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(Note: Attachment A training materials are a 3-22-05 version with brief notes May 2010 pointing out significant changes)

MENTAL HEALTH ELECTRONIC RESOURCE MANUAL

- ## Assistance programs for clients with mental health needs - eligibility issues

  See attachment A below

- ## Mental health services (public) for seniors

  - ### Medicaid-funded and state-funded services

The State of Washington's DSHS-Mental Health Division describes the state's public mental health system as follows (source: MHD website May 2010):

> County government agencies and 145 private and non-profit organizations provide treatment for most of Washington's estimated 188,100 adults and 74,000 children with mental illnesses. Counties, and their non-government providers, are organized into 13 Regional Support Networks (RSNs).
>
> The state provides inpatient treatment through community hospitals statewide and two adult state-run hospitals: Eastern State Hospital in Medical Lake and Western State Hospital in Lakewood. The hospitals are reserved for the most seriously ill or those sent by state courts for evaluation or treatment.[1]

Snohomish County Seniors, along with seniors in the counties north of Snohomish, are served through the North Sound Mental Health Administration, formerly known as the "Northsound RSN." The NSMHA manages Medicaid-funded services for Snohomish County residents and those living in the counties north of Snohomish. See the RSN link above for information about services in other parts of the state.

Website Sources for further information about MHD and RSNs:

State Mental Health Division [now called Division of Behavioral Health and Recovery]: http://www1.dshs.wa.gov/mentalhealth/index.shtml

North Sound Mental Health Administration:
http://www1.dshs.wa.gov/mentalhealth/nsound.shtml

- **Mental Health services provided through RSNs (Source[2]: NSMHA May-2010 website):**

The legislature created the Regional Support Network (RSN) system in 1989 as part of Washington's effort to manage the increasing cost of health care. "Managed care" started in the private health sector, and has moved to state-funded care of people with major mental illness.

There are 13 RSNs that manage Washington's mental health program. Each RSN is made up of one our more counties. The Department of Social and Health Services (DSHS) purchases mental health services from the RSNs for people covered by Medicaid, and others that may be eligible for these state-funded services.

Each RSN then contracts with mental health agencies throughout the county(s) served by the RSN, to provide direct outpatient clinic services and short-term inpatient treatment in community hospitals.

The RSNs authorize the following core mental health services to be provided by mental health agencies in the community:

- **Crisis Services**

  A 24-hour crisis telephone line, a team of crisis professionals, crisis counseling and treatment.

- **Outpatient Community Mental Health Services**

  Assessment to determine the medical necessity for additional services, individual/family/group counseling; medications; case management and medication management when longer term more intensive care is needed; help with returning to school, employment or a finding a more secure living arrangement.

- **Acute Psychiatric Inpatient Services**

  Individuals who are assessed to need, and voluntarily request to be hospitalized for their mental illness, may be admitted to a community psychiatric facility.

- **Involuntary Commitment Services**

  When an individual's actions create a substantial risk to self or others, results in substantial loss or damage to property, or the individual is unable to provide for his/her own care and safety, the law permits a special County Designated Mental Health Profession (CDMHP) to evaluate that person for involuntary commitment to a psychiatric facility.

- **Long-Term Inpatient Care**

  If long-term inpatient care is needed for an adult, the RSN can authorize treatment at one of two state-owned psychiatric hospitals: Western State Hospital (WSH) or Eastern State Hospital.

  If long-term inpatient care is needed for a child under age 18, the RSN can make a referral for a Children's Long Term In-Patient (CLIP) facility. There are four CLIP facilities in community settings around Washington, and one state-owned psychiatric hospital, the Child Study and Treatment Center (CSTC).

Eligibility for Mental Health Services through the RSN. (Source[3]: NSMHA website May 2010):

Children and adults qualify for medically necessary mental health services through the RSN if they are covered by Medicaid.

Other people not eligible for Medicaid, but having serious or long-term mental illness, can receive services as resources allow.

All citizens of the state are eligible for crisis mental health services, disaster response services, and involuntary treatment services.

ADVOCATE NOTE REGARDING ELIGIBILITY and access to services:

The RSNs operate under a contract with the state, governed by the terms of a federal Medicaid "waiver." See resources below. In 2005, the federal Medicaid agency required the state to stop using federal Medicaid funds for service programs serving people not qualified for Medicaid. Accordingly, Medicaid eligibility is a primary consideration for obtaining public mental health services. Non-Medicaid clients now can be served only with state funds, which are limited.

Waiver requirements, state statutes, and state regulations provide standards for programs for issues such as access, quality, grievances and appeals, and ombudsman services.

- ## Mental Health Services provided through "WMIP" instead of through RSNs

WMIP is a pilot "integration" managed care project in Snohomish County beginning October 2005. This project includes mental health services along with medical services and chemical dependency services in the same managed care plan. On October 1, 2005, this pilot expanded to include long term care services. The state hopes to replicate this project elsewhere in the state.

The state provides information about this program through the WMIP website: http://hrsa.dshs.wa.gov/MIP/

Clients on SSI-related Medicaid (See attachment A for details about Medicaid) can enroll in WMIP. They then receive most mental health and chemical dependency services through the WMIP contractor, currently Molina health plan, rather than through the RSN.

Clients enrolled in WMIP receiving mental health services through Molina receive mental health ombudsman assistance through Molina's program rather than through the RSN-contracted ombudsman program. Clients can request ombudsman assistance by calling Molina.

The details concerning client rights are recorded in the state's WMIP contract with Molina. These contract standards presumably comply with applicable federal waiver requirements state laws and regulations. Contract and contract amendments are accessible on the WMIP website: http://hrsa.dshs.wa.gov/MIP/

- **Resources for Research concerning service standards, access, grievance and appeals, quality, and client rights:**

Federal Medicaid waiver requirements:
http://www1.dshs.wa.gov/mentalhealth/waivers.shtml
Section G of the waiver addresses requirements for grievances and appeals. Quality issues are addressed throughout; use "find" function in the document to locate. and re quality, and enrollee information and rights
1

Benefits Booklet: http://www.dshs.wa.gov/pdf/Publications/22-661.pdf (This booklet is intended for clients, and has many details without citations to law or regulations. A revision of the Sept 2006 booklet is due in September 2010 – see this website to check for the update: http://www.dshs.wa.gov/mentalhealth/benefits.shtml)

RCW Chapter 71.05 -- Mental illness:
http://apps.leg.wa.gov/RCW/default.aspx?cite=71.05

RCW Chapter 71.24 – Community Mental Services Act
http://apps.leg.wa.gov/RCW/default.aspx?cite=71.24

WAC Chapter 388-865 – State regulations concerning Community Mental Health and Involuntary Treatment Programs: http://apps.leg.wa.gov/WAC/default.aspx?cite=388-865

WAC 388-865-0215-- Eligibility and payment for RSN services:
http://apps.leg.wa.gov/WAC/default.aspx?cite=388-865&full=true#388-865-0215

WAC Chapter 388-855- -- liability for costs for hospitalizations for mental illness:
http://apps.leg.wa.gov/WAC/default.aspx?cite=388-855

WAC 388-865-0410 -- Rights of consumers receiving Community Support services. The footnote below provides the list of rights from the WAC.[4]. Link: http://apps.leg.wa.gov/WAC/default.aspx?cite=388-865&full=true#388-865-0410

Geriatric "best practices" materials: http://www1.dshs.wa.gov/pdf/hrsa/mh/geriatricbestpract.pdf

Link to the Mental Health Division Access to Care Standards document (which is in general incorporated into contracts with RSNs and providers): http://www.dshs.wa.gov/pdf/hrsa/mh/Access_to_Care_Standards20060101.pdf

Links to contracts between the North Sound Mental Health Administration (the RSN organization serving Snohomish County and counties north) and other entities (DSHS, providers, counties): http://nsmha.org/Contracts/Default.htm

Requirements for "age competency" in serving seniors

Many sections of the law and regulations require that programs or contractors have age and cultural competency in their services. See, e.g., WAC 388-865-0229; -0225; -0405; -0300. To find these, go to the link for the chapter you want, load the full chapter text, and use "find" to locate the word "age" and "cultural."

- ## Other funded mental health services for seniors

Some local communities have special programs funded by other sources to serve mental health needs of seniors. Some are funded with federal Older Americans Act funds or other sources not devoted exclusively to health care. Examples in Snohomish County include the Hope Options program serving mentally ill seniors in subsidized housing, and peer support programs.

Many counties have started to collect a small increase in the sales tax to fund additional mental health services. Some programs serve people not eligible for other services.

The best source of current information about such resources in local communities for seniors (age 60 and older) is the Senior Information and Referral resource. Sr I and A services are funded through the Older Americans Act for every part of the state and the country, and are supported through local "area agencies on aging." Contacts for Washington state's area agencies on aging and other senior service providers are available through this link: http://www.aasa.dshs.wa.gov/Resources/clickmap.htm

- ## Rights of senior clients with mental health-based disabilities

DSHS regulations concerning "Needing Supplemental Accommodation" provides for accommodations for clients with disabilities, which includes people with mental health disabilities. The manual used by CSO workers includes reference to rules and policy materials: http://www.dshs.wa.gov/manuals/eaz/sections/NSA.shtml

These DSHS policies developed as a way to comply with Americans with Disabilities Act requirements. ADA “reasonable accommodation” requests are powerful tools to address problems seniors with mental health disabilities may have in many contexts. For example, housing discrimination against people with disabilities is prohibited, and may include the refusal to make reasonable accommodation in rules, policies, practices, or services, when doing so is necessary to provide an equal opportunity to use and enjoy a dwelling. Washington Law Help website contains materials or links to pamphlets regarding discrimination. The website link is: http://www.washingtonlawhelp.org/WA/index.cfm . That site has links to pamphlets regarding discrimination in housing and other topics, under the “Civil Rights” folder. Other links can be located on the Washington Law Help website by searching for “ADA,” “discrimination,” and “reasonable accommodation.”

Attachment A – Revision date 3-22-05

[Note: link corrections checked 12-06; notes in brackets [] for significant change issues done May 2010]

I. State Cash and Medical Assistance

1. General Assistance (GA)

- GA consists of cash assistance and medical coverage. The program is administered by the Department of Social and Health Services (DSHS).
- Recipients of GA must be
  - At least 18 years of age;
  - A U.S. citizen or legal immigrant (see WAC Chapter 388-42;
  - Incapacitated from gainful employment for at least 90 days; and
  - In financial need according to Department rules (see WAC Chapters 388-450 (income), -470(resources), -488(transfers of property).
- The legal standard for incapacity is set forth at RCW 74.04.005(6)(a)(ii)(B). Incapacity is determined by application of the Progressive Evaluation Process (PEP), a seven step continuum that weighs medical and vocational factors. WAC 388-448-0040 *et seq.* A person may be determined eligible at several points along the process. However, if a person is determined to have a medical condition with less than a moderate level of severity (at least level 3 on a scale of 1 to 5), they are denied benefits without further consideration.
- DSHS requires that GA applicants and recipients provide "objective" medical evidence in support of their claim of incapacity. WAC 388-448-0030(1). Although DSHS incapacity social workers (ISWs) will often insist that only measurable evidence (X-ray, MRI, MMPI) is acceptable proof of incapacity, objective medical evidence can also consist of observations from a physical examination and hospital history and reports. *Id.* at (a)(iv) and (v).
- The GA grant amount for a single adult is $339 per month, and $440 for a married couple when both persons are GA eligible. If there are no shelter costs, the amounts are reduced to $206 and 261 respectively, although a homeless person who does not pay for temporary lodging should be nevertheless considered to have shelter costs and receive a full grant.

- Once GA benefits are awarded, a GA recipient must follow treatment and referral requirements in order to remain eligible for assistance. WAC 388-448-0130. This includes following through on an application for the federal SSI program for GA recipients deemed likely to qualify for it. *See below* (GAX).
- A GA recipient's medical situation must be reviewed at least once every twelve months. When incapacity is reviewed, a GA recipient has the burden of showing no clear improvement from the prior determination in order to retain benefits. WAC 388-448-0180.
- If DSHS notifies a GA recipient in writing that s/he has been overpaid benefits in the past, s/he may deny that she was overpaid, claim that the overpayment was DSHS's fault, or do both. For the latter claim, s/he must prove or DSHS must stipulate that the requirements for equitably estopping a government agency's action are satisfied. See WAC 388-02-0495 and www.washingtonlawhelp.org, Government Benefits folder.
- [Note: Due to legislative budget cuts in 2010, GA is renamed "Disability Lifeline." Recipients who are not determined to be likely to meet the disability standards used in the federal SSI program will be limited to 24 months of the "Disability Lifeline" program within a 5 year period, beginning Sept 1, 2010. See resources on this topic on the legal services website under Government Benefits/Disability lifeline: www.washingtonlawhelp.org.]

2. Medical coverage for GA recipients

[Note: This program was renamed "Disability Lifeline" in 2010; "GA" is now "DL," and "GAX" is now "DL-X". See note above regarding time limits to this program.]

- CN Medicaid eligibility is available to those GA recipients who are considered likely to qualify for the federal disability program known as SSI. The Medicaid program for GA recipients is known as GAX.
- A GAX recipient is subject to the same twelve month incapacity review requirement as other GA recipients. However, someone whose SSI application is denied by Social Security may remain eligible for GAX as long as there is an administrative appeal of the denial pending in the Social Security system and other GA eligibility requirements are met.
- State-funded medical coverage, known as Medical Care Services (MCS), is available to those GA recipients who do not qualify for GAX. RCW 74.09.035. Because the scope of MCS coverage is narrower than the CN Medicaid coverage that GAX recipients receive, GA recipients who are denied GAX should be counseled

to consider appealing that decision. For example, a major difference between CN Medicaid and MCS is that mental health treatment is not generally available to MCS recipients. So if someone denied GAX is likely to have the need for mental health services, that person should consider appealing the GAX denial.

- GA recipients not eligible for CN Medicaid through GAX may receive coverage for nursing home services, but not for personal care services in their own homes. WAC 388-529-0200. GA recipients also can receive care in adult family homes or adult residential care facilities. WAC 388-513-1305(9); 388-71-0605(2) and (3)(c).

3. Alcoholism and Drug Addiction Treatment and Support Act (ADATSA)

- Persons who are incapacitated due solely to chemical dependence may not receive GA benefits but instead may be eligible to receive ADATSA benefits. RCW 74.04.005(6)(a)(ii)(C); RCW 74.50.010, *et seq.*
- Persons with an incapacitating physical or mental impairment *and* chemical dependence have a choice between GA and ADATSA benefits. WAC 388-448-0010(4), 388-448-0030(2)(b).
- ADATSA is administered by DSHS's Division of Alcohol and Substance Abuse (DASA) and consists of two components: treatment and shelter. WAC 388-800-0040(2).
- As with GA benefits, recipients of ADATSA benefits must be age 18 or greater, residents of the state, a U.S. citizen, and in financial need. Financial need may be established either by meeting GA income and resource requirements or by the receipt of SSI or TANF benefits. WAC 388-800-0048.
- In order to be eligible for ADATSA treatment services, an applicant must be "clinically incapacitated" due to chemical dependence: 1) psychoactive substance dependence; 2) used alcohol or drugs within previous 90 days, excluding time incarcerated; and 3) not gainfully employed within previous 30 days. WAC 388-800-0055.
- ADATSA shelter services consist of a monthly shelter assistance payment to an "intensive" protective payee, who is responsible for then making payments on behalf of the client directly to landlords and utility companies to maintain shelter and to other vendors providing goods and services to the client, including items for personal and incidental expense. WAC 388-800-0130, 0160.
- ADATSA clients receive medical coverage identical to GA recipients under the Medical Care Services (MCS) program. WAC 388-800-0045(3).

II. Federal Cash Assistance Benefits

1. Two disability programs, SSDI and SSI, have these common elements:

- The Social Security Administration (SSA) of the U.S. Department of Health and Human Services (HHS) administers two benefit programs that use an identical disability standard, more demanding than the GA incapacity standard. A person is disabled if she is unable to engage in substantial gainful activity (SGA) because of a medically determinable physical or mental impairment which is expected to last twelve months or more or to result in death. 20 CFR §§ 404.1505, 416.905.
- Disability is determined by a five-step process known as Sequential Evaluation. The steps consider whether the claimant (1) is already earning too much from employment (called "Substantial Gainful Activity"); (2) has a medically determinable impairment that significantly limits any work-related activities ("severe" impairment, analogous to the GA requirement that the person have at least one "moderate" (severity level 3) impairment; (3) has medical findings that match or are equivalent to any one of several "listed" impairments classified by body system (analogous to a GA finding of severity "5"); (4) is physically and mentally able to return to any work done in the past 15 years; and (5) is able to do other kinds of work. 20 CFR §§404.1520, 416.920. For a detailed discussion of the five steps, medical evidence considerations, and practice tips, see "NLADA SSDI and SSI Benefits" posted in two parts in the www.advocateresourcecenter.org "Library," Public Benefits/Training subfolder, beginning at ¶1.8.2., p. 54.
- Claimants apply to the local SSA office, but the initial disability decisions for both federal programs are by Washington State DSHS's Division of Disability Determination Services (DDDS). They usually take substantially longer than GA decisions. DDDS starts by obtaining existing medical records using authorizations signed by the claimant. If the records do not clearly document the disabling condition, DDDS will schedule a "consultative examination." By phoning the appropriate DDDS office (Seattle 800-843-4440, Spokane 800-572-5299, or Olympia 800-562-6074) a claimant or advocate can learn which "adjudicator" has been assigned the case and often work cooperatively in assembling medical information.
- SSA denies disability if drug addiction or alcoholism is "material" to the claimant's disability, i.e., s/he would not be disabled if s/he stopped using. 20 CFR §§404.1435(b), 416.935(b).

- The law provides that SSA must do a Continuing Disability Review (CDR) of most recipients at least every three years, but SSA is chronically behind in doing CDRs. Disability ceases if (1) there has been "medical improvement" in the severity of any impairment related to the ability to work and considering all of the claimant's current impairments, (2) the claimant is found currently not disabled under the Sequential Evaluation. 20 CFR §§404.1594, 416.994.
- If SSA notifies a claimant that s/he has been overpaid SSI or SSDI benefits in the past, s/he may either deny that the overpayment occurred by requesting reconsideration (see part IV.2., infra) or seek "waiver" on the grounds that s/he was "without fault" in causing the overpayment and cannot afford to repay it. If the claimant requests reconsideration or waiver within 30 days of the notice, SSA will not recoup any overpayment from the claimant's ongoing benefits pending its decision on that request. If s/he requests waiver at any later time, further collection will be stayed. See 20 CFR §§404.501-404.527 and "NLADA SSI and SSDI Benefits," §1.13, at pp. 90-95.
- In addition to the federal statute, regulations, and case law, SSA relies on its Social Security Rulings, Acquiescence Rulings, Program Operations Manual System (POMS), and Hearings, Appeals, and Litigation Law Manual (HALLEX), all on line at www.ssa.gov/regulations/index.htm .

2. Supplemental Security Income

- SSI is a need-based program created by 1974 amendments to Title XVI of the Social Security Act of 1935, codified as amended at 42 U.S.C. §§1381-1385 and implemented in 20 CFR Part 416.
- Recipients of SSI must be:
    - U.S. citizen or "qualified alien" residents as narrowed by the Personal Responsibility Act of 1996 (PRA) then somewhat re-expanded by the Balanced Budget Act of 1997 and the Noncitizen Benefit Clarification Act of 1998. SSI for several categories "qualified aliens" who achieved their status before August 22, 1996 but were not then receiving benefits SSI is time-limited, and most who achieved their status after that date cannot receive SSI for five years. For details, see "NLADA SSI and SSDI Benefits," Part I, §§1.5.3. – 1.5.10, pp. 10-16, and publications in the www.washingtonlawhelp.org Immigration/Government Benefits for Immigrants and Refugees/SSI subfolder.

- At least 65 years old, blind (see 20 CFR §416.981), or disabled. Children under age 18 may receive SSI if they are blind or if they meet the children's disability standard as amended by the PRA: "marked and severe functional limitations" as determined by a three-step Sequential Analysis. See "NLADA SSI and SSDI Benefits," supra, Part 1 §1.7, pp. 37-53, and "NLADA Childhood Disability" in two parts, also in the www.advocateresourcecenter.org Library, Public Benefits/Training subfolder.
- In financial need according to SSA income and resource rules that are conceptually similar to, but differ in detail from, DSHS's rules for GA. An excellent summary, "NLADA Basics of SSI Financial Eligibility" is posted in the www.advocateresourcecenter.org Library, Public Benefits/Training subfolder.

- SSI pays monthly cash assistance of up to the federal benefit level (currently $564 for an individual and $846 for a couple) which changes yearly with the cost of living. Some recipients also receive a state supplemental payment (SSP). For annual changes, check the Columbia Legal Services Senior Bulletins, posted on www.washingtonlawhelp.org in the Aging/Elder Law, Senior Bulletins subfolder.
- The earliest possible effective date for SSI benefits is the month after application.
- SSI recipients automatically qualify for Categorically Needy Medicaid coverage (see part III.1., infra.).
- If an SSI recipient works, the benefit amount is reduced according to the income rules, which disregard a portion of earnings. If s/he works at an SGA level, s/he can continue receiving SSI according to provisions of section 1619 of the Social Security Act, 42 U.S.C.§1382h; 20 CFR §§ 416.260-.267. SSI recipients may also shield a portion of their earnings from reduction through obtaining SSA approval of a Plan for Achieving Self Support (PASS) a little-used benefit. See Clearinghouse Review (March-April 1997), pp. 1101-31. SSI and SSDI work incentives are described in "NLADA SSI and SSDI Benefits," Part 2, §1.14, pp. 95-101).

3. Social Security Disability Insurance

- SSDI is an insurance program enacted as part of Title II (Old Age, Survivor's, and Disability Insurance) of the Social Security Act, codified as amended beginning at 42 U.S.C. § 201, and implemented in 20 CFR Part 404.
- SSDI eligibility and benefit amount is based on earnings records and payroll contributions and does not require proof of financial need. As is true with Social Security retirement benefits,

children and other relatives or survivors may also be entitled to cash benefits on the disabled claimant's account. *See* 20 CFR 404.330-.384.

- The earliest possible effective date for SSDI benefits is 12 months before application, or the sixth month after SSA determines that disability began, whichever is later.
- The monthly SSDI payment, less $20, counts as income under the SSI rules. A claimant recipient whose SSDI payment falls below the federal benefit level and meets other SSI requirements (resource limits, restrictions on transferring assets) may also receive some SSI payment.
- After two years of receiving cash benefits, SSDI recipients qualify for Medicare.
- SSDI recipients who work may have unlimited earnings for a total of nine months in a rolling 60-month period (called Trial Work Period), but after that SSA will review the work to see whether it amounts to SGA and should also start a CDR. If the recipient is then found to be doing SGA, s/he will be terminated unless s/he is found still medically disabled – in which case s/he qualifies for a 36-month Extended Period of Eligibility and will receive SSDI for months in which s/he does not do SGA. 20 CFR §404.1592.

III. Medical Benefits for Persons With Disabilities

1. Medicaid

- **Caveat about citizenship/immigration status**
  Medicaid is available to citizens. Very limited "Alien Emergency Medicaid" is available to all noncitizens. Whether broader Medicaid is available to other noncitizens is a very complex topic, not addressed here. For more information see pamphlets available on the website http://www.washingtonlawhelp under the folder for Immigration, subfolder for Public Benefits.
- **Federal funding, Federal controls**
  Medicaid has both federal and state funding, but is administered by the state (in Washington, by DSHS). Federal law still sets many requirements for states and provides many protections for clients. 42 USC §1396 *et seq*.; 42 CFR §430 *et seq*.
- **Category is required**
  Medicaid is not available to people just because they need health care and cannot afford to pay for it. Medicaid is available only to people in certain "categories": TANF and SSI recipients, low income children (and some of their parents), low income pregnant women, and people who are called "related" to SSI

because they, like SSI recipients, are aged (65 or older), blind, or "disabled". *See* WAC Chapters 388-503; 388-505; 388-475.

- **Disability determination**
  The Medicaid program standard for "disability" is the same as for SSI and SSDI. Persons not receiving SSI or SSDI but who meet federal disability standards may qualify for Medicaid coverage. In Washington State, the same division of DSHS that makes disability decisions for the SSI/SSDI programs also makes disability decisions when people apply for only Medicaid. If DSHS makes a favorable disability decision and awards Medicaid, the agency may continue to rely on that decision until an adverse SSI or SSDI disability decision becomes administratively final, i.e., either the client fails to appeal a decision or the SSA Appeals Council (the final administrative appeal step - see IV.2., infra) rules against the client.
- **Financial requirements**
  Medicaid benefits for aged/blind/disabled people have financial requirements for income and for "resources." The rules regarding what "counts" as income or as resources, and what is excluded from counting, are complex. For SSI-related Medicaid, the state must use income and resource rules *that are no less liberal than the SSI rules*. Washington has chosen a number of more liberal financial eligibility rules for Medicaid. Eligibility for long term care programs (but not for other Medicaid programs) is also affected for a period of time when a person gives away assets. Even if a person is barred from receiving SSI cash grant for disposing of assets, Medicaid for non-long-term care programs can continue. Financial requirements are described in WAC Chapter 388-450 (income), -470 (resources), -475 (new rules for SSI-related Medicaid), and -513 (special rules for long-term care programs).
- **"Categorically Needy" Medicaid (CN)**
  Categorically Needy Medicaid (CN) has the highest level of coverage for health services. Clients receiving SSI cash assistance (or who receive TANF cash assistance for children/parents) get CN Medicaid automatically. Some special groups of people qualify for CN Medicaid even without receiving cash assistance. (Example: developmentally disabled adults who lose SSI due to increased income when they qualify for SSDI based on their parent's earnings when the parent dies, retires, or becomes disabled). WAC 388-475-0880.
- **Retaining CN Medicaid**
  If the person's status that created the CN Medicaid eligibility changes, the person is entitled to a full **redetermination** of Medicaid eligibility before benefits terminate. For example, a person no longer considered "disabled" could continue to be

Medicaid eligible under the program for families, or a person still disabled with new income exceeding SSI levels could qualify for the Medically Needy program. WAC 388-416-0010(2); -418-0025; -434-0005; -503-0505(6); -503-0510(4); -503-0515; -474-0015.

- **Work incentive program**
  SSI recipients who return to work and lose SSI cash due to their earnings can continue to receive CN Medicaid under a work incentive program called "1619(b)." (Not kidding.) The income limits for this program are significantly higher than for SSI, but the person must continue to meet all the other SSI requirements (disability status, resource limits).
- **"Medically Needy" Medicaid (MN)**
  Medically Needy Medicaid (MN) recipients are like CN recipients but have income higher than allowed for the CN program. The income of the person is compared to a Medically Needy Income standard. Income exceeding the standard results in assessment of a "spenddown," which is like a deductible, based upon how much the person's income exceeds the standard during a 3 or 6 month period. The person must incur expenses exceeding the spenddown amount before Medically Needy eligibility begins. Except for clients with low spenddown or those in certain long term care programs, the high spenddown liabilities caused by Washington's low Medically Needy standard make this program difficult for clients to use for reliable access to health care services. The rules and policies regarding how to calculate the spenddown and what expenses can be used to "meet" the spenddown are complex. *See* WAC Chapter 388-519; WAC 388-475-0150; and policy materials in the Eligibility A-Z Manual found under Medical Programs and Spenddown: http://www1.dshs.wa.gov/esa/eazmanual/Sections/Spenddown.htm . A detailed pamphlet for clients is on the internet at http://www.washingtonlawhelp.org/documents/1539015104EN.pdf?stateabbrev=/WA/
- **Medicaid scope of benefits**
  Washington's scope of coverage for CN Medicaid is broader than that of many private health insurance plans. Federal law allows states to provide less comprehensive service coverage for MN clients than for CN clients, however. Washington's Medically Needy program does not cover outpatient physical, speech, or occupational therapy outside of approved home health programs, and it does not cover "personal care services." WAC 388-529-0200. SSI recipient and SSI–related Medicaid clients are not in Washington's Medicaid managed care program, Healthy Options, but in 2005 some areas will offer a different, voluntary managed care program to these clients. Some drugs,

medical equipment, surgeries and other services require DSHS approval in advance. WAC 388-501-0165 (procedure), 388-501-0160(exceptions to rules), and 388-500-0005 (definition of "medically necessary") govern prior approval requests made to DSHS's Medical Assistance Administration (MAA). Clients can appeal MAA denials of requested procedures, medical devices, or prescription drugs.

- **Medicaid "payment in full"**
  Unless the state is authorized to require some form of cost-sharing by recipients, medical providers participating in the Medicaid program may not charge recipients for their services covered by Medicaid. Acceptance of Medicaid reimbursement is *payment in full*. Medicaid clients may be billed only in limited situations. Examples: Medically Needy clients may need to pay for expenses used to meet the "spenddown." Long-term care clients can be required to pay a "participation," which is a share of the cost of services based upon their income and allowable deductions. Medicaid clients enrolled in a managed care plan may be liable for services obtained from providers not contracted or authorized by the plan. Provider billing restrictions are found in WAC 388-502-0160.
- **Estate recovery**
  Until recently, most people whose estates would be subject to recovery for Medicaid expenditures were those receiving long term care services. Effective June 1, 2004, however, clients age 55 and older are subject to estate recovery for almost all Medicaid-funded services. WAC Chapter 388-527. See the pamphlet concerning estate recovery on http://www.washingtonlawhelp.org under Aging/Elder Law, folder for Long term care.

2. Long Term Care Coverage

- **Eligibility: Broader than for regular Medicaid**
  People who qualify medically to receive the level of care in a nursing home can get Medicaid under "Institutional" and "waiver" Medicaid programs. These programs have more liberal income and resource rules than regular Medicaid, particularly for married people. These recipients also get CN Medicaid to cover their other medical expenses, except clients on the small "Medically Needy waiver" programs get access to Medically Needy benefits instead. Clients in the waiver programs can receive services at home or in community-based facilities. Clients receiving CN Medicaid apart from a long term care program (such as clients receiving SSI) can get "Medicaid Personal Care" services instead; the level of care standard is less stringent for this program. Eligibility for nursing home and

COPES programs are described in frequently revised pamphlets posted on www.washingtonlawhelp.org under the "Aging/Elder Law" folder.

- **Transfer of asset restrictions**
  In one respect, eligibility for long term care is more restrictive than eligibility for regular Medicaid programs. That is, clients may be made ineligible for giving away assets. "Transfer of assets" provisions are described in detail in the COPES and Nursing Home pamphlets on www.washingtonlawhelp.org. See WAC 388-513-1364, -1365, -1366.
- **Broad coverage, flexible programs**
  SSI-related (aged/blind/disabled) Medicaid recipients may have most, if not all, of their long term care expenses paid by the Medicaid long term care programs. Long term care expenses can include assistance with bathing, dressing, ambulation, toileting, and other "personal care" tasks, as well as with necessary daily living activities such as meal preparation, housekeeping, laundry and shopping. Washington's programs cover long term care in nursing homes, in community based facilities ("assisted living," boarding homes, adult family homes), or in the client's own home. The waiver program covering most of the services outside nursing homes is called "COPES." Another community-based waiver, now called "DDD waivers" (formerly called "CAP"), provides long term care services to children and adults eligible for services from DSHS's Division of Developmental Disabilities (DDD).
- **Assessments for services: The CARE tool controversy**
  The amount of care paid for under the COPES and DDD waivers is now being assessed and awarded using an instrument known as the CARE tool. Although many clients have received the same or increased levels of service after assessment by this new instrument, some clients face large reductions. This has caused numerous administrative appeals and some litigation. The rules regarding the CARE tool are in WAC Chapter 388-72A **[Note from May 2010:** The chapter with these rules is now WAC 388-106]. For more information and resources, see materials in the library under the "CARE" folder on the advocate resource center: http://www.advocateresourcecenter.org.

3. Medicare

- **Not based on financial need**
  Like SSDI, and unlike Medicaid, Medicare entitlement is based on payroll contributions. Financial need is irrelevant. Medicare is jointly administered by SSA and a private insurance carrier.
- **Medicare Eligibility**

        - People age 65 and older who qualify for monthly Social Security retirement or survivor benefits or railroad retirement benefits are eligible for Medicare. Most people age 65 who do not get Social Security can get Medicare by voluntarily enrolling and paying the significant premiums for Part A (hospital and related services) as well as the much lower premiums for Part B (outpatient and other services). An exception is that permanent resident aliens residing in the U.S. for less than five years cannot enroll.
        - People under age 65 are eligible for Medicare starting with the 25th month they are entitled to Social Security disability or railroad retirement disability benefits.
        - People of any age who receive dialysis or renal transplantation for end stage renal disease are eligible if they meet "insured status" requirements or get monthly Social Security or railroad retirement benefits, or if they are the spouses or dependent children of such insured or entitled people.
    - **Premiums**
      Medicare recipients are required to pay premiums for Part B. Premium payments are deducted from monthly Social Security benefits. Those who must "voluntarily enroll" in order to get Part A Medicare must also pay significant premiums for that coverage.
    - **Not payment in full, limited coverage**
      Unlike Medicaid, Medicare payment is not payment in full. Medical providers may seek payment from the recipient for the non-Medicare-covered portion of a bill. That portion may be significant. In addition, Medicare does not cover significant health care expenses, such as most prescription medication, much preventive care, and long-term care (only short, acute nursing home stays are covered).
    - **"Medicare savings" programs**
      These programs, funded by Medicaid, help clients pay some of the costs that Medicare does not cover. Depending on the client's income, the program may cover just premiums (SLMB) or also co-payments and deductibles (QMB). WAC 388-517-0300.

4. **Other medical programs**
    - Disabled people whose health care access needs are not met by the Medicaid and Medicare programs described above should consider other options, such as:
        - Alien Emergency Medicaid
        - Refugee Medical Assistance
        - Kidney Disease Program

    - State-subsidized "Basic Health Plan"
    - Washington State Health Insurance Pool
    - Special programs for HIV clients (HIV Early Intervention insurance Program and Evergreen Health Insurance Program)
    - Free or sliding fee community clinics and health district services
    - Drug company prescription programs,
    - Hospital Charity Care program
- The "Summary of Major DSHS Medical Benefit Categories, Basic Health Plan, and Subsidized Insurance Pools in Washington State" lists various options and provides legal citations. This material will soon be available under the Health Law folder at this site: http://advocateresourcecenter.org.

IV. Appeals

1. Office of Administrative Hearings (OAH)

- OAH handles appeals of decisions made by several state agencies, including DSHS. The appeals, known as adjudicative proceedings, are governed by the state Administrative Procedures Act (APA). Chapter 34.05 RCW.
- There is additional statutory authority pertaining to appeals of DSHS decisions involving public benefits programs at RCW 74.08.080. The rules governing DSHS hearings are set forth at Chapter 388-02 WAC.
- The time limit for appealing most DSHS decisions is 90 days. However, when the decision being appealed is to reduce or terminate benefits, it is important for the recipient to maintain the status quo while the appeal is pending. In order to maintain benefits during the appeal (called "continued benefits"), the hearing must be requested *within 10 days of the termination decision*. If the 10th day occurs *before* the end of the month after which the decision takes effect, the recipient can receive continued benefits by requesting a hearing on or before the final day of the month. *See* WAC 388-458-0040(3).
- In appeals of decisions by community services offices (CSOs) regarding cash assistance programs or eligibility for medical assistance programs, DSHS is represented by someone known as a "fair hearing coordinator." This person is not a lawyer. However, in cases involving decisions by the Medical Assistance Administration (MAA) to deny requests for medical procedures, devices or prescription drugs, the Department representative will be a lawyer.

- [Note: As of May 2010, ALJ hearing decisions are "final" and not subject to Board of Appeals review for most types of cases. They are "initial" and can be reviewed by the BOA for a "final" decision in other types of cases. See WAC 388-02-0217.]
- Individual appellants, but not DSHS, may seek judicial review of a final agency decision to state superior court. RCW 74.08.080; RCW 34.05.570. The payment of a filing fee is not required in the appeal of a decision involving a "public assistance program", and if the court renders a decision in favor of the appellant, the appellant "shall be entitled to reasonable attorneys' fees and costs." RCW 74.08.080(3).

2. Office of Hearings and Appeals (OHA)

- OHA is a unit within SSA that handles appeals of programs administered by SSA, including SSDI, SSI, and Medicare. The review and appeal process is set forth for SSDI beginning at 20 CFR 404.901 and for SSI at 20 CFR 416.1401.
- Written appeal of an adverse SSA decisions must be received by the agency within 60 days after the claimant receives written notice. However, as with DSHS hearings, the request must be received within 10 days to retain continued benefits pending the appeal decision. 20 CFR §§404.1597a, 416.1336, 416.996. SSA may consider a late-filed appeal at any stage if the claimant establishes good cause as provided in 20 CFR §§404.911(a)(4), 416.1411(a)(4).
- Unlike with DSHS, there is an intermediate appeal step between the original decision and the hearing, called *reconsideration*.
- In SSDI and SSI hearings, SSA does not have a representative at the hearing, but the ALJ may request guidance from a vocational or medical expert.
- Appellant may seek review of an adverse ALJ decision to the SSA Appeals Council.
- If still adverse, the decision may then be appealed to federal district court.

FOOTNOTES

[1] http://www1.dshs.wa.gov/mentalhealth/publicmh.shtml
[2] http://www1.dshs.wa.gov/mentalhealth/generalfaqs.shtml#mhservices
[3] http://www1.dshs.wa.gov/mentalhealth/generalfaqs.shtml#mhservices

[4] WAC 388-865-0410 Consumer rights

[link is: http://apps.leg.wa.gov/WAC/default.aspx?cite=388-865-0410]

(1) The provider must document that consumers, prospective consumers, or legally responsible others are informed of consumer rights at admission to community support services in a manner that is understandable to the individual. Consumer rights must be written in alternative format for consumers who are blind or deaf, and must also be translated to the most commonly used languages in the service area consistent with WAC 388-865-0260(3);

(2) The provider must post a written statement of consumer rights in public areas, with a copy available to consumers on request. Providers of telephone only services (e.g., crisis lines) must post the statement of consumer rights in a location visible to staff and volunteers during working hours;

(3) The provider must develop a statement of consumer rights that incorporates the following statement or a variation approved by the mental health division: "You have the right to:

(a) Be treated with respect, dignity and privacy;

(b) Develop a plan of care and services which meets your unique needs;

(c) The services of a certified language or sign language interpreter and written materials and alternate format to accommodate disability consistent with Title VI of the Civil Rights Act;

(d) Refuse any proposed treatment, consistent with the requirements in chapters 71.05 and 71.34 RCW;

(e) Receive care which does not discriminate against you, and is sensitive to your gender, race, national origin, language, age, disability, and sexual orientation;

(f) Be free of any sexual exploitation or harassment;

(g) Review your clinical record and be given an opportunity to make amendments or corrections;

(h) Receive an explanation of all medications prescribed, including expected effect and possible side effects;

(i) Confidentiality, as described in chapters 70.02, 71.05, and 71.34 RCW and regulations;

(j) All research concerning consumers whose cost of care is publicly funded must be done in accordance with all applicable laws, including DSHS rules on the protection of human research subjects as specified in chapter 388-04 WAC;

(k) Make an advance directive, stating your choices and preferences regarding your physical and mental health treatment if you are unable to make informed decisions;

(l) Appeal any denial, termination, suspension, or reduction of services and to continue to receive services at least until your appeal is heard by a fair hearing judge;

(m) If you are medicaid eligible, receive all services which are medically necessary to meet your care needs. In the event that there is a disagreement, you have the right to a second opinion from:

(i) A provider within the regional support network about what services are medically necessary;

or

(ii) For consumers not enrolled in a prepaid health plan, a provider under contract with the mental health division.

(n) Lodge a complaint with the ombuds, regional support network, or provider if you believe your rights have been violated. If you lodge a complaint or grievance, you must be free of any act of retaliation. The ombuds may, at your request, assist you in filing a grievance. The ombuds' phone number is:__________;

(o) Ask for an administrative hearing if you believe that any rule in this chapter was incorrectly applied in your case."