents show that a third party will pay for the treatment or to reimburse the person for some or all of the cost of treatment. The choice of providers available under a particular program may be limited to a selected group, but there is some level of choice. This definition distinguishes the provision of health care **coverage** through a third party provider from the direct provision of health care **treatment** at a free or reduced cost, such as, treatment provided in a free clinic, jail, or prison.

A health care coverage program is included in this report if:

- The state partially or fully pays for the health care coverage program; **and**
- A state-level agency determines whether a person is eligible for the coverage.

JLARC then looked at each health care coverage program and identified the specific eligibility criteria for individuals to access the program. A health care coverage program is identified separately and has its own Program Summary page if the program has:

- At least one eligibility requirement that differs from its closest comparable program; **or**
- A different funding source.

For example, the Public Employees Benefits Board provides coverage for public employees, certain retirees, and their dependents. Employees must be employed at least half time, but neither dependents nor retirees have this requirement. However, dependents' coverage is tied to their relationship to the employee or retiree, not to the employment itself. Consequently, each of these groups has a separate Program Summary Page.

What is Excluded from the Report?

Programs are not included in this report if they do not meet JLARC's definition of a health care coverage program, if the state does not fund the program, or if no state agency determines whether a person is eligible for the program. JLARC excluded the following programs from the report.

Not Within the Definition (Provide Treatment, Not Health Coverage):

- State Veterans' Nursing Homes
- Department of Corrections health care services

No State-Level Eligibility Decision

- Home care providers employed by agencies that have not unionized
- School district and local government employees accessing health care coverage through PEBB

No State Funding (Self-Supporting or federally funded)

- COBRA extensions of PEBB health care coverage benefits
- Student health programs at state colleges and universities
- Refugee Assistance
- Indian Health Services
- Workers' Compensation Insurance
- Private sector individual and group insurance

How Large are Health Care Coverage Programs?

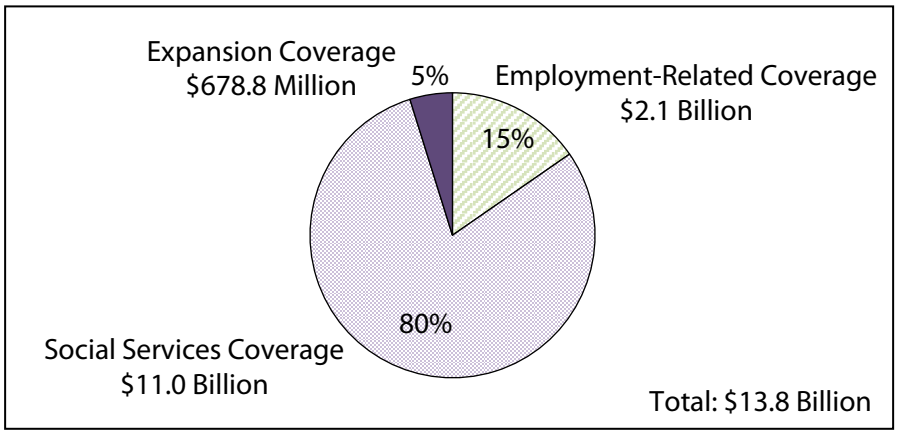
Washington State determines eligibility and participates in funding health care coverage programs in three categories: employment-related programs, social-services programs (also known as Medical Assistance) and expansion programs. In all three categories health care coverage is generally limited to those persons who meet specific eligibility criteria. JLARC looked at each category of health care coverage and determined which programs fell within that category, then analyzed the characteristics of the programs in the category. While we primarily examined the eligibility criteria, we also looked at the relative size of the programs.

Health care coverage programs included in this report range in size from under 60 enrollees to over one-hundred thousand. Small programs may exist because they are no longer accepting new applicants, but retain previously enrolled persons. Small programs may also exist because the state, usually DSHS, "buys in" to otherwise private insurance by paying the costs for the insured. Buy-in occurs in two situations:

1. Persons whose income is less than 301% of the federal poverty level are entitled to a premium subsidy under RCW 48.41.200 when they obtain insurance through the Washington State Health Insurance Pool (WSHIP).
2. DSHS may also "buy-in" to private coverage for persons who are eligible for Medical Assistance if it determines that it is better to leave the person on the existing coverage than to move the person to the program for which they are eligible. The state may pay the premium, deductibles, and co-payment or cost-sharing amounts up to the amount that DSHS would pay under the relevant Medical Assistance program.

Exhibit 1 provides a general idea of the relative size of total state and federal funding for the programs included in the three categories of health care coverage. Buy-in coverage under RCW 48.41.200 appears in the Expansion Coverage. Buy-in coverage under Medical Assistance is included in Social Services Coverage.

Exhibit 1 – The Largest Category of Current State and Federal Health Care Coverage Costs is for Social Services Programs



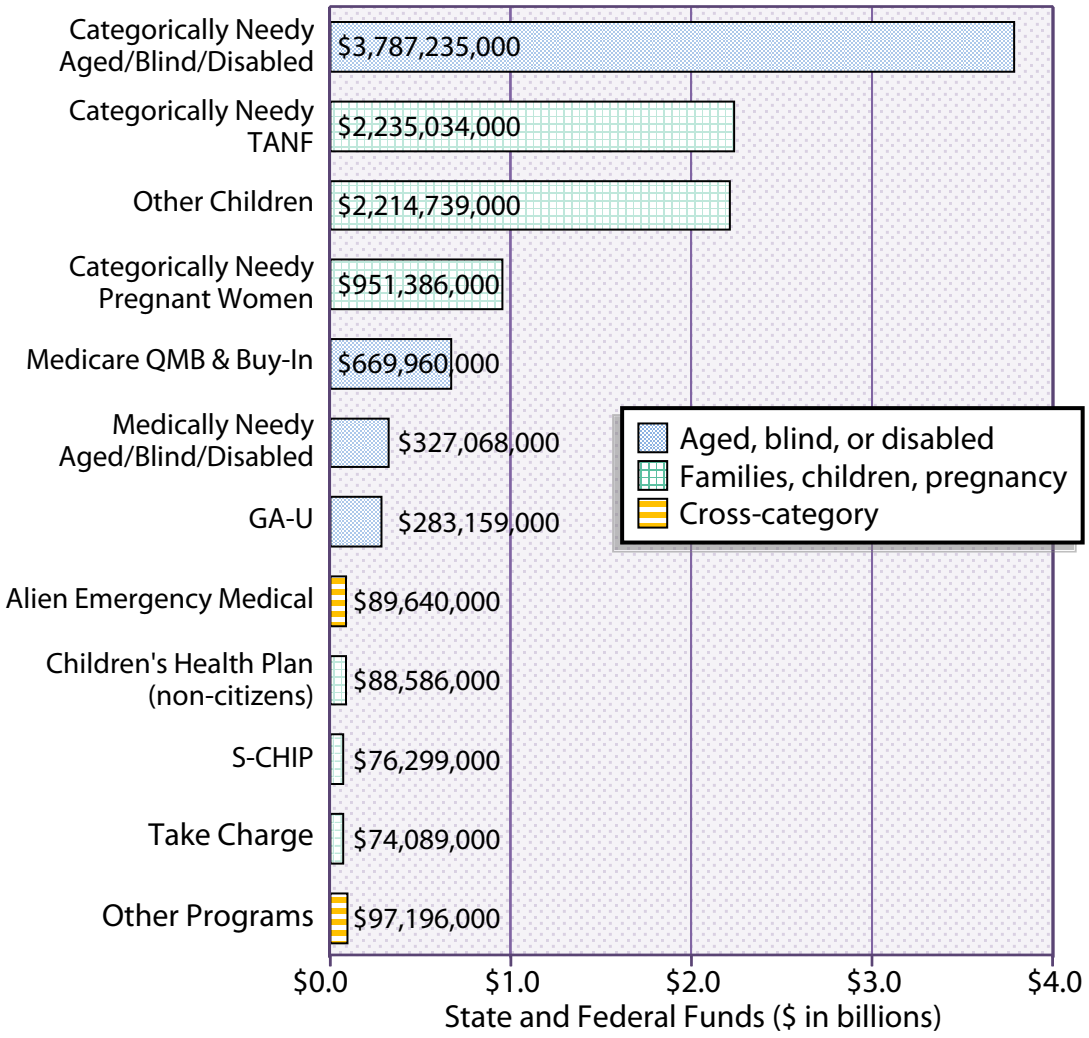
Source: JLARC analysis of data from DSHS and Senate Fiscal Staff.

Although overall cost information is available for the three broad categories of coverage, it is not regularly tracked to the detailed level of the 73 programs analyzed in this report. Therefore, specific cost information for each of the 73 programs is not available. However, there is some information available on large subgroups of programs within Medical Assistance. Exhibit 2, on page 6 shows this breakdown. In addition, we were able to break programs down into four very broad size groups based on 2-year costs. These size groups are:

- $0 to $10 million
- $10 million to $100 million
- $100 million to $1 billion
- $1 billion to $10 billion

This general size group is included on the Program Summary page for each program.

Exhibit 2 – 2007-09 Biennial Cost of Medical Assistance Programs



Source: HRSA Medical Assistance Forecast Summary Report – February 2008.

What Benefits are Provided for Different Programs?

The Program Summary pages identify the benefits or "scope of coverage" for that program. The scope of coverage varies among programs in each of the three program categories. In the Employment-Related category, the differences come in programs outside the PEBB programs. In the Expansion category, each program has a targeted audience and the scopes are tied to those targets. However, in the Social Services programs, people meeting very similar eligibility criteria may be eligible for quite different scopes of coverage. To help better understand the variation within the Social Services programs, this section explains the seven different scopes of coverage used for these programs.

Social service health care coverage programs, collectively, are called Medical Assistance, and most of those that have federal matching funds are collectively known as Medicaid. While this may give the impression that Medical Assistance and Medicaid are single programs, each with a single set of eligibility criteria and package of benefits, this is not an accurate impression.

Certain eligibility criteria, including income, age, citizenship, and family status affect the package of benefits or "scope of coverage" that a person may be eligible to receive. The combination of different eligibility criteria and different scopes of coverage result in there being many different Medical Assistance programs. Most Medical Assistance programs fall within seven scopes of coverage. Exhibit 3 provides a broad overview of these scopes of coverage. Appendix 3 provides more detail on each scope.

It is important to note that just because a particular service is within a scope of coverage does not mean that a particular person will be able to access that service. The services a person can access are limited by both what is provided within the scope of coverage for which the person qualifies and on the services that are medically necessary for the person, given the health situation and life circumstances in which the person finds himself or herself. For example, two persons may have medically identical situations and the same income need long-term care, but one person has significant family and community supports, while the other is isolated and has no living family. The second person will be eligible for more services due to the lack of other supports.

Exhibit 3 – Medical Assistance Programs Can be Grouped into Seven Scopes of Coverage

Scope of Coverage	Brief Description
Categorically Needy (CN)	Broad coverage, usually for lowest-income persons.
Medically Needy (MN)	Slightly narrower coverage than Categorically Needy, usually for persons with slightly higher incomes.
S-CHIP/CHP	Coverage for children that is almost identical to CN coverage, but may require the payment of a premium.
GA-U	Substantially narrower coverage for persons receiving General Assistance as unemployable because of a physical or mental impairment that prevents them from working for 90 days.
ADATSA	Similar to GA-U coverage, this is for persons receiving drug and alcohol treatment through the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) programs.
Family Planning Only	Treatment related only to family planning.
Alien Emergency Medical	Similar to the MN scope, but available only under emergency medical conditions.

Source: WAC, DSHS data.

How Do Eligibility Criteria Compare Across Programs?

The kinds of criteria used to determine eligibility within the employment-related and Social Services programs tend to be similar across programs within each category. In these two categories, there are few programs that have substantially different kinds of eligibility criteria and when this does occur, it is usually in a program designed to address a specialized need.

By contrast, health care coverage expansion programs tend to have only one common criterion: the

applicant's lack of, or inability to obtain, health care coverage through another source. The reasons for lack of coverage vary.

This section of the report begins with a discussion of the similar criteria used within the Employment-Related and Social Services categories. It also highlights those instances where a program uses different criteria. This section then turns to a common question about health care coverage programs: Is there duplication across the state's programs?

Employment-Related Programs

Among the employment-related health care coverage programs, the primary eligibility requirement is that the employee work at least half-time. While this is defined differently in some arenas, the basic rule is the same. For example, while PEBB programs simply specify "half-time," the contract for individual providers and home care workers requires them to work at least 86 hours per month, which is approximately half the working hours in a month.

Coverage through the state universities for graduate appointees is the one exception to the primary requirement to work half-time. Graduate appointees are graduate students who have been appointed to certain graduate research or teaching positions, or who may have been appointed to paid fellowships or training positions. Instead of having to meet only a threshold of work hours, graduate assistants must both receive an appointment that qualifies them for a tuition reduction and be enrolled for a minimum number of credits per term or receive a fellowship appointment that qualifies as a research assistantship and pays a stipend of at least $800 per month.

Generally, employment-related health care coverage programs do not have maximum income limits. There is one exception. Western Washington University has selected the Basic Health Plan as its insurance coverage for its graduate appointees. The Basic Health Plan is a state-subsidized health insurance expansion plan for persons with income at or below 200% of the Federal Poverty Level. As a consequence, a graduate appointee with income beyond this level is not eligible. In these situations, the University enrolls the otherwise eligible graduate appointee in the available regular student health insurance plan and pays the related premium.

Social Services Programs

Eligibility for most Medical Assistance programs is determined by a combination of criteria relating to citizenship or immigration status, age, disability, and family circumstances. Most programs are limited to citizens or legal immigrants who meet certain criteria. Appendix 4 provides an illustration of the decision process for determining the eligibility of a non-citizen for any Medical Assistance program.

Further, most Medical Assistance programs are limited to children, pregnant women, adults over 65, and persons who are blind or disabled. There is almost no health coverage available through Medical Assistance for adults under 65 who are neither blind nor disabled unless that adult has a dependent child who qualifies for Medicaid. In that case, that adult may be eligible for coverage under a plan related to Temporary Assistance for Needy Families (TANF).

Eligibility for most Medical Assistance programs is also tied to an applicant's income and resources. Income eligibility criteria take the form of income limits and spend-down requirements.

How Does DSHS Calculate a Person's Income for Eligibility Purposes?

In almost all Medical Assistance programs, the applicant's income is a determining eligibility factor. Income limits are related to one of three standards: the federal poverty level (FPL), the TANF cash benefit, or the Supplemental Security Income (SSI) benefit. **However, not all income is "countable income."** State and federal law require some exclusions and deductions. In addition, sometimes income must be allocated to persons other than the applicant. "Countable income" is the income that remains after all appropriate exclusions and deductions allowed by a specific program have been applied and after all income that must be allocated to another person has been allocated.[1]

Federal law excludes some types of income from use in eligibility determinations. Exclusions generally prevent other social service programs from operating at cross purposes with Medical Assistance programs. For example, if energy assistance were not excluded, receiving energy assistance to keep heat and lights on could make a person ineligible for health care coverage. Other examples of exclusions include most loans, legally required child support for a child who receives TANF or State Family Assistance; and income from employment and training programs such as VISTA and AmeriCorps. Excluded income can also be income received as reparations or due to a treaty or settlement with a government. These include things like Agent Orange settlement funds, and Holocaust reparations.

Deductions from income can be incentives, such as the incentive-to-work deduction under TANF, or they can be allowances, such as the allowances for personal needs, utilities, and maintenance under SSI.

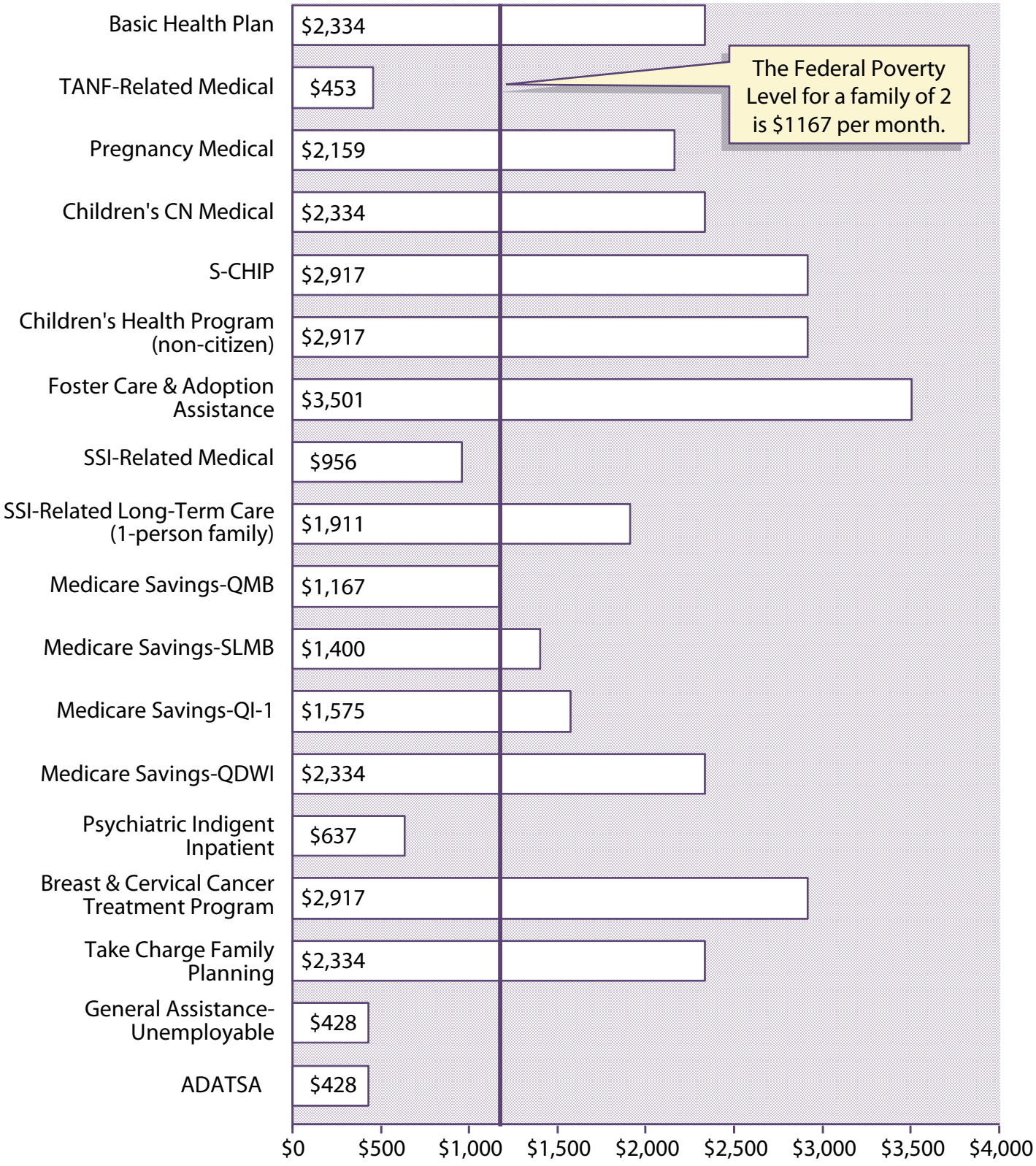
Sometimes income must be allocated to a person other than the program applicant. Allocations to others occur when the income that must be counted is properly applied to more than one person. An example is household income that must be allocated to an applicant's spouse when only the applicant is applying for Medical Assistance.

It is important to note that a child may have income that is separate from that of his or her parents. A child's income can come from earnings, child support payments, SSI benefits for blindness or disability, survivor's benefits, receipts from a lawsuit or settlement, or even the proceeds from investments. Consequently, a child's income may need to be calculated separately from that of his or her family, or a child may need to be considered as a separate family or "assistance unit." This report refers to "assistance units" as persons, families, applicants, or enrollees depending on the circumstance.

The exclusions, deductions, and allocations for programs differ, but each calculation results in a countable income that must be compared against the income limits for the program being considered. The income limits for each program are included on its Program Summary page. Exhibit 4, on page 10, groups Medical Assistance Programs together by income limit and compares these income limits to the federal poverty level. The Basic Health Plan (BHP) is an expansion program, but is included in the chart because it has an income limit that can be compared to Medical Assistance programs. However, BHP does not have most of the other eligibility criteria of Medical Assistance.

[1] WAC 388-450-0210 (1).

Exhibit 4 – Monthly Income Limits for Family of 2 Compared to Federal Poverty Level (2008)



Source: WAC, DSHS.

What are "Spend-down" Requirements for Medical Assistance?

Most Medical Assistance programs provide an opportunity for persons whose income exceeds a program's limit to bring their income down to the limit by "spending down" the excess. Spending down income means that the person is obligated to pay an amount in qualified medical expenses that is equal to the amount of his or her excess income before receiving any benefits. Excess income is the amount by which the person's income exceeds the income limit for the program. It is measured over a base period of either three months or six months, and all of the excess income for the period must be spent down before the person receives any benefits.

Is there Duplication Across the State's Programs?

Among Social Services programs, many programs that may appear to cover the same people or provide the same scope of coverage are delineated by income level. Because DSHS has established a priority order for eligibility determinations that is largely automated, there is little actual duplication in Medical Assistance programs.

In general, Medical Assistance is available to low-income children, their parents, and aged, blind, or disabled adults. Adults over age 18 and under age 65 are generally not eligible for coverage unless they are blind, disabled, or have a dependent child who qualifies for Medicaid or SSI-related Medical Assistance. Health care coverage for many non-citizen adults is limited to emergency situations unless the person is a pregnant woman. (See Appendix 4.)

One reason that there are so many different health care coverage programs is that many programs have been created to cover people excluded by other programs or to fill a gap in the services available to enrollees. Much of this is the result of changing federal and state legislative priorities and expectations over time. For example, federal law requires states to provide emergency health care coverage to non-citizens. This program partially fills the gap created by the federal decision to exclude most non-citizens from Medicaid. Another example is that pregnant women are eligible for Medical Assistance for themselves and their newborns at higher income levels than would be permitted if they were served under other Medical Assistance programs.

Most people who would be eligible for Medical Assistance would also technically be eligible for the Basic Health Plan (BHP) because it has fewer requirements. The application for BHP, however, requires disclosure of any other coverage and there is nothing to suggest that a person would be enrolled in both without coordination between DSHS and the Health Care Authority. Such coordination can occur in two areas: Basic Health Plus for children (discussed in more depth on page 14) and cases where a person has enrolled in BHP but is eligible for Medical Assistance in some months but not others. Inconsistent eligibility for Medical Assistance generally because the person's income varies and is close to the upper eligibility limit for Medical Assistance. For these individuals, the state may pay a BHP premium for the months in which the person is eligible for Medical Assistance rather than change the person's coverage from month to month.

Among employment-related programs in this state, almost all programs are for employees of state or local governments. However, the state does provide health care coverage for two kinds of non-employees. First, it pays for coverage for graduate appointees, who are not technically employees and so do not fall within the traditional scope of "employee" benefits. Group coverage for graduate appointees at the state's five universities fills this gap.

The state also provides health care coverage as an "employee benefit" to several groups of employees who provide a service the state pays for, but who are not actually employed by state or local government agencies. Under several statutes, the state negotiates a collective bargaining agreement with these employees and those agreements include health care coverage because, generally, these employees might not otherwise qualify for any type of group coverage. These groups include individual providers of home care services, unionized agency providers of home care services, family child care providers, and adult family home providers.

In addition, each of the state's expansion-related programs provides health care coverage to persons or groups of persons who do not have or cannot get other coverage. For many, their income is too low to be able to afford premiums for private coverage, but too high to qualify for Medical Assistance. For others, coverage would not be available without these programs because they have serious illnesses and are not eligible for coverage. Finally, some receive limited coverage because they were the victim of a crime and have no other coverage to pay for treatment.

How Do Eligibility Determination Processes Compare Across Programs?

The procedures used to determine eligibility are similar across all three main categories of programs. Applicants provide information and documents to verify the information. Once received, the administering agencies generally enter applicants' information into a computer system. Those systems vary in their degree of automation of the processes, but application procedures and, where applicable, subsequent determinations of eligibility are, to some extent, automated. The effect of the automation means that, in most cases, applicants are not required to fill out multiple applications or understand the nuances of eligibility requirements—they simply provide one application and are provided with health care coverage for which they applied or for which they qualify.

The remainder of this section looks at the procedures in the Department of Social and Health Services and the Health Care Authority.

The Department of Social and Health Services

The Department of Social and Health Services (DSHS) uses a largely automated and streamlined process within its Automated Client Eligibility System (ACES) to determine eligibility. DSHS staff enter information about applicants and enrollees into the ACES system and select a program within an appropriate "track" or group of programs, then the system checks the information against program requirements in an established order of priority. In this report, tracks of Medical Assistance programs are denoted on the Program Summary pages by the letter in the

program identifier. For example, F01 is a "Family" track program, and S01 is an "SSI" track program related to age, blindness, or disability.

While ACES is limited by the track that is entered, it does contain prompts to indicate where multiple programs might be appropriate and the DSHS staff should review them. For example, if an application is processed for SSI-Related medical where there is an indication that the applicant has Medicare, ACES provides DSHS staff with a message to consider screening in a Medicare Savings Plan. However, where multiple tracks must be considered, the DSHS staff must run the application in the appropriate tracks in an appropriate order to generate an accurate enrollment in the highest priority program.

Programs that are fully or partly federally funded are highest priority. That is, a person is not considered for programs that are completely state funded unless he or she is not eligible for programs with federal funding. Within federally funded programs, the priority is to the broadest scope of coverage for which a person is eligible.

While most applications for Medical Assistance at DSHS are processed automatically using the ACES system, some applications must have additional processing that is not automatic. This happens either because a program has a unique requirement (for example, a referral must come from qualified clinic) or because the eligibility requirements include additional assessments to determine whether the person meets functional criteria and whether the person's functional needs are being met outside of Medical Assistance. The DSHS Medical Eligibility Determination Services (MEDS) group processes applications for programs with a unique requirement, including:

- Basic Health Plus, where the parent is applying for Basic Health and wants his or her child to be considered for Medicaid;
- The Breast and Cervical Cancer Early Detection and Treatment Program, which has a separate application process and must come through a screening process contracted with the Department of Health and the federal Centers for Disease Control;
- Medical Assistance provided through the Foster Care and Adoption Support programs; and
- The Children's Health Program and the State Children's Health Insurance Program.

Some additional programs require multiple eligibility determinations across different staff groups and administrations to determine different kinds of eligibility. These include waiver services for long-term care and developmental disabilities, which require both a functional assessment and a determination that the particular person's needs are not being met through family, community, or other Medical Assistance.

For example, an application for home and community-based waiver services through the Aging and Disability Services Administration requires income and administrative eligibility determinations that can be determined with ACES. But DSHS must also determine whether the

applicant needs a nursing facility level of care, and then determine whether the person's need could be met through the person's community or through Medicaid Personal Care.[2]

The Health Care Authority

The Health Care Authority (HCA) determines eligibility for two large programs: the health care coverage employee benefits offered through the Public Employees Benefits Board (PEBB) for employees, retirees, and their dependents, and the Basic Health Plan.

HCA has somewhat automated health care coverage applications for the PEBB programs. Individual eligibility determinations are made at each employee's work place (or by PEBB for retiree's COBRA and self-pay populations). When the responsible person at the employee's work place enters the new employee information or changes to employee information into the computer system, the system may flag errors and stop the application until the issue is resolved. However, in many cases, the discovery and correction of errors must be done manually and some changes at HCA may not be combined, thus requiring a set of changes for one subscribers to take two or more days.

One example of flagging errors is that when a social security number is entered as a new enrollment, the system will search to see whether enrollment already exists for that social security number. If the system finds that coverage already exists, the dual enrollment will be included in a report and the employing agency will not be permitted to enroll the person until a decision is made about which work-group will cover the person. Coverage may exist in several situations such as both parents in a family work for the state and both try to enroll the children as dependents, a person who works for the state is a dependent of another person who works for the state, or a person works half time for two employing agencies. A dual enrollment error requires one work-group to withdraw the coverage request, and the other work-group to add it. Two technological limitations of the system are that when the system does find a dual enrollment, the stop on the application is not instantaneous, and that dual enrollment may not be prevented if the social security number is entered incorrectly at either employing agency.

The Health Care Authority (HCA) also administers the Basic Health Plan (BHP) for adults and children with incomes below 200% of the federal poverty level. BHP is a state-funded program requiring premiums and copayments from enrollees. Applications for this program begin with the applicant and can be made online or using paper and pen. Eligibility for the BHP is tied to Washington residency and income level.

Basic Health Plus

When a parent applies for BHP and requests that his or her child(ren) be considered for Medical Assistance through DSHS, the application is called a Basic Health Plus (BH-Plus) application. On a BH-Plus application, HCA transmits the information to DSHS for a determination whether the child or children included in the BH-Plus application are eligible for Medical Assistance. If

[2] Medicaid Personal Care is a program within Medicaid that provides some personal care tasks to Medicaid eligible persons with a functional disability. This service is provided in the person's own home by an individual or home care agency provider, or in a licensed adult family home or boarding home.

eligible, they enrolled in Medical Assistance through BHP. Under this program, DSHS pays HCA the BH-Plus Premium and provides coverage in addition to the BHP to ensure that children enrolled through BH-Plus receive the same coverage that they would have received had they are enrolled directly through DSHS. In this case, the additional coverage includes dental, hearing, and vision care, physical therapy, the elimination of waiting periods for pre-existing conditions, and the addition of non-emergency medical transportation.

Currently, almost every child who is eligible for BHP and whose parent applies for BH-Plus would also be eligible for children's Medical Assistance through DSHS. Most of the children's Medical Assistance programs operated by DSHS have federal matching funds. All children's Medical Assistance programs serving children under 200% of the federal poverty level are free to the parent and have broader coverage than BHP provides.

Under HCA's procedures, however, DSHS receives no information about children on BHP applications unless their parents actively check the "Applying for Basic Health Plus?" box on the application form and submit a social security number for each child. DSHS cannot determine whether the child is eligible for Medical Assistance unless it receives application information.

Ten days after a child is initially enrolled in subsidized Basic Health Plan coverage, HCA sends a letter with a joint DSHS/BH-Plus application to parents of dependents who have not enrolled in Medical Assistance. The letter explains that the child or children may be eligible for free health care coverage with no premiums, deductibles, or copayments if the parent applies. If HCA does not receive a response within 30 days, a second letter and joint application is sent. Thus, HCA makes two attempts, in addition to the initial application, to have eligible children apply for Medicaid through DSHS.

By not responding to any of these three opportunities to enroll their children in Medical Assistance, the parent chooses to have his or her child enrolled in BHP despite the broader benefits and lower costs available in Medical Assistance. Because a parent has the option to choose not to enroll his or her eligible children in Medical Assistance, there are some children eligible for Medical Assistance who are only enrolled in the Basic Health Plan.

RECOMMENDATIONS

The focus of this report is the compilation of information on the 73 health care coverage programs contained in the Program Summary pages that follow. However, in the course of assembling the Program Summary information, JLARC identified an area for needed improvements. This is reflected in the following discussion and recommendation.

Challenges Identifying Eligibility Criteria for Medical Assistance Programs

A necessary step to comparing eligibility criteria across programs is to identify eligibility criteria for individual programs. While compiling information about the programs, several challenges became apparent. A number of the Washington Administrative Code (WAC) rules related to these programs are out of date or not available in printed or online resources. In some places, the manuals that DSHS uses to administer Medical Assistance conflict with the administrative rules and, in some cases, with each other. Further, some of the publicly available information on the DSHS website is inaccurate. The challenges were most significant in the areas of scope of coverage and income limits.

Despite the challenges, by working with DSHS staff, JLARC was able to obtain current scope of coverage and income limit information for all Medical Assistance programs. The next two sections explain the challenges JLARC encountered.

Scope of Coverage

Because persons meeting similar eligibility criteria are eligible for different Medical Assistance programs, compiling Program Summary pages required identifying both the eligibility criteria and the scope of coverage for which those persons are eligible. However, neither the administrative rules nor other publicly available information from DSHS currently provide accurate, understandable descriptions of the various scopes of coverage for Medical Assistance programs. There are two primary sections of WAC that describe the scopes of coverage. One section implies that the two most common scopes of coverage, "Categorically Needy" and "Medically Needy," are identical, which is factually inaccurate. The other rule describes the scopes by cross-referencing other groups of administrative rules. However, many of the cross-references are irrelevant to scope of coverage, making a difficult subject more confusing. An average person reading the administrative code could not identify with any certainty the differences between the benefits they might receive under the "Categorically Needy" and "Medically Needy" scopes of coverage.

This would be less problematic if there were other current, clear information available to the public. DSHS reports that it is currently revising the WACs related to scope of coverage and provided JLARC with the table in Appendix 3, which it plans to make public when the WAC revisions are complete.

Income and Resource Limits

Almost all Medical Assistance programs have income limits or a combination of income and resource limits. The amount of the income limit may be based on cash benefits a person receives from Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI) or may correspond to the federal benefit payment standard or to a percentage of the Federal Poverty Level (FPL) . The FPL changes annually, and programs based on a federal benefit payment standard are also subject to annual adjustment by federal legislation. In some years, the state also adjusts the income levels for state-funded programs that are based on the FPL or on a federal benefit payment standard.

During the preparation of this report, DSHS updated many of the administrative rules covering income limits, but some rules did not match the online manuals and documents that DSHS uses to administer the program. In some cases, the online manuals were in conflict with each other due to having been updated at different times. Currently the most accurate information is provided in a DSHS "cheat sheet" which has been updated, but this sheet is not easily accessible to the general public.

Recommendation 1

The Department of Social and Health Services (DSHS) should update its administrative rules that relate to the scope of coverage, income limits, and eligibility to ensure that they reflect current criteria and are understandable to the general public. DSHS should also ensure that its administrative manuals are consistent with each other and the administrative rules and that its publicly available information is up to date.

Legislation Required:	None
Fiscal Impact:	JLARC assumes that this can be completed within existing resources.
Implementation Date:	June 30, 2009

HOW THE PROGRAM SUMMARY PAGES ARE ORGANIZED

In the pages that follow, each health care coverage program that meets the criteria for inclusion in this study has a one-sheet summary focusing on its eligibility criteria and the procedures for determining that an applicant is eligible for that program. The Program Summary Pages are organized by type of coverage: Employment-Related Programs, Social Service Programs, and Expansion–Related Programs. There is a colored divider page between each coverage type.

Social Service Programs are the largest group of programs and are organized in the following order: Families, Children, and Pregnancy related programs; Aged, Blind, and Disabled medical programs; Long-Term Care and Waiver Programs.

PROGRAM NAME

Program Description and Purpose: (Program [#])

This section provides a brief overview of the program. Medical assistance programs have a DSHS program number that identifies the scope of coverage and general type of eligibility.

Entitlement programs cannot be withheld from anyone meeting the eligibility criteria. Entitlements have no program caps.

Participant Cost Sharing means the enrollee pays part of the cost. An entitlement may have cost sharing.

This identifies program costs in one of four categories:
$0 million - 10 million
$10 million - $100 million
$100 million - $1 billion
$1 billion - $10 billion

Program Limitations and Costs: 2-year Program Costs:

Entitlement? [N] Program Caps: Enrollment [N] Funding [Y] Participant Cost Sharing? [N]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)* If both the "Federal" and "Negotiated" columns are checked, the requirement is in the State plan or a Medicaid Waiver. If only the "Negotiated" column is checked, it may be part of a collective bargaining agreement.	✓		✓ ✓
Exclusionary Criteria *(Applicant is not eligible if any apply)* Even if a person met all the eligibility requirements, he or she would be ineligible if any condition in this section applies.		✓	
Priority Populations Some programs with caps have rules about which eligible people have priority if enrollment is limited.			

Possible Alternative Programs — **Administrator:**

Generally, a person can only be enrolled in one program. However, the person may be eligible for more than one program. This section identifies additional programs for which a person might be eligible. It also identifies programs that permit concurrent enrollment.

Bordering Programs — **Administrator:**

Bordering programs are either programs that the same person might be eligible for at different times, if their circumstances changed, or that similar persons might be enrolled in.

Comments

"Comments" are either explanatory material or supplemental information that does not fit fully within another category on this page.

PROGRAM NAME

Eligibility Determination Process

Eligibility Determination Process describes what must be done to decide whether a person is eligible.

Frequency

Frequency describes how often eligibility issues are addressed.

Comments on Process

Explanatory or supplemental information to provide context to the process.

Eligibility Determination Overlaps

Identifies situations where duplicate determinations are made, where programs are considered in a priority order, and makes related comments.

For Further Information

Provides a website link or other resource for further information on the program.

Some, but not all, income limits are established as a percentage of the Federal Poverty Level.

Income and Asset Limits:

		Family Size								
	% of FPL	1	2	3	4	5	6	7	8	Max or +
Income										
Assets										

Generally identifies the monthly income above which a person is ineligible. For "Medically Needy" programs, it identifies the income limit above which a person will have to "spend down" excess income to be eligible.

Assets, or "resources," are things that could be turned into cash or a cash equivalent.

EMPLOYMENT-RELATED PROGRAMS

PUBLIC EMPLOYEES BENEFITS BOARD HEALTH BENEFITS—EMPLOYEES

Program Description and Purpose:

Administered by the Health Care Authority (HCA), the Public Employees Benefits Board (PEBB) provides comprehensive health and dental coverage for employees and retirees of eligible entities and certain non-employees described in the comments section below. Employees may cover dependents (*See* PEBB Dependents).

Program Limitations and Costs: 2-Year Costs: $1 billion to $10 billion (all PEBB combined)

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Employees must work at least half-time to be eligible		✓	
• Employees must be paid for at least 8 hours per month to remain eligible		✓	
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Employee is already enrolled in PEBB as a subscriber or dependent		✓	
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• PEBB Dependent coverage under which the employee would also be eligible.	HCA
• Private or federal employee health benefits in which the employee has vested, such as retiree benefits.	Varies
Bordering Programs	**Administrator:**
• Medicare	N/A

Comments

- "Eligible entities" include every state department, division, and separate agency, participating employee organizations representing state civil service employees, participating blind vendors operating under Chapter 74.18 RCW, participating local governments, participating K-12 school districts and educational service districts. The state is not required to bargain over the eligibility criteria for health insurance in its collective bargaining negotiations.
- Eligible non-employees include dislocated forest products workers enrolled under Chapter 50.70 RCW, school board members and students eligible to participate under RCW 28A.400.350.
- Employees are eligible for coverage on the following dates
  - Permanent employees—on the date of their employment
  - Non-permanent employees—on the 1st day of the 7th month of employment
  - Career seasonal employees—on the date of their employment
  - Instructional year employees—on the date of their employment
  - Part-time faculty and part time academic staff—on the first day of the second consecutive quarter or semester
  - Legislators—on the date their term begins
  - Other legislative and executive elected and appointed officials—on the earlier of the date their term begins or the date they are sworn in
  - Judges—on the date they take the oath of office
- Three groups of non-employees have state-funded health coverage governed by collective bargaining agreements with eligibility criteria separate from the PEBB health care coverage. These groups have separate Program Summary pages and include: individual home care providers, family child care providers, and adult family home providers.

PUBLIC EMPLOYEES BENEFITS BOARD HEALTH BENEFITS—EMPLOYEES

Eligibility Determination Process

- Eligibility determinations for employees are currently made at the employing agency. In some cases employee hours are averaged over a 6-month or academic-year period to establish eligibility.
- Employees must select coverage within 31 days of becoming eligible. Eligible employees who do not return an election form within 31 days are enrolled in the Uniform Medical Plan and the Uniform Dental Plan.
- When staff at the employing agency initially enter the employee into the benefits system, the system automatically searches to see if the employee is already enrolled by searching for duplicate social security numbers. If dual enrollment is found, the employee is contacted to determine where he or she will be covered. The administrators of each source of coverage must coordinate to ensure continued coverage without a break in service and assist employees in obtaining and submitting the forms to effect the correct enrollment.
- The system requires staff at the employing agency to enter codes for type of employee, coverage date, type of coverage, and carrier.
- If applications are incomplete, staff must request further information from the employee and postpone coverage until all eligibility information and dual enrollment decisions are received.
- When an employee leaves his or her job for a position that is not covered by PEBB, enrollment is determined for COBRA continuation coverage or retirement coverage. (For further information see the PEBB Retiree Program Summary page.)
- Appeals of HCA's eligibility determinations are permitted under the Administrative Procedures Act.

Frequency

- Eligibility is determined at the start of employment. Changes to enrollment, which may include eligibility determinations, occur during the annual open enrollment period and following any life event that changes the eligibility of an employee or the employee's dependent(s) (*e.g.,* marriage, birth of a child, divorce, death, child reaches age 20).
- Once an employee is found eligible, he or she must be paid for at least 8 hours per month to maintain eligibility.
- Eligibility is also determined at separation and subsequent enrollment in COBRA or retirement programs.

Comments on Process

- There is no current statewide system for validating information provided by employing agencies.
- Not every agency determines eligibility the same way.
- The process is partially automated. The computer system requires certain eligibility information to enroll the employee, and that information requires the staff member entering the information to have the required forms as verification.
- Under some circumstances, HCA must make multiple changes to employee's records one at a time with no more than one change per day. There is no automated system for reminding staff that the changes are not complete.

Eligibility Determination Overlaps

- Because an employee may be employed by more than one PEBB organization at the same time or may be a dependent of another PEBB employee, it is probable that some persons have eligibility determined more than once under different criteria. Multiple eligibility determinations will be necessary so long as situations exist in which a person could be eligible for coverage more than one way.

For Further Information

- http://www.perspay.hca.wa.gov/documents/EligbilityManual.pdf

Income and Asset Limits: Not Applicable

PUBLIC EMPLOYEES BENEFITS BOARD HEALTH BENEFITS—DEPENDENTS

Program Description and Purpose:

Administered by the Health Care Authority (HCA), the Public Employees Benefits Board (PEBB) provides comprehensive health and dental coverage for dependents of employees of the eligible entities and certain non-employees listed on the PEBB Employees Summary page. The State appropriates funding for family enrollment. Employees may cover their dependents by paying a reduced premium.

Program Limitations and Costs: 2-Year Costs: $1 billion to $10 billion (all PEBB combined)

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Employees maintain eligibility for dependents to be eligible		✓	
• Eligible dependents include: o Spouse or qualified domestic partner; o Children through age 19; o Students age 20-23; o Extended dependents (with court order); o Dependents with disabilities of any age; and o Parents enrolled in PEBB medical before July 1, 1990.		✓	
• All dependents except children through age 19 must be certified by HCA		✓	
• Employees must enroll eligible dependents unless the dependent is covered under another comprehensive group coverage		✓	
• Employee must enroll dependents: o Within 31 days of employee becoming eligible; o During the annual open enrollment period; o Within 60 days of: marriage; declaration or registration of a qualified domestic partnership; birth or assumption of legal obligation for a child in anticipation of adoption; the first day of the quarter/semester in which a student age 20-23 is registered if they are not currently enrolled; being awarded custody/guardianship of an extended dependent; a disabling event that occurs before the dependent's 20th birthday or while the child is a student over 20; an enrolled child's 20th birthday for students; or when the dependent loses his or her other insurance coverage.		✓	
• Eligible surviving dependents must enroll within 60 days of employees' death		✓	
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Dependent is already enrolled in a PEBB health care coverage program		✓	
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• N/A	N/A
Bordering Programs	**Administrator:**
• N/A	N/A

Comments

- For "eligible entities" and eligible non-employees, see the PEBB Employees Program Summary Page.

PUBLIC EMPLOYEES BENEFITS BOARD HEALTH BENEFITS—DEPENDENTS

Eligibility Determination Process

- Eligibility determinations for dependents are currently made at the employee's employing agency.
- Employee must submit the proper, completed certification forms for all dependents (except a child under age 20) within the time frames listed in the eligibility section on page 1 of this Program Summary.
- When employing agency staff initially enter the dependent's social security number into the benefits system, the system automatically searches for duplicates. If dual enrollment is found, the staff at each work group will coordinate to ensure no break in coverage following the employee's decision where the dependent will be covered.
- The benefits system requires staff to enter codes for type of dependent, coverage date, type of coverage, carrier, and temporary eligibility qualification for dependents requiring certification forms. For dependents requiring certification forms, the forms must be sent to HCA for reviews and the final eligibility determination for these dependents. HCA may deny coverage.
- If applications are incomplete or required certifications are missing, staff must request further information from the employee and postpone coverage until all eligibility information and dual enrollment decisions are received.
- Appeals of HCA's adverse eligibility determinations are permitted under the Administrative Procedures Act.

Frequency

- Eligibility is determined at the time of application for enrollment. Changes to enrollment, which may include eligibility determinations, occur regularly during the annual open enrollment period and following any life event that changes the eligibility of an employee or the employee's dependent(s) (*see eligibility section*).
- Dependents may lose eligibility following a divorce, separation, or termination of a qualified domestic partnership, or upon reaching age 20.
- Eligibility for dependents is also determined when an employee leaves a PEBB covered job and subsequently enrolls in COBRA or retirement programs.
- Student certification occurs annually, and disability recertification occurs periodically.

Comments on Process

- There is no current statewide system for validating information provided by employing agencies.
- The process is partially automated. The computer system requires certain eligibility information to enroll the employee's dependent(s), and that information requires the staff member entering the information to have the required forms as verification.
- The system is designed to check its own records for dual enrollment of dependents and requires resolution before enrolling the dependent. If the information entered into the system appears to be incorrect, the system requires resolution before the dependent can be enrolled.
- By reviewing the certifications, HCA separately verifies eligibility of all dependents except employees' children under 19, thereby providing two levels of scrutiny for those dependents where there is most opportunity for confusion about eligibility.

Eligibility Determination Overlaps

- Because an employee may be employed by more than one PEBB organization at the same time or may be a dependent of another PEBB employee, it is probable that some persons have eligibility determined more than once under different criteria. Multiple eligibility determinations will be necessary so long as situations exist in which a person could be eligible for coverage more than one way.

For Further Information

- http://www.perspay.hca.wa.gov/documents/EligbilityManual.pdf

Income and Asset Limits: Not Applicable

PUBLIC EMPLOYEES BENEFITS BOARD HEALTH BENEFITS—SURVIVING DEPENDENTS OF EMERGENCY SERVICE PERSONNEL KILLED IN THE LINE OF DUTY

Program Description and Purpose:

Administered by the Health Care Authority (HCA), the Public Employees Benefits Board (PEBB) provides comprehensive health and dental coverage for surviving dependents of emergency service personnel killed in the line of duty.

Program Limitations and Costs: 2-Year Costs: $1 billion to $10 billion (all PEBB combined)

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			

• Eligible dependents include:
  ○ Lawful spouse or an ex-spouse who has been provided benefits in a court order
  ○ Biological or adopted children and stepchildren, including;
  ▪ Posthumous children;
  ▪ Children through age 19;
  ▪ Children who are students aged 20-23;and
  ▪ Children with disabilities of any age.
		✓	

• All dependents except children through age 19 must be certified by HCA		✓	

• Eligible surviving dependents must enroll or defer enrollment within 180 days of the:
  ○ Emergency service worker's death;
  ○ Date on the letter from the Department of Retirement Systems or the Board For Volunteer Fire Fighters and Reserve Officers that informs the survivor that he or she is determined to be an eligible survivor; or
  ○ Last day that the surviving spouse or child was covered under any health plan through the emergency service worker's employer or COBRA.
		✓	

Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Dependent is already enrolled in a PEBB health care coverage program		✓	
• Dependent does not apply during the time limit or defers coverage but does not maintain comprehensive coverage during deferral		✓	
Priority Populations • N/A			

Possible Alternative Programs	Administrator:
• N/A	N/A
Bordering Programs	**Administrator:**
• N/A	N/A

Comments

- Survivors may defer enrollment if they are enrolled in a comprehensive health coverage program through an employer. Survivors who defer enrollment may enroll within 60 days of losing coverage and will need to provide proof of continuous coverage. Benefits for these survivors begins the first day of the month after the month the other coverage ended.
- Coverage for survivors who do not defer benefits begins either the first of the month that PEBB Benefits Services receives the election or the first of a month not more than 60 days before the election form is received.

PUBLIC EMPLOYEES BENEFITS BOARD HEALTH BENEFITS—SURVIVING DEPENDENTS OF EMERGENCY SERVICE PERSONNEL KILLED IN THE LINE OF DUTY

Eligibility Determination Process

- Eligibility determinations for survivors are currently made at the Department of Retirement Systems or the employee's employing agency.
- Survivors may not add new dependents acquired through birth (except posthumous children), remarriage, or a qualified domestic partnership.
- Survivors must submit the proper, completed certification forms for all dependents (except a child under age 20) within the time frames listed in the eligibility section on page 1 of this Program Summary.
- When PEBB Benefits Services staff initially enter each survivor's social security number into the benefits system, the system automatically searches for duplicates. If dual enrollment is found, the staff at each work group will coordinate to ensure no break in coverage following the enrollee's decision where the dependent will be covered.
- The benefits system requires staff to enter codes for type of dependent, coverage date, type of coverage, carrier, and temporary eligibility qualification for dependents requiring certification forms. For dependents requiring certification forms, the forms must be sent to HCA for reviews and the final eligibility determination for these dependents. HCA may deny coverage.
- If applications are incomplete or required certifications are missing, staff must request further information from the survivor and postpone coverage until all eligibility information and dual enrollment decisions are received. HCA will deny coverage if certifications are not received within the applicable timelines.
- Appeals of HCA's adverse eligibility determinations are permitted under the Administrative Procedures Act.

Frequency

- Eligibility is determined at the time of application for enrollment. Changes to enrollment, which may include eligibility determinations, occur regularly during the annual open enrollment period and following any life event that changes the eligibility of the employee's survivor(s) (*see eligibility section*).
- Dependents may lose eligibility following a divorce, separation, or upon reaching age 20.
- Student certification occurs annually, and disability recertification occurs periodically.

Comments on Process

- There is no current statewide system for validating information provided by employing agencies.
- The process is partially automated. The computer system requires certain eligibility information to enroll the employee's dependent(s), and that information requires the staff member entering the information to have the required forms as verification.
- The system is designed to check its own records for dual enrollment of dependents and requires resolution before enrolling the dependent. If the information entered into the system appears to be incorrect, the system requires resolution before the dependent can be enrolled.

Eligibility Determination Overlaps

- Because a survivor may also be employed by a PEBB organization or may be a dependent of another PEBB employee, it is probable that some persons have eligibility determined more than once under different criteria. Multiple eligibility determinations will be necessary so long as situations exist in which a person could be eligible for coverage more than one way.

For Further Information

- http://www.perspay.hca.wa.gov/documents/EligbilityManual.pdf

Income and Asset Limits: Not Applicable

PUBLIC EMPLOYEES BENEFITS BOARD HEALTH BENEFITS—RETIREES

Program Description and Purpose:

Administered by the Health Care Authority (HCA), the Public Employees Benefits Board (PEBB) provides comprehensive health and dental coverage for retirees of state sponsored-retirement systems listed in the comments section below. The premium of retirees enrolled in Medicare Parts A & B is subsidized by the State.

Program Limitations and Costs: 2-Year Costs: $1 billion to $10 billion (all PEBB combined)

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
Employee must:		✓	
• Be vested in a Washington-state-sponsored retirement plan **EXCEPT** for:			
o Elected officials who leave office voluntarily or involuntarily; **and**			
o Employees who retire from a local government that participates in PEBB insurance coverage but does not participate in a Washington State-sponsored retirement system.			
• Be eligible to retire under the plan when state-paid or COBRA coverage ends		✓	
• Receive or defer a monthly disability retirement plan payment, if permanently and totally disabled		✓	
• Immediately begin to receive a monthly retirement payment or fit within a listed exception		✓	
• If the person is not a member of PERS, he or she must meet the same age and years of service requirements as under PERS Plan 1 or 2		✓	
• Submit an election form to enroll or defer insurance coverage within 60 days Those who defer coverage must maintain comprehensive coverage		✓	
• Enroll in and maintain both Medicare Parts A & B, if entitled to Medicare (except persons who retired prior to July 1991)		✓	
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Employees who cancel PEBB health plan coverage or do not enroll in a PEBB health plan at retirement, if they failed to **either**:		✓	
o Defer PEBB enrollment at retirement; **or**			
o Maintain comprehensive health coverage while deferred or cancelled.			
• No enrollment or deferral form is submitted within 60 days	✓		
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Federal Retirement and private retirement health coverage programs	N/A
Bordering Programs	**Administrator:**
• N/A	N/A

Comments

- "State-sponsored" systems include: the higher education retirement plans; law enforcement officers' and fire fighters' retirement (LEOFF); public employees' retirement (PERS); public safety employees' retirement system (PSERS); school employees' retirement (SERS); state judges/judicial retirement system; teachers' retirement (TRS); state patrol retirement (SPRS); the federal civil service retirement system; and the federal employees' retirement system (for certain Washington State University Extension employees).

PUBLIC EMPLOYEES BENEFITS BOARD HEALTH BENEFITS—RETIREES

Eligibility Determination Process

- Eligibility determinations for retirees are currently made by PEBB.
- Employees must submit the proper, completed forms to PEBB within 60 days of retiring to either enroll or defer enrollment in health and dental coverage. Employees who fail to enroll or defer their coverage within 60 days lose their future right to enroll in PEBB retirement coverage.
- Retirees and their dependents eligible to enroll in Medicare must enroll in Medicare Parts A & B if the employee retired on or after July 1991. If the chosen carrier has both a regular plan and a Medicare Advantage plan, they must select the Medicare Advantage Plan. If the retiree wishes to enroll dependents and the family includes both those who are and are not Medicare eligible, the retiree cannot select a carrier with plans only for Medicare-eligible persons.
- Those who sign up for Medicare Part D (prescription drug coverage) are limited to Medicare Supplement Plan E or Plan J in the coverage they may select for other benefits and cannot sign up for a Medicare Advantage plan.
- The benefits system requires staff to enter codes for type of retiree, coverage date, type of coverage, and carrier.
- If applications are incomplete, staff must request further information from the employee and postpone coverage until all eligibility information is received.
- When an employee retires, but is not eligible for a pension, the employee may be eligible for COBRA continuation coverage on a self-pay basis. Employee must enroll within 60 days and eligibility is determined at the time of enrollment.
- Appeals of HCA's eligibility determinations are permitted under the Administrative Procedures Act.

Frequency

- There is no current statewide system for validating information provided to HCA.
- Eligibility is determined at retirement. Changes to enrollment, which may include eligibility determinations, occur regularly during the annual open enrollment period and following any life event that changes the eligibility of the retiree's dependent(s) (*e.g.,* marriage, birth of a child, divorce, death, child reaches age 20).
- If a person loses coverage under his or her retirement program or dies, his or her dependents' eligibility for continued coverage as a surviving dependent under PEBB retiree insurance coverage is determined at the time of enrollment in COBRA.

Comments on Process

- The process is partially automated. The computer system requires certain eligibility information to enroll the retiree, and that information requires the staff member entering the information to have the required forms as verification.
- The system is designed to check its own records for dual enrollment and requires resolution before the retiree can be enrolled.

Eligibility Determination Overlaps

- Because a retiree may be a dependent of another PEBB employee, it is probable that some persons have eligibility determined more than once under different criteria. Multiple eligibility determinations will be necessary so long as situations exist in which a person could be eligible for coverage more than one way.

For Further Information

- http://www.pebb.hca.wa.gov/documents/publications/51-205-2008.pdf

Income and Asset Limits: Not Applicable

PUBLIC EMPLOYEES BENEFITS BOARD HEALTH BENEFITS—RETIREES' DEPENDENTS

Program Description and Purpose:

Administered by the Health Care Authority (HCA), the Public Employees Benefits Board (PEBB) provides comprehensive health and dental coverage for dependents of retirees of eligible entities and certain non-employees described in the comments on the PEBB Employees Program Summary page. The premium for dependents of retirees enrolled in Medicare Parts A & B is subsidized by the State.

Program Limitations and Costs: 2-Year Costs: $1 billion to $10 billion (all PEBB combined)

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Eligible retirees' dependents include: o Spouse or qualified domestic partner or registered same-sex domestic partner; o Children through age 19; o Students age 20-23; o Extended dependents (with court order); o Dependents with disabilities of any age; **and** o Parents enrolled in PEBB medical before July 1, 1990.		✓	
• All dependents except children through age 19 must be certified by HCA		✓	
• Retirees may enroll eligible dependents		✓	
• Retirees who enroll dependents must enroll or waive them: o Within 60 days of retirement; o During the annual open enrollment period; o Within 60 days of: marriage; declaration or registration of a qualified domestic partnership; birth or assumption of legal obligation for a child in anticipation of adoption; the first day of the quarter/semester in which a student age 20-23 is registered if they are not currently enrolled; being awarded custody/guardianship of an extended dependent; a disabling event that occurs before the dependent's 20th birthday or while the child is a student over 20; an enrolled child's 20th birthday for students; or when the dependent loses his or her other insurance coverage.		✓	
• Eligible surviving dependents must enroll within 60 days of retirees' death		✓	
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Dependents of a retiree who has deferred enrollment, during the deferral	✓		
• Dependent is already enrolled in PEBB		✓	
• No enrollment or deferral form is submitted within 60 days	✓		
Priority Populations • N/A			

Possible Alternative Programs	Administrator:
• N/A	N/A
Bordering Programs	**Administrator:**
• N/A	N/A

Comments

- If a retiree defers enrollment, dependents' eligibility is automatically deferred, except for dependents of a retiree who defers due to enrollment in Medicare/Medicaid, in which case eligible dependents may be enrolled.

PUBLIC EMPLOYEES BENEFITS BOARD HEALTH BENEFITS—RETIREES' DEPENDENTS

Eligibility Determination Process

- Retiree must submit the proper, completed certification forms for all dependents (except a child under age 20) to PEBB within the time frames listed in the eligibility section, above.
- When PEBB staff initially enter the dependent's social security number into the benefits system, the system automatically searches for duplicates. If dual enrollment is found, the staff at each work group will coordinate to ensure no break in coverage following the employee's decision where the dependent will be covered.
- The benefits system requires staff to enter codes for type of dependent, coverage date, type of coverage, carrier, and temporary eligibility qualification for dependents requiring certification forms. The certification forms must be sent to HCA which reviews them and either issues the final eligibility qualification or denies coverage.
- If applications are incomplete or required certifications are missing, staff must request further information from the employee and postpone coverage until all eligibility information and dual enrollment decisions are received. HCA denies enrollment if certifications are not provided in a timely manner.
- When an employee dies or discontinues health coverage under his or her job retirement program, dependents' enrollment is determined for COBRA continuation coverage or retirement coverage.
- Appeals of HCA's adverse eligibility determinations are permitted under the Administrative Procedures Act.

Frequency

- There is no current statewide system for validating information provided to HCA.
- Eligibility is determined at request for enrollment. Changes to enrollment, which may include eligibility determinations, occur regularly during the annual open enrollment period and following any life event that changes the eligibility of the retiree's dependent(s) (*e.g.,* marriage, birth of a child, divorce, death, child reaches age 20).
- Dependents may lose eligibility following a divorce, separation, or termination of a qualified domestic partnership, or upon reaching age 20.
- Eligibility is also determined if a retiree drops retiree coverage or dies and dependents enrolled as surviving dependents or enrolled in COBRA.
- Student certification occurs annually, and disability recertification occurs periodically.

Comments on Process

- Most of the process is automated. The computer system requires certain eligibility information to enroll the retiree's dependent(s), and that information requires the staff member entering the information to have the required forms as verification.
- The system is designed to check its own records for dual enrollment of dependents and requires resolution before enrollment. If the information entered into the system appears to be incorrect, the system requires resolution before the dependent can be enrolled.
- By reviewing the certifications, HCA separately verifies eligibility of all dependents except the employees' children under 19, thereby providing two levels of scrutiny for those dependents where there is most opportunity for confusion about eligibility.

Eligibility Determination Overlaps

- Because an employee may be employed by more than one PEBB organization at the same time or may be a dependent of another PEBB employee, it is probable that some persons have eligibility determined more than once under different criteria. Multiple eligibility determinations will be necessary so long as situations exist in which a person could be eligible for coverage more than one way.

For Further Information

- http://www.perspay.hca.wa.gov/documents/EligibilityManual.pdf

Income and Asset Limits: Not Applicable

HOME CARE PROVIDERS REPRESENTED BY SEIU 775

Program Description and Purpose:

Under the collective bargaining agreement, this program provides health care coverage with dental and vision benefits to those eligible individual providers of home care who do not have other health insurance coverage and are not eligible for other coverage through another family member, other employment, or through military or veterans' benefits. These benefits are provided through a Taft-Hartley Trust. A Taft-Hartley Trust, or Taft-Hartley Multi-employer Health and Welfare Plan, is a tool created in federal labor law in 1947 so that unionized employees of multiple employers can obtain health and other employee benefits. Benefits are also available to agency providers who have unionized and joined the Trust as a result of their collective bargaining.

Program Limitations and Costs: 2-Year Costs: $10 million to $100 million

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Employed for at least three consecutive months and work at least 86 hours per month			✓
• Provides a written authorization for payroll deduction			✓
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Applicant has or is eligible for other health care benefits through other family coverage, other employment, or military or veterans benefits			✓
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Basic Health Plan	HCA
• TANF-Related Medical Assistance	DSHS
Bordering Programs	**Administrator:**
• N/A	

Comments

- This program does not provide dependent coverage.
- Home care providers at the entry level pay scale working 86 hours per month are below 100% of the Federal Poverty Level for a family of one and, with an eligible dependent, could fit the eligibility criteria for Medical Assistance under TANF. These same providers (as well as those at higher pay scales) would meet the statutory eligibility for the Basic Health Plan (for which they are a priority population under WAC 182-25-030) and their dependents would be eligible for S-CHIP.
- DSHS sends data from the Social Service Payment System (SSPS) to the plan administrator, Benefits Solutions, Inc. (BSI). SSPS is the computer system that DSHS uses to issue vendor payments and to withhold premiums for this program. SSPS is not a payroll system, however, so DSHS is not able to compile eligibility data within that program. BSI is able to extract a list of individual providers who meet the hours worked requirement for eligibility from the SSPS data and match it to the list of individual providers who do not have other health coverage.
- BSI sends the monthly list of enrollees for the month to DSHS and the Trust.
- DSHS makes the payroll deductions from the providers' payments and sends it to the Trust. The Trust pays the premium for the month's individual provider enrollees with state funds and the providers' payroll deduction.

HOME CARE PROVIDERS REPRESENTED BY SEIU 775

- For agency providers who are represented by SEIU 775, DSHS makes the determination of who has worked the requisite hours and is not otherwise insured and forwards the information to the Trust with payment for the employee deductions. This is subject to audit by the Trust.
- The Trust transmits the premium for the month's agency provider enrollees.

Eligibility Determination Process

Frequency

- Because eligibility requires at least 86 hours for three consecutive months, and each month thereafter, eligibility is determined monthly.
- The worker loses eligibility if he or she goes 12 consecutive months without working at least 86 hours in any month.
- Workers who lose eligibility for one or more months are eligible for COBRA benefits which allow them to pay the full premium and keep coverage for a limited period.

Comments on Process

- BSI makes the hours determination and matches it to the list of uninsured individual providers requesting insurance because DSHS is not able to extract the hours worked data for the Trust because SSPS is not structured to do so.

Eligibility Determination Overlaps

- None

For Further Information

- http://www.ofm.wa.gov/labor/agreements/07-09/homecare/homecare.pdf

Income and Asset Limits: Not Applicable

FAMILY CHILD CARE PROVIDERS REPRESENTED BY SEIU 925

Program Description and Purpose:

Beginning July 1, 2008, the Taft-Hartley Trust established through collective bargaining with individual providers of home care will also provide health care coverage to those licensed family child care providers who do not have other health insurance coverage, within the negotiated state funding limits. A Taft-Hartley Trust, or Taft-Hartley Multi-employer Health and Welfare Plan, is a tool created in federal labor law in 1947 so that unionized employees of multiple employers can obtain health and other employee benefits.

Program Limitations and Costs: 2-Year Costs: $0 to $10 million

Entitlement? [N] Program Caps: Enrollment [Y] Funding [Y] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Applicant is a licensed family child care provider			✓
• Applicant has submitted all Trust documents and elected to make the employee contribution			✓
• Applicant cared for at least four state-subsidized children for at least 22 days collectively each eligible month			✓
• Applicant enrolls before funding cap is reached			✓
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Applicant is otherwise eligible to receive health care benefits through other family coverage or other employment-based coverage			✓
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Basic Health Plan	HCA
• TANF-Related Medical Assistance	DSHS
Bordering Programs	**Administrator:**
• N/A	

Comments

- There is no dependent coverage under this plan.
- Some family child care providers who have dependents may still have income that qualifies them for the Basic Health Plan or even TANF related Medical Assistance.

FAMILY CHILD CARE PROVIDERS REPRESENTED BY SEIU 925

Eligibility Determination Process

- DSHS sends data from the Social Service Payment System (SSPS) to the plan administrator, Benefits Solutions, Inc. (BSI). SSPS is the computer system that DSHS uses to issue vendor payments and to withhold premiums for this program. SSPS is not a payroll system, however, so DSHS is not able to compile eligibility data within that program. BSI is able to extract a list of individual providers who meet the hours worked requirement for eligibility from the SSPS data and match it to the list of individual providers who do not have other health coverage.
- BSI sends DSHS the list of enrollees for the month. BSI also sends the list of enrollees to the Trust.
- DSHS makes the payroll deduction and the Trust transmits the premium for the month's family child care provider enrollees.

Frequency

- Because eligibility turns on whether a provider cared for four children for 22 days each month, eligibility is determined monthly.

Comments on Process

- Under the enabling statute, DSHS, not the Department of Early Learning, makes payments to child care providers and, as a consequence, has the information to provide to the third party administrator and the Trust.

Eligibility Determination Overlaps

- None

For Further Information

- http://www.ofm.wa.gov/labor/agreements/07-09/childcare/childcare.pdf

Income and Asset Limits: Not Applicable

ADULT FAMILY HOME PROVIDERS COLLECTIVE BARGAINING AGREEMENT

Program Description and Purpose:

Under the collective bargaining agreement, this program will provide health care coverage to eligible adult family home providers. This collective bargaining agreement does **not** cover the employees of adult family homes; it only covers the contracted providers. The collective bargaining agreement is scheduled to be negotiated between the Governor and the Washington State Residential Care Council in 2008 and has not yet taken effect.

Program Limitations and Costs: 2-Year Costs: Unknown

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [Unknown]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Not yet determined			✓
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Not yet determined			✓
Priority Populations			
• N/A			

Possible Alternative Programs	**Administrator:**
• Not possible to determine at this time	N/A
Bordering Programs	**Administrator:**
• N/A	N/A

Comments

- None, at this time

ADULT FAMILY HOME PROVIDERS COLLECTIVE BARGAINING AGREEMENT

Eligibility Determination Process

- Not yet determined

Frequency

- Not yet determined

Comments on Process

- Not yet determined

Eligibility Determination Overlaps

- Not yet determined

For Further Information

- Engrossed Substitute House Bill 2111 (2007) (Chapter 189, Laws of 2007)

Income and Asset Limits: Not yet Determined

CWU GRADUATE STUDENT ASSISTANTS INJURY AND SICKNESS INSURANCE PLAN

Program Description and Purpose:

This program provides a standard of health care coverage to eligible graduate assistants. These are graduate students who have been appointed to certain graduate research and teaching positions. Coverage is paid in full for the student by the University. If the student wishes to enroll in expanded coverage, the student must pay for the difference in the premium.

Program Limitations and Costs: 2-Year Costs: $0 to $10 million

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Must be enrolled for credit		✓	
• Must be a Graduate Assistant		✓	
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Not a graduate student		✓	
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Student Health Insurance (fully paid by student)	N/A
Bordering Programs	**Administrator:**
• N/A	N/A

Comments

- The policy does not automatically provide benefits for qualifying dependants. Eligible Graduate Assistants who are enrolled may also elect to insure their qualifying dependants on a self-pay basis. This requires a separate application.

CWU GRADUATE STUDENT ASSISTANTS INJURY AND SICKNESS INSURANCE PLAN

Eligibility Determination Process

- Graduate students with assistantships are automatically enrolled by the university during qualifying terms.
- If the student's assistantship ends, and during summer quarter, the student may enroll in the same policy on a self-pay basis.
- Continuation coverage is available for non-students on a self-pay basis.

Frequency

- Enrollment is either by quarter or annually for the quarters in which the student has a graduate appointment. Eligible graduate students are automatically enrolled in the Standard Plan for qualifying quarters, unless they elect otherwise.
- If a graduate student or dependent is hospitalized for a covered condition on the date coverage terminates and benefits have been paid for the condition, the benefits will be extended for as long as the condition continues or for 365 days after termination, whichever comes sooner.

Comments on Process

- The process of determining eligibility is akin to eligibility determination for employees.

Eligibility Determination Overlaps

- None

For Further Information

- http://www.cwu.edu/~bsc/insurance_home.html#Graduate%20Student%20Health%20Insurance
- https://www.uhcsr.com/Public/ClientBrochures/2007_686_1%20&%202_brochure_v8_NOC1.pdf

Income and Asset Limits: Not Applicable

EWU GRADUATE SERVICE APPOINTMENTS ACCIDENT & SICKNESS INSURANCE PLAN

Program Description and Purpose:

This program provides medical coverage to eligible graduate students in graduate service appointments as graduate assistants, graduate associates, or graduate instructors. Graduate assistants are graduate students who teach or support teaching. Graduate associates provide various forms of administrative support consistent with their program. Graduate instructors teach at least two courses per quarter in addition to carrying at least eight credit hours. The University pays for the graduate appointees' coverage.

Program Limitations and Costs: 2-Year Costs: $0 to $10 million

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Must have an appointment as a Graduate Service Appointment. These require:			✓
○ Graduate Associates and Graduate Assistants must be enrolled for at least 10 credit hours per quarter			✓
○ Graduate Instructors must be enrolled for at least 8 credit hours per quarter			✓
• Graduate appointees must "opt-in" by enrolling within the first week of classes following their appointment.			✓
• Graduate students must actively attend classes for 31 days following enrollment, not including home study, correspondence, television or internet courses.			✓
• Dependents must be enrolled within 30 days of the student's enrollment.			✓
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Not enrolled for the minimum number of credits, or does not actively attend class			✓
• Not a graduate student			✓
• Not being awarded a Graduate Service Appointment			
• Failing to maintain academic good standing with at least a 3.0 GPA or otherwise becoming ineligible for a Graduate Service Appointment			
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Student Health Insurance (fully paid by student)	N/A
Bordering Programs	**Administrator:**
• N/A	N/A

Comments

- Graduate students may pay the applicable premium and cover their legal spouse and their children under age 19 who are not self-supporting.
- While the program is an entitlement for the approximately 10-11% of graduate students with a graduate service appointment, it is not automatic; eligible students must opt in. The fact that the program is available only to graduate appointees creates a defacto upper limit on both enrollment and funding.

EWU GRADUATE SERVICE APPOINTMENTS ACCIDENT & SICKNESS INSURANCE PLAN

Eligibility Determination Process

- Graduate assistants must "opt in" to the program by submitting an enrollment form to the University by the end of the first week of classes.
- The insurer reserves the right to verify students' enrollment and actual course attendance.

Frequency

- Enrollment for the student's dependents is not automatic and dependent coverage is not effective until the student coverage is effective.
- If a graduate student or dependent is hospitalized on the date coverage terminates, the benefits will be extended for three months if the person is confined in the hospital for a covered sickness or accident and under a doctor's care.

Comments on Process

- The process of determining eligibility is akin to eligibility determination for employees.

Eligibility Determination Overlaps

- None

For Further Information

- http://www.ewu.edu/x54932.xml

Income and Asset Limits: Not Applicable

UW GRADUATE APPOINTMENT INSURANCE PROGRAM

Program Description and Purpose:

Under the graduate student collective bargaining agreement with the University of Washington, this program provides health coverage to eligible graduate appointees, fellows, and trainees. These are graduate students who have been appointed to certain graduate research and graduate teaching positions, or who have paid fellowships or training positions. Coverage is paid in full for the student and partially paid for dependents. The student must pay a premium for any dependents covered. Premiums may be paid by the University, by a fellowship, another research funding source, or a combination of sources.

Program Limitations and Costs: 2-Year Costs: $10 million to $100 million

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Must be enrolled for at least 10 credit hours per quarter			✓
• The appointment must be at least 50% time			✓
• The fellowship or trainee position must pay at least $800 per month			✓
• Must receive a minimum of 5 paychecks in each 6 paycheck coverage period.			✓
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Not a graduate student			✓
• Not enrolled for 10 credits per quarter			✓
• Student's appointment is unpaid			✓
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Student Health Insurance (fully paid by student)	N/A
Bordering Programs	**Administrator:**
• N/A	N/A

Comments

- The coverage and eligibility of this program are negotiated between the University of Washington and the United Automobile, Aerospace and Agricultural Implement Workers of America (UAW), which represents the graduate students. The coverage is administered for the union by Welfare and Pension Administration Service, Inc.
- The University of Washington tracks the benefits and eligibility offered to state employees through the Public Employees Benefits Board and attempts to negotiate comparable terms for graduate appointees.
- Graduate students may pay the applicable premium and cover their legal spouse or qualified domestic partner, their children under 19 years old, and their dependent children incapable of self-support.
- Graduate students who go on academic leave but will be eligible again upon their return, or who lose their covered position after qualifying for at least one quarter, may continue their coverage through the remainder of the plan year (plan year ends September 30) by paying 100% of the cost of coverage for themselves and their dependents.

UW GRADUATE APPOINTMENT INSURANCE PROGRAM

Eligibility Determination Process

- Student must apply for coverage during a designated enrollment period at least every Fall quarter.
- The application is verified against the student's enrollment and appointment information at the University of Washington by the Welfare and Pension Administration Service, Inc.

Frequency

- Enrollment is either by quarter, or annually beginning with Fall quarter. For students who are enrolled continuously, only an annual application is necessary.

Comments on Process

- The process of determining eligibility is akin to eligibility determination for employees.

Eligibility Determination Overlaps

- None

For Further Information

- http://www.washington.edu/admin/hr/benefits/insure/gaip/index.html

Income and Asset Limits: Minimum $800/month for full time fellows and trainees, otherwise not Applicable

WSU GRADUATE STUDENT ASSISTANTS MEDICAL & DENTAL INSURANCE PLAN

Program Description and Purpose:

This program provides medical and dental coverage to eligible graduate assistants, fellows, and trainees. These are graduate students who have been appointed to certain graduate research or teaching positions, or who have paid fellowships or training positions. Coverage is paid in full for the student; the student must pay a premium for any dependents covered and dependent coverage is less comprehensive. Premiums may be paid by the University, by a fellowship, another research funding source, or a combination of sources.

Program Limitations and Costs: 2-Year Costs: $0 to $10 million

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Graduate appointees who are:			
○ Graduate assistants must be enrolled for at least 10 credit hours per quarter and have an assistantship stipend of at least a 50% that qualifies the student for qualified tuition reduction or a tuition fee waiver; **or**		✓	
○ Graduate Research Fellows/Trainees must be in a Full Time position, paid a stipend of at least $800 per month, engaged in research similar to that of a Research Assistant, and eligible for a qualified tuition reduction or a tuition fee waiver; **or**		✓	
○ Graduate students enrolled in at least 2 credit hours on internships required by their course of study who were covered the previous semester; **or**		✓	
○ Graduate students who are defending in the final semester of a degree program enrolled in two to six credits.		✓	
• New dependents must be enrolled (at student expense) within 31 days of becoming a dependent.		✓	
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Not a graduate student			✓
• Not enrolled for at least 10 credit hours per quarter			✓
• Student's appointment is unpaid or too few hours			✓
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Student Health Insurance (fully paid by student)	N/A
Bordering Programs	**Administrator:**
• N/A	N/A

Comments

- Graduate students may pay the applicable premium and cover their legal spouse or qualified domestic partner, their children under age 19, and developmentally disabled or physically handicapped dependent children over age 19.
- Graduate students may continue coverage for one semester during a semester off by self-pay at a higher premium.

WSU GRADUATE STUDENT ASSISTANTS MEDICAL & DENTAL INSURANCE PLAN

Eligibility Determination Process

- Student must apply for coverage during a designated enrollment period.
- The student's enrollment is dependent on the student's enrollment and appointment information at the University.

Frequency

- The benefits year is August 16 to August 16.
- Enrollment for the student's dependents is not automatic and must occur at enrollment periods or with 31 days of acquiring a new dependent.
- If a graduate student or dependent is hospitalized on the date coverage terminates, the benefits will be extended as if coverage continued until the person is released from the hospital or the lifetime maximum benefit is reached, so long as the person is not covered by other insurance.

Comments on Process

- The process of determining eligibility is akin to eligibility determination for employees.

Eligibility Determination Overlaps

- None

For Further Information

- http://www.hws.wsu.edu/default.asp?PageID=2582

Income and Asset Limits: Minimum $800/month for Graduate Research Fellows/Trainees, otherwise not applicable.

WWU GRADUATE ASSISTANTS BASIC HEALTH COVERAGE

Program Description and Purpose:

This program provides medical coverage to eligible graduate assistants during the terms in which they hold graduate assistantships. Graduate assistants are students who have been appointed to certain graduate research and graduate teaching positions. Coverage is through the Basic Health Plan and the student health service and is paid in full for the student. When a graduate assistant is not eligible for the Basic Health Plan but is eligible for graduate assistant health coverage, WWU pays the premium for the Student Health Insurance plan.

Program Limitations and Costs: 2-Year Costs: $0 to $10 million

Entitlement? [N] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Be registered for a minimum of 8 credits per quarter, unless the graduate school determines that a lesser load is appropriate for the graduate assistant's course of study.		✓	
• Graduate assistants must be in a position that is at least 50% time and qualify the student for Qualified Tuition Reduction or a Tuition Fee Waiver.		✓	
• Although graduate assistant positions are not need-based, the BHP limits enrollees to those under 200% of the federal poverty level.		✓	
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Not a graduate student		✓	
• Student's appointment is unpaid or is a work-study position		✓	
• Student has income above the income limits for the BHP		✓	
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Student Health Insurance (fully paid by student)	N/A
Bordering Programs	**Administrator:**
• N/A	N/A

Comments

- The University also pays the student health fee for graduate assistants.
- While this health coverage is an employee benefit and, consequently, an entitlement, BHP coverage is not an entitlement to any enrollee and is subject to enrollment limits both by number of enrollees and by state funding limits. The University pays the graduate assistant's premium for the student health plan for any graduate assistant who is not eligible for the Basic Health Plan.
- Graduate students, like any other Washington resident with income under 200% of poverty, may enroll dependents in the Basic Health Plan and pay the applicable premium.

WWU GRADUATE ASSISTANTS BASIC HEALTH COVERAGE

Eligibility Determination Process

- The Health Care Authority takes 1-3 months to process applications for BHP.
- Application must be completed and signed by applicant, spouse (if any), and any dependent 18 years of age or older.
- Applicant must provide documentation of a full 30 days' income from all sources and most recent IRS form 1040 with all schedules (or zero-income statement and/or declaration of non-filing of income tax).
- Applicant must provide proof of residence including street address (includes documentation of residence or homeless status & location).

Frequency

- Coverage begins the earlier of October 1 or the date a student becomes eligible for coverage.
- Coverage as a graduate appointee is only available during the quarters in which the student has a graduate assistant appointment.

Comments on Process

- The process of determining eligibility is akin to eligibility determination for employees.

Eligibility Determination Overlaps

- None

For Further Information

- http://www.wwu.edu/depts/gradschool/pdfs/TA_Description.pdf

Income and Asset Limits:

		Family Size								
	% of FPL	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Max or +**
Income	200%	$1,734	$2,334	$2,934	$3,535	$4,134	$4,734	$5,334	$5,934	$600
Assets	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

SOCIAL SERVICES PROGRAMS

TANF FAMILY MEDICAL ASSISTANCE

Program Description and Purpose: (Program F01)

Persons receiving Temporary Assistance for Needy Families (TANF) are eligible for the Categorically Needy (CN) scope of coverage[3] under Medical Assistance. This program is a federally matched Medicaid program.

Program Limitations and Costs: 2-Year Costs: $100 million - $1 billion

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [N]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• US citizen, US national, or eligible non-citizen[4]	✓		
• Has a valid Social Security Number	✓		
• Meets income and resource guidelines (*See next page*)	✓		✓
• Cooperates to obtain medical support and assigns certain financial rights to the state	✓		
• Household includes a child who is eligible for family Medicaid, SSI, or Children's Medicaid	✓		
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Non-citizen who is not a "qualified alien"	✓		
• "Qualified alien" without five years of residency (unless exempt)	✓		
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Basic Health Plan	DSHS
• TANF-Related Family Medical Assistance	DSHS
• Medicare—*Applicant may be dually enrolled. If so, Medicare is the primary payer*	Federal Gov't.

Bordering Programs	Administrator:
• Basic Health Plan	HCA
• TANF-Related Family Medical Assistance	DSHS
• Employee benefits programs	Employers

Comments

- Medical Assistance for TANF-eligible families is not subject to the 60-month limit that applies to TANF cash grants.

[3] See Appendix 3.
[4] See Appendix 4.

TANF FAMILY MEDICAL ASSISTANCE

Eligibility Determination Process

- Persons applying for Medical Assistance are considered first for federally funded or federally matched programs, including Categorically Needy (CN) Medical Assistance.
- Families or persons eligible for SSI, SSI state supplement, or TANF cash grants are automatically eligible for CN Medical Assistance and receive Medical Assistance benefits without making a separate application. Certification for CN Medical Assistance parallels that for the cash benefits.
- Applicants must supply proof of citizenship and identity unless they are already receiving SSI cash benefits, SSA disability based on the clients own disability, or Medicare. (Persons already receiving these benefits have already proved their citizenship eligibility.)
- In addition to citizenship or eligible non-citizen status, DSHS verifies Social Security Number application (when no number is known), identity, income, and pregnancy (if pregnancy is claimed). DSHS also verifies income at each review and if person is self-employed the verification may be done through tax and business records. Partial year calculation procedures are established in WAC.

Frequency

- Certification is for one year. DSHS sends the family a report in month five, which must be completed and returned in month six for a "mid-certification review." Reviews for TANF Family Medical occur automatically at each review for cash assistance or food assistance.
- Continuously eligible during period that enrollee is eligible to receive SSI, SSI state supplement, or TANF
- Upon termination of SSI, SSI state supplement, or TANF cash benefits, Medical Assistance continues until the enrollee's eligibility redetermination for other Medical Assistance can be completed.
- Continuing Medical Assistance is terminated if enrollee does not cooperate with eligibility redetermination process.
- Coverage may be retroactive for up to three months prior to application, if the person had a medical need and would have been eligible during that period.
- Coverage usually stops at the end of the month in which ineligibility is determined due to changed circumstances, allowing for 10 days notice before termination.

Comments on Process

- Much of the process is automated once the information is entered into the computer system.
- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf

Income and Asset Limits:

		Family Size								
	% of FPL	1	2	3	4	5	6	7	8	Max or +
Income	N/A	$359	$453	$562	$642	$762	$866	$1,000	$1,107	$1,321
Assets	N/A	$1000	$1000	$1000	$1000	$1000	$1000	$1000	$1000	$1000

TANF-RELATED FAMILY MEDICAL ASSISTANCE

Program Description and Purpose: (F04)

Families eligible for Temporary Assistance for Needy Families (TANF) but not taking the cash grant, and families who would be eligible for TANF but their child is not eligible for federal Medicaid or Supplemental Security Income, are eligible for the Categorically Needy (CN) scope of coverage[5] under Family Medical Assistance. Benefits in this program may be federally matched.

Program Limitations and Costs: 2-Year Costs: $100 million - $1 billion

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [N]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• US citizen, US national, or eligible non-citizen[6]	✓		
• Has a valid Social Security Number	✓		
• Meets income and resource guidelines (*See next page*)	✓		✓
• Meets resource guidelines if person is a new applicant (*See next page*)	✓		✓
• Cooperates to obtain medical support and assigns certain financial rights to the state	✓		
• Either: o Is eligible for TANF cash benefits but is not taking them; **or** o Would be eligible for TANF cash benefits, but the child in the family is not eligible for Medicaid or Supplemental Security Income.	✓		
• Is eligible for TANF cash benefits or meets income and family criteria for TANF cash benefits but is excluded from cash benefits for a reason specified in WAC (*e.g.,* applicant has already received 60 months of cash benefits)			
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Non-citizen who is not a "qualified alien" or exempt	✓		
• "Qualified alien" without five years of residency (unless exempt)	✓		
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Basic Health Plan	HCA
• Medicare—*Applicant may be dually enrolled. If so, Medicare is the primary payer*	Federal Gov't.

Bordering Programs	Administrator:
• Basic Health Plan	HCA
• TANF Family Medical Assistance	DSHS
• Family Long-Term Care	DSHS

Comments

- Medical Assistance for TANF-eligible families is not subject to the 60-month limit that applies to TANF cash.

[5] See Appendix 3.
[6] See Appendix 4.

TANF-RELATED FAMILY MEDICAL ASSISTANCE

Eligibility Determination Process

- Persons applying for Medical Assistance are considered first for federally funded or federally matched programs, including Categorically Needy (CN) Medical Assistance.
- Applicants must supply proof of citizenship and identity unless they are already receiving SSI cash benefits, SSA disability based on the clients own disability, or Medicare (Persons already receiving these benefits have already proved their citizenship eligibility.)
- In addition to citizenship or eligible non-citizen status, DSHS verifies Social Security Number application (when no number is known), identity, income, and pregnancy (if pregnancy is claimed). DSHS also verifies income at each review and if person is self-employed the verification can be done through tax and business records. Partial year calculation procedures are established in WAC.

Frequency

- Certification is for one year. DSHS sends the family a report in month five, which must be completed and returned in month six for a "mid-certification review." For families receiving cash or Basic Food assistance, reviews for Medical Assistance occur automatically at each review for those programs.
- Continuously eligible during period that enrollee is eligible to receive SSI, SSI state supplement, or TANF
- Upon termination of SSI, SSI state supplement, or TANF cash benefits, Medical Assistance continues until the enrollee's eligibility redetermination for other Medical Assistance can be completed.
- Continuing Medical Assistance is terminated if enrollee does not cooperate with eligibility redetermination process.
- Coverage may be retroactive for up to three months prior to application, if the person had a medical need and would have been eligible during that period.
- Coverage usually stops at the end of the month in which ineligibility is determined due to changed circumstances, allowing for 10 days notice before termination.

Comments on Process

- Much of the process is automated once the information is entered into the computer system.
- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf

Income and Asset Limits: *

		Family Size								
	% of FPL	1	2	3	4	5	6	7	8	Max or +
Income	N/A	$359	$453	$562	$642	$762	$866	$1,000	$1,107	$1,321
Assets	N/A	$1000	$1000	$1000	$1000	$1000	$1000	$1000	$1000	$1000

***** Resource limits are for new applicants only. Recipients are not subject to an asset test.

TRANSITIONAL MEDICAL ASSISTANCE (INCOME)

Program Description and Purpose: (Program F02)

Enrollee who has received Medical Assistance through Temporary Assistance for Needy Families (TANF) may be eligible for Transitional Medical Assistance as two consecutive six-month extensions of the Categorically Needy (CN) scope of coverage.[7] These are families that have begun to earn more than the TANF income limits. During the second six months of the extension, a premium is charged if income exceeds 100% of the federal poverty level.

Program Limitations and Costs: 2-Year Costs: $100 million - $1 billion

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Received TANF Family Medical Assistance in three of the past six months	✓		
• No longer meets TANF income guidelines	✓		✓
• Continues to meet other non-income eligibility criteria for Medicaid	✓		
• Meets the ongoing reporting requirements	✓		
• Pays premiums within 30 days during the second six-month extension	✓		
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Was not enrolled in TANF Family Medical Assistance	✓		
• No longer meets the other non-income eligibility criteria for Medicaid	✓		
• During the second six-month extension, the family can lose eligibility if the person who is the caretaker adult stops working or the earned income stops	✓		
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Basic Health Plan	HCA
• Medicare— *Applicant may be dually enrolled. If so, Medicare is the primary payer*	Federal Gov't
Bordering Programs	**Administrator:**
• Basic Health Plan	HCA

Comments

- Medical Assistance for TANF-eligible families is not subject to the 60-month limit that applies to TANF cash grants.

[7] See Appendix 3.

TRANSITIONAL MEDICAL ASSISTANCE (INCOME)

Eligibility Determination Process

- When the enrollee becomes ineligible for TANF Family Medical Assistance because the income in the family exceeds the TANF grant level, the DSHS computer system, ACES, automatically reviews programs for which the enrollee remains eligible. If the enrollee meets eligibility for Transitional Medical Assistance, the new program will be approved automatically. If not, and no other program is applicable, the assistance will end.
- TANF Transitional Medical Assistance is comprised of two six-month periods, the second of which requires a premium of 1% of countable income. In the second extension, if the enrollee fails to pay any month's premium for more than 30 days, the enrollee loses eligibility for the remainder of the extension.
- The enrollee must report income and employment-related child care costs for the first six months to determine the income on which the premium is based. Failure to make the reports results in the enrollee being ineligible.

Frequency

- The enrollee must report income and employment-related child care costs at month four (covering months 1-3) and month seven (covering months 4-6).
- Transitional Medical Assistance due to increased income ends after a maximum of 12 months.

Comments on Process

- Much of the process is automated once the information is entered into the computer system.
- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf

Income and Asset Limits:

		Family Size								
	% of FPL	1	2	3	4	5	6	7	8	Max or +
Income	N/A	>$359	>$453	>$562	>$642	>$762	>$866	>$1,000	>$1,107	>$1,321
Assets	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

TRANSITIONAL MEDICAL ASSISTANCE (CHILD SUPPORT)

Program Description and Purpose: (Program F03)

Enrollee who has received Medical Assistance through Temporary Assistance for Needy Families (TANF) may be eligible for Transitional Medical Assistance for up to four months of the Categorically Needy (CN) scope of coverage.[8] These are families who are no longer eligible for cash assistance because their child or spousal support payments have exceeded the TANF income limits.

Program Limitations and Costs: 2-Year Costs: $0 to $10 million

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [N]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Received TANF Family Medical Assistance in three of the past six months	✓		
• No longer meets TANF income guidelines	✓		✓
• Continues to meet other non-income eligibility criteria for Medicaid	✓		
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Was not enrolled in TANF Family Medical Assistance	✓		
• No longer meets the other non-income eligibility criteria for Medicaid	✓		
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Basic Health Plan	HCA
• Family Long-Term Care	DSHS
• Medicare—*Applicant may be dually enrolled. If so, Medicare is the primary payer*	Federal Gov't
Bordering Programs	**Administrator:**
• Basic Health Plan	HCA

Comments

- Medical Assistance for TANF-eligible families is not subject to the 60-month limit that applies to TANF cash grants.

[8] See Appendix 3.

TRANSITIONAL MEDICAL ASSISTANCE (CHILD SUPPORT)

Eligibility Determination Process

- When the enrollee becomes ineligible for TANF Family Medical Assistance because the income in the family exceeds the TANF grant level, the DSHS computer system, ACES, automatically reviews programs for which the enrollee remains eligible. If the enrollee meets eligibility for Transitional Medical Assistance, the new program will be approved automatically. If not, and no other program is applicable, the assistance will be end.
- TANF Transitional Medical Assistance due to child support or spousal support that exceeds the payment standard is comprised of one four-month period.

Frequency

- Transitional Medical Assistance due to increased spousal or child support ends after a maximum of four months.

Comments on Process

- Much of the process is automated once the information is entered into the computer system.
- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf

Income and Asset Limits:

		Family Size								
	% of FPL	1	2	3	4	5	6	7	8	Max or +
Income	N/A	>$359	>$453	>$562	>$642	>$762	>$866	>$1,000	>$1,107	>$1,321
Assets	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

CATEGORICALLY NEEDY FAMILY MEDICAL EXTENSION

Program Description and Purpose: (Program F10)

Enrollee who has received Medical Assistance through Temporary Assistance for Needy Families (TANF) may be eligible for a Categorically Needy Family Medical Extension for up to two months of the Categorically Needy (CN) scope of coverage.[9] These are families that have begun to earn more than the TANF income limits but do not meet the criteria for the Transitional Medical Assistance (F02) extension.

Program Limitations and Costs: 2-Year Costs: $10 million to $100 million

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Received TANF Family Medical Assistance or TANF-Related Family Medical Assistance for at least one month		✓	
• No longer meets TANF income guidelines	✓		✓
• Continues to meet other non-income eligibility criteria for Medicaid		✓	
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Was not enrolled in TANF or TANF-Related Family Medical Assistance		✓	
• No longer meets the other non-income eligibility criteria for Medicaid		✓	
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Basic Health Plan	HCA
• Medicare—*Applicant may be dually enrolled. If so, Medicare is the primary payer*	Federal Gov't
Bordering Programs	**Administrator:**
• Basic Health Plan	HCA

Comments

- The ACES Manual describes this extension as lasting either one month or two months, "depending on which is necessary for the client to meet the 3-of-6 month requirement for F02."

[9] See Appendix 3.

CATEGORICALLY NEEDY FAMILY MEDICAL EXTENSION

Eligibility Determination Process

- When the enrollee becomes ineligible for TANF or TANF-Related Family Medical Assistance because the income in the family exceeds the TANF grant level, the DSHS computer system, ACES, automatically reviews programs for which the enrollee remains eligible. If the enrollee would meet the eligibility requirements for the 12-month Transitional Medical Assistance program except that the enrollee has not been on Categorically Needy Medical Assistance for three of the previous six months, but the enrollee has been on it for at least one month, the Categorically Needy Family Medical Extension will be approved automatically. If not, and no other program is applicable, the assistance will end.
- DSHS staff cannot manually initiate a review on an F10 extension; it is only generated from a closure or denial of TANF or TANF-Related Family Medical Assistance.

Frequency

- The Categorically Needy Family Medical Extension due to increased income lasts no more than two months.

Comments on Process

- Much of the process is automated once the information is entered into the computer system.
- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/manuals/aces/sections/medical/medicalextensions.shtml#who_is_elig_f10

Income and Asset Limits:

		Family Size								
	% of FPL	1	2	3	4	5	6	7	8	Max or +
Income*	N/A	>$359	>$453	>$562	>$642	>$762	>$866	>$1,000	>$1,107	>$1,321
Assets	N/A	$1000	$1000	$1000	$1000	$1000	$1000	$1000	$1000	$1000

FAMILY-RELATED ALIEN EMERGENCY MEDICAL (ADULTS)

Program Description and Purpose: (Program F09)

This program provides treatment for emergency medical conditions to non-citizens and immigrants who do not qualify for regular Medical Assistance programs. An "emergency medical condition" is the sudden onset of a medical condition with acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: placing the patient's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. The range of possible services is similar to those services available under the Categorically Needy (CN) scope of coverage[10] **EXCEPT that no treatment is available in the absence of an emergency medical condition** and each service must be authorized as part of an ongoing emergency. This is a mandatory program under the federal Social Security Act and receives a federal funding match.

Program Limitations and Costs: 2-Year Costs: $10 million to $100 million

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [N]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Applicant is not a US citizen, US national, or eligible non-citizen[11]	✓		
• Washington State Resident	✓		
• Meets the categorical eligibility criteria for Medicaid because his or her household includes a dependent child who would be eligible for family Medicaid, SSI, or Children's Medicaid if the child were a citizen	✓		
• Meets income and resource guidelines (*See next page*)	✓		✓
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Person entered Washington specifically to obtain medical care		✓	
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Basic Health Plan	HCA

Bordering Programs	Administrator:
• Basic Health Plan	HCA
• SSI-Related Alien Emergency Medical	DSHS
• Alien Emergency Medical for Long-Term Care	DSHS
• Refugee Medical Assistance	DSHS

Comments

- This program is established in the federal Medicaid statutes.
- Children under 19 years old, pregnant women, and adults who meet the categorical requirements for SSI-related Medical Assistance but who do not meet citizen or immigration status requirements are covered by separate programs.

[10] *See* Appendix 3
[11] See Appendix 4.

FAMILY-RELATED ALIEN EMERGENCY MEDICAL (ADULTS)

Eligibility Determination Process

- The eligibility determination process for Alien Emergency Medical is centralized. All applications, statewide, go through the Central Medical Unit.
- Staff must specifically identify Alien Emergency Medical Assistance in the application process. This program is not part of the normal priority order.
- Applicants must establish state residency.
- When there are both citizen and non-citizen family members, the family may be active in more than one program and be "shared" between the regular Community Service Office (CSO) and the statewide MEDS unit CSO. When an action by either CSO could affect both the citizen and non-citizen members of the family, an alert is automatically posted to the other CSO so that any necessary action can be taken.
- Income is verified at each review.

Frequency

- Determination that a condition is an emergency medical condition, when such a determination is necessary, is made by the Medical Consultant for the DSHS Health and Recovery Services Administration.
- Certification is for three months, and the person may be recertified if he or she continues to meet the categorical eligibility criteria for Medicaid and he or she continues to have an emergency medical condition.
- Continuing Medical Assistance is terminated if enrollee does not cooperate with eligibility redetermination process.
- Coverage may be retroactive for up to three months prior to application, if the person had a qualifying emergent condition, a medical need, and would have been eligible during that period.
- Coverage usually stops at the end of the month in which ineligibility is determined due to changed circumstances, allowing for 10 days notice before termination.

Comments on Process

- Alien Emergency Medical is processed by the DSHS Central Medical Unit in Seattle.
- When documentation of a fact is necessary, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Because an applicant's citizenship or immigration status makes him or her ineligible for other programs, there is no overlap in eligibility determination.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf

Income and Asset Limits:

		Family Size								
	% of FPL	1	2	3	4	5	6	7	8	Max or +
Income	N/A	$359	$453	$562	$642	$762	$866	$1,000	$1,107	$1,321
Assets	N/A	$1000	$1000	$1000	$1000	$1000	$1000	$1000	$1000	$1000

NEWBORN MEDICAL ASSISTANCE

Program Description and Purpose: (Program F05)

Newborns and infants less than one year old whose mothers were receiving Medical Assistance at the time of delivery are automatically eligible for the Categorically Needy (CN) scope of coverage[12] under Medical Assistance. This program is a federally matched Medicaid program.

Program Limitations and Costs: 2-Year Costs: $100 million - $1 billion

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [N]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• US citizen, US national, or eligible non-citizen[13]	✓		
• Under age one	✓		
• Mother was eligible for and receiving Medical Assistance at the time of child's birth	✓		
• Child remains with the mother	✓		
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• None			
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Basic Health Plan	HCA
• TANF and TANF-Related Family Medical Assistance	DSHS
• Children's Medical Assistance	DSHS
• S-CHIP	DSHS

Bordering Programs	Administrator:
• Basic Health Plan	HCA
• TANF and TANF-Related Family Medical Assistance	DSHS
• Children's Medical Assistance	DSHS
• S-CHIP	DSHS
• State Children's Health Program	DSHS

Comments

- Infants whose mothers were not receiving benefits from a Medical Assistance program or who, after birth are not living with their mothers, may be eligible for one of the other Medical Assistance programs for children.

[12] See Appendix 3.
[13] See Appendix 4.

NEWBORN MEDICAL ASSISTANCE

Eligibility Determination Process

- Persons applying for Medical Assistance are considered first for federally funded or federally matched programs, including Categorically Needy (CN) Medical Assistance.
- Infants whose mothers were receiving Medical Assistance at the infant's birth are automatically eligible for CN Medical Assistance and receive Medical Assistance until the end of the month of their first birthday if the infant remains living with the mother and is a Washington state resident.
- Newborns are covered under their mother's medical card until their own card is issued, following the 60-day post-partum extension period.
- After the end of the month in which the infant's first birthday occurs, the infant is reviewed for eligibility for one of the children's medical programs.
- Infants in the Newborn Medical Assistance program are exempt from the requirement for a Social Security Number until their first birthday.

Frequency

- Certification is for up to one year and one month (the end of the month of the infant's first birthday).
- Eligibility is continuous through the certification date.

Comments on Process

- Much of the process is automated once the information is entered into the computer system.
- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf

Income and Asset Limits: Not Applicable*

* Infants in this program are automatically eligible based on their mother's eligibility and receipt of benefits at the time of birth. Income and resources are not addressed until determining the child's continuing eligibility for Medical Assistance following his or her first birthday.

CATEGORICALLY NEEDY CHILDREN'S MEDICAL ASSISTANCE

Program Description and Purpose: (Program F06)

This program provides the Categorically Needy (CN) scope of coverage[14] under Medical Assistance to citizen and eligible non-citizen children. This program is a federally matched Medicaid program.

Program Limitations and Costs: 2-Year Costs: $1 billion to $10 billion (including Basic Health Plus)

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [N]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• US citizen, US national, or eligible non-citizen[15]	✓		
• Has a valid Social Security Number	✓		
• Meets income guidelines (*See next page*)	✓		✓
• Child is under 19	✓		
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Non-citizen who is not a "qualified alien" or exempt	✓		
• "Qualified alien" without five years of residency (unless exempt)	✓		
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Basic Health Plan	HCA
• TANF-Related Family Medical Assistance	DSHS
• Foster Care and Adoption Support Medical Assistance	DSHS
• Family Long-Term Care	DSHS

Bordering Programs	Administrator:
• Basic Health Plan	HCA
• TANF-Related Family Medical Assistance	DSHS
• S-CHIP	DSHS
• Children's Health Program	DSHS
• Children's Medically Needy level assistance	DSHS
• Foster Care and Adoption Support Medical Assistance	DSHS

Comments

- Children's Medical Assistance does not have a resource limit, and the child does not need to be living with a parent to receive this assistance.

[14] See Appendix 3.
[15] See Appendix 4.

CATEGORICALLY NEEDY CHILDREN'S MEDICAL ASSISTANCE

Eligibility Determination Process

- Children applying for Medical Assistance are considered first for federally funded or federally matched programs, including Categorically Needy (CN) Medical Assistance. Among the children's programs, this program is the first considered. Children ineligible for this program are automatically considered for other programs in an established priority order.
- Children eligible for SSI, SSI state supplement, or TANF cash grants are automatically eligible for CN Medical Assistance and receive Medical Assistance benefits without making a separate application.
- Children must supply proof of citizenship and identity unless they are already receiving SSI cash benefits or Medicare. (Persons receiving these benefits have already proved their citizenship eligibility.)
- In addition to citizenship or eligible non-citizen status, DSHS verifies Social Security Number or application (when no number is known), identity, income, and pregnancy (if pregnancy is claimed).
- Income is verified at each review.

Frequency

- Certification is for 12 months.
- Upon approval, child is continuously eligible through the certification date.
- If CN coverage ends, medical coverage is continued until enrollee's eligibility redetermination for other Medical Assistance can be completed.
- Continuing Medical Assistance is terminated if enrollee does not cooperate with eligibility redetermination process.
- Coverage may be retroactive for up to three months prior to application, if the person had a medical need and would have been eligible during that period.

Comments on Process

- Much of the process is automated once the information is entered into the computer system.
- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf

Income and Asset Limits:

		Family Size								
	% of FPL	1	2	3	4	5	6	7	8	Max or +
Income	200%	$1,733	$2,333	$2,933	$3,533	$4,133	$4,733	$5,333	$5,933	$600
Assets	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (S-CHIP)

Program Description and Purpose: (Program F07)

This program provides the Categorically Needy (CN) scope of coverage[16] under Medical Assistance to citizen and qualifying non-citizen children with family incomes between 200% and 250% of the federal poverty level. On January 1, 2009 the upper income limit in this program will increase to 300% of the federal poverty level. This program is a federally matched Medical Assistance program.

Program Limitations and Costs: 2-Year Costs: $10 million to $100 million

Entitlement? [N] Program Caps: Enrollment [Y] Funding [Y] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• US citizen, US national, or eligible non-citizen[17]	✓		
• Has a valid Social Security Number	✓		
• Meets income guidelines (*See next page*)	✓		✓
• Child is under 19; **and**	✓		
○ Child does not have other creditable coverage; **and**	✓		
○ The child's parent pays the premium for the coverage	✓		
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Non-citizen who is not a "qualified alien" or exempt	✓		
• "Qualified alien" without five years of residency (unless exempt)	✓		
• Parent or responsible person fails to pay a required premium	✓		
Priority Populations			
• Low-income children without "creditable" health care coverage	✓		

Possible Alternative Programs	Administrator:
• Basic Health Plan	HCA
Bordering Programs	**Administrator:**
• Basic Health Plan	HCA
• TANF and TANF-Related Family Medical Assistance	DSHS
• Children's Health Program	DSHS
• Children's Medically Needy level assistance	DSHS

Comments

- S-CHIP does not have a resource limit, and the child does not need to be living with a parent to receive this assistance.

[16] See Appendix 3.
[17] See Appendix 4.

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (S-CHIP)

Eligibility Determination Process

- Persons applying for Medical Assistance are considered first for federally funded or federally matched programs, including Categorically Needy (CN) Medical Assistance. Children are automatically considered for Medical Assistance programs in an established priority order. Children ineligible for S-CHIP based on having family income over 250% of the federal poverty level (300% in January 2009) are probably ineligible for other programs.
- Applicants must supply proof of citizenship and identity unless they are already receiving SSI cash benefits, SSA disability based on the clients own disability, or Medicare (Persons receiving these benefits have already proved their citizenship eligibility.)
- In addition to citizenship or eligible non-citizen status, DSHS verifies Social Security Number or application (when no number is known), identity, income, and pregnancy (if pregnancy is claimed).
- Income is verified at each review.

Frequency

- Certification is for 12 months.
- Continuing Medical Assistance is terminated if enrollee does not cooperate with eligibility redetermination process.

Comments on Process

- Much of the process is automated once the information is entered into the computer system.
- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf

Income and Asset Limits:

		Family Size								
	% of FPL	1	2	3	4	5	6	7	8	Max or +
Income 2008*	250%	$2,167	$2,917	$3,667	$4,417	$5,167	$5,917	$6,667	$7,417	$750
Income 2009*	300%	$2,600	$3,500	$4,400	$5,300	$6,200	$7,100	$8,000	$8,900	$900
Assets	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

* The current income limit of 250% of the federal poverty level is scheduled to be raised to 300% of the federal poverty level on January 1, 2009. Federal authorities permit this when states are covering 95% of eligible children with incomes under 250% of the federal poverty level. Income is calculated as under TANF.

CHILDREN'S HEALTH PROGRAM (CHP) FOR NON-CITIZEN CHILDREN

Program Description and Purpose: (Program F08)

This is a state-funded program to provide the Categorically Needy (CN) scope of coverage[18] under Medical Assistance to children who do not have documentation of citizenship or eligible alien status. As such, it is comparable to children's Medicaid and the S-CHIP program. This program is not eligible for a federal funding match.

Program Limitations and Costs: 2-Year Costs: $10 million to $100 million

Entitlement? [N] Program Caps: Enrollment [Y] Funding [Y] Participant Cost Sharing? [See comment]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Child is under 19		✓	
• Child is not a citizen or eligible non-citizen[19]		✓	
• Washington State Resident		✓	
• Meets income guidelines (*See next page*)		✓	
• As applicable, pays required premiums		✓	
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Child is eligible for federally supported Medical Assistance		✓	
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Basic Health Plan	HCA
• Alien Emergency Medical Assistance	DSHS

Bordering Programs	Administrator:
• Basic Health Plan	HCA
• Alien Emergency Medical Assistance	DSHS

Comments

- A premium is required for children from families with incomes between 200% and 250% of the federal poverty level. This is consistent with the premium required for citizen and eligible non-citizen children under S-CHIP.
- The Children's Health Program is designed to provide a CN scope of coverage to children resident in Washington who are ineligible for Medicaid because of their citizenship or Medicaid status.
- Some families have both citizen and non-citizen children. Consequently, some of the children will be eligible for Medicaid or S-CHIP, and others will be eligible for this program.

[18] See Appendix 3.
[19] See Appendix 4.

CHILDREN'S HEALTH PROGRAM (CHP) FOR NON-CITIZEN CHILDREN

Eligibility Determination Process

- The eligibility determination process for non-citizen children is centralized at DSHS. All applications, statewide, go through the Medical Eligibility Determination Services (MEDS) unit at the Health and Recovery Services Administration in Olympia.
- The MEDS staff must specifically screen for the Children's Health Program as it is considered a special program outside the automated program priority process.
- Child applicants must establish state residency, which is verified by staff at the MEDS unit if questionable.
- When there are both citizen and non-citizen family members, the family may have more than one file and be "shared" between the regular Community Service Office (CSO) and the statewide MEDS unit. When an action by either CSO could affect both the citizen and non-citizen members of the family, an alert is automatically posted to the other CSO so that any necessary action can be taken.
- Income is verified at each review.

Frequency

- Certification is for 12 months.
- Continuing Medical Assistance is terminated if enrollee does not cooperate with eligibility redetermination process.
- Coverage may be retroactive for up to three months prior to application, if the person had a medical need and would have been eligible during that period.

Comments on Process

- When documentation of a fact is necessary, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary, consequently, children are screened for the Children's Health Program only if they are not claiming status as a citizen or eligible immigrant under Medicaid.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf

Income and Asset Limits:

		Family Size								
	% of FPL	1	2	3	4	5	6	7	8	Max or +
Income 2008	250%	$2,167	$2,917	$3,667	$4,417	$5,167	$5,917	$6,667	$7,417	$750
Income 2009	300%	$2,600	$3,500	$4,400	$5,300	$6,200	$7,100	$8,000	$8,900	$900
Assets	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

MEDICALLY NEEDY CHILDREN'S MEDICAL ASSISTANCE

Program Description and Purpose: (Program F99)

This program provides the Medically Needy (MN) scope of coverage[20] under Medical Assistance to citizen and eligible immigrant children with incomes over 250% of the federal poverty level. This program is a federally matched Medicaid program and is subject to spend-down.[21]

Program Limitations and Costs: 2-Year Costs: $0 to $10 million

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• US citizen, US national, or eligible non-citizen[22]	✓		
• Has a valid Social Security Number	✓		
• Meets income guidelines (*See next page*)	✓		✓
• Child is under 19	✓		
• Except for income, child would be eligible for a children's program with a Categorically Needy scope of coverage	✓		
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Non-citizen who is not a "qualified alien" or exempt	✓		
• "Qualified alien" without five years of residency (unless exempt)	✓		
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• None	N/A
Bordering Programs	**Administrator:**
• Basic Health Plan	HCA
• TANF-Related Family Medical Assistance	DSHS
• S-CHIP	DSHS
• SSI-Related Medical Assistance	DSHS

Comments

- Children meeting these eligibility criteria with family incomes under 250% of the federal poverty level are eligible for Medical Assistance with a Categorically Needy scope of coverage.

[20] See Appendix 3.
[21] See explanation of spending down, above, page 11.
[22] See Appendix 4.

MEDICALLY NEEDY CHILDREN'S MEDICAL ASSISTANCE

Eligibility Determination Process

- Persons applying for Medical Assistance are considered first for federally funded or federally matched programs, including Categorically Needy (CN) Medical Assistance.
- When a child's family income is above 250% of the federal poverty level, the family must spend down the excess income before medical benefits are authorized. The family spends down the excess by incurring financial obligations for medical expenses equal to the spend-down amount.
- Until the family has spent down enough to receive benefits, the child remains as a pending case.
- DSHS staff must authorize the spend-down and enter the qualifying medical expenses in order for the system to recognize them and issue benefits.
- Applicants must supply proof of citizenship and identity unless they are already receiving SSI cash benefits, SSA disability based on the clients own disability, or Medicare. (Persons receiving these benefits have already proved their citizenship eligibility.)
- In addition to citizenship or eligible non-citizen status, DSHS verifies Social Security Number or application (when no number is known), identity, income, medical expenses, and pregnancy (if pregnancy is claimed).
- Income is verified at each review.

Frequency

- Certification is for six months unless a three-month period is selected. A child whose current medical expenses are low in comparison to his or her excess income may want to select the shorter certification period as the total amount to be spent down during the period is less.
- Continuing Medical Assistance is terminated if enrollee does not cooperate with eligibility redetermination process.
- Coverage may be retroactive for up to three months prior to application, if the person had a medical need, incurred unmet medical expenses, and would have been eligible during that period.
- Coverage usually stops at the end of the month in which ineligibility is determined due to changed circumstances, allowing for 10 days notice before termination.

Comments on Process

- Much of the process is automated once the information is entered into the computer system.
- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf
- http://fortress.wa.gov/dshs/maa/Eligibility/OVERVIEW/MedicallOverviewSpenddown.htm, Overview of Spend-down

Income and Asset Limits: *(Incomes above this limit are subject to spend-down.)*

		Family Size								
	% of FPL	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Max or +**
Income	250%	$2,167	$2,917	$3,667	$4,417	$5,167	$5,917	$6,667	$7,414	$750
Assets	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

CATEGORICALLY NEEDY FOSTER CARE, ADOPTION SUPPORT, OR JUVENILE REHABILITATION FOR CHILDREN RECEIVING SSI

Program Description and Purpose: (Program D01)

This program provides the Categorically Needy (CN) scope of coverage[23] under Medical Assistance to children in foster care, relative foster care placement, or juvenile rehabilitation, or who are receiving adoption support. Foster children and children in juvenile rehabilitation are dependents of the state; the state is responsible for their health coverage. Children receiving adoption support services are those for whom it has been determined that they would not be adopted without government support. This program is a federally matched Medicaid program.

Program Limitations and Costs: 2-Year Costs: $0 to $10 million

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [N]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• US citizen, US national, or eligible non-citizen[24]	✓		
• Has a valid Social Security Number	✓		
• Child is receiving SSI	✓		
• Child is in foster care, foster care relative placement, or juvenile rehabilitation; **and**	✓		
o The child has not passed the month of his or her 18th birthday; **or**	✓		
o DSHS determines he or she remains eligible for foster care services; **or**	✓		
o Under 21 and was in foster care on his or her 18th birthday; **or**	✓		
o Child is receiving subsidized adoption support services and has not passed the month of his or her 19th birthday.	✓		
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Non-citizen who is not a "qualified alien" or exempt	✓		
• "Qualified alien" without five years of residency (unless exempt)	✓		
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Basic Health Plan	HCA
• TANF-Related Family Medical Assistance	DSHS

Bordering Programs	Administrator:
• Basic Health Plan	HCA
• TANF or TANF-Related Family Medical Assistance	DSHS
• S-CHIP	DSHS
• Children's Medically Needy level assistance	DSHS

Comments

- None

[23] See Appendix 3.
[24] See Appendix 4.

CATEGORICALLY NEEDY FOSTER CARE, ADOPTION SUPPORT, OR JUVENILE REHABILITATION FOR CHILDREN RECEIVING SSI

Eligibility Determination Process

- Persons applying for Medical Assistance are considered first for federally funded or federally matched programs, including Categorically Needy (CN) Medical Assistance. Children are automatically considered for Medical Assistance programs in an established priority order.
- When an application is made for a dependent child (in foster care, foster care relative placement, or juvenile rehabilitation) or a child receiving adoption support, the application is referred to the Foster Care Medical Team (FCMT) of the DSHS Medical Eligibility Determination Services (MEDS) section at Health and Recovery Services to determine eligibility and benefits.
- FCMT manages and maintains the child's case while the child is in care in order to address the additional confidentiality issues for these children.
- Applicants must supply proof of citizenship and identity unless they are already receiving SSI cash benefits, SSA disability based on the clients own disability, or Medicare. (Persons receiving these benefits have already proved their citizenship eligibility.)
- In addition to citizenship or eligible non-citizen status, DSHS verifies Social Security Number or application (when no number is known), identity, income, and pregnancy (if pregnancy is claimed).
- Income is verified at each review.

Frequency

- Certification is continuous during the period that the person receives SSI.
- Continuously eligible during period that enrollee is dependent on the state.
- Upon termination of SSI, Medical Assistance continues until the enrollee's eligibility for other Medical Assistance can be completed.
- Continuing Medical Assistance is terminated if enrollee does not cooperate with eligibility redetermination process.
- Coverage may be retroactive for up to three months prior to application, if the person had a medical need and would have been eligible during that period.
- Coverage usually stops at the end of the month in which ineligibility is determined due to changed circumstances, allowing for 10 days notice before termination.

Comments on Process

- Much of the process is automated once the information is entered into the computer system.
- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf

Income and Asset Limits: Not Applicable

CATEGORICALLY NEEDY FOSTER CARE, ADOPTION SUPPORT, OR JUVENILE REHABILITATION FOR CHILDREN NOT RECEIVING SSI

Program Description and Purpose: (Program D02)

This program provides the Categorically Needy (CN) scope of coverage[25] under Medical Assistance to children in foster care, relative foster care placement, or juvenile rehabilitation, or who are receiving adoption support. Foster children and children in juvenile rehabilitation are dependents of the state; the state is responsible for their health coverage. Children receiving adoption support services are those for whom it has been determined that they would not be adopted without government support. This program is a federally matched Medicaid program.

Program Limitations and Costs: 2-Year Costs: $10 million to $100 million

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [N]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• US citizen, US national, or eligible non-citizen[26]	✓		
• Has a valid Social Security Number	✓		
• Child is NOT receiving SSI	✓		
• Child is in foster care, foster care relative placement, or juvenile rehabilitation; **and**	✓		
o Child has not passed the month of his or her 18th birthday; **or**	✓		
o DSHS determines he or she remains eligible for foster care services; **or**	✓		
o Under 21 and was in foster care on his or her 18th birthday; **or**	✓		
o Child is receiving subsidized adoption support services and has not passed the month of his or her 19th birthday.	✓		
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Non-citizen who is not a "qualified alien" or exempt	✓		
• "Qualified alien" without five years of residency (unless exempt)	✓		
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Basic Health Plan	HCA
• TANF-Related Family Medical Assistance	DSHS
Bordering Programs	**Administrator:**
• Basic Health Plan	HCA
• TANF or TANF-Related Family Medical Assistance	DSHS
• S-CHIP	DSHS
• Children's Medically Needy level assistance	DSHS

Comments

- None

[25] See Appendix 3.
[26] See Appendix 4.

CATEGORICALLY NEEDY FOSTER CARE, ADOPTION SUPPORT, OR JUVENILE REHABILITATION FOR CHILDREN NOT RECEIVING SSI

Eligibility Determination Process

- Persons applying for Medical Assistance are considered first for federally funded or federally matched programs, including Categorically Needy (CN) Medical Assistance. Children are automatically considered for Medical Assistance programs in an established priority order.
- When an application is made for a dependent child (in foster care, foster care relative placement, or juvenile rehabilitation) or a child receiving adoption support, the application is referred to the Foster Care Medical Team (FCMT) of the DSHS Medical Eligibility Determination Services (MEDS) section at Health and Recovery Services to determine eligibility and benefits.
- FCMT manages and maintains the child's case while the child is in care in order to address the additional confidentiality issues for these children.
- Applicants must supply proof of citizenship and identity unless they are already receiving SSI cash benefits, SSA disability based on the clients own disability, or Medicare. (Persons receiving these benefits have already proved their citizenship eligibility.)
- In addition to citizenship or eligible non-citizen status, DSHS verifies Social Security Number or application (when no number is known), identity, income, and pregnancy (if pregnancy is claimed).
- Income is verified at each review.

Frequency

- Certification is for twelve months.
- Continuously eligible during period that enrollee is dependent on the state.
- Coverage may be retroactive for up to three months prior to application, if the person had a medical need and would have been eligible during that period.
- Coverage usually stops at the end of the month in which ineligibility is determined due to changed circumstances, allowing for 10 days notice before termination.

Comments on Process

- Much of the process is automated once the information is entered into the computer system.
- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf

Income and Asset Limits: Not Applicable

CATEGORICALLY NEEDY MEDICAL ASSISTANCE FOR PREGNANT WOMEN

Program Description and Purpose: (Program P02)

This program provides the Categorically Needy scope of coverage[27] to eligible pregnant women for the duration of the pregnancy. Women enrolled under this program are eligible for a 60-day post-partum extension that provides continued Medical Assistance for the woman and her infant(s) through the end of the month that includes the 60th day after the pregnancy ends. This is a federally matched Medicaid program.

Program Limitations and Costs: 2-Year Costs: $100 million - $1 billion

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [N]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• US citizen, US national, or eligible non-citizen[28]	✓		
• Has a valid Social Security Number	✓		
• Meets income guidelines (*See next page*)	✓		✓
• Woman is pregnant	✓		
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Person is not female	✓		
• Woman is not pregnant	✓		
• Non-citizen who is not a "qualified alien"	✓		
• "Qualified alien" without five years of residency (unless exempt)	✓		
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Basic Health Plan	HCA
• TANF-Related Family Medical Assistance	DSHS
• Children's Medicaid (for pregnant girls)	DSHS
• S-CHIP Medical Assistance (for pregnant girls)	DSHS
• SSI-related medical assistance	DSHS
• Qualified Medicare Beneficiary	DSHS

Bordering Programs	Administrator:
• Basic Health Plan	HCA
• TANF-Related Family Medical Assistance	DSHS
• Medically Needy Medical Assistance for Pregnant Women	DSHS
• Medical Assistance for Non-Citizen Pregnant Women	DSHS
• Children's Medicaid (for pregnant girls)	DSHS
• S-CHIP Medical Assistance (for pregnant girls)	DSHS

Comments

- Once a woman is found eligible for this program, she is eligible for the duration of her pregnancy and the post-partum period, even if her income increases.
- Following the post-partum extension, women in this program are eligible for an additional 10 months of family planning services (*See* Family Planning Extension Program Summary page).

[27] See Appendix 3.
[28] See Appendix 4.

CATEGORICALLY NEEDY MEDICAL ASSISTANCE FOR PREGNANT WOMEN

Eligibility Determination Process

- A pregnant woman must be designated as the head of the household under Pregnancy Medical Assistance.
- Household size is calculated including all verified unborn children. That is, a single woman pregnant with twins and with no other children would be a household of three.
- Unless a pregnant child under the age of 19 is living with her parents and requesting medical benefits for the pregnancy only, her eligibility is determined for children's CN Medical Assistance rather than for Pregnancy Medical Assistance because children's CN Medical Assistance has a higher income level, and the child continues to be eligible beyond the post-partum extension.
- When a woman has had a positive home pregnancy test, DSHS will accept her statement that she is pregnant and the estimated due date.
- Families or persons eligible for SSI, SSI state supplement, or TANF cash grants are automatically eligible for CN Medical Assistance and receive Medical Assistance benefits without making a separate application. Certification for this coverage parallels that for the cash benefits.
- Applicants must supply proof of citizenship and identity unless they are already receiving SSI cash benefits, SSA disability based on the clients own disability, or Medicare. (Persons already receiving these benefits have already proved their citizenship eligibility.)
- In addition to citizenship or eligible non-citizen status, DSHS verifies Social Security Number application (when no number is known), identity, income, and pregnancy. DSHS also verifies income at each review and if person is self-employed the verification can be done through tax and business records. Partial year calculation procedures are established in WAC.
- The assignment of child support and medical support rights does not apply to pregnant women, so pregnant women are not required to assist child support enforcement establish support during their pregnancy.

Frequency

- Certification is for the period of pregnancy and the 60 day post-partum period.
- Coverage stops at the end of the 60-day post-partum extension and changes to the family planning extension program.

Comments on Process

- Much of the process is automated once the information is entered into the computer system.
- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Pregnancy Medical Assistance programs are considered in a defined priority order.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf

Income and Asset Limits:

		Family Size								
	% of FPL	1	2	3	4	5	6	7	8	Max or +
Income	185%	$1,604	$2,159	$2,714	$3,269	$3,824	$4,379	$4,934	$5,489	$555
Assets	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

MEDICAL ASSISTANCE FOR NON-CITIZEN PREGNANT WOMEN

Program Description and Purpose: (Program P04)

This program provides the Categorically Needy scope of coverage[29] to eligible pregnant women for the duration of the pregnancy. Women enrolled under this program are eligible for a 60-day post-partum extension that provides continued Medical Assistance for the woman and her infant(s) through the end of the month that includes the 60th day after the pregnancy ends. This is a federally matched program.

Program Limitations and Costs: 2-Year Costs: $100 million - $1 billion

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [N]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• Meets income guidelines (*See next page*)	✓		✓
• Woman is pregnant	✓		
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Person is not female	✓		
• Woman is not pregnant	✓		
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Basic Health Plan	HCA
• Alien Emergency Medical	DSHS
• Children's Health Program (for non-citizen pregnant girls)	DSHS

Bordering Programs	Administrator:
• Basic Health Plan	HCA
• Alien Emergency Medical (labor and delivery only)	DSHS
• Medically Needy Medical Assistance for Pregnant Women	DSHS
• Children's Health Program (for non-citizen pregnant girls)	DSHS

Comments

- Once a woman is found eligible for this program, she is eligible for the duration of her pregnancy and the post-partum period, even if her income increases.

[29] See Appendix 3.

MEDICAL ASSISTANCE FOR NON-CITIZEN PREGNANT WOMEN

Eligibility Determination Process

- A pregnant woman must be designated as the head of the household under Pregnancy Medical Assistance.
- Household size is calculated including all verified unborn children. That is, a single woman pregnant with twins and with no other children would be a household of three.
- Unless a pregnant child under the age of 19 is living with her parents and requesting Medical Assistance for the pregnancy only, her eligibility is determined for children's health program rather than for Pregnancy Medical Assistance because the children's health program has a higher income level and the child continues to be eligible beyond the post-partum extension.
- When a woman has had a positive home-pregnancy test, DSHS will accept her statement that she is pregnant and the estimated due date.
- The assignment of child support and medical support rights does not apply to pregnant women, so pregnant women are not required to assist child support enforcement establish support during their pregnancy.
- If a non-citizen woman does not meet the CN income limits (below), she may be eligible for a Medically Needy scope of service[30] if she is able to spend down[31] to the Medically Needy Income Level by offsetting income with medical expenses.

Frequency

- Certification is for the period of pregnancy and the 60 day post-partum period and the post-partum period.
- Coverage stops at the end of the post-partum period.

Comments on Process

- Much of the process is automated once the information is entered into the computer system.
- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Eligibility for citizen and non-citizen women is determined in the same process, and the absence of citizenship or eligible immigrant status automatically moves a woman to the non-citizen pregnancy medical program.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf
- http://fortress.wa.gov/dshs/maa/Eligibility/OVERVIEW/MedicallOverviewSpenddown.htm, Overview of Spend-down

Income and Asset Limits:

		Family Size								
	% of FPL	1	2	3	4	5	6	7	8	Max or +
CN Income	185%	$1,604	$2,159	$2,714	$3,269	$3,824	$4,379	$4,934	$5,489	$555
Assets	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

[30] See Appendix 3.
[31] See explanation of spending down, above, page 11.

MEDICALLY NEEDY MEDICAL ASSISTANCE FOR PREGNANT WOMEN

Program Description and Purpose: (Program P99)

This program provides the Medically Needy scope of coverage[32] to eligible pregnant women for the duration of the pregnancy. Women enrolled under this program are eligible for a 60-day post-partum extension that provides continued Medical Assistance for the woman and her infant(s) through the end of the month that includes the 60th day after the pregnancy ends. Women under this program must spend down[33] their income to the Categorically Needy income limit to receive benefits under this program. This is a federally matched Medicaid program.

Program Limitations and Costs: 2-Year Costs: $0 to $10 million

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [N]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• US citizen, US national, or eligible non-citizen[34]	✓		
• Has a valid Social Security Number	✓		
• Meets income guidelines (*See next page*)	✓		✓
• Woman is pregnant	✓		
• Woman's medical expenses spend down her income to the program limit	✓		✓
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Woman is not pregnant	✓		
• Non-citizen who is not a "qualified alien"	✓		
• "Qualified alien" without five years of residency (unless exempt)	✓		
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Basic Health Plan	HCA
• Children's Medicaid (for pregnant girls)	DSHS
• S-CHIP Medical Assistance (for pregnant girls)	DSHS
• SSI-related medical assistance	DSHS
• Qualified Medicare Beneficiary	DSHS

Bordering Programs	Administrator:
• Basic Health Plan	HCA
• TANF Eligible Family Medical Assistance	DSHS
• Categorically Needy Medical Assistance for Pregnant Women	DSHS
• Medical Assistance for Non-Citizen Pregnant Women	DSHS
• Children's Medicaid (for pregnant girls)	DSHS
• S-CHIP Medical Assistance (for pregnant girls)	DSHS

Comments

- Following the post-partum extension, women in this program are eligible for an additional 10 months of family planning services (*See* Family Planning Extension Program Summary page).

[32] See Appendix 3.
[33] See explanation of spending down, above, page 11.
[34] See Appendix 4.

MEDICALLY NEEDY MEDICAL ASSISTANCE FOR PREGNANT WOMEN

Eligibility Determination Process

- A pregnant woman must be designated as the head of the household under Pregnancy Medical Assistance.
- Household size is calculated including all verified unborn children. That is, a single woman pregnant with twins and with no other children would be a household of three.
- Unless a pregnant child under the age of 19 is living with her parents and requesting Medical Assistance for the pregnancy only, her eligibility is determined for children's CN Medical Assistance rather than Pregnancy Medical Assistance because children's CN Medical Assistance has a higher income level and she continues to be eligible beyond the post-partum extension.
- When a woman has had a positive home pregnancy test, DSHS will accept her statement that she is pregnant and the estimated due date.
- Applicants must supply proof of citizenship and identity unless they are already receiving SSI cash benefits, SSA disability based on the clients own disability, or Medicare. (Persons already receiving these benefits have already proved their citizenship eligibility.)
- In addition to citizenship or eligible non-citizen status, DSHS verifies Social Security Number application (when no number is known), identity, income, and pregnancy. DSHS also verifies income at each review and if person is self-employed the verification can be done through tax and business records.
- The assignment of child support and medical support rights does not apply to pregnant women, so pregnant women are not required to assist child support enforcement establish support during their pregnancy.
- Women must spend down their income to the Medically Needy income level by having eligible medical expenses to offset the income over this limit. In some cases this may not occur until the baby's birth but the woman would then be eligible for the post-partum and family planning extensions.

Frequency

- Certification is for the period of pregnancy and the 60 day post-partum period.
- Spend-down may have a look-back period of up to three months prior to the month of application.
- Coverage stops at the end of the 60-day post-partum extension and changes to the family planning extension.

Comments on Process

- Much of the process is automated once the information is entered into the computer system.
- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Pregnancy Medical Assistance programs are considered in a defined priority order.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf
- http://fortress.wa.gov/dshs/maa/Eligibility/OVERVIEW/MedicallOverviewSpenddown.htm, Overview of Spend-down

Income and Asset Limits: *(Persons over CN limit must spend-down must reduce income to the Medically Needy Income Level (MNIL))*

		Family Size								
	% of FPL	1	2	3	4	5	6	7	8	Max or +
CN Limit	185%	$1,604	$2,159	$2,714	$3,269	$3,824	$4,379	$4,934	$5,489	$555
MNIL	N/A	$637	$637	$667	$742	$858	$975	$1125	$1242	$1483
Assets	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

FAMILY PLANNING MEDICAL EXTENSION

Program Description and Purpose: (Program P05)

This program provides family planning services to women who were eligible for a pregnancy medical program on the last day of their pregnancies. The program does not provide any services beyond family planning. If the women received the 60-day post-partum extension, this program provides family planning for ten additional months. If the woman's eligibility was retroactively determined, this program provides 12 months of family planning services. This is a federally matched Medicaid program.

Program Limitations and Costs: 2-Year Costs: $10 million to $100 million

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [N]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Woman was pregnant	✓		
• Woman was eligible for Pregnancy Medical Assistance on the last day of her pregnancy	✓		
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Woman was not pregnant	✓		
• Woman was not eligible for a pregnancy medical program	✓		
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Basic Health Plan	HCA
• TANF Eligible Family Medical Assistance	DSHS
• Children's Medicaid (for pregnant girls)	DSHS
• S-CHIP Medical Assistance (for pregnant girls)	DSHS
• SSI-related medical assistance	DSHS
• Qualified Medicare Beneficiary	DSHS

Bordering Programs	Administrator:
• Basic Health Plan	HCA
• TANF Eligible Family Medical Assistance	DSHS
• Categorically Needy Medical Assistance for Pregnant Women	DSHS
• Medically Needy Medical Assistance for Pregnant Women	DSHS
• Children's Medicaid (for pregnant girls)	DSHS
• S-CHIP Medical Assistance (for pregnant girls)	DSHS

Comments

- Once a woman is found eligible for pregnancy medical, she is eligible for the duration of her pregnancy and the post-partum and family-planning extension periods, even if her income increases.
- A woman is also eligible for this program for 12 months if her eligibility for pregnancy medical was determined following the end of her pregnancy.

FAMILY PLANNING MEDICAL EXTENSION

Eligibility Determination Process

- A pregnant woman must be designated as the head of the household under Pregnancy Medical Assistance.
- A girl who is receiving TANF Related Medical Assistance or Children's Medical Assistance is not eligible for this extension, but her coverage under these programs is broader than under Family Planning Medical Assistance.

Frequency

- Certification is for 10 or 12 months following the end of the pregnancy.
- Coverage stops at the end of the family planning extension.

Comments on Process

- Much of the process is automated once the information is entered into the computer system.
- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- None. This program is an extension of CN or MN Pregnancy Medical.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf

Income and Asset Limits: Not Applicable

*Income is determined under Pregnancy Medical Assistance. This program is an extension of Pregnancy Medical Assistance.

TAKE CHARGE FAMILY PLANNING MEDICAL

Program Description and Purpose: (Program P06)

This program provides family planning services to women and men. The program does not provide any services beyond family planning. This is a federally matched demonstration waiver program.

Program Limitations and Costs: 2-Year Costs: $10 million to $100 million

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [N]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• US citizen, US national, or eligible non-citizen[35]	✓		
• Has a valid Social Security Number	✓		
• Meets income guidelines (*See next page*)	✓		✓
• Needs family planning services	✓		✓
• Applies voluntarily for services through a TAKE CHARGE provider	✓		✓
• Does not have other Medical Assistance or health insurance that provides family planning coverage unless there is a "good cause" exception			✓
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Applicant is pregnant or sterilized	✓		
• Applicant has other insurance, and no good cause exception applies	✓		✓
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Basic Health Plan	HCA
• All Medical Assistance programs with a Categorically Needy or Medically Needy scope of coverage	DSHS
Bordering Programs	**Administrator:**
• Basic Health Plan	HCA
• All Medical Assistance programs with a Categorically Needy or Medically Needy scope of coverage	DSHS

Comments

- None

[35] See Appendix 4.

TAKE CHARGE FAMILY PLANNING MEDICAL

Eligibility Determination Process

- This program is a federally funded pilot demonstration waiver program.
- Applications for TAKE CHARGE are sent to the DSHS Medical Eligibility Determination Services (MEDS) unit from contracted providers.
- Income declarations are verified through on-line resources.

Frequency

- Certification is for one year or the duration of the demonstration project, whichever is shorter.
- ACES will automatically terminate this program when a person becomes active in another medical program that covers family planning services or when the certification period ends.

Comments on Process

- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- None

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf
- http://fortress.wa.gov/dshs/maa/familyplan/Take%20Charge/TC.index.htm

Income and Asset Limits:

		Family Size								
	% of FPL	1	2	3	4	5	6	7	8	Max or +
Income	200%	$1,734	$2,334	$2,934	$3,535	$4,134	$4,734	$5,334	$5,934	$600
Assets	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

SSI MEDICAL ASSISTANCE

Program Description and Purpose: (Program S01)

Persons receiving federal Supplemental Security Income (SSI) are automatically eligible for the Categorically Needy (CN) scope of coverage[36] under Medical Assistance. This program is a federally matched Medicaid program.

Program Limitations and Costs: 2-Year Costs: $1 billion to $10 billion

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [N]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Person receives SSI for low-income persons because person is	✓		
○ Over 65; **or**			
○ Under 65 and blind; **or**			
○ Under 65 and disabled; **and**			
○ Meets federal income and resource standards	✓		
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Person does not receive Supplemental Security Income	✓		
• Person refuses to provide medical insurance information	✓		
Priority Populations			
• N/A			

Possible Alternative Programs	**Administrator:**
• Medicare—*Applicant may be dually enrolled. If so, Medicare is the primary payer*	Federal Gov't.
Bordering Programs	**Administrator:**
• Basic Health Plan	HCA

Comments

- The Social Security Administration administers Supplemental Security Income (SSI). SSI is not paid from Social Security taxes withheld from wages and, with regard to persons under 65, is available to blind and disabled persons who do not have enough work history to be eligible for full Social Security Income. Individuals eligible for SSI may also be entitled to receive Social Security Disability Benefits (SSDI).

[36] See Appendix 3.

SSI MEDICAL ASSISTANCE

Eligibility Determination Process

- Persons receiving SSI are automatically enrolled in CN SSI Medical Assistance through the State Data Exchange link to the federal SSI program.
- Because applicants are already receiving SSI cash benefits, they have already proved their citizenship or immigration status eligibility to the federal government and do not need to reprove it to the state.
- Income and resources are determined by the federal government in the eligibility determination for Supplemental Security Income. The State is not involved in this determination.
- In the case where an applicant for Medical Assistance is receiving SSI benefits but Medical Assistance was not automatically opened by the computer system, DSHS staff manually open SSI medical benefits and screen and resolve discrepancies between the state and federal information (for example, a different spelling of a name).

Frequency

- SSI medical has no end date and is certified for as long as the client is eligible to receive SSI.
- Continuing disability reviews are conducted by the Social Security Administration.
- Upon termination of SSI, Medical Assistance continues until the enrollee's eligibility for other Medical Assistance can be determined.
- Coverage usually stops at the end of the month in which ineligibility is determined due to changed circumstances, allowing for 10 days notice before termination.

Comments on Process

- This process is almost entirely automated including entry of Social Security information through the State Data Exchange (SDX).

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf
- For more information on SSI and SSDI, *see* http://www.ssa.gov/pubs/11000.pdf and http://www.ssa.gov/dibplan/index.htm

Income and Asset Limits:

		Family Size	
	% of FPL	1	2
Income*	N/A	$637	$956
Assets	N/A	$2,000	$3,000

* Income and resources are determined by the federal government in the eligibility determination for Supplemental Security Income. The State is not involved in this determination.

SSI-RELATED MEDICAL ASSISTANCE

Program Description and Purpose: (Program S02)

Persons who are aged, blind, or disabled but are not receiving Supplemental Security Income (SSI) may be eligible for the Categorically Needy (CN) scope of coverage[37] under Medical Assistance. This program is a federally matched Medicaid program.

Program Limitations and Costs: 2-Year Costs: $100 million - $1 billion

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [N]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• US citizen, US national, or eligible non-citizen[38]	✓		
• Has a valid Social Security Number	✓		
• Meets income and resource guidelines (*See next page*)	✓		✓
• Person meets eligibility criteria for SSI because person is	✓		
o Over 65; **or**	✓		
o Under 65 and blind; **or**	✓		
o Under 65 and disabled	✓		
• Cooperates to obtain medical support and assigns certain financial rights to the state	✓		
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Person is under 65 and is neither blind nor disabled	✓		
• Person does not meet citizenship or immigration status requirements	✓		
• Is receiving SSI	✓		
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• TANF-Related Family Medical Assistance	DSHS
• Children's Medical Assistance programs	DSHS
• Medicare—*Applicant may be dually enrolled. If so, Medicare is the primary payer*	Federal Gov't.
• Healthcare for Workers with Disabilities (HWD)	DSHS
• Women's pregnancy medical	DSHS

Bordering Programs	Administrator:
• Basic Health Plan	HCA
• SSI Medical Assistance	DSHS
• TANF-Related Family Medical Assistance	DSHS
• Medicare	Federal Gov't.
• Healthcare for Workers with Disabilities (HWD)	DSHS
• SSI-Related MN Medical Assistance	DSHS

Comments

- Persons who are eligible for and receiving SSI income are automatically enrolled in SSI Medical Assistance.

[37] See Appendix 3.
[38] See Appendix 4.

SSI-RELATED MEDICAL ASSISTANCE

Eligibility Determination Process

- Persons applying for Medical Assistance are considered first for federally funded or federally matched programs, including Categorically Needy (CN) Medical Assistance.
- Persons receiving SSI are automatically enrolled in CN SSI Medical Assistance through the State Data Exchange link to the federal SSI program.
- Persons who meet the disability criteria for SSI but who are not receiving cash benefits are considered for SSI-Related Medical Assistance.
- If disability is not already established, the DSHS Division of Disability Determination Services (DDDS) determines (under contract with the Social Security Administration) wither a person meets the federal disability requirements for SSI-Related Medical Assistance.
- Applicants must supply proof of citizenship and identity unless they are already receiving SSI cash benefits, SSA disability based on the clients own disability, or Medicare. (Persons already receiving these benefits have already proved their citizenship eligibility.)
- Some persons who have income in excess of the income standards may qualify for SSI-related medical benefits because of special income exclusions such as "Disabled Adult Children", Disabled Widow(er)s, and individuals who would continue to qualify for SSI if cost of living adjustments were disregarded.
- In addition to citizenship or eligible non-citizen status, DSHS verifies Social Security Number application (when no number is known), identity, income, resources, and disability. DSHS also verifies income at each review and if person is self-employed the verification can be done through tax and business records. Partial year calculation procedures are established in WAC.

Frequency

- Certification is for 12 months.
- Eligibility for other medical programs is determined before SSI-Related CN medical assistance terminates.
- Coverage usually stops at the end of the month in which ineligibility is determined due to changed circumstances, allowing for 10 days notice before termination.

Comments on Process

- Much of the process is automated once the information is entered into the computer system.
- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf
- For more information on SSI and SSDI, *see* http://www.ssa.gov/pubs/11000.pdf and http://www.ssa.gov/dibplan/index.htm

Income and Asset Limits:

		Family Size	
	% of FPL	1	2
Income	N/A	$637	$956
Assets	N/A	$2,000	$3,000

SSI-RELATED ALIEN EMERGENCY MEDICAL (ADULTS)

Program Description and Purpose: (Program S07, S95, S99)

This program provides treatment for emergency medical conditions to non-citizens and immigrants who do not qualify for regular Medicaid. An "**emergency medical condition**" is the sudden onset of a medical condition with acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: placing the patient's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. Depending on the person's income, the range of possible services is similar to those services available under the Categorically Needy (CN) or the Medically Needy scope of coverage[39] **EXCEPT that no treatment is available in the absence of an emergency medical condition** and each service must be authorized as part of an ongoing emergency. This is a mandatory program under the Social Security Act and receives a federal funding match.

Program Limitations and Costs: 2-Year Costs: S07-$0 to $10 million, S95/99-$10 to $100 million each

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [N]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Applicant not a citizen or eligible non-citizen[40]	✓		
• Washington State Resident	✓		
• Meets the categorical eligibility criteria for Medicaid because he or she is 65 years of age or older, or meets the blind and/or disability criteria of the federal SSI program	✓		
• Meets income and resource guidelines (*See next page*)	✓		✓
• As applicable, meet spend-down liability	✓		✓
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Person entered Washington specifically to obtain medical care		✓	
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Basic Health Plan	HCA
Bordering Programs	**Administrator:**
• Basic Health Plan	HCA
• Family-Related Alien Emergency Medical	DSHS
• Alien Emergency Medical for Long-Term Care	DSHS
• Refugee Medical Assistance	DSHS

Comments

- This program is established in the federal Medicaid statutes.
- Persons above the Categorically Needy income level in this program may be subject to medical spend-down requirements under the medically needy programs. This coverage transfers to S95 or S99 when a person meets Medically Needy criteria.
- Children under 18 and pregnant women who do not meet citizen or non-citizen eligibility criteria are covered by separate programs.

[39] *See* Appendix 3
[40] See Appendix 4.

SSI-RELATED ALIEN EMERGENCY MEDICAL (ADULTS)

Eligibility Determination Process

- The eligibility determination process for alien emergency medical is centralized. All applications, statewide, go through the Central Medical Unit.
- Staff must specifically identify Alien Emergency Medical Assistance in the application process. This program is not part of the normal priority order.
- Applicants must establish state residency, which is verified by staff through an automated program at the US Postal Service to which DSHS has access.
- When there are both citizen family members and non-citizen children in the family, the family may have more than one file and be "shared" between the regular Community Service Office (CSO) and the statewide MEDS unit CSO. When an action by either CSO could affect both the citizen and non-citizen members of the family, an alert is automatically posted to the other CSO so that any necessary action can be taken.
- Income is verified at each review.

Frequency

- Determination that a condition is an emergency medical condition, when such a determination is necessary, is made by the Medical Consultant for the DSHS Health and Recovery Services Administration.
- Certification is for three months, and the person may be recertified if he or she continues to meet the categorical eligibility criteria for Medicaid and he or she continues to have an emergency medical condition.
- Continuing Medical Assistance is terminated if enrollee does not cooperate with eligibility redetermination process.
- Coverage may be retroactive for up to three months prior to application, if the person had a medical need, an emergent medical condition, and would have been eligible during that period.
- Coverage usually stops at the end of the month in which ineligibility is determined due to changed circumstances, allowing for 10 days notice before termination.

Comments on Process

- When documentation of a fact is necessary, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Because an applicant's citizenship or immigration status makes him or her ineligible for other programs, there is no overlap in eligibility determination.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf

Income and Asset Limits:

		Family Size	
	% of FPL	1	2
CN Income Level	N/A	$637	$956
MN Income Level	N/A	>$637	>$637
Assets	N/A	$2000	$3000

*See discussion of spending down, above on page 11.

HEALTHCARE FOR WORKERS WITH DISABILITIES

Program Description and Purpose: (Program S08)

The Healthcare for Workers with Disabilities (HWD) program provides the Categorically Needy (CN) scope of coverage[41] for persons who are working and meet disability criteria. There are two groups of coverage: the Basic Coverage Group (BCG) and the Medical Improvement Group (MIG). Persons in the MIG are persons who were formerly part of the BCG and who have a "medically improved condition" as determined by the DSHS Division of Disability Determination Services. This program is a federally matched Medical Assistance program.

Program Limitations and Costs: 2-Year Costs: $0 to $10 million

Entitlement? [N] Program Caps: Enrollment [N] Funding [Y] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• US citizen, US national, or eligible non-citizen[42]	✓		
• Has a valid Social Security Number	✓		
• Age 16-64	✓		
• Meets income guidelines (*See next page*)	✓		✓
• Cooperates to obtain medical support and assigns certain financial rights to the state	✓		
• Employed full or part time and receiving taxable income	✓		
• Meets federal disability requirements by:	✓		
o Meeting federal requirements for SSI or SSDI; **or**			
o Being determined by DSHS to meet federal disability requirements; **or**			
o Being a former BCG enrollee with a "medically improved condition"			
• Pays premiums based on income	✓		✓
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Non-citizen who is not a "qualified alien" or is a "qualified alien" without five years of residency (unless exempt)	✓		
• Received Medically Needy Medical Assistance in the same month	✓		
Priority Populations			
• N/A			

Possible Alternative Programs	**Administrator:**
• Person may be eligible for more than one Medicaid program and, in this case, must choose among programs for which he or she is eligible as a person cannot be concurrently enrolled in more than one Medicaid program.	DSHS
• Person may be concurrently enrolled in Medicare and a Medicaid program.	
Bordering Programs	**Administrator:**
• Medically Needy Medical Assistance	DSHS
• CN and MN Home Care Services and DDD waiver services	DSHS

Comments

- The Division of Disability Determination Services at DSHS is contracted with the federal government to make determinations whether a person meets the federal disability criteria.

[41] See Appendix 3.
[42] See Appendix 4.

HEALTHCARE FOR WORKERS WITH DISABILITIES

Eligibility Determination Process

- Persons applying for Medical Assistance are considered first for federally funded or federally matched programs, including Categorically Needy (CN) Medical Assistance.
- Persons eligible for SSI, SSI state supplement, or TANF cash grants are automatically eligible for CN Medical Assistance and receive Medical Assistance benefits without making a separate application. Certification for CN Medical Assistance parallels that for the cash benefits.
- The Division of Disability Determination Services (DDDS) determines (under contract with the Social Security Administration) whether a person meets federal disability requirements for HWD. The Medical Improvement Group under HWD has a different disability evaluation.
- Staff must specifically screen for eligibility for the HWD program as it is outside the automatic process.
- Applicants who are not already receiving SSI cash benefits or Medicare must supply proof of citizenship and identity.
- In addition to citizenship or eligible non-citizen status, DSHS verifies Social Security Number application (when no number is known), identity, income, and pregnancy (if pregnancy is claimed). DSHS also verifies income at each review and if person is self-employed the verification can be done through tax and business records. Partial year calculation procedures are established in WAC.

Frequency

- Certification is 12 months and eligibility is continuous during the certification period.
- Upon termination of CN medical benefits, Medical Assistance continues until the enrollee's eligibility redetermination for other Medical Assistance can be completed.
- Continuing Medical Assistance is terminated if enrollee does not cooperate with eligibility redetermination.
- Coverage may be retroactive for up to three months prior to application, if the person had a medical need and would have been eligible during that period and pays the required premiums.
- Coverage usually stops at the end of the month in which ineligibility is determined due to changed circumstances, allowing for 10 days notice before termination.

Comments on Process

- Much of the process is automated once the information is entered into the computer system.
- Program requires the use of an additional stand-alone database to determine eligibility and premium amount.
- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary. State-funded programs are considered after federally funded programs are not available to the client except for brief periods when the state-funded programs offer a broad scope of coverage which meet a specific client need.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf

Income and Asset Limits:

		Family Size	
	% of FPL	1	2
Income	220%	$1907	$2567
Assets	N/A	N/A	N/A

SSI-RELATED MEDICALLY NEEDY MEDICAL ASSISTANCE

Program Description and Purpose: (Programs S95 and S99)

Persons who meet the eligibility criteria for Supplemental Security Income (SSI) but who do not meet the income limits for Categorically Need scope of coverage[43] are eligible for the Medically Needy (MN) scope of coverage under Medical Assistance. This program is a federally matched Medicaid program and is subject to spend-down.[44]

Program Limitations and Costs: 2-Year Costs: $10 million to $100 million

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• US citizen, US national, or eligible non-citizen[45]	✓		
• Has a valid Social Security Number	✓		
• Meets income and resource guidelines (*See next page*)	✓		✓
• Person meets eligibility criteria for SSI because person is	✓		
o Over 65; **or**	✓		
o Under 65 and blind or disabled	✓		
• Cooperates to obtain medical support and assigns certain financial rights to the state	✓		
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Person is under 65 and is neither blind nor disabled	✓		
• Person does not meet citizenship or immigration status requirements	✓		
• Person has resources in excess of the program standard	✓		
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• SSI Medical Assistance	DSHS
• TANF-Related Family Medical Assistance	DSHS
• Medicare—*Applicant may be dually enrolled. If so, Medicare is the primary payer*	Federal Gov't.
• Healthcare for Workers with Disabilities (HWD)	DSHS
• SSI-related long-term care and hospice	DSHS

Bordering Programs	Administrator:
• SSI Medical Assistance	DSHS
• TANF-Related Family Medical Assistance	DSHS
• Medicare	Federal Gov't.
• Healthcare for Workers with Disabilities (HWD)	DSHS
• SSI-related long-term care and hospice	DSHS

Comments

- Persons who are eligible for and receiving SSI income are automatically enrolled in SSI Medical Assistance.
- This program may include SSI-related AEM enrollees, the program differentiates based upon citizenship codes.

[43] See Appendix 3.
[44] See explanation of spending down, above, page 11.
[45] See Appendix 4.

SSI-RELATED MEDICALLY NEEDY MEDICAL ASSISTANCE

Eligibility Determination Process

- Persons applying for Medical Assistance are considered first for federally funded or federally matched programs, including Categorically Needy (CN) Medical Assistance. Persons who meet the disability criteria for SSI but are not receiving cash benefits are considered for SSI-Related Medical Assistance.
- Applicants must supply proof of citizenship and identity unless they are already receiving SSI cash benefits, SSA disability based on the clients own disability, or Medicare. (Persons already receiving these benefits have already proved their citizenship eligibility.)
- In addition to citizenship or eligible non-citizen status, DSHS verifies Social Security Number application (when no number is known), identity, income, resources, and disability. DSHS also verifies income at each review and if person is self-employed the verification can be done through tax and business records. Partial year calculation procedures are established in WAC.
- When an applicant's income is above Categorically Needy income level he or she must spend down the excess income by offsetting it against qualifying medical expenses that he or she is obligated to pay until the amount of medical expenses equals the amount of excess income for the certification period.
- Until the applicant has spent down enough to receive benefits, his or her application remains as a pending case.
- The staff must enter the qualifying medical expenses in order for the system to issue benefits.
- Income is verified at each review.

Frequency

- Certification for persons not subject to spend-down is 12 months.
- Certification for persons subject to spend-down is six months unless a three-month period is selected. A person whose current medical expenses are low in comparison to his or her excess income may want to select the shorter certification as the total amount to be spent down during the period is less.
- Coverage may be retroactive for up to three months prior to application, if the person had a medical need and would have been eligible during that period, and received qualifying medical services during that time.
- Coverage usually stops at the end of the month in which ineligibility is determined due to changed circumstances, allowing for 10 days notice before termination.

Comments on Process

- Much of the process is automated once the information is entered into the computer system.
- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf
- For information on SSI and SSDI, *see* http://www.ssa.gov/dibplan/index.htm
- http://fortress.wa.gov/dshs/maa/Eligibility/OVERVIEW/MedicallOverviewSpenddown.htm, Overview of Spend-down

Income and Asset Limits:

		Family Size		
	% of FPL	**1**	**2**	**Max or +**
Income*	N/A	$637	$956	$318.50
Assets	N/A	$2,000	$3,000	N/A

BREAST & CERVICAL CANCER TREATMENT COVERAGE

Program Description and Purpose (Program S30):

This program provides a Categorically Needy scope of coverage[46] for women diagnosed with breast or cervical cancer or a related pre-cancerous condition through a Centers for Disease Control's (CDC) Breast and Cervical Cancer Early Detection program (BCCEDP). The state Department of Health Breast and Cervical Health Program (BCHP) is Washington's CDC approved program.

Program Limitations and Costs: 2-Year Costs: $10 million to $100 million

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [See Comment]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• US citizen, US national, or eligible non-citizen[47]	✓		
• Has a valid Social Security Number	✓		
• Meets income guidelines (*See next page*)	✓		✓
• Cooperates to obtain medical support and assigns financial rights to the state	✓		
• Female		✓	
• Age under 65	✓		
• Has been screened by the BHCP in Washington or another CDC-BCCEDP	✓		
• Requires treatment for breast or cervical cancer	✓		
• Has no other insurance or no creditable coverage	✓		
• Is not eligible for other Categorically Needy Medicaid coverage	✓		
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Has other creditable health care coverage	✓		
• Was not screened by the BHCP or another state, territory, or tribal CDC-funded BCCEDP	✓		
Priority Populations			
• DOH states that for the BCHP "particular emphasis is placed on high-risk populations, including women ages 50 years and older, Native Americans, African Americans, Hispanics, Asian/Pacific Islanders, and lesbians."			

Possible Alternative Programs	**Administrator:**
• None. Eligibility is limited to women without other creditable insurance.	N/A
Bordering Programs	**Administrator:**
• Medical Assistance with Categorically Needy or Medically Needy scope of coverage and private group or individual health insurance.	Varies
• Women on Medicare, who do not have Medicare Part B are not considered to have creditable coverage and may be enrolled in this program.	Federal Gov't

Comments

- Where a woman is otherwise eligible with insurance that covers only part of the cost of screening and treatment, there is cost sharing with the other insurance to the extent of the other coverage .
- Otherwise eligible women with insurance that covers only part of the cost of screening and treatment are eligible to the extent of the uncovered portion.

[46] See Appendix 3.
[47] See Appendix 4.

BREAST & CERVICAL CANCER TREATMENT COVERAGE

Eligibility Determination Process

- The woman must be screened by the BCCEDP and found to need treatment for breast or cervical cancer or a related pre-cancerous condition.
- Once screened and determined to meet the age, need, treatment, and insurance criteria, the woman is presumed eligible until the last day of the month after the month in which the determination was made.
- The woman must file an application for Medical Assistance with DSHS by the last day of the month after the month in which the determination was made.
- If a woman contacts a local Community Service Office (CSO) directly, the CSO worker must refer her to the MEDS unit for instruction on the application process. If the woman has already been screened, or is found eligible for another Categorically Needy Medical Assistance program, the CSO staff must refer her to the DSHS Medical Eligibility Determination Services (MEDS) or send her application there.
- Staff at a CDC-BCCEDP facility will send MEDS a woman's completed application developed specifically for this program.
- DSHS must process the application within 10 days and the MEDS group uses the department's Automatic Client Eligibility System (ACES) to process the application. ACES requires all of the relevant eligibility information to be entered electronically by MEDS staff. In addition, certain items require verification through corroborating documentation, physical copies of which are kept in the person's file. If the person is applying for this program only, the areas requiring additional documentation include: identity and citizenship or immigration status and entry date, income, and SSN application if there is no Social Security Number.
- Following processing of the application, DSHS certifies the person's eligibility and issues Medical Assistance.
- On recertification, DSHS staff are to check the person's file for records that must be verified, but which will not have changed since the initial application (e.g., identity or citizenship) and not to ask for the documents again.

Frequency

- Certification is for one year. Documentation is required at renewal.

Comments on Process

- This program has a special application. It is provided to the woman through the participating screening provider.

Eligibility Determination Overlaps

- A woman who is not eligible for the this program solely because she does not meet the citizenship or non-citizen status requirements described in WAC 388-462-0020(2), is eligible for Medical Assistance under the Alien Emergency Medical (AEM) program because she is "related to" a Medicaid program through the BCCTP. In addition, her need for cancer treatment meets the emergency medical condition criteria.
- DSHS recognizes that men also contract breast cancer but notes that the federal program is limited to women. This exclusion presents a service gap for men with breast cancer that stems from inconsistent federal provisions.

For Further Information

- http://www.doh.wa.gov/wbchp/
- http://www.cdc.gov/cancer/nbccedp/

Income and Asset Limits:

		Family Size								
	% of FPL	1	2	3	4	5	6	7	8	Max or +
Income	250%	$2,167	$2,917	$3,667	$4,417	$5,167	$5,917	$6,667	$7,417	$750
Assets	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

INSTITUTION FOR MENTAL DISEASE MEDICAL ASSISTANCE

Program Description and Purpose: (Program I01)

The Institution for Mental Disease Medical Assistance program is a limited scope program for persons aged 18-21 and adults 65 and over that have been involuntarily admitted to Western or Eastern State Hospital for mental health treatment under the Involuntary Treatment Act. This is a federally funded program.

Program Limitations and Costs: 2-Year Costs: $0 to $10 million

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [N]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• US citizen, US national, or eligible non-citizen[48]	✓		
• Has a valid Social Security Number	✓		
• Meets income and resource guidelines (*See next page*)	✓		✓
• Cooperates to obtain medical support and assigns certain financial rights to the state	✓		
• Person was involuntarily committed to either Western State Hospital or Eastern State Hospital	✓		
• Person is:	✓		
o Under 21 years old; **or**			
o Over 65 years old; **or**			
o Began treatment under age 21 and is not yet 22			
• Has attained "institutional status" related to the length of anticipated stay of over 30 days	✓		
• Meets GA-U Progressive Evaluation Process		✓	
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Non-citizen who is not a "qualified alien"	✓		
• "Qualified alien" without five years of residency (unless exempt)	✓		
• Person voluntarily assigned property or cash to meet financial eligibility	✓		
• Applicant leaves the institution for at least 30 consecutive days		✓	
• Applicant does not receive waivered or hospice services for at least 30 consecutive days		✓	
Priority Populations			
• N/A			

Possible Alternative Programs	**Administrator:**
• Children's Long-Term Care • SSI-Related Medical Assistance	DSHS
Bordering Programs	**Administrator:**
• None	N/A

Comments

- This program is for involuntary inpatient psychiatric treatment for persons 18-21 and over age 65. There is no coverage for adults aged 22-64. This program is tied to General Assistance cash payments , not available under age 18

[48] See Appendix 4.

INSTITUTION FOR MENTAL DISEASE MEDICAL ASSISTANCE

Eligibility Determination Process

- DSHS staff must enter the application as an application for financial assistance.
- DSHS staff must identify the applicant's circumstances as "Institution for Mentally Diseased" and identify the client as a child or as aged.

Frequency

- Involuntary commitment for mental health treatment has established maximum time limits for inpatient treatment reviews.
- Coverage usually stops at the end of the month in which ineligibility is determined due to changed circumstances, allowing for 10 days notice before termination.
- Medical assistance is continued while DSHS determines whether the person qualifies for another medical program.

Comments on Process

- Much of the process is automated once the information is entered into the computer system.
- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- None

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf
- Chapter 71.05 RCW regarding mental health services and involuntary treatment

Income and Asset Limits:

		Family Size								
	% of FPL	1	2	3	4	5	6	7	8	Max or +
Income*	N/A	$41.62	$41.62	$41.62	$41.62	$41.62	$41.62	$41.62	$41.62	$41.62
Assets	N/A	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000	$1,000

PSYCHIATRIC INDIGENT INPATIENT PROGRAM

Program Description and Purpose: (Program M99)

The Psychiatric Indigent Inpatient (PII) Program is a limited scope program that provides emergency medical care to indigent persons who voluntarily admit themselves for inpatient psychiatric treatment in Washington community hospitals with Regional Support Network (RSN) approval. This is a state-funded program.

Program Limitations and Costs: 2-Year Costs:

Entitlement? [N] Program Caps: Enrollment [N] Funding [Y] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Is not receiving any other cash or Medical Assistance		✓	
• Applicant must have a voluntary inpatient psychiatric admission authorized by an RSN within the past three months		✓	
• Meets income and resource guidelines *(See next page)*		✓	
• If income and/or resources exceed the standard for Medically Needy (MN) programs, the client must "spend down" the amount over that limit with offsetting obligations for medical expenses		✓	
• Applicant must have incurred qualifying emergency medical expenses for psychiatric inpatient services in a community hospital of $2000 over a consecutive twelve-month period		✓	
• Applicants are limited to one three-month period of PII eligibility per twelve-month emergency medical expense requirement period		✓	
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Applicant is eligible for, or receiving, any other cash or Medical Assistance		✓	
• Applicant entered Washington specifically to obtain medical care		✓	
• Applicant is an inmate of a state or federal prison		✓	
• Applicant was civilly committed under the Involuntary Treatment Act (ITA)		✓	
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Basic Health Plan	DSHS
• Any Medical Assistance program with psychiatric inpatient benefits	DSHS
• Medicare—*Applicant may be dually enrolled. If so, Medicare is the primary payer*	Federal Gov't.

Bordering Programs	Administrator:
• Basic Health Plan	HCA
• Any Medical Assistance program with psychiatric inpatient benefits	DSHS
• Medicare	Federal Gov't.
• Employee benefits programs	Employers

Comments

- This program does not cover ancillary charges for physician, transportation, pharmacy, or other costs related to a voluntary inpatient psychiatric hospital stay.

PSYCHIATRIC INDIGENT INPATIENT PROGRAM

Eligibility Determination Process

- Persons applying for Medical Assistance are considered first for federally funded or federally matched programs, including Categorically Needy (CN) Medical Assistance. This is a state-funded program and, as such, is not available to persons eligible for federally funded programs.
- DSHS staff must manually select the PII program because it is outside the automated eligibility screening review.
- DSHS staff must enter the authorization code for the inpatient psychiatric hospitalization from the RSN into the DSHS Automated Client Eligibility System (ACES).
- If a PII application is made and the applicant is receiving cash or other Medical Assistance ACES will deny the application. If an approved PII applicant begins receiving cash or other Medical Assistance ACES will immediately close the PII coverage.
- Staff must enter the amounts of applicant's qualifying inpatient psychiatric hospital expenses necessary to meet the $2000 Emergency Medical Expense Requirement (EMER) before the applicant is eligible for benefits.
- If the applicant has income and/or resources in excess of the Medically Needy limits, staff must enter the amounts of the applicant's qualifying medical expenses necessary to offset that excess and make the applicant eligible for benefits.

Frequency

- Certification is for three months. Each three-month certification requires a new $2000 EMER over 12 months qualifying emergency medical expense for psychiatric inpatient services in a community hospital.
- Coverage may be retroactive for up to three months prior to application, if the person had a medical need, would have been eligible during that period, and received qualifying medical services during that time.
- Coverage generally stops at the end of the three-month certification.

Comments on Process

- Much of the process is automated once the information is entered into the computer system.
- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- None

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf
- http://fortress.wa.gov/dshs/maa/Eligibility/OVERVIEW/MedicalOverviewMI.htm

Income and Asset Limits:

		Family Size								
	% of FPL	1	2	3	4	5	6	7	8	Max or +
Income	N/A	$637	$637	$667	$742	$858	$975	$1,125	$1,242	$1,483
Assets	N/A	$2,000	$3,000	$3,050	$3,100	$3,150	$3,200	$3,250	$3,300	$50

GENERAL ASSISTANCE—EXPEDITED (GA-X) MEDICAL ASSISTANCE

Program Description and Purpose: (Program G02)

This program provides a Categorically Needy (CN) scope of Medical Assistance[49] to persons receiving General Assistance cash benefits while their eligibility for SSI is being determined by the federal Social Security Administration. These persons are unable to be gainfully employed as a result of a physical or mental impairment that is expected to continue for at least 12 months. This program is a federally matched program.

Program Limitations and Costs: 2-Year Costs: $100 million - $1 billion

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [N]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• US citizen, US national, or eligible non-citizen[50]	✓		
• Has a valid Social Security Number	✓		
• Meets income and resource guidelines (*See next page*)	✓		✓
• Has been enrolled in General Assistance-Unemployable (GA-U)		✓	
• Has a pending application for SSI and appears to meet the criteria for SSI because he or she is over 65, blind, or disabled and the disability is expected to last at least 12 months	✓		✓
• Cooperates to obtain medical support and assigns certain financial rights to the state	✓		
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Person is receiving for TANF, State Family Assistance (SFA), SSI, or is an ineligible spouse of an SSI recipient	✓		
• Person can, but refuses, to follow an eligibility rule for TANF, SFA, or SSI		✓	
• Person does not meet citizenship or immigration status requirements		✓	
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Basic Health Plan	HCA
• SSI-Related Medical Assistance	DSHS
• Medicare—*Applicant may be dually enrolled. If so, Medicare is the primary payer*	Federal Gov't.
• SSI-Related Long-Term Care or home care services	DSHS

Bordering Programs	Administrator:
• Basic Health Plan	HCA
• SSI Medical Assistance	DSHS
• Medicare	Federal Gov't.

Comments

- None

[49] See Appendix 3.
[50] See Appendix 4.

GENERAL ASSISTANCE—EXPEDITED (GA-X) MEDICAL ASSISTANCE

Eligibility Determination Process

- Persons applying for Medical Assistance are considered first for federally funded or federally matched programs, including Categorically Needy (CN) Medical Assistance.
- General Assistance applications require DSHS staff to pay special attention to coding so that the system will make correct eligibility determinations.
- Applicants must supply proof of citizenship and identity.
- Social workers refer persons receiving general assistance who appear likely to qualify for SSI to the DSHS Division of Disability Determination Services (DDDS) to determine if the person meets the criteria for presumptive eligibility based on Social Security rules.
- In addition to citizenship or eligible non-citizen status, DSHS verifies Social Security Number application (when no number is known), identity, income, resources, and pregnancy (if pregnancy is claimed). DSHS also verifies income at each review and if person has been self-employed the verification is done through tax records. Partial year calculation procedures are established in WAC.

Frequency

- Certification is for 12 months.
- Enrollee must report any changes in circumstances, complete a mid-certification review, and provide DSHS with proof of any changes to remain eligible.
- A new Progressive Evaluation Process (PEP) review is required 45 days before the end of certification.
- Coverage usually stops at the end of the month in which ineligibility is determined due to changed circumstances, allowing for 10 days advance notice before termination.

Comments on Process

- Much of the process is automated once the information is entered into the computer system.
- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf

Payment Standard:

	Family Size	
	1	2
With Shelter Costs	$339	$428
Without Shelter Costs	$206	$261

The payment standard is the cash assistance amount available for clients receiving General Assistance—Unemployable benefits. These clients are financially eligible for GA-U cash and CN Medical Assistance.

GENERAL ASSISTANCE-UNEMPLOYABLE (GA-U) MEDICAL ASSISTANCE

Program Description and Purpose: (Program G01)

This program provides a narrower scope of Medical Assistance[51] to persons receiving General Assistance – Unemployable (GA-U) cash benefits who cannot be gainfully employed as a result of a physical or mental impairment that is expected to continue for at least 90 days. This program is a state funded Medical Assistance program.

Program Limitations and Costs: 2-Year Costs: $100 million - $1 billion

Entitlement? [N] Program Caps: Enrollment [N] Funding [Y] Participant Cost Sharing? [N]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident (unless receiving care out of state with intent to return)		✓	
• US citizen, US national, or eligible non-citizen[52]		✓	
• Has a valid Social Security Number		✓	
• Meets income and resource guidelines (*See next page*)		✓	
• At least 18 years old		✓	
• Undergoes a treatment and referral assessment		✓	
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Person can, but refuses, to follow an eligibility rule for TANF, SFA, or SSI		✓	
• Person is eligible for SSI cash assistance	✓		
• Person is the ineligible spouse of an SSI recipient		✓	
• Person does not meet citizenship or immigration status requirements		✓	
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Basic Health Plan	HCA
• SSI-Related Medical Assistance	DSHS
• SSI-Related Long-Term Care (nursing home)	DSHS
• Medicare—*Applicant may be dually enrolled. If so, Medicare is the primary payer*	Federal Gov't.

Bordering Programs	Administrator:
• Basic Health Plan	HCA
• SSI Medical Assistance	DSHS
• TANF-Related Family Medical Assistance	DSHS

Comments

- Persons whose incapacity is related to chemical dependency may be eligible for a program with a similar scope of coverage through the Alcohol and Drug Addiction Treatment and Support Act (ADATSA).

[51] See Appendix 3.
[52] See Appendix 4.

GENERAL ASSISTANCE-UNEMPLOYABLE (GA-U) MEDICAL ASSISTANCE

Eligibility Determination Process

- Persons applying for Medical Assistance are considered first for federally funded or federally matched programs, including Categorically Needy (CN) Medical Assistance.
- General Assistance applications require DSHS staff to pay special attention to coding so that the system will make correct eligibility determinations.
- Functional eligibility is determined using the Progressive Evaluation Process (PEP) and the determination that a person is functionally eligible for the program is made by the GA-U social workers.
- In addition to citizenship or eligible non-citizen status, DSHS verifies Social Security Number application (when no number is known), identity, income, and resources. DSHS also verifies income at each review and if person is self-employed the verification can be done through tax and business records. Partial year calculation procedures are established in WAC.

Frequency

- General Assistance certification is for 12 months.
- Enrollee must report any changes in circumstances, complete a mid-certification review, and provide DSHS with proof of any changes to remain eligible.
- A new Progressive Evaluation Process, called a PEP review, is required 45 days before the end of certification.
- Coverage usually stops at the end of the month in which ineligibility is determined due to changed circumstances, allowing for 10 days notice before termination.

Comments on Process

- Much of the process is automated once the information is entered into the computer system.
- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf

Payment Standard:

	Family Size	
	1	2
With Shelter Costs	$339	$428
Without Shelter Costs	$206	$261

ADATSA MEDICAL ASSISTANCE

Program Description and Purpose: (Program W01)

This program provides a narrower scope of Medical Assistance[53] under the Medical Care Services (MCS) program to persons receiving chemical dependency treatment under the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) who cannot be gainfully employed as a result of a chemical dependency related incapacity that has lasted for at least 90 days. This program is a state funded program.

Program Limitations and Costs: 2-Year Costs: $10 million to $100 million

Entitlement? [N] Program Caps: Enrollment [N] Funding [Y] Participant Cost Sharing? [N]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident		✓	
• US citizen, US national, or eligible non-citizen[54]		✓	
• Has a valid Social Security Number		✓	
• Meets income guidelines *(See next page)*;		✓	
• At least 18 years old		✓	
• Chemically dependent and has not abstained from use for the last 90 days		✓	
• Have not been gainfully employed in the last 30 days and are incapacitated due to chemical dependency or pregnancy		✓	
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Person can, but refuses, to follow an eligibility rule for TANF, SFA, or SSI		✓	
• Person does not meet citizenship or immigration status requirements		✓	
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• GA-U Medical	DSHS
• Basic Health Plan	HCA
• SSI-Related Medical Assistance	DSHS
• Medicare—*Applicant may be dually enrolled. If so, Medicare is the primary payer*	Federal Gov't.

Bordering Programs	Administrator:
• Basic Health Plan	HCA
• SSI Medical Assistance	DSHS
• TANF-Related Family Medical Assistance	DSHS

Comments

- This program covers inpatient treatment. A person eligible for outpatient treatment may be placed directly in outpatient treatment without an inpatient period under the ADATSA Medical Only Medical Assistance program (W02).
- Persons whose incapacity is unrelated to chemical dependency may be eligible for a program with a similar scope of coverage through General Assistance—Unemployable.
- Persons receiving TANF or SSI benefits receive ADATSA services under their own respective programs.

[53] See Appendix 3.
[54] See Appendix 4.

ADATSA MEDICAL ASSISTANCE

Eligibility Determination Process

- Persons receiving TANF, GA-U, GA-X, or Medicaid must receive outpatient treatment services from an agency certified by the Division of Alcohol and Substance Abuse (DASA) in order to have the treatment paid from DASA funding.
- DSHS must determine that a person is financially eligible before the certified chemical dependency service provider makes an ADATSA assessment.
- To determine eligibility a certified chemical dependency service provider makes an in-person diagnostic assessment to determine incapacity, chemical dependency, course of treatment, and initial placement.
- When the certified chemical dependency service provider has determined that the person is functionally eligible, he or she develops a treatment plan and initial placement, provides legally required notices, and notifies the Central Service Office of placement and status changes.
- In addition to citizenship or eligible non-citizen status, DSHS verifies Social Security Number application (when no number is known), identity, income, resources, and pregnancy (if pregnancy is claimed). DSHS also verifies income at each review and if person is self-employed the verification can be done through tax and business records. Partial year calculation procedures are established in WAC.

Frequency

- ADATSA certification is for six months.
- Enrollee must report any changes in circumstances, complete a mid-certification review, and provide DSHS with proof of any changes to remain eligible.
- Enrollees who voluntarily leave treatment for more than 72 hours will be terminated and must reapply to receive services. Coverage stops at the end of the month in which a person is terminated from treatment.

Comments on Process

- Much of the process is automated once the information is entered into the computer system.
- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf

Payment Standard		
	Family Size	
	1	2
With Shelter Costs	$339	$428
Without Shelter Costs	$206	$261

The payment standard is up to the maximum cash assistance amount available for clients receiving General Assistance—Unemployable cash benefits. Generally, these funds are overseen by a protective payee. These clients are eligible for the same scope of care for Medical Assistance as GA-U enrollees.

ADATSA MEDICAL ONLY MEDICAL ASSISTANCE

Program Description and Purpose: (Program W02)

This program provides a narrower scope of Medical Assistance[55] under the Medical Care Services (MCS) program to persons waiting for treatment or receiving methadone maintenance treatment under the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) who cannot be gainfully employed as a result of a chemical dependency related incapacity that has lasted for at least 90 days. This program is a state funded Medical Assistance program.

Program Limitations and Costs: 2-Year Costs: $10 million to $100 million

Entitlement? [N] Program Caps: Enrollment [N] Funding [Y] Participant Cost Sharing? [N]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident		✓	
• US citizen, US national, or eligible non-citizen[56]		✓	
• Has a valid Social Security Number		✓	
• Meets income guidelines *(See next page)*;		✓	
• At least 18 years old		✓	
• Chemically dependent and has not abstained from use for the last 90 days		✓	
• Has not been gainfully employed in the last 30 days and is incapacitated due to chemical dependency or pregnancy		✓	
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Person can, but refuses, to follow an eligibility rule for TANF, SFA, or SSI		✓	
• Person does not meet citizenship or immigration status requirements		✓	
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• GA-U Medical	DSHS
• Basic Health Plan	HCA
• Medicare—*Applicant may be dually enrolled. If so, Medicare is the primary payer*	Federal Gov't.

Bordering Programs	Administrator:
• Basic Health Plan	HCA
• SSI Medical Assistance	DSHS
• TANF Family Medical Assistance	DSHS

Comments

- Persons whose incapacity is unrelated to chemical dependency may be eligible for a program with a similar scope of coverage through General Assistance—Unemployable.
- Persons receiving TANF or SSI benefits receive ADATSA services under their own respective programs

[55] See Appendix 3.
[56] See Appendix 4.

ADATSA MEDICAL ONLY MEDICAL ASSISTANCE

Eligibility Determination Process

- Persons receiving TANF, GA-U, GA-X, or Medicaid must receive outpatient treatment services from an agency certified by the Division of Alcohol and Substance Abuse (DASA) in order to have the treatment paid from DASA funding.
- DSHS must determine that a person is financially eligible before a certified chemical dependency service provider makes an ADATSA assessment.
- To determine functional eligibility, a certified chemical dependency service provider makes an in-person diagnostic assessment to determine incapacity, chemical dependency, course of treatment, and initial placement.
- When the certified chemical dependency service provider has determined that the person is functionally eligible, he or she develops a treatment plan, initial placement, provides legally required notices, and notifies the Community Service Office of placement and status changes.
- In addition to citizenship or eligible non-citizen status, DSHS verifies Social Security Number application (when no number is known), identity, income, and pregnancy (if pregnancy is claimed). DSHS also verifies income at each review and if person is self-employed the verification can be done through tax and business records. Partial year calculation procedures are established in WAC.

Frequency

- ADATSA certification is for six months.
- Enrollee must report any changes in circumstances, complete a mid-certification review, and provide DSHS with proof of any changes to remain eligible.
- Enrollees who voluntarily leave treatment for more than 72 hours will be terminated and must reapply to receive services. Coverage stops at the end of the month in which a person is terminated from treatment.

Comments on Process

- Much of the process is automated once the information is entered into the computer system.
- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf

Payment Standard

	Family Size	
	1	2
With Shelter Costs	$339	$428
Without Shelter Costs	$206	$261

The payment standard is up to the maximum cash assistance amount available for clients receiving General Assistance—Unemployable cash benefits. Generally, these funds are overseen by a protective payee. These clients are eligible for the same scope of care for Medical Assistance as GA-U enrollees.

ADATSA DETOX MEDICAL ASSISTANCE

Program Description and Purpose: (Program W03)

This program provides three to five days of detoxification treatment under the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) for persons eligible for TANF, SSI, GA-U, or a Medical Assistance program. This program is a state funded program.

Program Limitations and Costs: 2-Year Costs: $0 to $10 million

Entitlement? [N] Program Caps: Enrollment [N] Funding [Y] Participant Cost Sharing? [N]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Is financially eligible for TANF, SSI, GA-U, or a Medical Assistance program; **or**		✓	
• Meets income and resource guidelines *(See next page)*		✓	
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Person is not eligible for and receiving TANF, SSI, GA-U, or a Medical Assistance program		✓	
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• ADATSA Medical Assistance	DSHS
• TANF Family or TANF-Related Medical Assistance	DSHS
• SSI or SSI-Related Medical Assistance	DSHS
• GA-U Medical Assistance	DSHS

Bordering Programs	Administrator:
• Basic Health Plan	HCA
• SSI Medical Assistance	DSHS
• TANF-Related Family Medical Assistance	DSHS

Comments

- This program provides an extremely limited benefit and does not provide full scope Medical Assistance.
- Detoxification services must be performed by a certified detoxification center or by a general hospital that is contracted with DSHS to provide detoxification services.

ADATSA DETOX MEDICAL ASSISTANCE

Eligibility Determination Process

- Persons applying for ADATSA detoxification are considered first for federally funded or federally matched programs, including Categorically Needy (CN) and Medically Needy (MN)Medical Assistance, before being approved for this program.
- DSHS reviews application material to determine whether a person may be eligible for detox services and determines eligibility for the necessary underlying public assistance programs. However, in those counties that have a direct detox contract with the DSHS Division of Alcohol and Substance Abuse (DASA) the county makes the detox eligibility determination. DSHS makes the eligibility determination in all other counties.

Frequency

- This is a five-day program.
- Detox eligibility begins the date detoxification begins and continues through the end of the month in which the enrollee completes the detoxification.

Comments on Process

- This program is unusual because DSHS is not involved in every eligibility determination process.

Eligibility Determination Overlaps

- N/A

For Further Information

- http://www.dshs.wa.gov/dasa/services/treatment/treatmentexpansion.shtml
- http://www.dshs.wa.gov/pdf/hrsa/dasa/ABCsofADATSA.pdf

Income and Asset Limits:

		Family Size								
	% of FPL	1	2	3	4	5	6	7	8	Max or +
Income	N/A	$359	$453	$562	$642	$762	$866	$1,000	$1,107	$1,321
Assets	N/A	$1000	$1000	$1000	$1000	$1000	$1000	$1000	$1000	$1000

MEDICARE SAVINGS —QMB

Program Description and Purpose: (Program S03)

DSHS may pay the Medicare Premiums for Qualified Medical Beneficiaries (QMB) who are entitled to or enrolled in Medicare Part A. DSHS will pay the premiums for Parts A (if any) and B, as well as the deductibles and copayments. This is a federally matched program.

Program Limitations and Costs: 2-Year Costs: $10 million to $100 million

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [N]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• Has a valid Social Security Number	✓		
• Meets income and resource guidelines (*See next page*)	✓		✓
• Person meets eligibility criteria for SSI because person is	✓		
o Over 65; **or**	✓		
o Under 65 and blind; **or**	✓		
o Under 65 and disabled; **or**	✓		
o Entitled to Medicare due to end-stage renal disease	✓		
• Cooperates to obtain medical support and assigns certain financial rights to the state	✓		
• All clients receiving SSI-related long-term care benefits are eligible for QMB	✓		✓
• Entitled to or enrolled in Medicare Part A	✓		
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Person is not entitled to or enrolled in Medicare Part A.	✓		
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• SSI or SSI-Related Medical Assistance	DSHS
• Healthcare for Workers with Disabilities	DSHS
• Long-Term Care Programs, both wavier and institutional	DSHS
• Hospice Care program	DSHS
• Non-Institutional Medical Assistance in an Alternative Living Facility	DSHS
• TANF or TANF-Related Family Medical Assistance *(if person is also Medicare eligible)*	DSHS

Bordering Programs	Administrator:
• SSI or SSI-Related Medical Assistance	DSHS

Comments

- Some persons may be dually enrolled if they are eligible for Categorically Needy (CN) or Medically Needy (MN)Medical Assistance as well as Medicare. Dual eligibility is intended when the person is eligible for both Medicaid and Medicare.
- Medicare automatically assigns QMB enrollees to Medicare Part D.

MEDICARE SAVINGS —QMB

Eligibility Determination Process

- Persons applying for Medical Assistance are considered first for federally funded or federally matched programs.
- Eligibility occurs the month after the eligibility is determined.
- DSHS staff must open a separate federal program for QMB.
- Because applicants are already eligible for Medicare Part A and are enrolled in or receiving Medicare, they have already proved their citizenship or eligible non-citizen status to the federal government and do not need to re-prove it to the state.
- A person with pending spend-down may be eligible for a Medicare Savings Program if his or her income and resources meet program requirements and will continue to receive QMB while spend-down is pending.

Frequency

- The certification period is 12 months.
- There is no retroactive coverage.
- Coverage usually stops at the end of the month in which ineligibility is determined due to changed circumstances, allowing for 10 days notice before termination.

Comments on Process

- N/A

Eligibility Determination Overlaps

- In this case, some overlaps are intended in order to ensure that premium payments and benefits payments are made on time.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf

Income and Asset Limits:

		Family Size	
	% of FPL	1	2
Income	100%	$867	$1,167
Assets	N/A	$4,000	$6,000

* This table shows the upper limit, 100% of the Federal Poverty Level.

MEDICARE SAVINGS —SLMB

Program Description and Purpose: (Program S05)

DSHS may pay the Medicare Premiums for Specified Low-Income Medical Beneficiaries (SLMB) who are entitled to or enrolled in Medicare Parts A and/or Part B. DSHS will pay the premiums for **Part B only** and does not pay deductibles and copayments. This is a federally matched Medical Assistance program.

Program Limitations and Costs: 2-Year Costs: $10 million to $100 million

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [N]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• US citizen, US national, or eligible non-citizen[57]	✓		
• Has a valid Social Security Number	✓		
• Meets income and resource guidelines (*See next page*)	✓		✓
• Person meets eligibility criteria for SSI because person is	✓		
o Over 65; **or**	✓		
o Under 65 and blind; **or**	✓		
o Under 65 and disabled	✓		
• Cooperates to obtain medical support and assigns certain financial rights to the state	✓		
• Eligibility begins the first month applicant is eligible for Part B benefits	✓		✓
• Entitled to or enrolled in Medicare Parts A and B	✓		
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Person is not entitled to or enrolled in Medicare Part A.	✓		
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• SSI or SSI-Related Medical Assistance	DSHS
• Healthcare for Workers with Disabilities	DSHS
• Long-Term Care Programs, both wavier and institutional	DSHS
• Hospice Care program	DSHS
• Non-Institutional Medical Assistance in an Alternative Living Facility	DSHS
• TANF or TANF-Related Family Medical Assistance *(if person is also Medicare eligible)*	DSHS

Bordering Programs	Administrator:
• SSI or SSI-Related Medical Assistance	DSHS

Comments

- Some persons may be dually eligible if they are receiving both CN or MN Medical Assistance and Medicare. Dual eligibility is intended when the person is eligible for both CN or MN Medical Assistance and Medicare, for example, where a person who worked many years is disabled and then reaches retirement age.
- Medicare automatically assigns SLMB enrollees to Medicare Part D.

[57] See Appendix 4.

MEDICARE SAVINGS —SLMB

Eligibility Determination Process

- Persons applying for Medical Assistance are considered first for federally funded or federally matched programs.
- DSHS staff must open a separate federal program for SLMB Medicare Savings.
- Because applicants are already entitled to Medicare Part A and are already enrolled in and receiving Medicare or SSI cash benefits, they have already proved their citizenship or immigration status eligibility to the federal government and do not need to re-prove it to the state.
- A person with pending spend-down may be eligible for Medicare Savings Programs if his or her income and resources meet program requirements and will continue to receive SLMB while spend-down is pending.

Frequency

- The certification period is 12 months.
- Up to three months of retroactive coverage is permitted if applicant was enrolled in Part A.
- Coverage usually stops at the end of the month in which ineligibility is determined due to changed circumstances, allowing for 10 days notice before termination. and must allow ten days advance notice before termination.

Comments on Process

- N/A

Eligibility Determination Overlaps

- In this case, some overlaps are intended in order to ensure that premium payments and benefits payments are made on time.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf

Income and Asset Limits:

		Family Size	
	% of FPL	1	2
Income	100% -120%	$1,040	$1,400
Assets	N/A	$4,000	$6,000

* This table shows the upper limit, 120% of the Federal Poverty Level.

MEDICARE SAVINGS —QUALIFIED INDIVIDUAL

Program Description and Purpose: (Program S06)

DSHS may pay the Medicare Premiums for Qualified Individuals (QI) who are entitled to or enrolled in Medicare Parts A and B and who are not eligible for Categorically Needy (CN) or Medically Needy (MN) Medical Assistance. [58] DSHS will pay the premiums for **Part B only** and does not pay deductibles and copayments. This is a fully federally funded Medical Assistance program.

Program Limitations and Costs: 2-Year Costs: $10 million to $100 million

Entitlement? [N] Program Caps: Enrollment [N] Funding [Y] Participant Cost Sharing? [N]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• Has a valid Social Security Number	✓		
• Meets income and resource guidelines (*See next page*)	✓		✓
• Person meets eligibility criteria for SSI because person is	✓		
o Over 65; **or**	✓		
o Under 65 and blind; **or**	✓		
o Under 65 and disabled	✓		
• Cooperates to obtain medical support and assigns certain financial rights to the state	✓		
• Eligibility begins the first month applicant is eligible for Part B benefits	✓		
• Entitled to or enrolled in Medicare Parts A and B	✓		
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Person is not eligible for or enrolled in Medicare Part A	✓		
• Person is eligible for CN or MN Medical Assistance		✓	
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Family Planning Extension	DSHS
Bordering Programs	**Administrator:**
• Medicare Savings—QMB	DSHS
• Medicare Savings—SLMB	DSHS
• Medicare Savings—QDWI	DSHS
• Medicare Buy-In	DSHS
• SSI or SSI-Related Medical Assistance	DSHS

Comments

- If a person becomes eligible for Medicaid, they lose eligibility for this program.
- Medicare automatically assigns QI enrollees to Medicare Part D.

[58] See Appendix 3.

MEDICARE SAVINGS —QUALIFIED INDIVIDUAL

Eligibility Determination Process

- Persons applying for Medical Assistance are considered first for federally funded or federally matched programs.
- DSHS staff must open a separate federal program for QI Medicare Savings.
- Because applicants are already eligible for Medicare Part A and may already be entitled to or enrolled in and receiving Medicare or SSI cash benefits, they have already proved their citizenship or immigration status eligibility to the federal government and do not need to re-prove it to the state.
- A client with pending spend-down may be eligible for Medicare Savings Program if his or her income and resources meet program requirements.
- When a QI enrollee with pending spend-down receives Medicare Savings Program benefits and is later certified for a CN or MN medical program, DSHS staff must close the enrollee's QI program. The program can be reopened for the balance of any remaining original QI certification period when the spend-down certification ends, subject to available funding.

Frequency

- The certification period is 12 months.
- If an applicant applies in December, the certification period is until December 31st of the next year or until the date that the next year's allotment of federal funds is exhausted.
- Up to three months of retroactive coverage is permitted if applicant was entitled to or enrolled in Part A.
- Coverage usually stops at the end of the month in which ineligibility is determined due to changed circumstances, allowing for 10 days notice before termination.

Comments on Process

- N/A

Eligibility Determination Overlaps

- In this case, some overlaps are intended in order to ensure that premium payments and benefits payments are made on time.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf

Income and Asset Limits:

		Family Size	
	% of FPL	1	2
Income	120% -135%	$1,170	$1,575
Assets	N/A	$4,000	$6,000

* This table shows the upper limit, 135% of the Federal Poverty Level.

MEDICARE SAVINGS —QUALIFIED DISABLED WORKING INDIVIDUAL

Program Description and Purpose: (Program S04)

DSHS may pay the Medicare Premiums for Qualified Disabled Working Individuals (QDWI) who are entitled to or enrolled in Medicare Parts A and B. DSHS will pay the premiums for **Part A only** and does not pay deductibles and copayments. This is a federally matched Medical Assistance program.

Program Limitations and Costs: 2-Year Costs: $0 to $10 million

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [N]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• Has a valid Social Security Number	✓		
• Meets income and resource guidelines (*See next page*)	✓		✓
• Person meets eligibility criteria for SSI because person is	✓		
o Over 65; **or**	✓		
o Under 65 and blind; **or**	✓		
o Under 65 and disabled	✓		
• Cooperates to obtain medical support and assigns certain financial rights to the state	✓		
• Eligibility begins the first month applicant is eligible for Part B benefits	✓		
• Entitled to or enrolled in Medicare Parts A and B	✓		
• Under age 65 and working	✓		
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Person is not entitled to or enrolled in Medicare Part A	✓		
• Person is eligible for Medicaid	✓		
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Healthcare for Workers with Disabilities (HWD)	DSHS

Bordering Programs	Administrator:
• Medicare Savings—QMB	DSHS
• Medicare Savings—SLMB	DSHS
• Medicare Savings—QI	DSHS
• Medicare Buy-In	DSHS
• Healthcare for Workers with Disabilities (HWD)	DSHS

Comments

- In most cases, Healthcare for Workers with Disabilities (HWD) is a better program choice for applicants; However, no one may receive benefits under both programs at the same time because a person who becomes eligible for Medicaid, in this case HWD, loses eligibility for QDWI.
- Medicare automatically assigns QDWI enrollees to Medicare Part D.

MEDICARE SAVINGS —QUALIFIED DISABLED WORKING INDIVIDUAL

Eligibility Determination Process

- Persons applying for Medical Assistance are considered first for federally funded or federally matched programs.
- DSHS staff must open a separate federal program for QDWI Medicare Savings.
- Because applicants are already entitled to Medicare Part A and are already enrolled in or receiving Medicare or SSI cash benefits, they have already proved their citizenship or immigration status eligibility to the federal government and do not need to re-prove it to the state.

Frequency

- The certification period is 12 months until December 31st of each year or until the date that the annual allotment of federal funds is exhausted.
- If an applicant applies in December, the certification period is until December 31st of the next year or until the date that the next year's allotment of federal funds is exhausted.
- Up to three months of retroactive coverage is permitted if applicant was enrolled in Medicare Part A.
- Coverage usually stops at the end of the month in which ineligibility is determined due to changed circumstances, allowing for 10 days notice before termination.

Comments on Process

- N/A

Eligibility Determination Overlaps

- In this case, some overlaps are intended in order to ensure that premium payments and benefits payments are made on time.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf

Income and Asset Limits:

		Family Size	
	% of FPL	1	2
Income*	135% -200%	$1,734	$2,334
Assets	N/A	$4,000	$6,000

* This table shows the upper limit, 200% of the Federal Poverty Level.

MEDICARE BUY-IN

Program Description and Purpose:

DSHS may pay the Medicare Premiums for disabled persons who receive Medicaid and also receive or are entitled to Medicare Part B and who are not eligible for QMB or SLMB. The process is automatic. This is a state funded program.

Program Limitations and Costs: 2-Year Costs: Not able to define in this way

Entitlement? [N] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [N]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Entitled to or enrolled in Medicare Parts A and B	✓		✓
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Person is not entitled to or enrolled in Medicare Parts A or B	✓		
• Person is eligible for the QMB, SLMB, or QI programs	✓		
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Healthcare for Workers with Disabilities (HWD)	DSHS
Bordering Programs	**Administrator:**
• Medicare Savings—QMB	DSHS
• Medicare Savings—SLMB	DSHS
• Medicare Savings—QI-1	DSHS
• Medicare Savings—QDWI	DSHS

Comments

- None

MEDICARE BUY-IN

Eligibility Determination Process

- The Automated Client Eligibility System (ACES) automatically runs a search application called the "Potential Buy-In Processor" every month after the last benefit index update and before monthly benefits are issued. The Potential Buy-In Processor identifies clients who meet the buy-in criteria and sends it to the Social Security Administration (SSA).
- SSA matches the potential buy-in list to the master file from ACES and forwards matched data to payment centers to issue Part B refund checks and to update its system.
- DSHS notifies staff for any necessary corrective action and notifies the enrollee to tell DSHS if the Part B premiums are still being deducted or billed after 60-90 days.
- Persons applying for Medical Assistance are considered first for federally funded or federally matched programs.
- DSHS staff must update "third party liability" in the client file in order to "buy them into" the program.
- Because applicants are already entitled to Medicare Part A and may already be enrolled in and receiving Medicare or SSI cash benefits, they have already proved their citizenship or immigration status eligibility to the federal government and do not need to re-prove it to the state.
- A client with pending spend-down may be eligible for Medicare Savings Program if his or her income and resources meet program requirements.

Frequency

- Up to three months of retroactive coverage is permitted if applicant was enrolled in Part A.
- Coverage usually stops at the end of the month in which ineligibility is determined due to changed circumstances, allowing for 10 days notice before termination.

Comments on Process

- N/A

Eligibility Determination Overlaps

- In this case, some overlaps are intended in order to ensure that premium payments and benefits payments are made on time.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf

Income and Asset Limits: Not Applicable

FAMILY LONG-TERM CARE ASSISTANCE

Program Description and Purpose: (Program K01)

Persons eligible for TANF, TANF-Related, or Children's Medical Assistance are eligible for long-term care assistance if they meet the requirements for needing institutional care. This program is a federally matched Medicaid program.

Program Limitations and Costs: 2-Year Costs: $0 to $10 million

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• US citizen, US national, or eligible non-citizen[59]	✓		
• Has a valid Social Security Number	✓		
• Meets income and resource guidelines (*See next page*)	✓		✓
• Cooperates to obtain medical support and assigns certain financial rights to the state	✓		
• Person received family or children's Medical Assistance before entering a medical institution; **or**	✓		
• Person is would be eligible for a family or children's Medical Assistance if they were not in an institution	✓		
• Person is aged 19 or 20 and would not otherwise qualify for family or children's Medical Assistance due to age or not having a dependent child	✓		
• Person meets institutional criteria because he or she:			
○ Resides in or is likely to reside in a medical facility for at least 30 days; **or**	✓		
○ Is under 18 and resides in or is likely to reside in a psychiatric facility for at least 90 days		✓	
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Non-citizen who is not a "qualified alien" or exempt	✓		
• "Qualified alien" without five years of residency (unless exempt)	✓		
• Person voluntarily assigned property or cash to meet financial eligibility	✓		
• Person is not institutionalized		✓	
• Person is over 22 years old and is institutionalized in a psychiatric facility	✓		✓
• Person has excess home equity over $500,000	✓		
Priority Populations			
• N/A			

Possible Alternative Programs	**Administrator:**
• SSI-Related Long-Term Care Assistance	DSHS
• Home and Community-Based Services	DSHS

Bordering Programs	**Administrator:**
• SSI-Related Long-Term Care Assistance	DSHS
• TANF Family Medical Assistance	DSHS
• Medicare—*Applicant may be dually enrolled. If so, Medicare is the primary payer.*	Federal Gov't.

Comments

- Community-based services are provided under Medicaid Personal Care or CN Home Services program waivers.

[59] See Appendix 4.

FAMILY LONG-TERM CARE ASSISTANCE

Eligibility Determination Process

- Persons applying for Medical Assistance are considered first for federally funded or federally matched programs, including Categorically Needy (CN) Medical Assistance.
- Persons receiving SSI are automatically enrolled in CN SSI Medical Assistance through the State Data Exchange link to the federal SSI program and may be eligible for SSI Long-Term Care if they meet the institutional criteria.
- DSHS determines whether the applicant meets institutional criteria.
- If the applicant is a child, the child is entered as the head of household for long-term care. If the child is a dependent child, only money contributed to the child is counted toward income.
- If the applicant is institutionalized, the facility may be named as the applicant's authorized representative.
- Applicants must supply proof of citizenship and identity unless they are already receiving SSI cash benefits, SSA disability based on the clients own disability, or Medicare. (Persons already receiving these benefits have already proved their citizenship eligibility.)
- If person is income eligible for CN coverage but has excess resources, the person may spend down resources to meet CN eligibility standards.
- In addition to citizenship or eligible non-citizen status, DSHS verifies Social Security Number application (when no number is known), identity, income, resources, disability, and pregnancy (if pregnancy is claimed). DSHS also verifies income at each review and if person is self-employed the verification can be done through tax and business records. Partial year calculation procedures are established in WAC.

Frequency

- The certification period is 12 months, so long as the person retains his or her institutional status. If the person loses that status, DSHS staff re-determine eligibility for other Medical Assistance programs.
- Coverage usually stops at the end of the month in which ineligibility is determined due to changed circumstances, allowing for 10 days notice before termination. However, if the person is under 19, there is no reexamination until the end of the certification period.

Comments on Process

- Either a child or an adult in a family assistance unit may be eligible for long-term care Medical Assistance.
- Functional eligibility for nursing facility care is determined by the Aging and Adult Services Administration.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf

Income and Asset Limits:

	% of FPL	Family Size 1
Income—under 19	200%	$1734
Income— over 19	N/A	$359
Assets— over 19	N/A	$1000

NON-CITIZEN FAMILY LONG-TERM CARE ASSISTANCE

Program Description and Purpose: (Program K03)

This program provides long-term care for emergency medical conditions to non-citizens and immigrants who would otherwise qualify for regular Medicaid if they were citizens, but do not because of their immigration status. An "emergency medical condition" is the sudden onset of a medical condition with acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: placing the patient's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. **No treatment is available in the absence of an emergency medical condition** and long-term care must be pre-authorized as part of an ongoing emergency. This is a mandatory program under the federal Social Security Act and receives a federal funding match.

Program Limitations and Costs: 2-Year Costs: $0 to $10 million

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• Meets income and resource guidelines (*See next page*)	✓		✓
• Meets the categorical eligibility criteria for Medicaid because his or her household includes a dependent child who would be eligible for family Medicaid, or Children's Medicaid if the child were a citizen	✓		
• Cooperates to obtain medical support and assigns certain financial rights to the state	✓		
• Meets institutional criteria because he or she resides in or is likely to reside in a medical facility for at least 30 days	✓		✓
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Person does not have a dependent child	✓		
• Prior authorization is denied		✓	
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Non-Citizen SSI-Related Long-Term Care	DSHS
Bordering Programs	**Administrator:**
• Non-Citizen Hospice Care	DSHS

Comments

- Washington does not have any non-institutional long-term-care programs for non-citizens.

NON-CITIZEN FAMILY LONG-TERM CARE ASSISTANCE

Eligibility Determination Process

- Persons applying for Medical Assistance are considered first for federally funded or federally matched programs, including Categorically Needy (CN) Medical Assistance.
- Persons who meet the criteria for TANF-Related Long-Term Care but who do not meet citizenship criteria may be eligible for long-term care under the Alien Emergency Medical program if their condition qualifies as an emergency medical condition.
- Determination that a condition is an emergency medical condition is made by the Medical Consultant for the DSHS Health and Recovery Services Administration.
- If the Medical Consultant determines that there is an emergency medical condition, he or she may pre-authorize long-term care under this program. This program may not be opened unless pre-authorized.
- DSHS verifies identity, income, and pregnancy (if pregnancy is claimed). DSHS also verifies income at each review and if person is self-employed the verification can be done through tax and business records. Partial year calculation procedures are established in WAC.

Frequency

- Certification is for three months, and the person may be recertified if he or she continues to meet the categorical eligibility criteria for Medicaid and continues to have an emergency medical condition.
- Continuing Medical Assistance is terminated if the enrollee does not cooperate with eligibility redetermination process.
- Coverage usually stops at the end of the month in which ineligibility is determined due to changed circumstances, allowing for 10 days notice before termination.

Comments on Process

- When documentation of a fact is necessary, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf

Income and Asset Limits:		
		Family Size
	% of FPL	1
Income	N/A	$359
Assets	N/A	$1000

Income eligibility for this program is always determined based on a one-person family.

FAMILY MEDICALLY NEEDY LONG-TERM CARE ASSISTANCE

Program Description and Purpose: (Program K95/99)

Children who would be eligible for TANF, TANF-Related, or Children's Medical Assistance except for their income may be eligible for long-term care assistance with a Medically Needy scope of coverage[60] if they meet the requirements for needing institutional care or have been approved for and need hospice care or waivered services. This program is also available to persons 19-20 years old, with no dependents, who would not otherwise be eligible for TANF-related or children's medical programs. This program is a federally matched Medicaid program and is subject to spend-down.[61]

Program Limitations and Costs: 2-Year Costs: $0 to $10 million each program

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• US citizen, US national, or eligible non-citizen[62]	✓		
• Has a valid Social Security Number	✓		
• Meets income and resource guidelines (*See next page*)	✓		✓
• Cooperates to obtain medical support and assigns certain financial rights to the state	✓		
• Child received family or children's Medical Assistance before entering a medical institution; **or**	✓		
• Child is eligible for family or children's Medical Assistance	✓		
• Child meets institutional criteria because he or she:	✓		✓
○ Resides in or is likely to reside in a medical facility for at least 30 days; **or**	✓		
○ Is under 18 and resides in or is likely to reside in a psychiatric facility for at least 90 days.		✓	
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Non-citizen who is not a "qualified alien" or exempt	✓		
• "Qualified alien" without five years of residency (unless exempt)	✓		
• Person voluntarily assigned property or cash to meet financial eligibility	✓		
• Person is not institutionalized		✓	
• Person has home equity in excess of $500,000	✓		
Priority Populations			
• N/A			

Possible Alternative Programs	**Administrator:**
• Home and Community-Based Services	DSHS
Bordering Programs	**Administrator:**
• TANF-Related Long-Term Care Assistance	DSHS
• Home and Community-Based Services	DSHS

Comments

- This is an institutional program. However, hospice and community-based services are provided under the Categorically Needy Home Services programs

[60] See Appendix 3.
[61] See explanation of spending down, above, page 11.
[62] See Appendix 4.

FAMILY MEDICALLY NEEDY LONG-TERM CARE ASSISTANCE

Eligibility Determination Process

- Persons applying for Medical Assistance are considered first for federally funded or federally matched programs, including Categorically Needy (CN) Medical Assistance.
- DSHS determines whether the applicant meets institutional criteria.
- The institutionalized person is entered as the head of household for long-term care and, if the child is a dependent child, only money contributed to the child, or received in the child's own name is counted toward income.
- If the applicant is institutionalized, the facility may be named as the applicant's authorized representative.
- When a child's income is above the MN income limit, he or she must spend down the excess income by offsetting it against medical expenses that he or she is obligated to pay until the amount of medical expenses equals the amount of excess income for the certification period.
- Until the child has spent down enough to receive benefits, the case remains a pending case.
- DSHS staff must authorize the spend-down and enter the qualifying medical expenses in order for the system to apply them and issue benefits.
- Applicants must supply proof of citizenship and identity unless they are already receiving SSI cash benefits, SSA disability based on the clients own disability, or Medicare. (Persons already receiving these benefits have already proved their citizenship eligibility.)
- In addition to citizenship or eligible non-citizen status, DSHS verifies Social Security Number application (when no number is known), identity, income, and pregnancy (if pregnancy is claimed). DSHS also verifies income at each review and if person is self-employed the verification can be done through tax and business records. Partial year calculation procedures are established in WAC.

Frequency

- The certification period if spend-down is not required is 12 months, so long as the person retains his or her institutional status.
- The certification period if spend-down is required is six months unless a three-month period is selected. A child whose current medical expenses are low in comparison to his or her excess income may want to select the shorter certification as the total amount to be spent down during the period is less.
- Medically Needy coverage does not have an automatic redetermination of benefits. Each period of benefits must be applied for separately.
- Coverage usually stops at the end of the month in which ineligibility is determined due to changed circumstances, allowing for 10 days notice before termination.

Comments on Process

- Functional eligibility regarding institutional care in a nursing home is determined by DSHS's Aging and Adult Services Administration.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf
- http://fortress.wa.gov/dshs/maa/Eligibility/OVERVIEW/MedicallOverviewSpenddown.htm, (Spend-down)

Income and Asset Limits:

	% of FPL	Family Size 1
Income	N/A	Based on the state monthly cost of care in the facility
Assets	N/A	$1,000 (persons 19 and older)

SSI LONG-TERM CARE ASSISTANCE

Program Description and Purpose: (Program L01)

Persons receiving federal Supplemental Security Income (SSI) are automatically eligible for the Categorically Needy (CN) scope of coverage[63] under Medical Assistance and are eligible for long-term care if they meet the requirements for needing institutional care or have been approved for and need hospice care or waivered services. Persons eligible for institutional care may be able to receive services in the community through Medicaid Personal Care if these services meet their need. This program is a federally matched Medicaid program.

Program Limitations and Costs: 2-Year Costs: $10 million to $100 million

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Person receives SSI for low-income persons because person is o Over 65; **or** o Under 65 and blind; **or** o Under 65 and disabled; **and** o Meets federal income standards	✓		
• Meets institutional criteria because he or she resides in or is likely to reside in a medical facility for at least 30 days	✓		✓
• Cooperates to obtain medical support and assigns certain financial rights to the state	✓		
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Person does not receive Supplemental Security Income	✓		
• Person voluntarily assigned property or cash to meet financial eligibility	✓		
• Person has home equity in excess of $500,000	✓		✓
• Person has an annuity that does not meet Deficit Reduction Act requirements	✓		
Priority Populations • N/A			

Possible Alternative Programs	**Administrator:**
• SSI-Related Long-Term Care Assistance	DSHS
• Home and Community-Based Services	DSHS
• Medicare—*Applicant may be dually enrolled. If so, Medicare is the primary payer*	Federal Gov't.

Bordering Programs	**Administrator:**
• SSI-Related Long-Term Care Assistance	DSHS
• Home and Community-Based Services	DSHS
• Medicare	Federal Gov't.

Comments

- This is an institutional program. However, hospice and community-based services are provided under the Categorically Needy Home Services programs.

[63] See Appendix 3.

SSI LONG-TERM CARE ASSISTANCE

Eligibility Determination Process

- Persons applying for Medical Assistance are considered first for federally funded or federally matched programs, including Categorically Needy (CN) Medical Assistance.
- Persons receiving SSI are automatically enrolled in CN SSI Medical Assistance through the State Data Exchange link to the federal SSI program and may be eligible for SSI Long-Term Care if they meet the institutional criteria.
- DSHS determines whether the applicant meets institutional criteria.
- Because applicants are already receiving SSI cash benefits, they have already proved their citizenship or immigration status eligibility to the federal government and do not need to reprove it to the state.
- Because applicants are already receiving SSI cash benefits and the federal government establishes and monitors income and resource limits, there are no income or resource requirements for this program.

Frequency

- SSI Long-Term Care assistance has no end date and is certified for as long as the client is eligible for both Medicaid and institutional long-term care.
- Continuing disability reviews are conducted by the federal Social Security Administration.
- Continuously eligible during period that enrollee is eligible to receive SSI.
- Upon termination of SSI, Medical Assistance continues until the enrollee's eligibility for other Medical Assistance can be determined.
- Coverage for long-term care services stops when the person leaves the medical facility. Medicaid eligibility continues, or is re-determined if the person is no longer eligible for SSI.

Comments on Process

- A person who meets all the criteria except the receipt of SSI income may be eligible for SSI-Related Long-Term Care.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf
- For more information on SSI and SSDI, *see* http://www.ssa.gov/pubs/11000.pdf and http://www.ssa.gov/dibplan/index.htm

Income and Asset Limits:

		Family Size	
	% of FPL	1	2
Income*	N/A	$637	—
Assets	N/A	$2,000	—

*As with SSI Medical Assistance, the federal government monitors income and resources limits for SSI recipients.

SSI-RELATED LONG-TERM CARE ASSISTANCE

Program Description and Purpose: (Program L02)

Persons meeting the eligibility criteria for Supplemental Security Income (SSI), with income below the Special Income Level (SIL), will be eligible for the Categorically Needy (CN) scope of coverage[64] under Medical Assistance for long-term care if they meet the requirements for needing institutional care or have been approved for and needs hospice care or waivered services. This program is a federally matched Medicaid program.

Program Limitations and Costs: 2-Year Costs: $100 million to $1 billion

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [N]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• US citizen, US national, or eligible non-citizen[65]	✓		
• Has a valid Social Security Number	✓		
• Meets income and resource guidelines (*See next page*)	✓		✓
• Person meets eligibility criteria for SSI because person is	✓		
o Over 65; **or**	✓		
o Under 65 and blind; **or**	✓		
o Under 65 and disabled	✓		
• Meets institutional criteria because he or she resides in or is likely to reside in a medical facility for at least 30 days	✓		✓
• Cooperates to obtain medical support and assigns certain financial rights to the state	✓		
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Person is under 65 and is neither blind nor disabled	✓		
• Person does not meet citizenship or immigration status requirements	✓		
• Person voluntarily assigned property or cash to meet financial eligibility	✓		
• Person has home equity in excess of $500,000	✓		✓
• Person has an annuity that does not meet Deficit Reduction Act requirements	✓		
Priority Populations			
• N/A			

Possible Alternative Programs	**Administrator:**
• Hospice Services	DSHS
• Medicare—*Applicant may be dually enrolled. If so, Medicare is the primary payer.*	Federal Gov't.
Bordering Programs	**Administrator:**
• SSI Long-Term Care Assistance	DSHS
• Home and Community-Based Services	DSHS
• Medicare—*Applicant may be dually enrolled. If so, Medicare is the primary payer.*	Federal Gov't.

Comments

- This is an institutional program. However, hospice and community-based services are provided under the Categorically Needy Home Services programs.

[64] See Appendix 3.
[65] See Appendix 4.

SSI-RELATED LONG-TERM CARE ASSISTANCE

Eligibility Determination Process

- Persons applying for Medical Assistance are considered first for federally funded or federally matched programs, including Categorically Needy (CN) Medical Assistance.
- Persons who meet the disability criteria for SSI but who are not receiving cash benefits are considered for SSI-Related Long-Term Care.
- DSHS determines whether the applicant meets institutional criteria.
- Applicants must supply proof of citizenship and identity unless they are already receiving SSI cash benefits, SSA disability based on the clients own disability, or Medicare. (Persons already receiving these benefits have already proved their citizenship eligibility.)
- In addition to citizenship or eligible non-citizen status, DSHS verifies Social Security Number application (when no number is known), identity, income, resources, disability, and pregnancy (if pregnancy is claimed). DSHS also verifies income at each review and if person is self-employed the verification can be done through tax and business records. Partial year calculation procedures are established in WAC.

Frequency

- Certification is for 12 months provided that the person retains institutional status. If he or she loses institutional status, DSHS staff re-determine eligibility for other Medical Assistance programs.
- Coverage for long-term care services usually stops when the person leaves the medical facility. Medical Assistance eligibility continues while eligibility for other Medical Assistance is re-determined.

Comments on Process

- Much of the process is automated once the information is entered into the computer system.
- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf
- For more information on SSI and SSDI, *see* http://www.ssa.gov/pubs/11000.pdf and http://www.ssa.gov/dibplan/index.htm

Income and Asset Limits:

		Family Size	
	% of FPL	1	2
Income*	N/A	$1,911	—
Assets	N/A	$2,000	—

* Long-term care income limits are based on the Medicaid "SIL" or Special Income Limit, not the Federal Poverty Level.

NON-CITIZEN LONG-TERM CARE ASSISTANCE

Program Description and Purpose: (Program L04)

This program provides long-term care for emergency medical conditions to non-citizens and immigrants who do not qualify for regular Medicaid. An "emergency medical condition" is the sudden onset of a medical condition with acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: placing the patient's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. Depending on the person's income, the range of possible services is similar to those services available under the Categorically Needy (CN) or the Medically Needy scope of coverage[66] **EXCEPT that no treatment is available in the absence of an emergency medical condition** and each service must be authorized as part of an ongoing emergency. This is a mandatory program under the federal Social Security Act and receives a federal funding match.

Program Limitations and Costs: 2-Year Costs: $0 to $10 million

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [N]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• Meets income and resource guidelines (*See next page*)	✓		✓
• Person meets eligibility criteria for SSI because person is	✓		
o Over 65; **or**	✓		
o Under 65 and blind; **or**	✓		
o Under 65 and disabled	✓		
• Meets institutional criteria because he or she resides in or is likely to reside in a medical facility for at least 30 days	✓		✓
• Cooperates to obtain medical support and assigns certain financial rights to the state	✓		
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Person is under 65 and is neither blind nor disabled	✓		
• Person voluntarily assigned property or cash to meet financial eligibility	✓		
• Person has home equity in excess of $500,000	✓		✓
• Person has an annuity that does not meet Deficit Reduction Act requirements	✓		
Priority Populations			
• N/A			

Possible Alternative Programs	**Administrator:**
• None	N/A
Bordering Programs	**Administrator:**
• Alien Emergency Medical	DSHS
• GA-U	DSHS
• Medicare	Federal Gov't.

Comments

- Hospice services for non-citizens are provided under C04.

[66] See Appendix 3.

NON-CITIZEN LONG-TERM CARE ASSISTANCE

Eligibility Determination Process

- Persons who meet the disability criteria for SSI but who are not receiving cash benefits are considered for SSI-Related Long-Term Care. Where the person is not a citizen or eligible non-citizen, the system will shift to non-citizen emergency coverage.
- DSHS determines whether the applicant meets institutional criteria.
- DSHS verifies identity, income, resources, disability, and pregnancy (if pregnancy is claimed). DSHS also verifies income at each review and if person is self-employed the verification can be done through tax and business records. Partial year calculation procedures are established in WAC.

Frequency

- Determination that a condition is an emergency medical condition, when such a determination is necessary, is made by the Medical Consultant for the DSHS Health and Recovery Services Administration.
- Certification is for three months, and the person may be recertified if he or she continues to meet the categorical eligibility criteria for Medicaid and the person continues to have an emergency medical condition.
- Continuing Medical Assistance is terminated if enrollee does not cooperate with eligibility redetermination process.
- Coverage may be retroactive for up to three months prior to application, if the person had a medical need, a qualifying emergent medical condition, would have been eligible, and incurred expenses during that period.
- Coverage for long-term care services usually stops when the person leaves the medical facility. Medical Assistance eligibility continues while eligibility for other Medical Assistance is re-determined.

Comments on Process

- Much of the process is automated once the information is entered into the computer system.
- When documentation of a fact is necessary, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf
- For more information on SSI and SSDI, *see* http://www.ssa.gov/pubs/11000.pdf and http://www.ssa.gov/dibplan/index.htm

Income and Asset Limits:

		Family Size	
	% of FPL	1	2
Income*	N/A	$1,911	—
Assets	N/A	$2,000	—

* Long-term care income limits are based on the Medicaid "SIL" or Special Income Limit, not the Federal Poverty Level.

SSI-RELATED LONG-TERM CARE ASSISTANCE FOR MEDICALLY NEEDY PERSONS

Program Description and Purpose: (Programs L95 and L99)

Persons meeting the eligibility criteria for Supplemental Security Income (SSI) but with incomes above the Special Income Level may be eligible for the Medically Needy (MN) scope of coverage[67] under Medical Assistance for long-term care if they meet the requirements for needing institutional care or have been approved for and need hospice care or waivered services. This program is a federally matched Medicaid program and is subject to spend-down.[68]

Program Limitations and Costs: 2-Year Costs: $0 to $10 million each program

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• US citizen, US national, or eligible non-citizen[69]	✓		
• Has a valid Social Security Number	✓		
• Meets income and resource guidelines (*See next page*)	✓		✓
• Person meets eligibility criteria for SSI because person is	✓		
o Over 65; **or**	✓		
o Under 65 and blind **or** disabled	✓		
• Cooperates to obtain medical support and assigns certain financial rights to the state	✓		
• Meets institutional criteria because he or she resides in or is likely to reside in a medical facility for at least 30 days	✓		✓
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Person is under 65 and is neither blind nor disabled	✓		
• Person does not meet citizenship or immigration status requirements	✓		
• Person voluntarily assigned property or cash to meet financial eligibility	✓		
• Person has home equity in excess of $500,000	✓		✓
• Person has an annuity that does not meet Deficit Reduction Act requirements	✓		
• Person has income that exceeds the private pay rate at the facility	✓		
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Home and Community-Based Services	DSHS
• Medicare—*Applicant may be dually enrolled. If so, Medicare is the primary payer.*	Federal Gov't.

Bordering Programs	Administrator:
• Hospice in a Medical facility	DSHS
• Home and Community-Based Services	DSHS
• Medicare	Federal Gov't.

Comments

- This is an institutional program. However, hospice and community-based services are provided under the Categorically Needy Home Services programs.

[67] See Appendix 3.
[68] See explanation of spending down, above, page 11.
[69] See Appendix 4.

SSI-RELATED LONG-TERM CARE ASSISTANCE FOR MEDICALLY NEEDY PERSONS

Eligibility Determination Process

- Persons applying for Medical Assistance are considered first for federally funded or federally matched programs,.
- Persons who meet the disability criteria for SSI but who are not receiving cash benefits are considered for SSI-Related Long-Term Care.
- DSHS determines whether the applicant meets institutional criteria.
- Applicants must supply proof of citizenship or eligible non-citizen status.
- DSHS also verifies Social Security Number application (when no number is known), identity, income, and pregnancy (if pregnancy is claimed). DSHS verifies income at each review and if person is self-employed the verification can be done through tax and business records.
- When an applicant's gross income is above the Special Income Level and net countable income is less than the Medicaid state rate at the facility, he or she is eligible for coverage without a spend-down requirement. However, if net countable income is over the Medicaid state rate at the facility, he or she must spend down the excess income by offsetting it against medical expenses that he or she is obligated to pay until the amount of medical expenses equals the amount of excess income for the certification period. Persons subject to spend-down do have the benefit of paying the facility at the Medicaid rate instead of the private facility rate.
- Until the applicant has spent down enough to receive benefits, it remains as a pending case.
- DSHS staff must authorize and enter the qualifying medical expenses in order for the system to issue benefits.

Frequency

- Certification without spend-down is for 12 months (L95).
- Certification with spend-down (L99) is for six months unless a three-month period is selected.
- Continuing Medical Assistance is terminated if enrollee does not cooperate with eligibility redetermination.
- Coverage may be retroactive for up to three months prior to application, if the person had a medical need and would have been eligible during that period.
- Coverage usually stops when the person leaves the medical facility.

Comments on Process

- Much of the process is automated once the information is entered into the computer system.
- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf
- For more information on SSI and SSDI, *see* http://www.ssa.gov/pubs/11000.pdf and http://www.ssa.gov/dibplan/index.htm
- http://fortress.wa.gov/dshs/maa/Eligibility/OVERVIEW/MedicallOverviewSpenddown.htm, (Spend-down)

Income and Asset Limits:				
	% of FPL	**Family Size 1**	**State Daily Facility Rate x 30.42** (Use actual daily rate)	**Private Daily Facility Rate x 30.42** (Use actual daily rate)
Income	N/A	$1,911 (SIL)	EXAMPLE: If state rate is $150/day: ($150 x 30.42 = $4563)	EXAMPLE: If Private Rate is $200/day: ($200 x 30.42 = $6084)
Assets	N/A	$2,000	$2,000	$2,000

If income is above all three limits, the person not eligible for benefits. If income is between the State and Private rates the person must spend down to the State Daily Rate calculation to be eligible, but will be approved to pay the facility at the Medicaid state rate.

SSI-RELATED CATEGORICALLY NEEDY NON-INSTITUTIONAL MEDICAL ASSISTANCE — ALTERNATE LIVING FACILITY

Program Description and Purpose: (Program G03)

Persons meeting the eligibility criteria for Supplemental Security Income (SSI) other than income may be eligible for the Categorically Needy (CN) scope of coverage[70] under non-institutional Medical Assistance in an alternative living facility if they meet the living arrangement requirements. This program is a federally matched Medicaid program.

Program Limitations and Costs: 2-Year Costs: $10 million to $100 million

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• US citizen, US national, or eligible non-citizen[71]	✓		
• Has a valid Social Security Number	✓		
• Meets income and resource guidelines (*See next page*)	✓		✓
• Person meets eligibility criteria for SSI-related medical because person is	✓		
o Over 65;	✓		
o Under 65 and blind; **or**	✓		
o Under 65 and disabled	✓		
• Resides in a department contracted, licensed alternative care facility		✓	
• Cooperates to obtain medical support and assigns certain financial rights to the state	✓		
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Person is under 65 and is neither blind nor disabled	✓		
• Person does not meet citizenship or immigration status requirements	✓		
• Facility is not licensed, not contracted with DSHS, or person lives at home		✓	
Priority Populations			
• N/A			

Possible Alternative Programs	**Administrator:**
• Home and Community-Based Services	DSHS
• SSI-Related Medical Assistance	DSHS
• Medicare—*Applicant may be dually enrolled. If so, Medicare is the primary payer.*	Federal Gov't.

Bordering Programs	**Administrator:**
• SSI-Related Medical Assistance	DSHS
• Home and Community-Based Services	DSHS
• Medicare	Federal Gov't.

Comments

- Hospice and community-based services are provided under the Categorically Needy Home Services programs.

[70] See Appendix 3.
[71] See Appendix 4.

SSI-RELATED CATEGORICALLY NEEDY NON-INSTITUTIONAL MEDICAL ASSISTANCE — ALTERNATE LIVING FACILITY

Eligibility Determination Process

- Persons applying for Medical Assistance are considered first for federally funded or federally matched programs, including Categorically Needy (CN) Medical Assistance.
- Persons who meet the disability criteria for SSI, but are not receiving cash benefits, are considered for SSI-Related non-institutional Medical Assistance if they reside in an alternative living facility.
- Applicants must supply proof of citizenship and identity unless they are already receiving SSI cash benefits, SSA disability based on the clients own disability, or Medicare. (Persons already receiving these benefits have already proved their citizenship eligibility.)
- In addition to citizenship or eligible non-citizen status, DSHS verifies Social Security Number application (when no number is known), identity, income, resources, disability, and pregnancy (if pregnancy is claimed). DSHS also verifies income at each review and if person is self-employed the verification can be done through tax and business records. Partial year calculation procedures are established in WAC.

Frequency

- Certification for CN Medical under this program is for 12 months.
- Coverage usually stops at the end of the month in which ineligibility is determined due to changed circumstances, allowing for 10 days notice before termination.

Comments on Process

- Much of the process is automated once the information is entered into the computer system.
- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf
- For more information on SSI and SSDI, *see* http://www.ssa.gov/pubs/11000.pdf and http://www.ssa.gov/dibplan/index.htm

Income and Asset Limits:			
	% of FPL	**Family Size 1**	**State Daily Facility Rate x 31 + $38.84** (Use actual daily rate)
Income	N/A	(SIL) $1,911	EXAMPLE: If state rate is $65/day: ($65 x 31 + $38.84 = $2053.84)
Assets	N/A	$2,000	$2,000

If income is under both the SIL and the State Daily Rate Calculation person is Categorically Needy.

SSI-RELATED MEDICALLY NEEDY NON-INSTITUTIONAL MEDICAL ASSISTANCE — ALTERNATE LIVING FACILITY

Program Description and Purpose: (Program G95/G99)

Persons meeting the eligibility criteria for Supplemental Security Income (SSI) but who have incomes over the limit for the Categorically Needy (CN) scope of coverage,[72] and who live in an alternative living facility, may be eligible for Medically Needy (MN) non-institutional Medical Assistance coverage if they meet all of the other program requirements. This program is a federally matched Medicaid program and is subject to spend-down.[73]

Program Limitations and Costs: 2-Year Costs: $0 to $10 million each program

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• US citizen, US national, or eligible non-citizen[74]	✓		
• Has a valid Social Security Number	✓		
• Meets income and resource guidelines (*See next page*)	✓		✓
• Person meets eligibility criteria for SSI because person is	✓		
o Over 65; **or**	✓		
o Under 65 and blind or disabled	✓		
• Cooperates to obtain medical support and assigns certain financial rights to the state	✓		
• Resides in a licensed, DSHS contracted alternative living facility		✓	
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Person is under 65 and is neither blind nor disabled	✓		
• Person does not meet citizenship or immigration status requirements	✓		
• Facility is not licensed or DSHS contracted, or the person lives at home		✓	
Priority Populations			
• N/A			

Possible Alternative Programs	**Administrator:**
• Home and Community-Based Services	DSHS
• SSI-Related medical assistance	DSHS
• Medicare—*Applicant may be dually enrolled. If so, Medicare is the primary payer.*	Federal Gov't.
Bordering Programs	**Administrator:**
• SSI-Related Medical Assistance	DSHS
• Home and Community-Based Services	DSHS
• Medicare	Federal Gov't.

Comments

- Hospice and community-based services are provided under the Categorically Needy Home Services programs.

[72] See Appendix 3.
[73] See explanation of spending down, above, page 11.
[74] See Appendix 4.

SSI-RELATED MEDICALLY NEEDY NON-INSTITUTIONAL MEDICAL ASSISTANCE — ALTERNATE LIVING FACILITY

Eligibility Determination Process

- DSHS determines whether the applicant meets institutional criteria.
- Income limits for this program require a comparison of three figures. (An example is in the table below.)
  1. Special Income Level (SIL) (which is published);
  2. **State** Daily Rate for the facility (which varies) times 31 days plus the GA Personal Needs Allowance (PNA; **and**
  3. **Private** Daily Rate for the facility (which varies) times 31 days plus the GA Personal Needs Allowance (PNA).
- Persons who meet disability criteria for SSI-Related Non-Institutional Medical Assistance and who live in an Alternate Living Facility but who do not receive SSI are considered for CN SSI-Related Long-Term Care—Alternate Living Facility unless the person's income exceeds either the Special Income Level (SIL) or the State Daily Rate Value, in which case the person may be eligible for the MN level of coverage.
- If the applicant's income is above the SIL and/or the State Daily Rate Value, but below the monthly private rate, the person is eligible for MN coverage without a spend-down. If countable income is above the private monthly cost of care, the person must spend down the excess income by offsetting it against medical expenses that he or she is obligated to pay before receiving benefits.
- Until the applicant has spent down enough to receive benefits, it remains as a pending case.
- The staff must authorize and enter the qualifying medical expenses in order for the system to issue benefits.
- Applicants must supply proof of citizenship and identity.
- In addition to citizenship or eligible non-citizen status, DSHS verifies Social Security Number application (when no number is known), identity, income, and pregnancy (if claimed). Income is verified at each review.

Frequency

- Certification is for 12 months if eligible without a spend-down (G95).
- Certification is for six months unless a three month period is selected if a spend-down is required (G99). Continuing Medical Assistance is terminated if enrollee does not cooperate with eligibility redetermination.
- Coverage usually stops at the end of the month in which ineligibility is determined due to changed circumstances, allowing for 10 days notice before termination.

Comments on Process

- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf

Income and Asset Limits:				
	% of FPL	**Family Size 1**	**State Daily Facility Rate x 31 + $38.84** (Use actual daily rate)	**Private Daily Facility Rate x 31 + $38.84** (Use actual daily rate)
Income	N/A	$1,911 (SIL)	EXAMPLE: If State Rate is $65/day: ($65 x 31 + $38.84 = $2053.84)	EXAMPLE: If Private Rate is $75/day: ($75 x 30.42 = $2363.84)
Assets	N/A	$2,000	$2,000 single/$3000 couple	$2,000 single/$3000 couple

If income is above all three limits, the person not eligible for benefits. If income is between the State and Private rates the person must spend down to the State Daily Rate calculation to be eligible.

CATEGORICALLY NEEDY HOME SERVICES

Program Description and Purpose: (Program C01)

This program provides home care services to persons eligible for the Categorically Needy (CN) scope of care[75] who also meet the requirements for needing institutional care and who have been approved for and need waivered services or hospice care. Waiver programs are federally matched programs under which one or more Medicaid rules are waived and which enable the person to remain in the community rather than in a nursing facility. These programs are limited in scope and may have program caps for enrollment or funding.[76] Applicants who are entitled to Medicaid may have access to community-based services through Medicaid Personal Care (MPC).

Program Limitations and Costs: 2-Year Costs: $100 million to $1 billion (total C01)

Entitlement? [N] Program Caps: Enrollment [Y] Funding [Y] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• US citizen, US national, or eligible non-citizen[77]	✓		
• Has a valid Social Security Number	✓		
• Meets income and resource guidelines (*See next page*)	✓		✓
• Person meets eligibility criteria for SSI because person is	✓		
o Over 65; **or**	✓		
o Under 65 and blind or disabled	✓		
• Cooperates to obtain medical support and assigns rights to the state	✓		
• Meets institutional criteria because he or she needs and has been approved for waivered services	✓		
Waiver programs require the following and are identified in parentheses at the end:			
• Requires level of care provided in intermediate care facilities for the mentally retarded (ICF/MR) but able to and chooses to live in community (DDD)			✓
• NOT eligible for MPC, or DSHS staff determine that the scope of needs is beyond what MPC can provide (COPES, New Freedom)			✓
• DSHS functional assessment shows person needs, or is likely to need, nursing facility level of care without waiver services (COPES, New Freedom)			✓
• Is not enrolled in any other comparable third party insurance coverage plan that purchases services on a prepaid basis (WMIP)			✓
• Live in his or her own home in the New Freedom service area, or will be doing so by the time waiver services start (New Freedom)			✓
• Eligible for services from the Division of Developmental Disabilities (DDD)			✓
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Person does not meet citizenship or immigration status requirements	✓		
• Person is eligible for MPC, and MPC covers these needs	✓		
• Person voluntarily assigned property or cash to meet financial eligibility	✓		
• Person has home equity in excess of $500,000	✓		✓
• Person has an annuity that does not meet Deficit Reduction Act requirements	✓		

[75] See Appendix 3.
[76] See Appendix 5.
[77] See Appendix 4.

CATEGORICALLY NEEDY HOME SERVICES

Priority Populations

- Waivers have caps. If necessary, headquarters staff prioritize slots based on the person's level of functional needs

Possible Alternative Programs	Administrator:
• Medicaid Personal Care	DSHS
• Hospice	DSHS
• Healthcare for Workers with Disabilities (for persons with DDD waivers only)	DSHS
• General Assistance programs	DSHS
• TANF or TANF-Related Family Medical Assistance	DSHS

Bordering Programs	Administrator:
• Medicaid Personal Care	DSHS
• SSI Long-Term Care Assistance	DSHS

Comments

- Persons may be SSI-related and be eligible under the TANF or GA-X programs and receive Waiver Services.

Eligibility Determination Process

- DSHS determines whether the applicant meets institutional criteria.
- DSHS determines whether the applicant meets criteria for the particular waivered program.
- Applicants must supply proof of citizenship and identity unless they are already receiving SSI cash benefits, SSA disability based on the clients own disability, or Medicare.
- In addition to citizenship or eligible non-citizen status, DSHS verifies Social Security Number application (when no number is known), identity, income, and pregnancy. DSHS also verifies income at each review and if person is self-employed the verification can be done through tax and business records. Partial year calculation procedures are established in WAC.

Frequency

- Certification for community based programs is 12 months.
- Coverage usually stops at the end of the month in which ineligibility is determined due to changed circumstances, allowing for 10 days notice before termination.
- Medicaid eligibility continues while eligibility for other Medical Assistance programs is redetermined.

Comments on Process

- While much of the process is automated, the determinations that a person meets institutional criteria or the criteria for a particular waivered program require multiple determinations by different parts of DSHS.
- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf

Income and Resource Limits

		Family Size	
	% of FPL	1	2
Income*	N/A	$1,911	$1,911
Assets	N/A	$2,000	$3000 if both spouses are applying or $45,104 if a community spouse is not applying

CATEGORICALLY NEEDY HOSPICE SERVICES

Program Description and Purpose: (Program C01)

This program provides hospice services to persons eligible for the Categorically Needy (CN) scope of care[78] who have a terminal illness with a prognosis of six months or less to live and who have elected hospice services. Hospice services may be provided under this program in the person's own home, an alternate living facility, or in a medical facility.

Program Limitations and Costs: 2-Year Costs: $100 million to $1 billion (total C01)

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• US citizen, US national, or eligible non-citizen[79]	✓		
• Has a valid Social Security Number	✓		
• Meets income and resource guidelines (*See next page*)	✓		✓
• Cooperates to obtain medical support and assigns rights to the state	✓		
• Meets institutional criteria because he or she needs and has elected hospice services	✓		✓
• For hospice, person chooses palliative care rather than cure	✓		✓
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Person does not meet citizenship or immigration status requirements	✓		
• Person does not meet the diagnostic criteria	✓		

Priority Populations

- N/A

Possible Alternative Programs	Administrator:
• Medicaid Personal Care	DSHS
• Medicare	Federal Gov't

Bordering Programs	Administrator:
• Medicaid Personal Care	DSHS
• SSI Long-Term Care Assistance	DSHS
• Home-based Waiver Services	DSHS
• Medicare	Federal Gov't

Comments

- None

[78] See Appendix 3.
[79] See Appendix 4.

CATEGORICALLY NEEDY HOSPICE SERVICES

Eligibility Determination Process

- Persons applying for medical coverage are considered first for federally funded or federally matched programs, including categorically needy (CN) medical coverage, and persons who meet the disability criteria for SSI are eligible for hospice services.
- The eligibility determinations for Hospice Medical is centralized. All applications, statewide, and notices of election and revocation go through the Central Medical Unit except in cases where Aging and Disabilities Services Administration (ADSA) has approved the person for Home-based Waiver Services. These cases are maintained by Home and Community Services.
- Contracted hospice providers determine whether the person meets the diagnostic criteria and notify DSHS of the hospice election.
- Applicants must supply proof of citizenship and identity unless they are already receiving SSI cash benefits, SSA disability based on the clients own disability, or Medicare. (Persons already receiving these benefits have already proved their citizenship eligibility.)
- In addition to citizenship or eligible non-citizen status, DSHS verifies Social Security Number application (when no number is known), identity, income, resources, and disability. DSHS also verifies income at each review and if person is self-employed the verification can be done through tax and business records. Partial year calculation procedures are established in WAC.

Frequency

- Certification for hospice is 12 months.
- Coverage usually stops at the end of the month in which ineligibility is determined due to changed circumstances, allowing for 10 days notice before termination.
- Medicaid eligibility continues while eligibility for other Medical Assistance programs is redetermined.

Comments on Process

- While much of the process is automated, the determinations that a person meets institutional criteria require communication with a Department Contracted provider.
- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf

Income and Resource Limits

		Family Size	
	% of FPL	1	2
Income*	N/A	$1,911	$1,911
Assets	N/A	$2,000	$3000 if both spouses are applying or $45,104 if a community spouse is not applying

*Long-term care income limits are based on the Medicaid "SIL" or Special Income Limit, not the Federal Poverty Level.

NON-CITIZEN HOSPICE CARE

Program Description and Purpose: (Program C04)

This program provides hospice care in a medical institution to non-citizens with emergency medical conditions who also meet the requirements for needing hospice care. An "emergency medical condition" is the sudden onset of a medical condition with acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably be expected to result in: placing the patient's health in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part. Depending on the person's income, the range of possible services is similar to those hospice services available under the Categorically Needy (CN) or the Medically Needy scope of care[80] **EXCEPT that no treatment is available in the absence of an emergency medical condition,** and each service must be authorized as part of an ongoing emergency.

Program Limitations and Costs: 2-Year Costs: $0 to $10 million

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓	✓	
• Meets income and resource guidelines (*See next page*)	✓		✓
• Meets SSI-related eligibility criteria	✓	✓	
• Cooperates to obtain medical support and assigns rights to the state	✓	✓	
• Meets institutional criteria because he or she			
o Resides in or is likely to reside in a medical facility for at least 30 days; **and**	✓		✓
o Needs and has been approved for hospice services	✓		✓
• Person has a terminal condition and a medical prognosis of six months or less to live		✓	
• Person or person's family member or physician initiates request for hospice (electing palliative, rather than curative, care)		✓	
• Hospice Providers must get pre-approval from DSHS Health and Recovery Services Administration in order to bill services under the AEM program		✓	
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Person is between 18 and 65 and neither blind nor disabled	✓		
• Medical consultant does not approve the emergent condition or give prior authorization for the nursing home admission	✓		✓

Priority Populations

- N/A

Possible Alternative Programs	Administrator:
• Private Long-Term Care Insurance	Varies
Bordering Programs	**Administrator:**
• Private Long-Term Care Insurance	Varies

Comments

- This program includes both persons receiving CN and MN scope of coverage and is subject to spend-down. [81]

[80] *See* Appendix 3.
[81] See explanation of spending down, above, page 11.

NON-CITIZEN HOSPICE CARE

Eligibility Determination Process

- Determination that a condition is an emergency medical condition, when such a determination is necessary, is made by the Medical Consultant for the DSHS Health and Recovery Services Administration.
- DSHS determines whether the applicant meets both institutional criteria and criteria for the particular services.
- DSHS verifies identity, income, and pregnancy. DSHS also verifies income at each review and if person is self-employed the verification can be done through tax and business records. Partial year calculation procedures are established in WAC.
- When an applicant's income is above the Medically Needy income limit, he or she must spend down the excess income by offsetting it against medical expenses that he or she is obligated to pay until the amount of medical expenses equals the amount of excess income for the certification period.
- Until the applicant has spent down enough to receive benefits, it remains as a pending case.
- DSHS staff must authorize and enter the qualifying medical expenses in order for the system to issue benefits.

Frequency

- Certification is for three months and the person may be recertified if he or she continues to have an emergency medical condition and the person continues to meet eligibility criteria.
- Coverage usually stops at the end of the month in which ineligibility is determined due to changed circumstances, allowing for 10 days notice before termination.

Comments on Process

- The determinations that a person meets institutional criteria and receives necessary prior authorization are managed by different DSHS departments.
- Copies of verified documentation are kept in case files to prevent the need to re-verify at each recertification.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf

Income and Resource Limits

		Family Size	
	% of FPL	1	2
Income*	N/A	$1,911	N/A
Assets	N/A	$2,000	N/A

* Long-term care income limits are based on the Medicaid "SIL" or Special Income Limit, not the Federal Poverty Level.

MEDICALLY NEEDY HOSPICE IN A MEDICAL FACILITY

Program Description and Purpose: (Program C95/C99)

This program provides hospice services to persons eligible for the Medically Needy (MN) scope of care[82] who reside in a medical facility. This is a federally matched program and is subject to spend-down.[83]

Program Limitations and Costs: 2-Year Costs: C95 – $0 to $10 Million

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• US citizen, US national, or eligible non-citizen[84]	✓		
• Has a valid Social Security Number	✓		
• Meets income and resource guidelines (*See next page*)	✓		✓
• Meets SSI-Related eligibility criteria	✓		
• Cooperates to obtain medical support and assigns rights to the state	✓		
• Meets institutional criteria because he or she			✓
o Resides in a medical facility; **and**			
o Needs and has been approved for hospice services			✓
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Person does not meet citizenship or immigration status requirements	✓		
• Person does not meet spend-down liability	✓		
• Person has net countable income above the private facility rate	✓		

Priority Populations

- N/A

Possible Alternative Programs	Administrator:
• SSI-Related Medical Assistance	DSHS
Bordering Programs	**Administrator:**
• Medicaid Personal Care	DSHS
• SSI Long-Term Care Medical Assistance	DSHS
• SSI-Related Medical Assistance	DSHS

Comments

- None

[82] See Appendix 3.
[83] See explanation of spending down, above, page 11.
[84] See Appendix 4.

MEDICALLY NEEDY HOSPICE IN A MEDICAL FACILITY

Eligibility Determination Process

- Persons applying for medical coverage are considered first for federally funded or federally matched programs, including categorically needy (CN) medical coverage.
- The eligibility determination for Hospice Medical is centralized. All applications, statewide, go through the Central Medical Unit.
- Income limits for this program require a comparison of three figures. (An example is in the table below.)
  1. Special Income Level (SIL) (which is published)
  2. **State** Daily Rate for the facility (which varies) times 30.42 days (average days in a month)
  3. **Private** Daily Rate for the facility (which varies) times 30.42 (average days in a month)
- When an applicant's gross income is above the Special Income Level and net countable income is less than the Medicaid state rate at the facility, he or she is eligible for coverage without a spend-down requirement. However, if net countable income is over the Medicaid state rate at the facility, he or she must spend down the excess income by offsetting it against medical expenses that he or she is obligated to pay until the amount of medical expenses equals the amount of excess income for the certification period. Persons subject to spend-down do have the benefit of paying the facility at the Medicaid rate instead of the private facility rate.
- If an applicant's net countable income is above the private monthly rate, the person is not eligible.
- DSHS determines both whether applicant meets institutional criteria and criteria for the particular program.
- Applicants must supply proof of citizenship and identity unless they are already receiving SSI or Medicare.
- In addition to citizenship or eligible non-citizen status, DSHS verifies Social Security Number application (when no number is known), identity, income, pregnancy and income at each review. If person is self-employed the verification may be done through tax and/or business records.

Frequency

- Certification is for six months unless a three-month period is selected.

Comments on Process

- While much of the process is automated, the determinations that a person meets institutional criteria or the criteria for a particular waivered program require multiple determinations by different parts of DSHS.
- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf
- http://fortress.wa.gov/dshs/maa/Eligibility/OVERVIEW/MedicallOverviewSpenddown.htm, Overview of Spend-down

Income and Asset Limits:				
	% of FPL	**Family Size 1**	**State Daily Facility Rate x 30.42** (Use actual daily rate)	**Private Daily Facility Rate x 30.42** (Use actual daily rate)
Income	N/A	$1,911 (SIL)	EXAMPLE: If state rate is $150/day: ($150 x 30.42 = $4563)	EXAMPLE: If Private Rate is $200/day: ($200 x 30.42 = $6084)
Assets	N/A	$2,000	$2,000	$2,000

If income is above all three limits, the person not eligible for benefits. If income is between the State and Private rates the person must spend down to the State Daily Rate calculation to be eligible.

EXPANSION PROGRAMS

BASIC HEALTH PLAN—SUBSIDIZED

Program Description and Purpose:

The Basic Health Plan (BHP) provides state-subsidized health care coverage through private health plans for low-income persons. The Health Care Authority pays the difference in the premium between the enrollee's responsibility and the total premium.

Program Limitations and Costs: 2-Year Costs: $100 million to $1 billion

Entitlement? [N] Program Caps: Enrollment [Y] Funding [Y] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident		✓	
• Meets income guidelines (*See next page*)		✓	
• Pays enrollee's portion of monthly premium		✓	
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Eligible for Medicare		✓	
• Institutionalized* at time of enrollment		✓	
• Attending a US school full-time on a student visa		✓	
Priority Populations			
• Children found ineligible for Basic Health Plus		✓	
• Employees of a home care agency		✓	
• Eligible individual home care providers		✓	
• Licensed foster care workers		✓	
• Persons returning to BHP from Medicaid after becoming ineligible for Medicaid		✓	
• Limited enrollment of new employer groups		✓	
• Washington National Guard Members who served in Operations Enduring Freedom, Iraqi Freedom, or Noble Eagle, and their spouses and dependents		✓	
• Persons not included in the above populations who are on a waiting list, in the order of their waiting list request		✓	

Possible Alternative Programs	Administrator:
• Medical Assistance	DSHS
• SEIU 775 Collective Bargaining Agreement	DSHS
• Pregnancy Medical Assistance Program	DSHS

Bordering Programs	Administrator:
• Medical Assistance	DSHS

Comments

- *In this case "institutionalized" means confined to a state hospital or a correctional facility.
- Some persons on the edge of Medical Assistance eligibility transfer back and forth between Medicaid and BHP depending on eligibility.
- At this time the Basic Health Plan is not accepting new employer groups.

BASIC HEALTH PLAN—SUBSIDIZED

Eligibility Determination Process

- Application must be completed and signed by applicant, spouse (if any), and any dependent 18 years of age or older (including signature of a spouse out of the state or country).
- Applicant must provide the Health Care Authority (HCA) with documentation of a full 30 days' income from all sources and most recent IRS form 1040 with all schedules (or zero-income statement and/or declaration of non-filing of income tax).
- Applicant must provide HCA with proof of residence including street address (includes documentation of residence or homeless status & location).
- HCA sends the application to DSHS for review by the Medical Eligibility Determination Services (MEDS) group if the parent is financially ineligible but was applying for BH-Plus for child or was applying due to pregnancy.
- Enrollee's payment of first premium is part of the eligibility criteria. If not paid in two months, enrollment is rescinded.

Frequency

- Certification is generally for one year.
- BHP members are required to notify HCA of any circumstance that affects their premium within 30 days.

Comments on Process

- HCA enters both residence and mailing addresses into system. Residency is determined by enrollee's zip code. If zip code is not in Washington, this trips a flag in the system.
- Enrollees who leave the state are flagged for disenrollment after three months and must contact the Health Care Authority upon return (within three months to maintain coverage).
- Eligibility determination is normally a 6-8 week process.

Eligibility Determination Overlaps

- None at this time

For Further Information

- http://www.basichealth.hca.wa.gov/understanding.shtml
- http://www.basichealth.hca.wa.gov/doc/22-405.pdf

Income and Asset Limits:

(Standard)

		Family Size								
	% of FPL	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Max or +**
Income	200%	$1734	$2334	$2934	$3534	$4134	$4734	$5334	$5934	Add $600
Assets	—	—	—	—	—	—	—	—	—	—

(200% to 250% of FPR Limits —Not Currently Funded by Legislature)

		Family Size								
	% of FPL	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Max or +**
Income	250%	$2167	$2917	$3667	$4417	$5167	$5917	$6667	$7417	Add $750
Assets	—	—	—	—	—	—	—	—	—	—

BASIC HEALTH PLUS (CHILDREN'S MEDICAID)

Program Description and Purpose: (Program F06)

This program provides the Categorically Needy (CN) scope of coverage under Medical Assistance to citizen and qualifying non-citizen children whose parent(s) apply for the Basic Health Plan and request Basic Health Plus for their children. The program is called Basic Health Plus because: the benefits under Categorically Needy Medical Assistance are greater than under the Basic Health Plan; the state pays the premiums, and there are no copayments or deductibles. It is the same program as Categorically Needy Children's Medical Assistance and is a federally matched Medicaid program.

Program Limitations and Costs: 2-Year Costs: $1 billion to $10 billion (including all Children's Medicaid)

Entitlement? [Y] Program Caps: Enrollment [N] Funding [N] Participant Cost Sharing? [N]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• US citizen, US national, or eligible non-citizen[85]	✓		
• Has a valid Social Security Number	✓		
• Meets income guidelines (*See next page*)	✓		✓
• Child is under 19; **and**	✓		
○ Child is eligible for SSI-related CN or MN coverage; **or**	✓		
○ Child is in foster care **and**:	✓		
▪ The child has not passed the month of his or her 18th birthday; **or**	✓		
▪ DSHS determines he or she remains eligible for foster care services; **or**	✓		
▪ Under 21 and was in foster care on his or her 18th birthday; **or**	✓		
○ Child is receiving subsidized adoption support services	✓		
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Non-citizen who is not a "qualified alien" or exempt	✓		
• "Qualified alien" without five years of residency (unless exempt)	✓		
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Basic Health Plan	HCA

Bordering Programs	Administrator:
• Basic Health Plan	HCA
• TANF-Related Family Medical Assistance	DSHS
• S-CHIP	DSHS
• Children's Health Program	DSHS
• Children's Medically Needy level assistance	DSHS

Comments

- Children's Medical Assistance does not have a resource limit.

[85] See Appendix 4.

BASIC HEALTH PLUS (CHILDREN'S MEDICAID)

Eligibility Determination Process

- A parent who applies for the Basic Health Plan may apply for "Basic Health Plus" for qualifying children. Only those applications that specifically request Basic Health Plus for a child are considered jointly for Basic Health and Medical Assistance.
- Children are considered first for federally funded or federally matched programs, including Categorically Needy (CN) Medical Assistance. Among the children's programs, this program is the first considered. Children ineligible for this program are then considered for other programs in an established priority order.
- Children eligible for SSI, SSI state supplement, or TANF cash grants are automatically eligible for CN Medical Assistance and receive Medical Assistance benefits without making a separate application.
- The parent must supply a Social Security Number for the child. For the child to be eligible for CN Children's Medicaid the parent must also proved documentation of citizenship or eligible non-citizen status unless the child is already receiving SSI cash benefits or Medicare. A non-citizen child may be eligible for the Children's Health Program.
- In addition to citizenship or eligible non-citizen status and the Social Security Number, DSHS, identity, income, and pregnancy (if pregnancy is claimed).
- Income is verified at each review.

Frequency

- Certification is for twelve months.
- Continuously eligible during period that enrollee is eligible to receive SSI, SSI state supplement, or TANF.
- Upon termination of SSI, SSI state supplement, or TANF cash benefits, Medical Assistance continues until the enrollee's eligibility redetermination for other Medical Assistance can be completed.
- Medical coverage is terminated if enrollee does not cooperate with eligibility redetermination process.
- Coverage may be retroactive for up to three months prior to application, if the person had a medical need and would have been eligible during that period.
- Coverage usually stops at the end of the month in which ineligibility is determined due to changed circumstances, allowing for 10 days notice before termination.

Comments on Process

- Although the 200% of federal poverty level income limit for the Basic Health Plan is within the income qualification for federally matched children's Medical Assistance programs, there is no automatic review of children's eligibility for federally matched programs. Only those children whose parents request Basic Health Plus are reviewed for Medical Assistance eligibility.
- Much of the process is automated once DSHS enters the information into the computer system.
- When documentation of a fact is necessary, such as birth or citizenship, a copy of the documentation is kept in the case file to prevent the need for re-verifying this information at each recertification.

Eligibility Determination Overlaps

- Eligibility determination for all federally funded and federally matched programs is primary.

For Further Information

- http://www.dshs.wa.gov/pdf/Publications/22-315.pdf

Income and Asset Limits:

		Family Size								
	% of FPL	1	2	3	4	5	6	7	8	Max or +
Income*	200%	$1,733	$2,333	$2,933	$3,533	$4,133	$4,733	$5,333	$5,933	$600
Assets	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

HEALTH INSURANCE PARTNERSHIP

Program Description and Purpose:

The Health Insurance Partnership grew out of the Small Employer Health Insurance Partnership to provide access to insurance for low-income employees with incomes under 200% of the federal poverty level through a public-private partnership. The program is not yet operational. The legislation establishing HIP established a board which is to make two reports:

- By December 1, 2008, the Partnership Board must report to the Legislature and Governor on the impact of incorporating the individual and small group markets into the Partnership.
- By September 1, 2009, the Partnership Board must report to the Legislature and Governor on the risk and benefits of incorporating the high risk pool, Basic Health, Public Employees Benefits Board, and public school employees, as well as the impact of requiring all residents over 18 to be covered.

The final shape of this program has yet to be determined.

Program Limitations and Costs: 2-Year Costs: $0 to $10 million

Entitlement? [N] Program Caps: Enrollment [N] Funding [Y] Participant Cost Sharing? [Unknown]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident		✓	
• Meets income guidelines (*See next page*)		✓	
• Employer subsidizes enrollee's premium		✓	
• Enrollee pays enrollee's portion of monthly premium		✓	
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Not yet determined			
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Not possible to determine at this time	N/A
Bordering Programs	**Administrator:**
• N/A	N/A

Comments

- None at this time

HEALTH INSURANCE PARTNERSHIP

Eligibility Determination Process

- Not yet determined

Frequency

- Not yet determined

Comments on Process

- Not yet determined

Eligibility Determination Overlaps

- Not yet determined

For Further Information

- Engrossed Second Substitute House Bill 1569 (Chapter 260, Laws of 2007)
- Engrossed Second Substitute Senate Bill 5930 (Chapter 259, Laws of 2007)

Income and Asset Limits:

		Family Size								
	% of FPL	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**Max or +**
Income	200%	$1734	$2334	$2934	$3534	$4134	$4734	$5334	$5934	Add $600
Assets	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

WASHINGTON STATE HEALTH INSURANCE POOL

Program Description and Purpose:

The Washington State Health Insurance Pool (WSHIP) provides health insurance to the persons that insurers found to be too high a risk to insure. While this is private health insurance, there are two small groups of persons for whom the state determines eligibility and pays all or part of the premiums and cost-sharing. These are persons eligible for Medical Assistance but who the state has determined it is more cost effective to serve through WSHIP and persons whose incomes are under 301% of the federal poverty level and who are subsidized under RCW 48.41.200.

Program Limitations and Costs: 2-Year Costs: $0 to $10 million

Entitlement? [N] Program Caps: Enrollment [N] Funding [Y] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident		✓	
• Has been rejected for health insurance coverage by an insurance carrier or the Basic Health Plan, or live in a county where individual health plans are not offered		✓	
• Pays enrollee's portion of monthly premium		✓	
• A Medicare enrollee who has been rejected or the subject of other adverse action is eligible		✓	
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• N/A			
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• Medical Assistance	DSHS
• Basic Health Plan	HCA

Bordering Programs	Administrator:
• Medical Assistance	DSHS
• Basic Health Plan	HCA

Comments

- Less than 1% of WSHIP enrollees are subsidized because their income is under 301% of the federal poverty level.

WASHINGTON STATE HEALTH INSURANCE POOL

Eligibility Determination Process

- All insurance programs in Washington use the Standard Health Questionnaire to screen for eligibility. Persons rejected by insurers using this tool are eligible for WSHIP.
- The Health Care Authority (HCA) verifies family size, name, Social Security Numbers, income, and full-time student status for applicants subsidized under RCW 48.41.200.
- If an application is incomplete, HCA will generate a list of needed documents to complete the verification.
- DSHS processes WSHIP applicants for Medicaid as it does other applicants for Medicaid and, following an eligibility determination, decides whether the person may remain in the WSHIP or be transferred to Medicaid.

Frequency

- Standard insurance terms of coverage with underwriting.

Comments on Process

- WSHIP is overseen by an appointed board and operated by an Executive Director and a 3rd Party Administrator.

Eligibility Determination Overlaps

- There is no overlap in the eligibility determination processes.

For Further Information

- https://www.wship.org/Default.asp

Income and Asset Limits for State Subsidy under RCW 48.41.200

		Family Size								
	% of FPL	1	2	3	4	5	6	7	8	Max or +
Income	301%	$2,609	$3,512	$4,415	$5,318	$6,221	$7,124	$8,027	$8,930	$903
Assets	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

HIV EARLY INTERVENTION PROGRAM

Program Description and Purpose:

This program provides medically necessary treatment and wrap-around services for persons with HIV to financially eligible Washington residents. Coverage includes medical care, pharmaceutical assistance, oral health care, and assistance with health insurance premiums and cost sharing (co-payments and deductibles). This program is a federally matched program.

Program Limitations and Costs: 2-Year Costs: $10 million to $100 million

Entitlement? [N] Program Caps: Enrollment [N] Funding [Y] Participant Cost Sharing? [Y]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Washington State Resident	✓		
• Meets income and resources guidelines (*See next page*)	✓		
• Is HIV-positive	✓		
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Not HIV-positive	✓		
• Not a state resident	✓		
Priority Populations			
• No priority populations are specified. However, federal law specifies that persons with co-occurring disorders are eligible, and funding is available to treat the co-occurring disorder as well as the HIV.	✓		

Possible Alternative Programs	Administrator:
• Medicaid	DSHS
• Basic Health Plan	HCA
• Washington State Health Insurance Pool	3rd Party Admin

Bordering Programs	Administrator:
• Medicaid	DSHS
• Basic Health Plan	HCA
• Washington State Health Insurance Pool	3rd Party Admin

Comments

- This program is funded under the federal Ryan White HIV/AIDS Treatment Modernization Act of 2006, which requires that 75% of the funding be used for direct services. The remaining 25% may fund support services such as respite care for caregivers, outreach services, medical transportation, linguistic services, and referrals for health care and support services.
- This program is administered by the Department of Health.

HIV EARLY INTERVENTION PROGRAM

Eligibility Determination Process

- Persons with HIV apply to the Department of Health (DOH).
- The application forms contain instructions for documentation of the eligibility criteria, which are then verified by DOH staff.
- DOH verifies HIV status, residency, family size, income, resources, Medicaid status, and other insurance.
- Persons with incomes at or below 100% of the federal poverty level must also apply to Medicaid. If they have previously been denied Medicaid coverage the requirement may be waived.

Frequency

- Certification is for 12 months.

Comments on Process

- The process is largely dictated by the terms of the Ryan White Act, Part B, which is mirrored in DOH requirements.

Eligibility Determination Overlaps

- None

For Further Information

- http://hab.hrsa.gov/treatmentmodernization/partb.htm
- http://www.doh.wa.gov/cfh/hiv.htm

Income and Asset Limits:

		Family Size								
	% of FPL	1	2	3	4	5	6	7	8	Max or +
Income	300%	$2,600	$3,500	$4,400	$5,300	$6,200	$7,100	$8,000	$8,900	$900
Assets*	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000	$10,000	N/A

*The $10,000 resource limit does not include one home, one automobile, and certain retirement funds.

CRIME VICTIM'S COMPENSATION PROGRAM

Program Description and Purpose:

The Crime Victims' Compensation (CVC) program is operated by the Department of Labor and Industries to provide compensation to victims of violent crime. Labor and Industries acts as the insurer of last resort for health issues resulting from being a victim of violent crime.

Program Limitations and Costs: 2-Year Costs: $10 million to $100 million

Entitlement? [N] Program Caps: Enrollment [N] Funding [Y] Participant Cost Sharing? [Unknown]

Source of Requirement:	Federal	State	Negotiated
Eligibility Criteria *(Applicant must meet these requirements)*			
• Victim must exhaust all other forms of payment before using Crime Victims' Compensation		✓	
• Crime must have occurred in Washington		✓	
• Crime committed must be classified as a gross misdemeanor or felony		✓	
• Crime must have been reported to law enforcement within required time frames		✓	
• The application for benefits must be received by the department within two years of the crime being reported to law enforcement, or for good cause, within five years		✓	
• Victim must be willing to cooperate with law enforcement		✓	
• Documentation demonstrating that bodily injury or severe emotional distress is present as the result of the crime injury		✓	
• Claims for intra-family crimes are restricted		✓	
Exclusionary Criteria *(Applicant is not eligible if any apply)*			
• Victim's injury occurred because victim consented, provoked, or incited it		✓	
• Injury occurred while victim was committing a felony or was incarcerated		✓	
• Victim is enrolled in health care coverage that will pay for his or her treatment		✓	
Priority Populations			
• N/A			

Possible Alternative Programs	Administrator:
• N/A	N/A
Bordering Programs	**Administrator:**
• N/A	N/A

Comments

- Some costs related to this program are paid with Victim's Compensation penalties levied on convicted offenders.
- The program also pays hospitals and other facilities for processing sexual assault kits. The kits are not necessarily connected to a person who makes a claim on the fund.

CRIME VICTIM'S COMPENSATION PROGRAM

Eligibility Determination Process

- Crime must have been reported to law enforcement within one year of the occurrence, or when it could have reasonably been reported.
- There is an exception to the one-year rule for victims involved in the civil commitment process of a sexual predator: For these victims, the one-year timeframe begins when they are notified of the proceeding or are interviewed or deposed or required to testify in connection with the proceedings.
- Labor and Industries staff must investigate each claim to determine eligibility.

Frequency

- Where CVC is the primary payer, review is every 30 days.
- If victim is enrolled in a state-funded Medical Assistance program, reviews are every 60 days .
- If victim has private insurance or a private HMO, reviews are every 90 days.
- If victim has Medicare or Veteran's benefits, reviews are every 180 days.

Comments on Process

- None

Eligibility Determination Overlaps

- N/A

For Further Information

- Chapter 7.68 RCW

Income and Asset Limits: Not Applicable

APPENDIX 1: SCOPE & OBJECTIVES

STATE HEALTH CARE COVERAGE ELIGIBILITY STUDY

SCOPE AND OBJECTIVES

MARCH 2008

STATE OF WASHINGTON
JOINT LEGISLATIVE AUDIT AND REVIEW COMMITTEE

STUDY TEAM
Fara Daun

PROJECT SUPERVISOR
Keenan Konopaski

LEGISLATIVE AUDITOR
Ruta Fanning

Joint Legislative Audit & Review Committee
1300 Quince St SE
Olympia, WA 98504
(360) 786-5171
(360) 786-5180 Fax

Website:
www.jlarc.leg.wa.gov
e-mail: neff.barbara@leg.wa.gov

Why a JLARC Study of State Health Care Coverage Eligibility?

After completion of its two Basic Health Plan reports in 2006 (Reports 06-1 and 06-9), the Joint Legislative Audit and Review Committee (JLARC) identified a need to review requirements and procedures for determining eligibility for health care coverage programs in which the state both participates financially and determines eligibility. The 2007-09 Operating Budget requires JLARC to "conduct a review of the eligibility requirements and eligibility review processes that apply to any state program that offers individual health care coverage for qualified recipients."

Background

The state determines eligibility and participates in funding a variety of health coverage programs. There are two main categories of health coverage in which the state participates. First, the state acts as an employer in providing health care coverage as an employee benefit to public employees and retirees. Second, the state provides health care coverage for persons who are members of qualified classes, for example, low-income children, families on assistance, and disabled adults. To be a member of a qualified class, individuals must meet specific criteria related to income, family status, disability status, or a combination of criteria in these areas. Federal law establishes eligibility parameters for many programs. These parameters define the minimum classes of persons that the state must cover and may provide outer limits beyond which the state may not use federal funds to provide coverage.

Washington has also created a number of state programs that are independent of federal programs. These programs tend to be targeted to very specific needs, such as pregnant women who do not qualify for Medicaid, persons who have been denied health insurance through employment-based or individual policies, and medical care services for persons in treatment under the Alcohol and Drug Addiction Treatment and Support Act (ADATSA) or who receive General Assistance because they are unemployable (GA-U).

Study Scope

The study will identify the health coverage programs in which the state both participates financially and determines eligibility. Using statutes, administrative rules, and departmental directives and policies, the study will identify the eligibility criteria for each program and assess the extent to which these requirements are governed by federal and state law. The study will also review the processes and internal controls used by agencies for establishing and verifying eligibility for coverage under these programs.

Study Objectives

The study will include answers to the following questions:

1) For which health coverage programs does the state both participate financially and determine eligibility?
2) What are the eligibility criteria for each program and to what extent are the criteria established by federal law, state law, or both?
3) How do eligibility criteria compare across the programs?
4) What are the processes by which eligibility is determined, verified, and re-determined for each program?
5) How do eligibility determination processes compare across the programs?

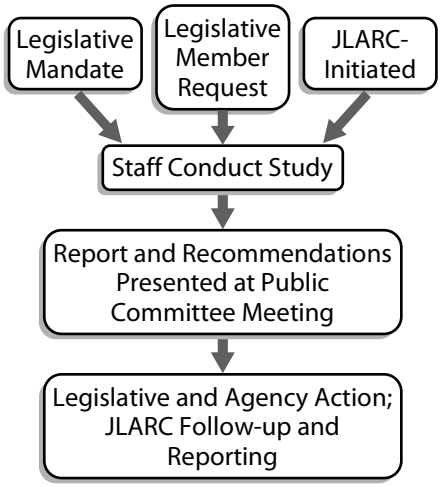
Timeframe for the Study

Staff will present the preliminary and final reports at the JLARC meetings in August and September 2008, respectively.

JLARC Staff Contact for the Study

Fara Daun (360) 786-5174 daun.f@leg.wa.gov

JLARC Study Process



Criteria for Establishing JLARC Work Program Priorities

- Is study consistent with JLARC mission? Is it mandated?
- Is this an area of significant fiscal or program impact, a major policy issue facing the state, or otherwise of compelling public interest?
- Will there likely be substantive findings and recommendations?
- Is this the best use of JLARC resources? For example:
  - Is JLARC the most appropriate agency to perform the work?
  - Would the study be nonduplicating?
  - Would this study be cost-effective compared to other projects (e.g., larger, more substantive studies take longer and cost more, but might also yield more useful results)?
- Is funding available to carry out the project?

APPENDIX 2: AGENCY RESPONSES

- Health Care Authority
- Department of Social and Health Services
- Office of Financial Management

Washington State
Health Care Authority

P.O. Box 42700 • Olympia, Washington 98504-2700
360-923-2828 • FAX 360-923-2606 • TTY 360-923-2701 • www.hca.wa.gov

September 30, 2008

Ruta Fanning, Legislative Auditor
Joint Legislative Audit and Review Committee
Post Office Box 40910
Olympia, Washington 98504-0910

Dear Ms. Fanning:

Thank you for the opportunity to respond to the "Preliminary Report on State Health Care Coverage Eligibility" on behalf of the Health Care Authority (HCA). I am impressed with the level of detail and thoroughness of this report given the tremendous complexity and volume of programs covered in your review.

We recognize that the Health Care Authority shares this report with the Department of Social and Health Services. However, we do not want to lose sight of operating issues which complicate our ability to do our jobs efficiently and effectively. We are concerned that as legislators use this report as a reference on state health care programs, the implication will be that HCA programs have no major eligibility issues. We have two major issues related to eligibility for our programs.

First, without appropriate laws and rule making, HCA is unable to effectively manage eligibility within the Public Employees Benefits Board (PEBB) program. PEBB's authorizing statute (Chapter 41.05 RCW) does not provide clear authority to the PEB Board to create eligibility and at the very least does not provide HCA the ability to enforce accurate and consistent eligibility determinations. PEBB has operated for 30 years under laws, rules and policies which contain complex, contradictory requirements. This complexity is further compounded by the "substantially equivalent" language of RCW 41.05.065. While we have identified some improvements we can make to our rules to improve clarity and promote consistency, we have statutory limitations that severely reduce our ability to address this issue. We will look to the Legislature this session for support in addressing these limitations.

Second, HCA's infrastructure is in immediate need of an upgrade in order to maintain eligibility. Addressing this issue will require additional funding and legislative support for the effort. Today, we struggle to perform simple transactions, reconcile that the right people are receiving benefits, and ensure that the $1.5 Billion in healthcare spent every year for PEBB and BH enrollees is accurately paid.

Ruta, I want to express my appreciation for a professional audit experience. I am pleased with how our organizations worked together to ensure a thoughtful and complete report. Please extend our appreciation to your team.

Sincerely,

Steve Hill
Administrator

cc: Christina Hulet, Office of the Governor
Beth Dupre, Deputy Administrator, HCA
Kelly Foster, Director of Performance and Accountability
Mary Fliss, Assistant Administrator PEBB
Preston Cody, Assistant Administrator BH

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

P.O. Box 45010, Olympia, Washington 98504-5010

September 30, 2008

TO: Ruta Fanning, Legislative Auditor

FROM: Robin Arnold-Williams, Secretary
Department of Social and Health Services

SUBJECT: STATE HEALTH CARE COVERAGE ELIGIBILITY – PRELIMINARY REPORT

Thank you for the opportunity to review the State Health Care Coverage Eligibility preliminary report.

RECOMMENDATION	AGENCY POSITION	COMMENTS
Rec. 1	Concur	

The recommendation to ensure our administrative rules related to scope of coverage, income limits, and eligibility reflect current criteria and are understandable is a constant work in progress. The Department of Social and Health Services (DSHS) does update the eligibility manual whenever there are changes to the income standards or deductions for medical assistance programs. However, there are three major standard changes that occur every January, April, and July. Depending on legislative policy changes, some years there can even be additional income standards update. Cost would prohibit the Department from updating consumer publications more often than once a year. That is why publications, such as the "Eligibility Overview" booklet, contain the dates that income standards are updated for each program. Due to these ongoing changes it is a challenge and unfortunately we will be out of sync at times.

DSHS strives to make eligibility policy as easy to understand and read, although, this can also be challenging with the complex federal regulations that drive Washington State policy. The Department continues to "plain talk" WACs whenever they are revised in an effort to achieve this recommended goal.

Thank you again for the opportunity to review and respond.

cc: Steve Hill, Administrator, HCA
Victor Moore, Director, OFM
Kelly Foster, Director of Performance & Accountability, HCA
Carole Holland, Senior Budget Analyst, OFM
Christina Hulet, Executive Policy Advisor (HCA & DOH), OFM
Kari Burrell, Executive Policy Advisor (DSHS), OFM
Peter Bogdanoff, Executive Policy Advisor (L&I), OFM
Kathy Brockman, Chief Administrative Officer, DSHS
Troy Hutson, Assistant Secretary, DSHS
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October 1, 2008

TO: Ruta Fanning, Legislative Auditor
Joint Legislative Audit and Review Committee

FROM: Victor A. Moore, Director
Office of Financial Management

SUBJECT: **STATE HEALTH CARE COVERAGE ELIGIBILITY – PRELIMINARY REPORT**

Thank you for giving the Office of Financial Management the opportunity to review and provide comments on JLARC's preliminary report on State Health Care Coverage Eligibility. Our comments are as follows:

Recommendation	OFM Position	Comments
1. The Department of Social and Health Services (DSHS) should update its administrative rules that relate to the scope of coverage, income limits and eligibility to ensure that they reflect current criteria and are understandable to the general public. DSHS should also ensure that its administrative manuals are consistent with each other and the administrative rules and that its publicly available information is up to date.	Concur	

We look forward to your final report. If you have any questions, please contact Nick Lutes at (360) 902-0570.

APPENDIX 3: SCOPE OF COVERAGE

This table is provided to give general information on the scope of coverage for Medical Assistance programs. It does not in any way guarantee that any service will be covered for a particular person. Whether a service is covered for any particular person depends upon his or her individual circumstances.

Legend: **Y**=Yes, service is usually covered; **N**=No, service is not usually covered; **R**=Restricted with coverage limitations

				General Assistance		
Service	**CN**	**MN**	**S-CHIP/CHP**	**GA-U**	**ADATSA**	**FP/TC**
Adult day health	Y	N	N	N	N	N
Ambulance (ground/air)	Y	Y	Y	Y	Y	N
Ambulatory surgery center	Y	Y	Y	R[1]	R[1]	N[1]
Blood/Blood administration	Y	Y	Y	Y	Y	N
Childbirth education	Y	N	Y	N	N	N
Dental services	Y	Y	Y	R[2]	R[2]	N
Crowns/Dentures	Y[3]	Y[3]	Y[3]	N	N	N
Detoxification	Y	Y	Y	R	R	N
Diabetes education	Y	Y	Y	Y	Y	N
Family Planning Services	Y	Y	Y	Y	Y	Y
Hearing care (audiology/hearing exams/aids)	Y	N[4]	Y	Y	Y	N
Home health services	Y	Y	Y	Y	Y	N
Hospice/Pediatric Palliative care services	Y	Y	Y	N	N	N
Hospital services – inpatient/outpatient	Y	Y	Y	Y	Y	N[1]
Intermediate care facility/services for mentally retarded (IMR)	Y	Y	Y	Y	Y	N
Maternity care & delivery services	Y	Y	Y	N	N	N
Maternity supp. services/infant case management	Y	Y	Y	N	N	N
Medical equipment, durable (DME)	Y	Y	Y	Y	Y	N
Medical equipment, nondurable (MSE)	Y	Y	Y	Y	Y	N
Medical nutrition (enteral) services	Y	Y	Y	Y	Y	N
Medical nutrition therapy	Y	Y	Y	R[4]	R[4]	N
Mental health services (general)	Y	Y	Y	N	N	N
Inpatient hospital care	Y	Y	Y	Y	Y	N
Outpatient hospital care	Y	Y	Y	N	N	N
Nursing facility services	Y	Y	Y	Y	N	N
Organ transplants	Y	Y	Y	Y	Y	N
Out-of-state services	Y	Y	Y	N	N	N
Oxygen/respiratory services	Y	Y	Y	Y	Y	N
Personal care services	R	R	R	N	N	N
Physician-related services	Y	Y	Y	Y	Y	N
Prescription drugs*	Y	Y	Y	Y	Y	R
Private duty nursing	Y	Y	Y	N	N	N
Prosthetic/Orthotic devices	Y	Y	Y	Y	Y	N
Psychological Evaluations	Y	Y	Y	N[5]	N[5]	N
School medical services	Y	Y	N	N	N	N
Smoking Cessation	Y	Y	Y	Y	N	N
Substance abuse services	Y	Y	Y	N[6]	N[6]	N
Therapy – occupational, physical, speech	Y	N[4]	Y	Y	Y	N
Vision care services	Y	Y	Y	Y	Y	N

* Medicare recipients receive outpatient prescriptions through their Medicare Part D plan.

(See next page for footnotes.)

[1] Services limited by parent program (e.g., Dental Program limitations, Family Planning sterilizations service).

[2] Covers only emergent services codes as listed in the Dental Program billing instructions.

[3] Coverage requirements are located in the Dental Program billing instructions.

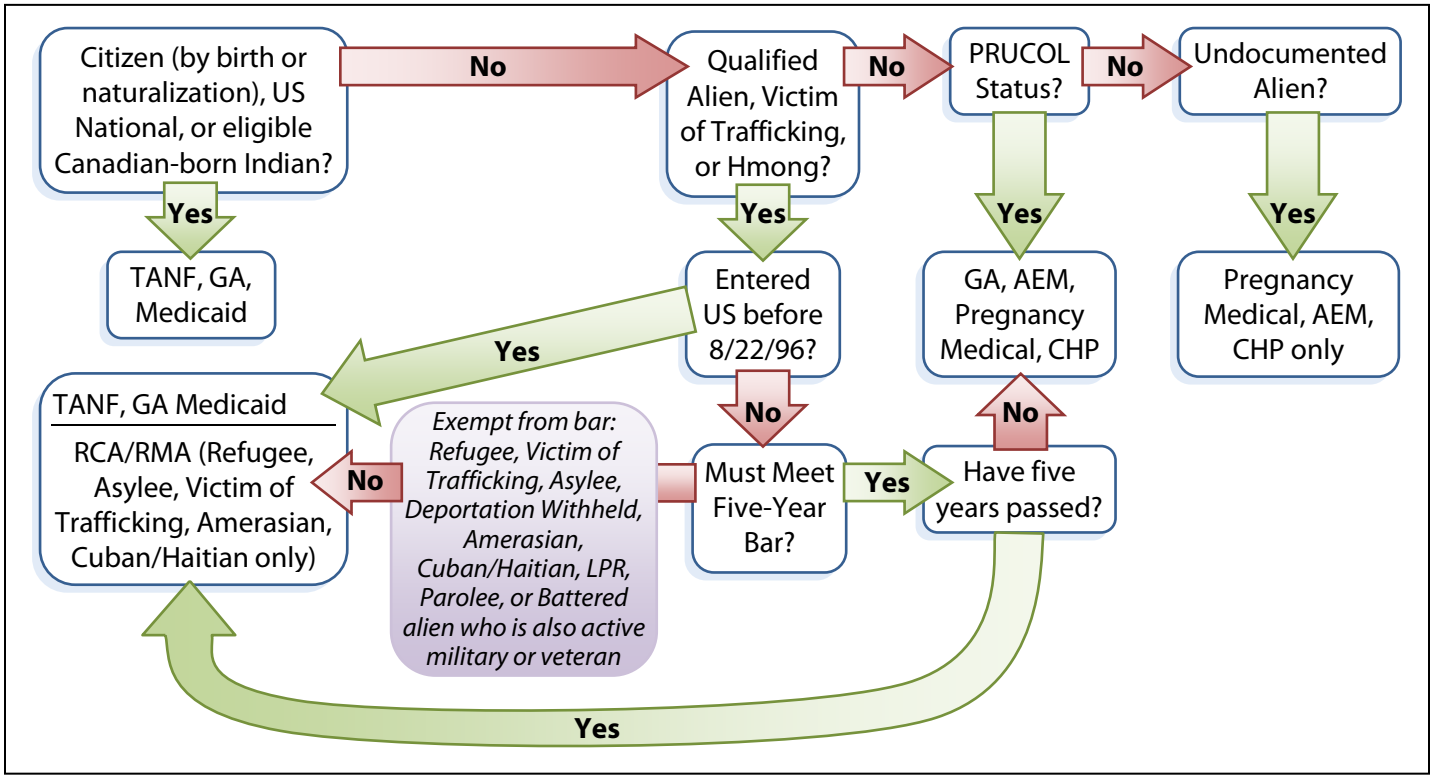
[4] Coverage limited to children age 20 years old and under.

[5] Services covered by the local community mental health center.

[6] Service is covered directly though the Division of Alcohol and Substance Abuse (DASA).

APPENDIX 4: CITIZENSHIP AND IMMIGRATION ELIGIBILITY

Exhibit 5 – Citizenship and Alien Status Decision Tree: Medical Assistance Programs



Source: DSHS

"PRUCOL" ....Permanent resident under color of law
AEM.....Alien Emergency Medical
CHP.....Children's Health Plan
GA.....General Assistance
TANF.....Temporary Assistance to Needy Families
RCA/RMA.....Refugee Cash/Medical Assistance *(not included in this report)*

APPENDIX 5: WAIVER PROGRAMS

Waiver Programs and Waiver Services are programs and services for which the federal government authorizes exceptions to Medicaid rules. These programs provide an eligible client with a variety of services not normally covered under Medicaid. Usually, the purpose of these programs is to assist people to remain in, or return to, living in the community rather than in an institutional setting. Often the costs of services to the person, including the costs of the waiver, are limited to the costs of services provided in the institutional setting for which the person would otherwise be eligible.

COPES Waiver

The Community Options Program Entry System (COPES) is a Medicaid-waiver program that provides case management and personal care services to aged, blind, or disabled adults who live in their own home, an adult family home, or a boarding home. These persons have incomes below 300% of the Federal Benefit Level and would otherwise be required to reside in a nursing home. Services include specialized medical equipment, transportation, environmental modifications, client training, in-home nurse delegation, skilled nursing, community transition services, adult day care, personal emergency response (PERS), home health, and home-delivered meals.

MNIW Waiver

The Medically Needy In-Home Waiver (MNIW) provides case management and personal care services to aged, blind, or disabled adults who live in their own home and who have incomes over the limit for the COPES waiver. These persons meet the Medically Needy income eligibility level and would otherwise need to reside in a nursing home. Services include transportation, specialized medical equipment, environmental modifications, client training, in-home nurse delegation, skilled nursing, community transition services, adult day care, personal emergency response (PERS), home health, and home-delivered meals.

MNRW Waiver

The Medically Needy Residential Waiver (MNRW) provides case management and personal care services to aged, blind, or disabled adults who live in an adult family home or a boarding home and who have incomes over the limit for the COPES waiver. These persons meet the Medically Needy income eligibility level and would otherwise need to reside in a nursing home. Services include transportation, specialized medical equipment, environmental modifications, client training, in-home nurse delegation, skilled nursing, community transition services, adult day care, personal emergency response (PERS), home health, and home-delivered meals.

New Freedom Waiver

The New Freedom consumer directed services (New Freedom) waiver is a pilot program that continues until December 2009. This pilot provides services for aged, blind, and disabled persons over 18 years old whose disabilities are based on medical issues or chronic illness and who meet institutional care standards. The program offers personal assistance services, financial management services, and person-centered planning and consultation.

PACE Waiver

The Program of All-inclusive Care for the Elderly (PACE) waiver is a managed care service operated by treatment providers. It includes the full scope of long-term care, medical, mental health, and chemical dependency services within one service package for persons at least 55 years old who meet institutional care standards and live within the PACE service area.

Road to Community Living Waiver

The Road to Community Living (RCL) demonstration waiver is Washington's program under the federal "Money Follows the Person" grant. RCL provides specialized planning and services to 660 persons with complex needs wanting to move into the community from nursing homes, hospitals, and intermediate care facilities for the mentally retarded in which they have resided for at least six months. This grant extends until December 2011.

WMIP Waiver

The Washington Medicaid Integration Partnership (WMIP) waiver includes long-term care, medical, mental health, and chemical dependency services within one service package for aged, blind, and disabled persons at least 21 years old as well as persons who are dually eligible for Medicare and Medicaid, meet institutional care standards, and live in Snohomish County.

DDD Basic Waiver

The Division of Developmental Disabilities (DDD) Basic waiver is a Medicaid waiver program that provides home and community-based services as additional support when Medicaid state plan services and other supports are not sufficient to provide an alternative to intermediate care facility for the mentally retarded (ICF-MR) placement for persons who live with family or in their own homes. These persons meet ICF-MR level of care guidelines but have a strong natural support system. The ability of the person's family or care giver to continue caring for the person is at risk but can be continued with the addition of services. The risk is present because:

- The person needs some support to maintain his or her home or to participate successfully in the community;
- The person has physical assistance needs or medical problems requiring extra care;

- The person has behavior episodes which challenge the family or caregiver's ability to support them; **or**
- The family or caregiver needs support due to his or her own physical, medical, or psychiatric disability.

DDD Basic Plus Waiver

The DDD Basic Plus waiver is a Medicaid waiver program that provides home and community-based services for individuals who live with family or in another setting with assistance. These persons meet intermediate care facility for the mentally retarded (ICF-MR) guidelines and are at high risk of out-of-home placement or loss of current living situation due to having:

- Been abused, neglected, or exploited within the last six months;
- Been returned from out-of-home placement within the last six months;
- A serious medical problem requiring close monitoring or specialized treatment;
- A dual diagnosis of developmental disability and major mental illness or substance abuse;
- Challenging behavior resulting in danger to health or safety;
- Family/care giver who needs significant help to provide direct physical assistance needed to assure the health and safety of the individual;
- Substantial functional limitations resulting in a need for frequent assistance to maintain his/her home and to successfully participate in the community; **or**
- Protective supervision needs due to impaired judgment.

DDD Core Waiver

The DDD Core waiver is a Medicaid waiver program that provides home and community-based services as an alternative to "intermediate care facility for the mentally retarded" (ICF-MR) placement for individuals eligible for services from DDD who require residential habilitation services or who live at home but are at immediate risk of out-of-home placement due to one or more of the following extraordinary needs.

- The individual has extreme and frequently occurring behavior challenges resulting in danger to health or safety;
- Has had 18 or more days of inpatient psychiatric care in the past 12 months;
- The individual lives in an ICF/MR and requests community placement; **or**
- The person requires daily to weekly one-on-one support, supervision, and 24-hour access to trained persons to meet basic health and safety needs.

DDD Community Protection Waiver

The DDD Community Protection waiver is a Medicaid waiver program that provides home and community-based services as an alternative to an "intermediate care facility for the mentally retarded" (ICF-MR) to persons determined eligible for services from DDD who:

- Are at least 18 years of age;
- Meet the criteria for ICF/MR level of care;
- Live or are moving into the community;
- Require 24-hour, on-site, awake staff supervision to ensure the safety of others;
- Require therapies and other habilitation; **and**
- Are found by DDD to meet the criteria for an "individual with community protection issues" due to a history of violent criminal offenses, or of stalking, predatory, or opportunistic behavior which has not resulted in criminal charges but constitutes a current risk to others.

CHORE Services

The Chore program closed to new applicants on August 1, 2001. This program provides personal care services to persons who were receiving state-funded long-term care on the program closing date. The program is limited to persons living in their own home who have functional limitations based on medical issues, who have an unmet need for personal care services, and who are not eligible for Medicaid Personal Care.

INDEX OF PROGRAMS

Employment-Related Programs

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Expansion Programs