Linking Low-Income Washingtonians with Health Care Financing Arrangements

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I. INTRODUCTION

Low-income residents of Washington State are fortunate to have a myriad of health care financing arrangements designed to protect them from access barriers and financial ruin.1 The challenge facing professionals charged with linking clients to these arrangements is to competently advise and empower them to make informed decisions while still taking into account their specific circumstances. The challenge facing lawmakers charged with balancing the state’s budget is to understand the impact of their actions on end users in the already vastly confusing world of health care.

The universe of federal, state, and combined federal-state health care financing arrangements available to Washington residents cannot be described statically. To a new practitioner attempting to gain a full understanding of the range and inner workings of available health insurance programs, frustration is sure to ensue. The most troubling scenario is the hindsight discovery of a previously unknown health care financing arrangement from the recesses of a reference binder or camouflaged by verbiage in a statute or regulation.

Elements of the snapshot presented in this Article may be dated shortly after publication. For example, although unlikely in the present economic climate, it is possible that the Washington State Legislature will authorize new financing arrangement options that this Article will not reflect. More likely, some of the programs described in

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1. At least through April 2003, this is a true statement. The future of state-assisted health care financing in Washington is threatened by the state’s current fiscal situation.
this Article will be reduced, restructured, or even repealed.\textsuperscript{2} The reader is advised to pay special attention to the footnotes, which are intended to link assertions with the most current information. Referring to the Washington State Department of Social and Health Services (DSHS) and other states' authorities for information on new health care financing arrangements allows this Article to retain utility for future readers.\textsuperscript{3}

The focus of the Article remains strictly on describing the various available financing arrangements. The complex accompanying issues that surround how low-income persons actually access health care services\textsuperscript{4} are critically important, but they are outside the scope of this Article, as are the mechanics of how a client enrolls\textsuperscript{5} in a particular health care financing arrangement. For reference, Appendix A presents data reflecting how many persons each arrangement affects and the administering agency.

The financing arrangements described in the following pages are grouped by category of client served\textsuperscript{6} and by coverage from mandatory to optional.\textsuperscript{7} Doing so takes into account relevant implications of the

\begin{enumerate}
\item Adding to the complexity, some of the health care financing arrangements are smaller or have unstable sources of funding because of political volatility. This aspect of the overall picture is outside the scope of this Article.
\item Several documents describing the health care financing arrangements designed to serve low-income Washingtonians are posted on the Medical Assistance Administration (a subdivision of DSHS) website, at http://fortress.wa.gov/dshs/maa/Eligibility/Index.html (last visited May 11, 2003). However, since the information on this website is designed to be user-friendly for low-income Washington residents, the assertions generally do not cite to authority.
\item The Washington State Department of Social and Health Services (DSHS) offers a website intended to query client data with eligibility requirements of various health care financing arrangements: https://wws2.wa.gov/dshs/onlineapp/introduction_1.asp (last visited May 11, 2003; queries for general medical assistance, children's medical, and long-term care). Further information on how to assist a client with enrolling in one of the arrangements below is available through a DSHS Community Service Officer. For contact information of the nearest Community Service Officer, consult https://wws2.wa.gov/dshs/onlinecso/findservice.asp (last visited May 11, 2003).
\item Many of the financing arrangements overlap to cover the same categories of people. Therefore, to determine arrangements applicable to a particular category of client, it may be necessary to consult multiple sections of this Article. For example, a low-income mother and child may qualify for Medicaid, but if that same mother and child do not qualify for Medicaid, they may qualify for Washington's Basic Health Plan.
\item People in mandatory coverage groups are afforded an "entitlement" to the benefit, which gives rise to greater legal protections. Alternatively, clients enrolled in optional arrangements may not have the same rights as those in mandatory programs. Under an optional Medicaid program, which is both federally and state funded, the details will be provided in the current state Medicaid Plan and eligible clients will be entitled to coverage for the duration of the Plan's term; whereas under a purely state-financed arrangement, change or revocation may occur with less process. The current Washington Medicaid Plan is available at http://cms.hhs.gov/
source of income, which may become important when a client qualifies for multiple financing arrangements. If the state is the sole source of funding or a federal-state matching scheme is involved, a legal entitlement to funding may be created, giving rise to the legal protections of due process. For clients and practitioners alike, understanding and explaining why some forms of health care coverage come with rights to due process, while others do not, can be confusing and troubling. The confusion is compounded by the perception that health care financing, once statutorily granted, is something a person is politically entitled to, regardless of the source of income.

Nonetheless, at its core, this Article is a compilation of the various health care financing arrangements designed to serve low-income Washington residents. It illustrates the eligibility requirements of each available program and details the medical services each arrangement covers. Advisors should then be able to devise questions for their low-income clients to direct them to the health care financing option that best fits each individual's personal situation. Specifically, this Article briefly describes Washington State's health care financing landscape in order to facilitate more informed counseling of low-income clients with respect to the best financing arrangement for an individual client's needs.

By doing so, the authors hope that a series of secondary goals will be met—lawmakers will better understand that navigating health care funding devices is overly complex, that quality should not be based on quantity but on practicalities, and that uncertain political commitment creates confusion about when people are entitled to funding and when they are not.

Following this introductory section, Part II presents a comprehensive description of the health financing arrangements available to low-income residents of Washington State, from federally funded Medicaid programs to state-subsidized insurance. The Article concludes in Part III, outlining the interrelationship between these arrangements and the political process, and suggesting that the Washington State Legislature should be aware of how policy actually affects people.


8. The import of this is a matter of administrative law, which encompasses issues of where the money comes from and what due process rights are attached to enrollment.

II. HEALTH FINANCING PROGRAMS AVAILABLE TO LOW-INCOME RESIDENTS IN THE STATE OF WASHINGTON

This part contains detailed descriptions of the health financing arrangements available to low-income residents of Washington State. Descriptions proceed in the following order: mandatory categorically needy Medicaid programs; optional Medicaid programs; children's programs; other state-only medical assistance programs; and state-subsidized health insurance.

Since many of the financing arrangements described have some relation to Medicaid, a simplified structural illustration is necessary to establish the linguistic framework. The federal Medicaid statute specifies that a participating state must cover certain individuals synonymously referred to as "mandatory eligible" or "categorically needy" consistent with federally set minimum eligibility levels.10 States can extend the levels of eligibility for categorically needy popu-

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10. 42 U.S.C. § 1396a(a)(10)(i) (2003). The level of federal match is individually determined for each state by the federal Centers for Medicare and Medicaid Services (CMS), formerly HCFA, of the U.S. Department of Health and Human Services (HHS). It currently ranges between fifty percent and eighty-three percent, depending on the state's per capita income. Washington's reimbursement rate is 50.37%. See 65 Fed. Reg. 59,650 (Nov. 17, 2000). Eligibility for several health care financing arrangements is based on a determination of a percentage of the Federal Poverty Level (FPL). For example, if a single person makes twice as much as the FPL benchmark, they are said to be at 200% of the FPL. As such, the following table is a reference for the descriptions that follow, in real dollars. WASH. ADMIN. CODE 388-478-0075 (April 1, 2003); 68 Fed. Reg. 6456-03 (Feb. 7, 2003). This chart applies to the forty-eight contiguous states; Alaska and Hawaii have different charts. Id.
lations to allow more residents to meet the eligibility requirements. 11 In addition, a state may cover "optional eligible" categories and treat them as categorically needy. 12 Finally, a state may cover the Medically Needy (MN) and a number of other narrowly defined categories of people. 13 Each state must establish its plan on a yearly basis and file it with the Centers for Medicare and Medicaid Services (CMS), formerly HCFA, of the United States Department of Health and Human Services (HHS). 14

Title XIX of the Social Security Act 15 requires a state to cover certain categories of services for the mandatory Categorically Needy (CN), although the federal law gives the state some discretion in determining the scope and duration of this coverage. 16 Generally, the mandatory groups are low-income aged, blind, and disabled persons or low-income families with children. If a state chooses to cover optional CN or MN persons, the Act also establishes minimum eligibility levels and covered services. 17 The importance to a client with respect to covered services is that all CN individuals receive the same list of covered services, as opposed to all MN individuals who receive fewer covered services (see Appendix B). 18 Because CN Medicaid is broader than MN, the CN and MN terms are used throughout this Article to more precisely indicate the type of Medicaid. Table 1 is a chart of the abbreviated categories covered under Washington's Medicaid plan, each of which is discussed further below. 19

11. This is usually done by adopting more liberal income standards and/or resource tests, discussed infra Part II.A.
13. Id. § 1396a(a)(10)(C) (2003).
15. The Medicaid sections of the Social Security Act, §§ 1902–1933, are correspondingly codified in Title 42 of the U.S. Code as §§ 1396a–1396q, §§ 1396r–1396r-8, §§ 1396s–1396t, §§ 1396u–1396w, and §§ 1396v–1396w.
16. 42 U.S.C.A. § 1396a (2003). Medical assistance shall be made available, including at least the care and services listed in paragraphs (1) through (5), (17) and (21) of section 1396d(a), to all individuals receiving aid or assistance under a state-approved plan consistent with subparagraph (A) or (B) of subsection (I)(1) of this section and whose family income does not exceed the minimum income level the state is required to establish under subsection (I)(2)(A) of this section or who are qualified family members as defined in section 1396d(m)(1) of this title.
17. The specific coverage and eligibility requirements are discussed for each program infra.
18. A chart of covered services is provided on the Medical Assistance Administration website, illustrating the continuum of breadth from categorically needy (most broad) to the medically indigent (least broad), available at http://fortress.wa.gov/dshs/maa/Eligibility/OVERVIEW/MedicalOverviewCoveredServices.htm.
19. This chart reflects only Medicaid coverage groups and does not include financing arrangements that are completely state financed or state subsidized.
Table 1. Categories Covered Under Washington’s Medicaid Plan

Washington must cover the following “mandatory eligible” persons:

- Low-income families receiving TANF cash assistance.\(^{20}\)
- Families that would be eligible for TANF if not for time limits.
- Families that must leave TANF due to increased income (transitional Medicaid).
- Pregnant women and infants with income at or below 185% of the federal poverty level.
- Children who are recipients of adoption assistance and foster care under Title IV-E of the Social Security Act.
- Children between the ages of one and five with family income at or below 133% of the federal poverty level, and children between the ages of six and eighteen with family incomes at or below 100% of the federal poverty level.
- All persons with disabilities who are receiving Supplemental Security Income (SSI).
- Seniors who receive Supplemental Security Income.
- Medicare buy-in recipients.
- Undocumented aliens who meet other Medicaid requirements (for whom Medicaid pays for emergency medical conditions such as labor and delivery).
- “Pickle people,” many, but not all, are recipients of both SSI and Social Security who have lost their SSI benefits because of Social Security cost-of-living adjustments.

Washington currently covers the following “optional eligibles”:

- Children between the ages of one and five with family income between 133% and 200% of the federal poverty level and children between the ages of six and eighteen with family income between 100% and 200% of the federal poverty level.
- Certain children under age twenty-one in foster care, in subsidized adoption, or receiving institutionalized care.
- Women diagnosed with breast or cervical cancer.
- Individuals earning under 200% of the federal poverty level receiving family planning services under the Take Charge waiver.

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\(^{20}\) This group is also referred to as families who would have received AFDC (Aid to Families with Dependent Children) under Washington’s AFDC standards as of July 16, 1996. However, AFDC has been repealed and replaced by TANF (Temporary Assistance to Needy Families).
• Individuals eligible for, but not receiving, cash assistance.
• Working persons who previously qualified for SSI and now qualify for Healthcare for Workers with Disabilities (HWD).
• Seniors and persons receiving optional state supplemental payments.
• Nursing home and other facility residents with income above SSI levels but below federal limits.
• Seniors and persons with disabilities receiving home and community-based services.

Washington currently covers the optional "medically needy":

• People who would otherwise qualify under any of the mandatory or optional groups listed above, except that their income and resources are too high; they may be covered subject to "spend down" requirements.

A. Mandatory CN Medicaid Programs

For Medicaid purposes, mandatory CN individuals include low-income families with dependent children and aged, blind, and disabled persons eligible for benefits under Supplemental Security Income (SSI). As an agency within DSHS, the Medical Assistance Administration (MAA) is responsible for administering a program providing all CN residents at least the mandatory covered services described in the Social Security Act.

1. CN Family Medical

Families with dependent children who meet the income and resource guidelines of TANF and are currently receiving TANF cash

24. Dependent children are children under age nineteen, or over age nineteen if participating full time in a secondary school, vocational program, or technical program pursuant to the requirements of WASH. ADMIN. CODE § 388-404-0005(1)(b) (2002).
25. WASH. ADMIN. CODE § 388-478-0020 (payment standards chart):

<table>
<thead>
<tr>
<th>Number of Persons</th>
<th>CN Monthly Income Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$349</td>
</tr>
<tr>
<td>2</td>
<td>$440</td>
</tr>
<tr>
<td>3</td>
<td>$546</td>
</tr>
</tbody>
</table>
benefits are eligible to receive CN Medicaid. Persons receiving cash diversion assistance or persons eligible for TANF cash benefits, but who choose not to receive them, also qualify for CN Medicaid.

Families not receiving or not eligible for TANF cash benefits are also eligible for CN Medicaid if they meet the eligibility criteria for AFDC that were in effect on July 16, 1996. Eligibility is also granted to families who are not eligible for or currently receiving TANF cash benefits because the lifetime sixty-month limit on TANF benefits tolled for a member of the family, the school attendance requirement was not met, or the client is an unmarried minor parent who is not in a Department-approved living situation. Pregnancy does not affect the eligibility or benefits of a person already receiving TANF or State Family Assistance (SFA) benefits.

Until October 2002, the Washington Administrative Code (WAC) sections defining eligibility included a provision for state-funded family medical with the same benefits as CN Medicaid when a person was eligible for or receiving SFA. Recipients of SFA are no longer eligible for CN Medicaid, although they can apply for the Basic Health Plan (BHP), discussed infra Part II(C)(1). Additionally, inmates in public institutions are not eligible for CN Medicaid.

When determining eligibility for CN Medicaid, families may deduct fifty percent of their earnings, all work-related child care ex-

| 4 | $642 |
| 5 | $740 |
| 6 | $841 |

See also WASH. ADMIN. CODE § 388-470-0005(6)(a) (2002) (countable resources must be at or below $1000.00); WASH. ADMIN. CODE § 388-470-0050 (resources that count toward asset limit: burial insurance or term insurance in excess of $1,500, child’s irrevocable educational trust in excess of $4,000, life insurance, sales contracts, real estate mortgages, security interests, and savings accounts in excess of $3,000).

27. Pursuant to WASH. ADMIN. CODE § 388-432.
29. Id. § 388-505-0220(1)(d) (2002) (residents qualifying in this manner are still subject to the current state earned income and resource limits that apply pursuant to WASH. ADMIN. CODE § 388-505-0220(1)(d)(i)–(ii) (2002), but this does not affect anyone currently because the TANF eligibility requirements are broader).
31. Id. § 388-505-0220(2)(b) (school attendance requirement pursuant to WASH. ADMIN. CODE § 388-400).
32. Id. § 388-505-0220(2)(c).
33. Id. § 388-462-0010 (1999).
34. Id. § 388-505-0220(3)–(5) (2002).
35. Id. § 388-505-0220(3) (inmate intended as defined by WASH. ADMIN. CODE § 388-500-0005; exceptions provided in WASH. ADMIN. CODE § 388-505-0210(5)(c)(i)–(ii)).
penses,\textsuperscript{37} and all child support paid.\textsuperscript{38} Additionally, there are allowances for car and house deductions,\textsuperscript{39} amongst others.\textsuperscript{40} The fifty percent earned income deduction does not apply to CN Medicaid where income eligibility is based on the Federal Poverty Level (FPL).\textsuperscript{41} For these arrangements, monthly income deductions are limited to $90, plus work-related childcare and child support.\textsuperscript{42}

Once a family begins receiving CN Medicaid, earned income increases are disregarded as countable income during the second and third month of eligibility.\textsuperscript{43} There are complex rules for determining when an increase in income or assets is counted for purposes of determining CN eligibility.\textsuperscript{44}

When families exceed program standards for family income, they are eligible for a four-\textsuperscript{45} or twelve-month\textsuperscript{46} extension of CN Medicaid benefits, often referred to as Transitional Medical Assistance (TMA).\textsuperscript{47}

2. CN Pregnant Women and Infants

States are required to provide CN Medicaid to pregnant women with income up to 133\% of FPL.\textsuperscript{48} If a state chooses to cover a higher

\begin{itemize}
  \item 37. Id. § 388-450-0210(4)(b).
  \item 38. Id. § 388-450-0210(4)(c).
  \item 39. Id. § 388-470-0070 (value of vehicle under $5,000 is excluded; vehicles of any value are excluded if for transportation of a physically disabled individual); Id. § 388-470-0045 (3) (2002) (home that the applicant, applicant’s spouse, or applicant’s dependent resides in).
  \item 40. Id. § 388-470-0045.
  \item 41. Id. § 388-450-0210(4)(f) (namely pregnant women’s, children’s medical, and the children’s health program).
  \item 42. Id. § 388-450-0210(4)(f) (child care and child support deductions pursuant to sections (b) and (c) of this section, respectively).
  \item 43. Id. § 388-450-0210(4)(j) (disregard stops the last day of the third month of eligibility).
  \item 44. For example, nonrecurring lump sum payments are considered income in the month the client receives payment, and a resource if the client retains the payment after the month of receipt. Id. § 388-450-0210(4)(b) (2002). For clients receiving cash diversion assistance, the amount received is not included as countable income. Id. § 388-450-0210(4)(i). Moreover, who comprises the “medical assistance unit” (MAU) has implications on income deeming rules (WASH. ADMIN. CODE § 388-408-0055 (2002)) and at least one other related exception. See, e.g., Sneede v. Kizer, No. C89-1932, 1990 WL 155532, at *5-7 (N.D. Cal. May 3, 1990), aff'd mem., 951 F.2d 360 (9th Cir.1991), cert. denied, 506 U.S. 939 (1992) (allowing more generous income deeming rules for the medical assistance unit).
  \item 45. WASH. ADMIN. CODE §§ 388-523-0100(1)(a), (2)(a) (2002) (where child or spousal support exceeds payment standards described WASH. ADMIN. CODE § 388-478-0065, and the applicant is not eligible for any other CN medical program).
  \item 46. Id. §§ 388-523-0100(1)(b), (2)(b) (where increased earned income causes ineligibility pursuant to WASH. ADMIN. CODE § 388-478-0065).
  \item 47. Id. § 388.523.0100 (eligible applicants are subject to monthly premiums for second six months pursuant to WASH. ADMIN. CODE § 388-523-0120(2)).
income level, as Washington has (185%), federal law dictates that the higher standard become the mandatory coverage requirement.

A pregnant adult woman is eligible for CN Medicaid if she meets the general requirements and has her pregnancy confirmed. Contrary to TANF requirements, there is no resource limit as a condition of eligibility for CN pregnant women coverage in Washington. Once a CN Medicaid covered woman gives birth, she may qualify for a sixty-day postpartum care extension even if she and her family do not qualify for CN Medicaid. Pregnant women who are ineligible for CN Medicaid may qualify for MN or Medically Indigent (MI) Medicaid.

If the act of placing a child for adoption at birth causes the woman to lose TANF benefits, Washington offers an optional state-funded post-adoption cash benefit for a short time.

3. CN Mandatory Child's Medical

Children's eligibility for CN Medicaid is divided into two categories: children under the age of one and children under the age of nineteen. Children under the age of one are eligible if the child's mother is eligible for and receiving Medicaid at the time of the child's birth and the child is living with the mother in Washington.

49. WASH. ADMIN. CODE § 388-478-0075 (2002). In making this calculation, only income contributed by an unmarried father of an unborn child to the pregnant woman is considered income. Id. § 388-462-0015(7). Additionally, the assignment of child support and medical support rights described in WASH. ADMIN. CODE § 388-422-0015 do not apply to pregnant women.

50. Supra, note 48.

51. Special rules regarding assistance units exist for pregnant minors. WASH. ADMIN. CODE § 388-408-0055(2)–(3) (2002).

52. Id. § 388-503-0505 (must be a citizen or have qualifying immigrant status, have applied for or currently have a social security number, be a Washington state resident, and meet countable income standards)

53. Id. § 388-462-0015(1) (must be confirmed by a licensed medical practitioner, licensed laboratory, community clinic, family planning clinic, or health department clinic).

54. Id. § 388-462-0015(8) (resource limit only applies to eligibility for medically needy (MN) and medically indigent (MI) programs).

55. Id. § 388-462-0015(11)–(12). Eligibility is granted so long as the woman was eligible and received medical coverage on the last day of pregnancy. If the family is no longer eligible for cash or medical assistance, DSHS will notify the family that they may qualify for the “Take Charge” waiver, a program offering birth control and family planning services. The “Take Charge” waiver is a pilot program temporarily codified in WASH. ADMIN. CODE §§ 388-532-700–780. More information is available at http://fortress.wa.gov/dshs/maa/familyplan/TC front.html.

56. WASH. ADMIN. CODE § 388-462-0015(3), (4), (6), and (11) (2002).

57. Id. § 388-462-0011.

58. Or under the age of twenty-one, in certain circumstances. Id. § 388-505-0210 (2002).

59. Id. § 388-505-0210(1)(a)–(b).
children under the age of nineteen are eligible for CN Medicaid when they have appropriate citizenship\(^{60}\) or immigrant status,\(^{61}\) are state residents,\(^{62}\) have applied for or currently have a social security number,\(^{63}\) and have a family income up to 200% of FPL.\(^ {64}\)

Beyond the cut-off age of nineteen, CN Medicaid continues until age twenty-one for children meeting the same eligibility requirements as children under the age of nineteen\(^ {65}\) and who also satisfy one of four additional criteria: 1) they reside in a medical hospital, intermediate care facility for the mentally retarded (ICF/MR), or a nursing facility for more than thirty days; 2) they reside in a psychiatric or chemical dependency facility; 3) they reside in foster care; or 4) they receive subsidized adoption services.\(^ {66}\)

Washington has increased children’s eligibility beyond the mandatory levels to cover children ages one through five with income between 133% and 200% of the federal poverty level and children ages six through eighteen with income between 100% and 200% of the federal poverty level.\(^ {67}\)

Certain children under the age of twenty-one in foster care, in subsidized adoption, or receiving institutionalized care also qualify for CN Medicaid.\(^ {68}\)

Children not eligible for CN Medicaid may be eligible for Supplemental Security Income (SSI), the MN program, or the State Children’s Health Insurance Program (SCHIP), each discussed below.

4. CN SSI-Related: Aged, Blind, or Disabled

Aged, blind, or disabled persons may qualify for CN Medicaid in several ways. First, if the person is currently receiving SSI cash benefits,\(^ {69}\) he is automatically eligible for CN Medicaid.\(^ {70}\) Second, aged, blind, or disabled persons not eligible for SSI because of excess income, but considered related\(^ {71}\) to the SSI program, are eligible.\(^ {72}\)

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60. As described in WASH. ADMIN. CODE § 388-424-0005(1) (2002).
61. As described in WASH. ADMIN. CODE § 388-424-0010(1)-(2) (2002).
62. As described in WASH. ADMIN. CODE § 388-468.
63. As described in WASH. ADMIN. CODE § 388-476.
64. WASH. ADMIN. CODE § 388-505-0210(2)(a)-(d) (2002). This is an expansion of the federal mandatory levels of 133% and 100% of FPL for children under six and nineteen years of age, respectively.
65. Id. § 388-505-0210(4)(a)-(b).
66. Id. § 388-505-0210(4)(c).
67. Id. § 388-505-0210.
68. Id.
70. WASH. ADMIN. CODE § 388-503-0510(1)(b) (2002).
71. A person is considered "related to" SSI if she is age sixty-five or older, blind, or disabled, but does not qualify for SSI cash assistance. Id. § 388-511-1105.
Third, disabled children who were eligible for and receiving SSI cash assistance in August 1996, but are no longer eligible due to the passage of the 1996 Welfare Act, are eligible for CN Medicaid.\(^73\)

Except where the state has adopted more liberal income guidelines, SSI income rules are used to determine a client’s countable income.\(^74\) The standard in Washington is referred to as the SSI-related Categorically Needy Income Level (CNIL) standard and is used to determine eligibility for persons not receiving SSI, who have income less than MN requirements. SSI-related CNIL divides the state into two “areas” with differing income level requirements.\(^75\) If the client is SSI-related and has income at or below the CNIL, he is eligible for CN Medicaid.

If a person’s SSI cash assistance is terminated due to a determined end of the disability or if re-determination of eligibility is pending, CN Medicaid coverage continues for a 120-day automatic extension period\(^76\) and the person is eligible for General Assistance- Expedited Medicaid Disability (GA-X).\(^77\)

5. Long-Term Care

Long-term care is a service provided in a variety of forms to the disabled and elderly.\(^78\) Home and community-based services, institutional services, and hospice care are all included in the broad heading of long-term care, depending on the client’s particular care needs.

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72. Id. § 388-503-0510(1)(a). Pursuant to aged, blind, or disabled definitions in WASH. ADMIN. CODE § 388-511-1105(1), an applicant must be sixty-five years of age, blind with 20/200 vision in the better eye with the use of corrective lens, or be disabled as defined by the Medical Assistance Administration (MAA). While age and blindness are relatively simple to quantify, the relevant meaning of disability requires more description. The MAA has defined “disabled” as being unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which (1) can be expected to result in death or (2) has lasted or can be expected to last for a continuous period of not less than twelve months. Id. § 388-511-1105(c)(2) (emphasis added). Other SSI-related covered groups include (1) SSI-terminated children who qualified under the pre-1996 definition of disability; (2) SSA recipients who become SSI-ineligible due to their own cost of living increases or those of their families; (3) SSI recipients who are working and no longer eligible for SSI, but still blind or disabled; (4) disabled widows/widowers; (5) disabled adult children; and (6) other “grandfatheres.” Id. § 388-505-0110.

73. Id. § 388-503-0510(1)(c) (2002); Id. § 388-505-0210(6).

74. Id. § 388-450-0210(6).

75. Id. § 388-478-0080 (Area 1 includes King, Pierce, Snohomish, Thurston, and Kitsap counties. Area 2 is all other counties,); see also id. § 388-450-0020 (income exclusions for SSI-related medical).

76. Id. § 388-474-0015(2). The change in disability status must be consistent with federal guidelines promulgated in 20 C.F.R. §404.1520 (2000).


78. For criteria, see id. § 388-513-1320 (2002).
Eligibility for long-term care\textsuperscript{79} requires that the client attain "institutional status"\textsuperscript{80} by showing a documented need for care over an extended period of time. Once established, the client must be "related to" the SSI program or eligible for GA-X,\textsuperscript{81} and meet the financial requirements.\textsuperscript{82} Alternatively, eligibility for CN children's medical\textsuperscript{83} or TANF\textsuperscript{84} is an automatic qualifier for CN long-term care services.

Eligibility for the MN scope of coverage requires that the client be eligible for MN children's medical\textsuperscript{85} or be related to the SSI program.\textsuperscript{86} A client meeting the CN eligibility requirements is approved for twelve months\textsuperscript{87} and a client meeting the MN eligibility requirements is approved for nine months.\textsuperscript{88}

Waivered home and community-based services are alternative programs for persons who would otherwise be institutionalized or hospitalized, and can safely receive care at a lesser cost at home, in an adult family home, or in an assisted living facility. While the eligibility intricacies of each waivered program are outside the scope of this Article, the relevant programs are the Community Options Program Entry System (COPES)\textsuperscript{89} for adults and Community Alternatives Pro-

\textsuperscript{79}\textit{Id.} § 388-513-1315(1) (2002). For long-term care services, client must preliminarily fulfill the following criteria: meet the general eligibility for medical programs, attain institutional status, and not be subject to the penalty period of ineligibility. Then, the client must meet specific requirements of a waivered program described above or meet CN or MN long-term care requirements.

\textsuperscript{80} Pursuant to WASH. ADMIN. CODE § 388-513-1320.

\textsuperscript{81} WASH. ADMIN. CODE § 388-513-1315(2)(a) (2002) (or be approved for the GA-X program described above).

\textsuperscript{82} Id. § 388-513-1315(2)(b) (gross nonexcluded income, pursuant to WASH. ADMIN. CODE § 388-513-1315(7)(a) that does not exceed special income level (SIL) of 300%). Resource standards are provided in WASH. ADMIN. CODE § 388-513-1315(6). However, resources calculated in the month of application or review exceeding these standards do not preclude eligibility so long as, when added to gross nonexcluded income, the total does not exceed the SIL. Id. § 388-513-1315(3).

\textsuperscript{83} Id. § 388-513-1315(2)(c).

\textsuperscript{84} Id. § 388-513-1315(2)(d).

\textsuperscript{85} Id. § 388-513-1315(5)(a).

\textsuperscript{86} Id. § 388-513-1315(5)(b) (and also meet the requirements of WASH. ADMIN. CODE § 388-513-1395, Determining Eligibility for Institutional or Hospice Services and for Facility Care Only Under the MN Program).

\textsuperscript{87} Id. § 388-513-1315(8).

\textsuperscript{88} Id. § 388-513-1315(9).

\textsuperscript{89} Id. § 388-515-1505. COPES pays for an aid to visit the client at home and assist with custodial, non-medical functions such as bathing or cooking. Generally, the client must be at least eighteen years of age, meet SSI disability criteria, require nursing home level of care, be residing in a medical facility or likely to be in the next thirty days, obtain institutional status, be determined in need of waivered services and be approved for a plan of care, be able to live at home or in a state-contracted facility, and meet resource, income, and asset transfer requirements. Other requirements and more detail are provided in the regulation.
gram (CAP)\textsuperscript{90} and Outward Bound Residential Alternatives (OBRA)\textsuperscript{91} for developmentally disabled children and adults.

Alternative living facilities (ALF)\textsuperscript{92} are also in the category of long-term care. However, non-institutionalized medical assistance in department-contracted ALFs have separate eligibility requirements.\textsuperscript{93}

If a client does not wholly meet the requirements of any above-mentioned program, he may also qualify for long-term care services through the MN,\textsuperscript{94} alien emergency medical (AEM),\textsuperscript{95} general assistance (GA),\textsuperscript{96} or the MI\textsuperscript{97} programs.

If the long-term care facility has a fraternal, religious, or benevolent affiliation, additional requirements apply.\textsuperscript{98}

6. Medicare Cost-Sharing Program

Washington State is required to pay for a share of Medicare Part B premiums, as well as Part A deductibles and co-payments, for certain aged, blind, and disabled clients who are receiving or are eligible to receive Medicare Part A benefits.\textsuperscript{99} In ascending order from least to most restrictive, in terms of income and resource limits when determining eligibility, the programs are Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualified Individual programs (QI-1 and QI-2), and Qualified Disabled

\textsuperscript{90} Id. § 388-515-1510. CAP provides home and community-based services as alternatives to an institution for the mentally retarded. Generally, the client must be Medicaid eligible under a CN program and meet requirements for services provided by the Division of Developmental Disabilities (DDD), have attained institutional status, be assessed as requiring the level of care provided in an intermediate care facility for the mentally retarded (ICF-MR), have a department-approved plan of care that includes support services to be provided in the community, be able to reside in the community according to the plan of care and choose to do so, meet income and resource requirements, and, for OBRA only, be a medical facility resident at the time of application. Other requirements and more detail are provided in the regulation.

\textsuperscript{91} Id. OBRA provides a person approved for services from the Division of Developmental Disabilities with the option to remain at home or in an alternative living facility.

\textsuperscript{92} Alternative living facilities consist of adult family homes, adult residential care facilities, adult residential rehabilitation centers, and enhanced adult residential care facilities. Id. 388-513-1301 (2000).

\textsuperscript{93} Id. § 388-513-1305 (2002). ALFs include adult family homes, adult residential care facilities, adult residential rehabilitation centers, adult residential treatment facilities, assisted living facilities, division of disabilities group homes, and enhanced adult residential care facilities. Id.

\textsuperscript{94} Id. § 388-513-1395.

\textsuperscript{95} Id. § 388-513-1315(10) (where client is not a citizen or "qualified immigrant"); see infra Part II.D.5, Programs for Immigrants Not Otherwise Qualified.

\textsuperscript{96} WASH. ADMIN. CODE § 388-513-1315(11) (if client meets all preliminary long-term care criteria in WASH. ADMIN. CODE § 388-513-1315(1), but fails to meet eligibility requirements of a specific program).

\textsuperscript{97} Id. § 388-513-1315(12); see infra Part II.D.4, Medically Indigent Program.

\textsuperscript{98} WASH. ADMIN. CODE § 388-513-1396 (2002).

\textsuperscript{99} Id. § 388-517-0300(2)(a).
Working Individual (QDWI). The five cost-sharing arrangements have relatively high income\(^{100}\) and resource limits.\(^{101}\)

The Qualified Medicare Beneficiary (QMB) program is available to clients with income up to 100% of the FPL.\(^{102}\) Under QMB, DSHS pays for any Medicare Part A, plus Part B premiums, coinsurance, deductibles,\(^{103}\) and any Medicare managed care charges.\(^{104}\)

A client is eligible for the Specified Low-Income Medicare Beneficiary (SLMB) program if his income is between 100% and 120% of the FPL.\(^{105}\) SLMB pays only Medicare Part B premiums.\(^{106}\)

There are two Qualified Individual programs: (QI-1) and (QI-2). QI-1 (formerly ESLMB) serves clients between 120% and 135% of the FPL\(^{107}\) and pays only Medicare Part B premiums.\(^{108}\) QI-2 serves clients between 135% and 175% of the FPL\(^{109}\) and pays only a part of Medicare Part B paid on an annual basis.\(^{110}\)

The QDWI program is available to disabled clients who are employed and under the age of sixty-five.\(^{111}\) QDWI pays any unpaid Medicare Part A premiums\(^{112}\) for eligible clients up to 200% of the FPL.\(^{113}\)

7. Refugee Assistance

A person who is granted asylum in the United States as a refugee and is earning up to 200% of the FPL is eligible for Refugee Medical Assistance (RMA) for a maximum of eight months from the time she entered the United States.\(^{114}\) However, if a refugee is eligible for

\(^{100}\) In addition to higher income limits measured as a greater percentage of the FPL, state-paid buy-in programs have no maximum income limit for persons receiving services either under CN or MN programs for QMB or SLMB programs. Id. § 388-517-0300(3)(f). However, clients are ineligible for the QI-1, QI-2, and QDWI programs if they are receiving CN or MN.

\(^{101}\) Id. § 388-478-0085(6) (resource limits for Medicare cost-sharing programs are $4,000 for one person and $6,000 for two persons).

\(^{102}\) Id. § 388-517-0300(1)–(3); see also id. § 388-478-0085(1).

\(^{103}\) As defined by WASH. ADMIN. CODE § 388-517-0300(7) (2002).

\(^{104}\) Id. § 388-517-0300(6)(a) (2002).

\(^{105}\) Id. § 388-517-0300(1)–(3); see also id. § 388-478-0085(2).

\(^{106}\) Id. § 388-517-0300(6)(b) (subject to annual funding cap on federal funds pursuant to WASH. ADMIN. CODE § 388-517-0300(11)).

\(^{107}\) Id. § 388-478-0085(3).

\(^{108}\) Id. § 388-517-0300(6)(b) (subject to annual funding cap on federal funds pursuant to WASH. ADMIN. CODE § 388-517-0300(11)).

\(^{109}\) Id. § 388-478-0085(5).

\(^{110}\) Id. § 388-517-0300(6)(d).

\(^{111}\) Id. § 388-517-0300(2)(b).

\(^{112}\) Id. § 388-517-0300(6)(c).

\(^{113}\) Id. § 388-478-0085(4).

\(^{114}\) Id. § 388-400-0035 (must also provide the volunteer settling agency and meet the immigration status requirements). The program is really for recent arrival adults who are not aged,
Medicaid or is a full-time student in higher education, she is not eligible for RMA.\textsuperscript{115} Once eligible for RMA, increases in earned income beyond the initial eligibility allowance of 200% of the FPL do not disqualify the person.\textsuperscript{116} If a refugee client does not qualify for Medicaid or RMA, MN assistance is available subject to spend-down requirements discussed below.\textsuperscript{117}

B. Optional Medicaid Programs

In addition to the mandatory categorically needy programs Washington must administer in order to receive federal Medicaid matching funds, Washington offers optional Medicaid coverage through expansion of CN programs and MN programs.

1. CN Optional Breast and Cervical Cancer

A woman\textsuperscript{118} diagnosed with breast or cervical cancer or a related pre-cancerous condition may be eligible for CN Medicaid.\textsuperscript{119} Eligibility requires that the woman be under the age of sixty-five, ineligible for any other CN Medicaid program, and without any other health care insurance.\textsuperscript{120} The applicant also must meet the citizenship requirements\textsuperscript{121} and income requirements.\textsuperscript{122} Effective July 1, 2001, coverage is available for women under the age of sixty-five whose household income is at or below 200% of the FPL.\textsuperscript{123}

\begin{footnotes}
\item[115] Id. § 388-400-0035(2) (but a refugee whose eligibility ends due to earned income increases is transferred to RMA for the remainder of the eight month period).
\item[116] Id. § 388-400-0035(5).
\item[117] Id. § 388-400-0035(1)(c).
\item[118] While men are also diagnosed with breast cancer, federal requirements of this Medicaid program limit coverage only to women who meet the eligibility criteria.
\item[119] WASH. ADMIN. CODE § 388-462-0020(1)(a)–(b) (2002). Diagnosis requires screening pursuant to the Center for Disease Control (CDC) Breast and Cervical Cancer Early Detection Program (BCCEDP), administered by the Department of Health (DOH). If a woman seeks coverage under this program, she must be screened by a CDC-BCCEDP designated facility. A list of qualified providers is available at the DOH Breast and Cervical Health Program website at http://www.doh.wa.gov/wbchp/default.htm.
\item[120] WASH. ADMIN. CODE § 388-462-0020(1)(c)–(e) (2002).
\item[121] Id. § 388-462-0020(1)(f)–(h) (a woman who meets all eligibility criteria but citizenship/immigrant status is eligible for MN scope of coverage through the Alien Emergency Medical Program, discussed infra Part II.D.5).
\item[122] WASH. ADMIN. CODE § 388-462-0020(3) (2002) (income guidelines are determined by the CDC-BCCEDP program).
\item[123] Id.
\end{footnotes}
2. MN Program

The MN program is an optional federal-state matching program for aged, blind, or disabled persons.\(^{124}\) Additionally, MN coverage is available for pregnant women, children, and refugees who otherwise qualify for CN Medicaid if the only disqualifying factor is income level.\(^ {125}\) The breadth of coverage for MN is slightly less than for CN.\(^{126}\)

In addition to any applicable resource limits, which are the same as those of the CN program, the MN program requires further financial participation in the form of an income "spend-down."\(^ {127}\) It works much like an insurance deductible whereby the applicants must personally incur their medical expenses to the point where the difference between their monthly income and monthly medical bills is below the medically needy income level (MNIL).\(^ {128}\) For example, a married woman with one child and a monthly income of $700 after applicable income deductions must pay out-of-pocket $33 per month before MN Medicaid will pay.

Countable Income $700

Less MN income limit\(^ {129}\) $667

Excess income $33

In this example the woman would not qualify for CN Medicaid because her income is above the allowable amount of $546,\(^ {130}\) but she may nonetheless spend down the income she does get to receive MN coverage. To determine the amount of the spend-down, the applicant has the choice of a three- or six-month base period to calculate the income and medical expenses differential.\(^ {131}\)

\(^{124}\) Id. § 388-519-0100 (specific eligibility requirements of MN program).

\(^{125}\) Subject to spend-down requirements, discussed infra.

\(^{126}\) WASH. ADMIN. CODE § 388-529-0200 (2002) (chart of services comparing the CN, MCS, MN, and MI programs.).

\(^{127}\) The level to which a person must spend down depends on the family size. See id. § 388-478-0070 (2002).

\(^{128}\) Id. § 388-478-0070 (This chart provides the ascending MNIL for households up to ten members, currently $571, $592, and $667, for one-, two-, and three-person households, respectively.) For comparison with other programs, the MNIL for one-, two-, and three-person households represents seventy-seven percent, fifty-nine percent, and fifty-three percent of FPL, respectively.

\(^{129}\) See supra note 128.

\(^{130}\) Supra note 25.

\(^{131}\) WASH. ADMIN. CODE § 388-519-0110 (2002). This is the spend-down regulation that describes in more detail the implications of base periods.
Just as each category of CN Medicaid has slightly different eligibility criteria, the categories for MN also have slightly different eligibility criteria. In particular, SSI-related persons,\footnote{Id. § 388-505-0110(3).} children,\footnote{Id. § 388-505-0210(7)-(9).} and pregnant women\footnote{Id. § 388-462-0015(5).} are each treated separately. In addition, MN coverage is available to SSI-related ineligible spouses,\footnote{Id. § 388-505-0110(4); see also id. § 388-519-0100.} institutionalized persons,\footnote{Id. § 388-513-1395.} and persons receiving non-institutionalized long-term care.\footnote{Id. § 388-513-1305 \((\text{generally, non-nursing home care such as boarding homes, adult family homes, and other non-nursing home facilities)}\).}

Refugees may qualify for MN Medicaid if their monthly income exceeds the 200\% of the FPL eligibility requirement of CN Medicaid, so long as they conform to the spend-down guidelines.\footnote{Id. § 388-400-0035(1)(c).}

3. Healthcare for Workers with Disabilities

Healthcare for Workers with Disabilities (HWD) allows disabled persons to work and still qualify for CN Medicaid. To be eligible for HWD, a person must be between the ages of sixteen and sixty-four and have income below 220\% of the FPL.\footnote{Id. §§ 388-475-1000, -1050.} Since HWD qualifies a recipient for CN Medicaid, Medicaid Personal Care (MPC) services are available. The recipient will pay a premium based on a sliding income scale.\footnote{Id. § 388-475-1250.} Unlike other CN programs, there is no assets test.\footnote{Id. § 388-475-1050(3).}

Long-term care is not authorized through HWD. If the recipient develops a need for long-term care, she would be subject to eligibility requirements and financial participation described in the \textit{Long-Term Care} section above.

\textbf{C. Additional Children’s Programs}

1. Basic Health Plan Plus

Basic Health Plan Plus (BHP+), statutorily described in Washington with the Basic Health Plan (discussed \textit{infra} Part II.E.1), is es-
sentially Medicaid for children whose parents are not on Medicaid through DSHS. There are no copayments or deductibles for BHP+.

2. Children’s Health Insurance Program

Washington participates in the Children’s Health Insurance Program (CHIP), a state-federal matching non-entitlement program designed to insure children up to nineteen years of age with family incomes between 200% and 250% of the FPL. To be eligible, the child must not qualify for Medicaid and not have other creditable coverage. CHIP coverage requires a monthly premium payment of $10 per child, up to a maximum of $30 per family, and there are no resource limits. The benefit levels are the same as the Medicaid program for children, BHP+.

D. Other State Medical Assistance Programs

1. Medical Care Services

The Medical Care Services (MCS) program is designed to provide medical coverage to persons receiving cash benefits under General Assistance-Unemployable (GA-U) and general assistance for alcohol and drug treatment pursuant to the Alcohol and Drug Addiction Treatment and Support Act (ADATSA).

The benefits under MCS are less comprehensive than under CN Medicaid. Most notably absent are coverage for long-term care, psychiatric services, dental services, and maternity care. Additionally, unlike the CN and MN programs, MCS will not cover services provided out-of-state.

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142. Since BHP+ is essentially Medicaid for children under a different name, no copayments or deductibles are applicable. This is distinguished from BHP, discussed infra Part II.E.1, where copayments and deductibles are applicable.

143. WASH. ADMIN. CODE § 388-478-0075(1)(d) (2002). The purpose of CHIP is to insure more children by extending the children’s Medicaid minimum level of 200% to the maximum amount allowable for federal match—250%.

144. "Creditable" means coverage under a group health plan or other health insurance. Id. § 388-542-0150(1) (2002) (also subject to requirements of WASH. ADMIN. CODE § 388-478-0075).

145. Id. § 388-542-0250.

146. Id. § 388-478-0075(3).

147. Id. § 388-556-0500.

148. See id. § 388-529-0200 (chart of covered services for CN, MCS, MN, and MI programs).

149. Id. § 388-556-0500(2). Out-of-state services are not covered unless the services are provided in one of the recognized border cities: Coeur d’Alene, Moscow, Sandpoint, Priest River, and Lewiston, Idaho; or Portland, The Dalles, Hermiston, Hood River, Rainier, Milton-Freewater, and Astoria, Oregon. Id. § 388-501-0175.
2. AIDS Insurance

If ineligible for any other state or federally funded medical program, clients diagnosed with AIDS may qualify for the AIDS health insurance premium payment program.\(^{150}\) The client must have less than $15,000 in assets and income below 375\% of the FPL.\(^ {151}\) So long as the client continues to meet the eligibility requirements, DSHS will pay health insurance premiums until the patient is deceased or the Legislature has terminated benefits.\(^ {152}\) The MAA may limit payment so as not to exceed fifty percent of the average of charges billed to MAA for its AIDS clients.\(^ {153}\)

3. Kidney Disease Program

Washington residents with end stage renal disease (ESRD) are eligible for state assistance with associated medical bills if they meet the eligibility requirements of the Kidney Disease Program (KDP).\(^ {154}\) To be eligible, a client must have resources below $15,000\(^ {155}\) and have countable income\(^ {156}\) below 300\% of the FPL.\(^ {157}\) Additionally, KDP is only available for residents who have exhausted all other resources providing similar benefits such as government or private disability programs.\(^ {158}\) Once eligible, DSHS will reimburse qualified kidney centers\(^ {159}\) for ESRD-related covered services.\(^ {160}\)

4. Medically Indigent Program

For clients who do not qualify for any other program and have an emergency medical condition, the Medically Indigent (MI) program provides very limited medical services. Resource and income re-

\(^{150}\) Id. § 388-539-0200(1).

\(^{151}\) Id. § 388-539-0200(2) (home of primary residence and vehicle used for transportation are not included in asset calculation).

\(^{152}\) Id. § 388-539-0200(5).

\(^{153}\) Id. § 388-539-0200(6).

\(^{154}\) Id. §§ 388-540-001, -005.

\(^{155}\) Id. § 388-540-030 (primary residence, household furnishings, and an automobile are excluded).

\(^{156}\) Pursuant to WASH. ADMIN. CODE § 388-500-0005 (2002).


\(^{158}\) Id.

\(^{159}\) Id. § 388-540-060 (stipulations kidney centers must follow to be eligible for reimbursement under KDP).

\(^{160}\) Id. § 388-540-010 (covered services include: dialysis when medically indicated, kidney transplantation when medically indicated, treatment for conditions directly related to ESRD, training and supervision of personnel and clients for care and treatment, and supplies and equipment for home dialysis).
requirements for MI are the same as for MN.\textsuperscript{161} Much like a deductible, a yearly emergency medical expense requirement (EMER) of $2,000 per family\textsuperscript{162} is required and the maximum length of certification for MI is three months in any twelve-month period.\textsuperscript{163} Covered services include emergency hospital and physician services received in the hospital, inpatient or outpatient services received as a result of an emergency, and ground or air ambulance transportation to the hospital.\textsuperscript{164} There is no United States citizenship requirement for the MI program.\textsuperscript{165}

5. Programs for Immigrants Not Otherwise Qualified

In addition to the MI program, non-U.S. citizens may qualify for medical care coverage under one of three other programs. Pregnant women are eligible for CN Medicaid if otherwise eligible but for immigration, citizenship, or SSN status.\textsuperscript{166}

For emergency medical conditions, aliens may qualify for the federally funded Alien Emergency Medicaid Program (AEM).\textsuperscript{167} The client must be categorically related to a Medicaid program but ineligible for Medicaid due to citizenship or alien status.\textsuperscript{168} An alien's arrival date in the United States is disregarded in eligibility determination for AEM.\textsuperscript{169}

In addition to the limited medical care services available to aliens, disabled aliens may also be eligible for state-funded General Assistance-Expedited Medicaid Disability (GA-X) cash grants.\textsuperscript{170}

\begin{enumerate}
\item Id. \textsection 388-438-0100(3) (monthly income and countable resource standards for MI and MN are provided in \textsc{washington admin. code}\ \textsection 388-478-0070).
\item Id. \textsection 388-438-0100(1)(c). However, DETOX services, treatment under the Involuntary Treatment Act (ITA), and institutional or waived services are not subject to the EMER, but they do meet the MI definition of emergency. \textsection 388-438-0100(6).
\item \textsection 388-438-0100(3)-(4).
\item \textsection 388-438-0100(1)(c)(i)-(ii).
\item \textsection 388-438-0100 (1998).
\item \textsection 388-462-0015(4) (2002).
\item \textsection 388-438-0110.
\item \textsection 388-438-0110(2). The client must meet eligibility requirements of one of the following categorical programs: SSI-related (\textsc{washington admin. code}\ \textsection 388-505-0110); family medical (\textsc{washington admin. code}\ \textsection 388-505-0220); child under the age of nineteen (\textsc{washington admin. code}\ \textsection 388-505-0210); or medical extensions (\textsc{washington admin. code}\ \textsection 388-523-0100). If income exceeds CN medical standards, DHS has the discretion to consider children or adults over the age of sixty-five meeting SSI disability criteria for the MN program, pursuant to \textsc{washington admin. code}\ \textsection 388-438-0110(3). Furthermore, if not categorically related to a Medicaid program, refer to the MI program discussed supra Part II.D.4.
\item \textsection 388-438-0110(5) (2002).
\item Id. \textsection 388-505-0110(6). Aliens are eligible when they meet the cash requirements of \textsc{washington admin. code}\ \textsection 388-400-0025 and \textsc{washington admin. code}\ \textsection 388-478-0030 and meets SSI-related disability standards. Additionally, "clients may be eligible for GA cash benefits and CN Medicaid due to different sponsor deeming requirements." \textit{Id.}
E. State Subsidized Health Insurance

Beyond federally funded and federal and state matching financing arrangements, the state of Washington also subsidizes health care insurance for select groups of residents. In the abstract, these groups include the working poor, high risk individuals, and residents infected with AIDS.

1. Basic Health Plan

The Basic Health Plan (BHP) is designed to provide subsidized managed health care for the working poor—those who do not meet Medicaid income or resource requirements, and do not otherwise have health insurance. To be eligible, a client must be a Washington resident, ineligible for Medicare, not institutionalized, and have a family income below 200% of the FPL.\(^\text{171}\) The client must pay a monthly premium based on income, age, the managed care provider selected, and county of residence. The Basic Health Plan is subject to enrollment waiting lists when the State expends the specified amount of funds allocated for subsidization.\(^\text{172}\)

2. Washington State Health Insurance Pool

Clients who are unable to obtain health care insurance due to their medical condition may purchase a state-subsidized individual plan through the Washington State Health Insurance Pool (WSHIP), often referred to as the "high risk pool."\(^\text{173}\) Additionally, in counties where no health plan offers individual plans, clients may also purchase coverage under WSHIP.\(^\text{174}\) A lifetime cap of $1 million applies to WSHIP beneficiaries.\(^\text{175}\)

III. CONCLUSION

Low-income residents and their professional advisers should appreciate the wide range of choices available to them in the State of

\(^{171}\) Id. §§ 182-25-030, -010(38).

\(^{172}\) Current information on politically volatile financing arrangements such as covered services and covered populations is available at http://www.basichealth.hca.wa.gov (last visited May 19, 2003).

\(^{173}\) WASH. REV. CODE § 48.41.100 (2002).

\(^{174}\) WASH. REV. CODE § 284.91.001 (2002); WASH. REV. CODE § 48.41.100 (2001). The RCW provides specific requirements for administration of this type of insurance, but it is privately administered at very high premiums. For further information, consult the website for the company offering the plan at http://www.onlinehealthplan.com/oasys/ or contact the Office of the Insurance Commissioner at 1-800-877-5187.

\(^{175}\) WASH. REV. CODE § 48.41.100(2) (2002) (among other disqualifications listed in this section).
Washington for financing their health care needs. Washington offers a broadly structured Medicaid program, both in terms of the scope of the services covered and in the definition of eligibility for those benefits. In essence, the State has opted to provide comparatively generous Medicaid benefits to virtually every category of recipient permitted by the federal law. In many other states, the scope of Medicaid coverage is more limited, eligibility is confined to the mandatory eligible, and the income, resource, and other limits that prescribe eligibility are much more stringently drawn. Washington also has chosen to participate in the federal SCHIP program and in various federal, Medicaid-related programs such as limited assistance for immigrants. Washington supplements these federally sponsored programs with several entirely state-financed programs including medical assistance for General Assistance recipients, the high risk insurance pool, and the Basic Health Plan.

As demonstrated in this Article, the array of options is also noteworthy for its complexity. The legal structure of the Medicaid program is an intricate and constantly changing web of state and federal, statutory, and administrative rules. Determining whether a particular client may be eligible for one or more of the Medicaid options, or able to contest a denial of Medicaid eligibility, is virtually impossible for anyone without considerable experience with the structure of the federal and state programs and the agencies that administer them. Simply amassing the relevant sources of law, particularly the state’s regulations and related interpretive administrative materials can be an arduous and frustrating task, a task made all the more difficult if done in tandem with a review of the client’s potential eligibility for the other federally sponsored or state-funded programs available in Washington, or while comparing the different features of the potential options.

That latter point—that there are significant differences between these programs—should not be overlooked, even if it is obscured by the difficulty inherent in their description or assessment. Notwithstanding their complexity, the programs in the State of Washington demonstrate the importance of evaluating any health-financing scheme not simply in terms of whether a client would be “eligible” or


177. The Basic Health Plan is a particularly noteworthy undertaking since it is funded exclusively from state revenues and provides assistance to hundreds of thousands of low-income people otherwise ineligible for Medicaid or other health financing programs. This is virtually unique to Washington. In most other states, these people would suffer the fate of the uninsured.
"covered," but rather in terms that more realistically reflect the actual benefits for a particular beneficiary. In this regard, determining whether a client is eligible for one of these programs is only the first of several critical inquiries.

Other questions need to be asked. What services are covered for an eligible recipient and what duration or other service-limiting exclusions are imposed on the availability of those services? In other words, how much is really being covered? At times, eligibility for an essential service under one system comes at the price of sacrificing other benefits. Additionally, all of the state's health financing programs cover inpatient hospital care, yet each limits the number of days that are covered as well as coverage of ancillary and related services. For a client with a serious or long-term illness, one or more of these programs can hardly be described as a viable option.

The practical implications of eligibility for a particular program also may be determined by the extent to which eligibility means enrollment, particularly if it is mandatory enrollment in a private health maintenance organization or other managed care plan, as opposed to a program under which eligible beneficiaries receive insurance-type, fee-for-service reimbursement and are given a choice among many of the state's providers. For example, under Basic Health Plan, eligible recipients are essentially allowed to purchase enrollment with state-subsidized premiums in any of the managed care plans that choose to participate in Basic Health Plan. For low-income residents who live in parts of the state where there are no participating plans, their eligibility to participate in the state's Basic Health Plan may be practically meaningless.

Even under programs that reimburse providers on a fee-for-service basis and allow eligible recipients a freedom of choice among many of the state's providers, the terms and levels of reimbursement can be as important in describing and assessing a health financing scheme as the scope of covered services and can have critical implications for some beneficiaries. Medicaid offers coverage for physician services, but many physicians refuse to accept Medicaid reimbursement because the fees paid by the state's program for their services are

178. The obvious illustration is CN Medicaid, which covers a wide range of services for its beneficiaries. Coverage under CN Medicaid is broader than most of the private health insurance plans available in the state; nonetheless, it specifically excludes coverage for abortion services (as mandated by the federal Medicaid statute).

179. The Basic Health Plan provides coverage for abortions, yet, as its name implies, Basic Health Plan coverage is rather limited, excluding coverage of prescription drugs, nursing home services, and, in some years, pregnancy and child birth services.
only a fraction of those paid by private insurers. Medicaid, on the other hand, requires both individual and institutional providers to accept assignment of their patients' claims and prohibits a participating provider from "balance billing"—the billing of the beneficiary for any additional amount above the Medicaid program payment. Other state fee-for-service programs reimburse providers for a portion of their charges but allow the provider to "balance bill" the beneficiary or require the beneficiary to pay a sizable deductible or copayment as a prerequisite to the program's payment of a claim. For many low-income residents, "eligibility" for a program that "covers" services but that either pays providers so little that many are discouraged from participating or leaves the eligible beneficiary with high out-of-pocket costs even for covered services is hardly a realistic option.

In a more fundamental sense, low-income people and those that advise them also should be aware of the nature of the State's legal and political commitment to maintain these programs. As noted in the introduction, Medicaid is structured as a statutory entitlement program. That is, if a state chooses to participate in the federal Medicaid program, that state must cover certain categories of low-income people and, within the limits of the federal law, may choose to cover others, as Washington has. Anyone who meets the eligibility requirements outlined in the state's Medicaid law is "entitled" to Medicaid benefits. There is no fixed federal or state Medicaid budget or upper limit on annual expenditures. The state's Medicaid program can be modified by legislation or administrative action, again, within the limits of the federal Medicaid statute; it could even be repealed entirely by the state legislature. Otherwise, Medicaid is a permanent statutory entitlement. Should the state fail to grant eligibility or provide the benefits authorized by federal or state law, a potential beneficiary would have judicially enforceable remedies. Any state eligibility or coverage denial or other administrative action would be subject to due process considerations.

Perhaps most importantly, Medicaid has long been regarded as a political entitlement as well. While theoretically the state of Washington could repeal its Medicaid program entirely or cut optional catego-

180. WING & JACOBS, supra note 176, at Section 2.C.1.a.
182. For example, none of the State's non-Medicaid medical assistance programs described in notes 146-166 put limits on the ability of providers to balance bill or require providers to accept assignment.
183. For a discussion of Medicaid and the characteristics of an entitlement program, see WING & JACOBS, supra note 176, at Section 2.C.1.d.
ries of eligibility or discretionary services, any decision to do so would be highly controversial. At both the state and the federal level, the political commitment to provide Medicaid has been remarkably resilient through both good and bad times.

The same cannot be said of the legal and political commitment to other state programs such as the WSHIP, MI-GA, or even the Basic Health Plan. Each of these programs is structured as a discretionary spending program; no one is "entitled" to these benefits. To the extent that funding is available, low-income people can seek eligibility or enrollment in these programs. When the funding that is appropriated for any one of these programs is exhausted, the program is unavailable, even for people who would otherwise be eligible for benefits. Current beneficiaries would stop receiving benefits and would have no legal recourse. The basic structure of these programs may be permanently authorized in state law, but their continuation requires the state legislature to periodically appropriate funding to continue these programs.

While the state legislature has continued these programs for a number of years, the political commitment to provide these supplemental programs is far less apparent. Even the political commitment to the Basic Health Plan can be questioned. In the most recent legislative session, funding for the Basic Health Plan was slashed, virtually repealing the program for the biennium 2003-2005. On the other hand, it is doubtful that any decision to completely reduce or abandon these programs would be politically viable.

Faced with a number of other competing demands for state revenues and with the projected budget shortages for the next several years, Washington’s legislators will face several daunting choices. One of the most fundamental choices they will have to make is whether to continue to provide this network of support for health care financing for low-income people. Hopefully, neither the range of the programs through which that support has been maintained nor the complexity of the programmatic details will disguise their importance.

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184. For that matter, it is unlikely that most Washingtonians are even aware of WSHIP or that the State provides a modest program of health benefits for those on general assistance.

185. In May of 2003, the State Legislature repealed prior state law that had required the Basic Health Plan to cover a minimum of 125,000 (and allowed the program to enroll up to 175,000). See Chapter 259, Wash. Laws of 2003. The final state budget enacted during the first special session of the State Legislature included language that directed the health care authority to reduce the actuarial value of the Basic Health Plan by eighteen percent by January 1, 2004. See S. 5404, 58th Leg., 1st Spec. Sess., § 213 (2003).
## APPENDIX A

### Number of People Enrolled in Various Financing Arrangements as of December 2002:

<table>
<thead>
<tr>
<th>Financing Arrangement</th>
<th>Administering Agency</th>
<th>Number of Enrollees</th>
</tr>
</thead>
<tbody>
<tr>
<td>CN TANF</td>
<td>MAA</td>
<td>273,872</td>
</tr>
<tr>
<td>CN Aged</td>
<td>MAA</td>
<td>56,199</td>
</tr>
<tr>
<td>CN Blind/Disabled</td>
<td>MAA</td>
<td>117,521</td>
</tr>
<tr>
<td>CN Pregnant Women</td>
<td>MAA</td>
<td>24,757</td>
</tr>
<tr>
<td>CN Family Planning Only</td>
<td>MAA</td>
<td>23,628</td>
</tr>
<tr>
<td>CN Take Charge Family Planning</td>
<td>MAA</td>
<td>62,622</td>
</tr>
<tr>
<td>CN Breast and Cervical Cancer</td>
<td>MAA</td>
<td>101</td>
</tr>
<tr>
<td>CN Healthcare for Workers with Disabilities</td>
<td>MAA</td>
<td>144</td>
</tr>
<tr>
<td>CN Other Children—Mandatory</td>
<td>MAA</td>
<td>171,644</td>
</tr>
<tr>
<td>CN Other Children—Optional</td>
<td>MAA</td>
<td>158,253</td>
</tr>
<tr>
<td>CN Foster Care/Adoption Support</td>
<td>MAA</td>
<td>15,949</td>
</tr>
<tr>
<td>State Only—Children</td>
<td>MAA</td>
<td>0</td>
</tr>
<tr>
<td>SCHIP</td>
<td>MAA</td>
<td>7,569</td>
</tr>
<tr>
<td>MN Aged</td>
<td>MAA</td>
<td>6,128</td>
</tr>
<tr>
<td>MN Blind/Disabled</td>
<td>MAA</td>
<td>8,854</td>
</tr>
<tr>
<td>Special Low-Income Medicare Only (SLMB)</td>
<td>MAA</td>
<td>7,703</td>
</tr>
<tr>
<td>MN Other</td>
<td>MAA</td>
<td>55</td>
</tr>
<tr>
<td>MCS GAU</td>
<td>MAA</td>
<td>7,274</td>
</tr>
<tr>
<td>MCS ADATSA</td>
<td>MAA</td>
<td>3,381</td>
</tr>
<tr>
<td>MI</td>
<td>MAA</td>
<td>2,462</td>
</tr>
<tr>
<td>Refugees</td>
<td>MAA</td>
<td>674</td>
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<tr>
<td>Basic Health Plan</td>
<td>Health Care Authority</td>
<td>123,550</td>
</tr>
<tr>
<td>WSHIP</td>
<td>Private Insurer*</td>
<td>2,532</td>
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</tbody>
</table>
**APPENDIX B**

*Services Covered Under Various Financing Arrangements*

The table below is a reproduction of Washington Administrative Code (WAC) section 388-529-0200 and lists major services which are available to clients by category of Medicaid: CN (Categorically Needy), MCS (Medical Care Services for GAU and ADATSA), MN (Medically Needy), and MI (Medically Indigent).

<table>
<thead>
<tr>
<th>Service</th>
<th>CN</th>
<th>MCS</th>
<th>MN</th>
<th>MI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Day Health</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Advanced RN Practitioner Services</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>R²</td>
</tr>
<tr>
<td>Ambulance/Ground and Air</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>R²</td>
</tr>
<tr>
<td>Anesthesia Services</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>R²</td>
</tr>
<tr>
<td>Audiology</td>
<td>Yes</td>
<td>Yes</td>
<td>HK</td>
<td>No</td>
</tr>
<tr>
<td>Blood/Blood Administration</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>R²</td>
</tr>
<tr>
<td>Case Management—Maternity</td>
<td>L</td>
<td>No</td>
<td>L</td>
<td>No</td>
</tr>
<tr>
<td>Chiropractic Care</td>
<td>HK</td>
<td>No</td>
<td>HK</td>
<td>No</td>
</tr>
<tr>
<td>Clinic Services</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>R²</td>
</tr>
<tr>
<td>Community Mental Health Centers</td>
<td>Yes</td>
<td>L⁴</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Dental Services</td>
<td>Yes</td>
<td>R</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Dentures Only</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Detox Alcohol (3 days)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>L⁸</td>
</tr>
<tr>
<td>Detox Drugs (5 days)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>L⁹</td>
</tr>
<tr>
<td>Drugs and Supplies—Prescription</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>R⁹</td>
</tr>
<tr>
<td>Elective Surgery</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Emergency Room Services</td>
<td>Yes⁸</td>
<td>Yes⁸</td>
<td>Yes⁸</td>
<td>R²</td>
</tr>
<tr>
<td>Emergency Surgery</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>R²</td>
</tr>
<tr>
<td>Eyeglasses and Exams</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Family Planning Services⁵</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Healthy Kids (EPSDT)</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Service</td>
<td>Yes</td>
<td>Yes</td>
<td>HK</td>
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<td>----------------------------------</td>
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<td>----</td>
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<tr>
<td>Hearing Aid</td>
<td></td>
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<td></td>
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<tr>
<td>Home Health Services</td>
<td>Yes</td>
<td>Yes</td>
<td>L</td>
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<tr>
<td>Hospice</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Indian Health Clinics</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Inpatient Hospital Care</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>R</td>
</tr>
<tr>
<td>Involuntary Commitment</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
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<tr>
<td>Maternity Support Services</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Medical Equipment</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Neuromuscular Centers</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Nursing Facility Services</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Nutrition Therapy</td>
<td>HK</td>
<td>No</td>
<td>HK</td>
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<tr>
<td>Optometry</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Organ Transplants</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>R</td>
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<tr>
<td>Orthodontia</td>
<td>L</td>
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<td>No</td>
<td>No</td>
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<tr>
<td>Out-of-State Care</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Outpatient Hospital Care</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>R</td>
</tr>
<tr>
<td>Oxygen/Respiratory Therapy</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>R</td>
</tr>
<tr>
<td>Pain Management (Chronic)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Personal Care Services</td>
<td>Yes</td>
<td>No</td>
<td>HK</td>
<td>No</td>
</tr>
<tr>
<td>Physical/Occupational Therapy</td>
<td>Yes</td>
<td>Yes</td>
<td>HKL</td>
<td>No</td>
</tr>
<tr>
<td>Physical Medicine and Rehab</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>R</td>
</tr>
<tr>
<td>Physician</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>R</td>
</tr>
<tr>
<td>Podiatry</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Private Duty Nursing</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>No</td>
</tr>
<tr>
<td>Prosthetic Devices and Mobility Aids</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>R</td>
</tr>
<tr>
<td>Psychiatric Services</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Psychological Evaluation</td>
<td>L</td>
<td>L</td>
<td>L</td>
<td>No</td>
</tr>
<tr>
<td>Rural Health Services and FQHC</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>School Medical Services</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>-------------------------</td>
<td>-----</td>
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<td>----</td>
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<tr>
<td>Substance Abuse/Outpatient</td>
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<td>Yes</td>
<td>No</td>
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<tr>
<td>Total Enteral/Parenteral Nutrition</td>
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<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>Transportation Other Than Ambulance</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
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<tr>
<td>X Ray and Lab Services</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>R</td>
</tr>
</tbody>
</table>

**KEY:**

**Yes**—Service is covered (may require prior approval or have other requirements)

**No**—Service is not covered

**HK**—Coverage limited to Healthy Kids program only (health checkup and treatment program for children under 21)

**L**—Limited coverage

**R**—Restricted to emergency medical conditions only

1. Includes all CN programs, the state-funded Children's Health (V) program and services available to undocumented alien pregnant women.
2. Only covered if an emergency medical condition requiring inpatient hospital services.
3. A program for Medicaid children in school special education programs.
4. Clients must meet the priorities and definitions of the Community Mental Health Act. Limited grants to counties fund these services.
5. All clients covered under all medical care programs receive family planning services. Women eligible for medical care during pregnancy receive family planning services only up to twelve months after pregnancy ends.
6. When the client is receiving home health care services.
7. Paid for out of ADATSA funds.
8. $3 copayment will be charged to non-pregnant adults who use the emergency room for services that are not related to an emergency medical condition.
9. In-hospital emergency detoxification only.