

Training

Statewide Health Insurance Benefits Advisors (SHIBA)

Medicare & Medicaid Dual Eligibles June 2017 Training

Table of contents

Learning objectives.....	1
Short item: Performance Measures- new LIS item.....	2
Materials review.....	3
QMB and balance billing.....	4
Transitioning from MAGI Medicaid to Medicare.....	6
Scenarios.....	9
Evaluation.....	11

Handouts:

Eligibility Overview – Washington Apple Health (Medicaid) Programs (updated April 2017)

QRC-Calling the HCA phone system to check Medicaid and MSP enrollment (October 2016)

Medicare Savings Program – Reference Guide (updated May 2017)

QRC- Rainbow Chart (updated May 2017)

Learning objectives

Volunteers will learn and be able to:

- Correctly mark the CCR for low-income contacts to receive credit for the updated Performance Measure.
- Describe what is covered for someone with Medicare and full Medicaid.
- Describe what is covered for someone with QMB – Medicare only.
- Describe what actions a client with QMB should take if he or she receives a bill for medical care.
- Describe what the Medicare Savings Programs SLMB and QI pay for.
- Call the Health Care Authority using the voice-activated service to verify a client's eligibility for Medicaid or Medicare Savings Programs.
- Explain what actions a client should take who is losing his or her MAGI Medicaid due to starting Medicare.

Short item: Collecting data for new performance measure on low-income

Screen all clients using the Rainbow chart. Please always check the "Below 150% FPL" radio button to get credit for helping people who are low-income.

PM4: Hard-to-Reach Contacts (NEW)

Number of low-income, rural, and non-native English contacts per 1,000 "hard-to-reach" Medicare beneficiaries in the State.

22

□ Low-Income:

- Includes client contacts when the beneficiary's income is below 150% of the Federal Poverty Level

To count you must check the "Below 150% FPL" in NPR



*** Client Monthly Income:**

- Below 150% FPL
- At or Above 150% FPL
- Not Collected

On SHIBA Online, it looks like this:

(Tab 3-Client Eligibility)

Client Household Information

Family Size: Number of relatives living in home, including client

2

Household

Household Monthly Income Before Taxes:

- \$0-\$908
- \$909-\$1,226
- \$1,227-\$1,362
- \$1,363-\$1,816

Individual

Individual Monthly Income Before Taxes: *

- Below 150% FPL
- At or Above 150% FPL
- Not Collected



Materials review

Eligibility Overview – Washington Apple Health (Medicaid) Programs (HCA 22-315)

- Page 2: How to use this guide
- Page 3: Modified Adjusted Gross Income (MAGI) Programs – Review Adult Medical (this is the “Obamacare,” “Expanded” Medicaid that low-income adults may have until they become eligible for Medicare. There are no resource limits for this program.)
- Page 8: Supplemental Security Income (SSI)-related programs
- Page 9: Medically Needy (MN) and Spenddown
- Page 10: Medicare Savings Program (MSP) Please note the 2017 version of this guide has typos in the resource limits on this page. Correct resource limits are: \$7,390/one person and \$11,090/two people for QMB, SLMB and QI-1. We’ve notified the HCA of this error.
- Page 11: Long-Term Services and Supports (LTSS) and Hospice.
- Page 14: Where to apply for health care coverage
- Page 15: Resources
- Page 16: Definitions

QRC –Rainbow Chart (Updated 5/2017)

We took the information from the QRC Overview of “Classic” Medicaid programs affecting people on Medicare and combined it with the Rainbow Chart to make one QRC, since the information in both were very similar. The Rainbow chart orientation has changed to landscape from the earlier portrait version.

QRC-Calling the Health Care Authority (HCA) phone system to check Medicaid and MSP enrollment

With the client's zip code and Social Security or Provider One number, you can call and immediately verify if a client is currently enrolled in Medicaid or a Medicare Savings Program. There is no waiting on hold and it's available 24/7.

Medicare Savings Program (MSP) – Reference Guide

This is a document from the HCA that educates people about the Medicare Savings Program. It's been updated with 2017 income guidelines and includes the contact number for the Medicare Buy-in Unit. SHIBA volunteer advisors can call the number to verify a client is enrolled in a Medicare Savings Program or ask questions about the deduction of Medicare premiums from a client's Social Security income. To call, you'll need to have the client's Social Security number.

QMB and balance billing information

Medicare providers are not allowed to bill people with QMB for most costs. This is sometimes referred to as "balance billing." Please refer to page 99 of *Medicare & You 2017* for more information about this issue.

Qualified Medicare Beneficiary (QMB) Program – If clients are eligible, the QMB program helps pay for Part A and/or Part B premiums. In addition, Medicare providers aren't allowed to bill clients for Medicare deductibles, coinsurance, and copayments when they get services and items that Medicare covers- except outpatient prescription drugs. Pharmacists may charge clients up to a limited amount (no more than \$3.70 in 2017) for prescription drugs covered by Medicare Part D. (If clients have QMB, they automatically get Extra Help. See page 97.)

Tell clients to make sure his or her provider knows they have QMB. They should show both their Medicare and Medicaid (“Provider One”) card each time they get care.

If they get a bill for medical care Medicare covers, they should call their provider or plan about the charges. They should tell them that they have QMB and can’t be charged for Medicare deductibles, coinsurance and copayments. If this doesn’t resolve the billing problem, clients should call 1-800-MEDICARE.

Transitioning from MAGI Medicaid to Medicare

Differences between MAGI (Modified Adjusted Gross Income) Medicaid for adults and “Classic” Medicaid programs for people with Medicare:

MAGI Medicaid for adults	“Classic” Medicaid programs
<p>This program provides coverage for adults age 19-65 with countable income below 133% of the FPL.</p>	<p>This includes:</p> <ul style="list-style-type: none"> • SSI-related Medicaid • Medically Needy (“Spendedown”) • Medicare Savings Program • Long-Term Care Services & Supports. <p>Income limits vary by program.</p>
<p>There are no resource limits for this program.</p>	<p>These programs have resource limits. They vary by program.</p>
<p>Apply for this program via the Washington Health Benefit Exchange at www.wahealthplanfinder.org</p>	<p>Apply for these programs with DSHS online via www.washingtonconnection.org or by paper application.</p>
<p>Clients cannot have Medicare and MAGI Medicaid. They’ll be dropped MAGI Medicaid when Medicare starts.</p>	<p>These programs are compatible with Medicare; eligible people can have both kinds of coverage.</p>
<p>Sometimes, but not always, people will be “deemed” (automatically eligible) for Extra Help for Part D when their Medicare starts. Usually, they need to apply to SSA for this benefit.</p>	<p>People with Medicare who are found eligible for one of these programs will be “deemed” (automatically eligible) for Extra Help for Part D. They will receive a Purple Letter (“Deemed Status Notice”) from CMS.</p>

When people with MAGI adult Medicaid get Medicare, they'll receive the following letter from DSHS. The letter will include a paper application for "Classic" Medicaid programs.

DSHS - CSD - Customer Service Center
PO BOX 11699
Tacoma, WA 98411-6699

 Washington State
Department of Social
& Health Services
Phone # 360-725-1788
TTY/TDD # 800-204-6430
Toll Free # 877-501-2233

12/08/16

Client ID # 0000000

Recipient's Name
Address

Reprint Options					
<input checked="" type="radio"/>	Local	<input type="radio"/>	State	<input type="radio"/>	None
<input checked="" type="checkbox"/>	Include Attachments				

Dear **Client**

Washington Apple Health benefits for **(client name)** will end as of 1/31/2017, as they are eligible for Medicare.

To see what other programs they may be eligible for:

- 1) Complete and return the enclosed application.
- 2) Provide copies of proof of all household income, such as child and spousal support, L&I, pensions, Veterans benefits, unemployment income, social security income, earnings from employment, and some educational benefits.
- 3) Provide copies of proof of resources, such as copies of bank statements, stocks and bonds, life insurance, trust funds, properties, vehicles and other assets.

If this information is not received by 12/23/16, your benefits may stop or be denied.

If you have questions about the information requested in this letter, please call DSHS Customer Support at 1-877-501-2233.

Label all submitted documentation with your Client ID.
You may send documents by way of

Mail: DSHS
CSD – Customer Service Center
PO BOX 11699

How can SHIBA volunteer advisors help people who are losing their MAGI adult Medicaid because their Medicare is starting?

- Educate people about how Medicare works and that Medicare will become the primary payer.
- Let them know that, unfortunately, they'll likely have to pay some of their medical costs, and they can't drop Medicare to keep their MAGI Medicaid.
- Screen them for Medicaid, Medicare Savings Programs and Extra Help, and assist them to apply if appropriate.
- Help them to find the most cost-effective drug plan, MA plan or other supplement.
- Refer them for other assistance in your community if needed, such as energy or food assistance, Charity Care, etc.

Scenarios

1. Mr. and Mrs. Sanders have a combined Social Security income before any deductions of \$2000 per month. Mr. Sanders has been on Medicare for two years, but Mrs. Sanders is just turning 65, and won't be working anymore. You meet with her about her Medicare options. She tells you they have combined assets of more than \$200,000. You're entering your contact with Mrs. Sanders in a CCR. What button should you choose for income in Tab 3, Client Eligibility?

Bonus: Will you refer her to apply for Extra Help?

2. Susan calls you and says she really needs dental care. Also, she doesn't drive and she really has trouble getting to the doctor. She is 67 and single. She doesn't know much about what coverage she has. You screen her about her income and assets and she tells you that her Social Security is \$735 per month, and she has about \$200 in her checking account. Based upon her income and assets, could she be eligible for help with dental and medical transportation?

Bonus: How can you find out if she needs to apply for help or if she already has it?

3. Jonas calls you for help. He's single, 52 years old, on Medicare due to disability and gets SSDI of \$1,000 per month. He has no savings to speak of. He has a stand-alone prescription drug plan and he doesn't pay a premium for it. He went to a new doctor about a month ago for a really bad sore throat and he just got a bill. He tells you he has a Provider One (Medicaid) card. This is the first time that has happened, he can't afford it. What should he do?

Bonus: Is there a way to confirm what level of help he gets?

4. Rebecca is starting Medicare in a couple of months. She's single and her only income will be Social Security of \$1,300. She has about \$5,000 in an IRA. What assistance do you think she should apply for? If she's found eligible for help, what can you tell her about her expected medical costs? What can you tell her about her expected prescription costs?

5. Samantha is 60 years old and has been on SSDI for almost two years. She's had MAGI Medicaid for the past two years and she doesn't have to pay anything for her doctors or prescriptions. Her SSDI is \$1,300 per month and she has less than \$3,000 in the bank. She just got a letter from DSHS that says her Apple Health will end at the end of the month because she is eligible for Medicare. What can she do? What do you want to be sure she knows? She asks you if she just can drop her Medicare to keep her current plan. What do you tell her?

Training Course Evaluation

Date of Training: _____

Training Location: _____

How can SHIBA improve the monthly trainings?

What additional trainings within our SHIBA scope would you like to see?

What SHIBA training materials (including QRCs) would you like to see added to My SHIBA?

Other: _____

If you prefer to give electronic feedback about curriculum please contact:

Liz Mercer: lizm@oic.wa.gov or Judith Bendersky: judithb@oic.wa.gov



April 2017

Eligibility Overview

Washington Apple Health (Medicaid) Programs





Contents

What is Washington Apple Health (Medicaid)?	2	Medicare Savings Programs (MSP)	10
How to use this guide	2	Qualified Medicare Beneficiary (QMB) (S03)	
Scope of care	3	Specified Low-Income Medicare Beneficiary (SLMB) (S05)	
Modified Adjusted Gross Income (MAGI) Programs ...	3	Qualified Individual (QI-1) (S06)	
Adults		Qualified Disabled Working Individual (QDWI) (S04)	
<i>Adult Medical (N05)</i>		Long-term Care (LTC) and Hospice	11
<i>Family Medical (N01)</i>		Covered services—scope of service	11
<i>Health Care Extension (N02)</i>		Scope of service categories	
Pregnancy and Family Planning		Table: Benefit packages by program	
<i>Pregnancy Medical (N03, N23)</i>		Other services	14
<i>Medically Needy Pregnant Women (P99)</i>		Non-emergency Medical Transportation (brokered transport)	
<i>Family Planning Extension (P05)</i>		Interpreter Services for Sign and Spoken Language	
<i>Take Charge (P06)</i>		Where to apply for health care coverage	14
Apple Health for Kids		MAGI Programs	
<i>Apple Health for Newborns (N10):</i>		Classic Medicaid Programs	
<i>Apple Health for Kids (N11, N31)</i>		Long-term Care	
<i>Apple Health for Kids with Premiums (N13, N33)</i>		Aged, Blind, Disabled Coverage	
<i>Apple Health for Medically Needy Kids (F99)</i>		Resources	15
Classic Medicaid Programs	6	Apple Health Toll-free Customer Services (through the Health Care Authority)	
Breast and Cervical Cancer Treatment Program (BCCTP) for Women (S30)		HCA Online Resources	
Foster Care/Adoption Support/Former Foster Care (D01, D02, D26)		Scope of Care WACs	
Medical Care Services (A01, A05)		Definitions	16
Refugee (R02, R03)			
Non-Citizen Program	7		
Alien Emergency Medical (AEM) (K03, L04, L24, N21, N25, S07):			
Supplemental Security Income (SSI) Related Programs	8		
SSI Program (S01)			
SSI-Related Program (S02)			
SSI-Related MN Program (S95, S99)			
Healthcare for Workers with Disabilities (HWD) (S08)			
Medically Needy (MN) and Spenddown	9		



What is Washington Apple Health (Medicaid)?

Medicaid is the federally matched medical aid programs under Title XIX of the Social Security Act (and Title XXI of the Social Security Act for the Children's Health Insurance Plan) that covers the Categorically Needy (CN) and Medically Needy (MN) programs.

Washington Apple Health is an umbrella term or "brand name" for all Washington State medical assistance programs, including Medicaid. The brand name may be shortened to "Apple Health."

The Health Care Authority (HCA) administers most Washington Apple Health programs. (The Department of Social and Health Services administers the Classic Medicaid programs.)

Medicaid expansion: Building on compassion

The Patient Protection and Affordable Care Act (ACA), enacted by Congress in 2010, created an unrivaled opportunity for increasing health coverage. States had the option to expand eligibility for Medicaid and Washington State said yes.

Before Medicaid expansion, coverage was essentially limited to low-income children, people with

disabilities or devastating illnesses, and those whose incomes were far below the federal poverty level.

Today, Apple Health covers adults with incomes up to 138 percent of the federal poverty level. In April 2017, that translated to about \$16,643 for a single person or \$33,948 for a family of four.

For the first time, many low-income adults suffering from chronic conditions, such as diabetes, high blood pressure, asthma, and other diseases have better options than waiting until they are sick enough to go to the emergency room. People living on the edge financially don't have to choose between going to the doctor and paying the electric bill. And people used to doing without are able to get regular doctor visits, including preventive care.

More people served today

The number of people eligible for Apple Health increased significantly with higher income limits. Others who had previously qualified but not enrolled also obtained coverage. By 2017, nearly 618,000 new enrollees were receiving Apple Health for Adults coverage.



How to use this guide

This guide gives an overview of eligibility requirements for Washington Apple Health. It doesn't include every requirement or consider every situation that might arise. The explanation of Scope of Care on page 3 will be helpful in understanding the differences between the programs. Also, refer to the Definitions on page 16 if you are not familiar with some of the terms used in this guide.

Income levels, such as those based on Federal Poverty Level (FPL) and Cost of Living Adjustments (COLA), and specific program standards change yearly, but in different months. Please understand that, while the information in this publication is current at the time of publication, some of these standards will change before the next annual update. For the most current information, go to the Health Care Authority website www.hca.wa.gov/free-or-low-cost-health-care/apple-health-medicaid-coverage.





Scope of care

Scope of care describes which medical and health care services a particular Apple Health program covers. There are four categories of scope of care:

- **Categorically Needy (CN):** The broadest, most comprehensive scope of health care services covered.
- **Alternative Benefits Plan (ABP):** The same scope of care as CN, with the addition of habilitative services, applicable to the Apple Health for Adults program.
- **Medically Needy (MN):** This scope of care covers slightly fewer health care services than Categorically Needy. Medically Needy coverage is available to individuals who qualify for disability-based Apple Health, Apple Health for Long-Term Care, or Apple Health for Kids or Pregnant Women, except that their income and/or resources are above the applicable Apple Health program limits.
- **Medical Care Services (MCS):** This scope of care covers fewer health care services than Medically Needy. MCS is a state-funded medical program available to adults who are not eligible for Apple Health programs with CN, ABP, or MN scope of care and meet the eligibility criteria for either the Aged, Blind or Disabled–cash or the Housing Essential Needs (HEN) program.



Modified Adjusted Gross Income (MAGI) Programs

Adults

Adult Medical (N05):

Effective April 1, 2017	
Household Size	Monthly Income Limit
1	\$1,337
2	\$1,800
3	\$2,263
4	\$2,829
5	\$3,310
6	\$3,790

This program provides ABP coverage to adults with countable income at or below 133 percent of the FPL who are ages 19 up to 65, who are not incarcerated, and who are not entitled to Medicare.

Family Medical (N01):

Effective April 1, 2017	
Household Size	Monthly Income Limit
1	\$511
2	\$658
3	\$820
4	\$972
5	\$1,127
6	\$1,284

This program provides CN coverage to adults with countable income at or below the applicable Medicaid standard and who have dependent children living in their home who are under the age of 18.

Health Care Extension (N02):

This program provides CN coverage to individuals who lost eligibility for Family Medical because of an increase in their earned income after they received Family Medical coverage for at least 3 of the last 6 months. These individuals are eligible for up to 12 months extended CN medical benefits.

Pregnancy and Family Planning

Pregnancy Medical (N03, N23):

Effective April 1, 2017	
Household Size	Monthly Income Limit
1	N/A
2	\$2,612
3	\$3,284
4	\$3,957
5	\$4,629
6	\$5,301

This program provides CN coverage to pregnant women with countable income at or below 193 percent of the FPL without regard to citizenship or immigration status. Once enrolled in Apple Health for Pregnant Women, the individual is covered regardless of any change in income through the end of the month after the 60th day after the pregnancy end date (e.g., pregnancy ends June 10, health care coverage continues through August 31). Women receive this post-partum coverage regardless of how the pregnancy ends.

Women who apply for Pregnancy Medical after the baby's birth may not receive postpartum coverage, but they may qualify for help paying costs related to the baby's birth if they submit the application within three months after the month in which the child was born.

To determine the pregnant woman's family size, include the number of unborn children with the number of household members (e.g., a woman living alone and pregnant with twins is considered a three-person household).

Medically Needy Pregnant Women (P99):

This program provides MN coverage to pregnant women with income above 193 percent of the FPL. Individuals who qualify are eligible for MN coverage after incurring medical costs equal to the amount of the household income that is above the 193 percent FPL standard.

Family Planning Extension (P05):

This program provides family planning services only for 10 months after Pregnancy Medical ends. Women receive the Family Planning Extension automatically, regardless of how the pregnancy ends.

Take Charge (P06):

This program provides both men and women coverage for pre-pregnancy family planning services to help participants take charge of their lives and prevent unintended pregnancies.

Take Charge covers:

- Annual examination.
- Family planning education and risk reduction counseling.
- FDA-approved contraceptive methods including: birth control pills, IUDs, and emergency contraception.
- Over the counter contraceptive products, such as condoms, and contraceptive creams and foams.
- Sterilization procedures.

Clients access Take Charge services through local family planning clinics that participate in the program.

Find additional information at www.hca.wa.gov/free-or-low-cost-health-care/apple-health-medicaid-coverage/take-charge-family-planning-non-medicaid.

Apple Health for Kids

Apple Health for Kids coverage is free to children in households with income at or below 210 percent of the FPL and available for a monthly premium to children in households with income at or below 312 percent of the FPL.

Effective April 1, 2017

Household Size	Monthly Income Limit 210% FPL (No Cost)	Monthly Income Limit 260% FPL (\$20 Premium/Child, \$40 Family Maximum)	Monthly Income Limit 312% FPL (\$30 Premium/Child, \$60 Family Maximum)
1	\$2,111	\$2,613	\$3,136
2	\$2,842	\$3,519	\$4,290
3	\$3,574	\$4,424	\$5,394
4	\$4,305	\$5,330	\$6,499
5	\$5,037	\$6,236	\$7,603
6	\$5,768	\$7,141	\$8,707

Apple Health for Newborns (N10):

This program provides 12 months of CN coverage if the mother was enrolled in an Apple Health program when the child was born. There is no resource or income limit for this program.

Apple Health for Kids (N11, N31):

This program provides CN coverage to children under age 19 whose families have income at or below 210 percent of the FPL. Children who would have been eligible for Apple Health for Kids had they met immigration status requirements receive CN coverage under state-funded Apple Health for Kids.

Apple Health for Kids with Premiums (N13, N33):

This program provides CN coverage to children under age 19 whose families have income above 210 percent and at or below 312 percent of the FPL. Participants pay a low-cost monthly premium.

Children who would have been eligible for Apple Health for Kids with Premiums had they met immigration status requirements receive CN coverage under state-funded Apple Health for Kids with Premiums.

Apple Health for Medically Needy Kids (F99):

This program provides MN coverage to children under age 19 whose families have income above 312 percent of the FPL. Children who qualify and are enrolled in Apple Health for Medically Needy Kids become eligible for MN coverage after incurring medical costs equal to the amount of the household income that is above the 312 percent FPL standard.





Classic Medicaid Programs

Breast and Cervical Cancer Treatment Program (BCCTP) for Women (S30):

This federally-funded program provides health care coverage for women diagnosed with breast or cervical cancer or a related pre-cancerous condition. Eligibility is determined by the Breast, Cervical, and Colon Health Program (BCCHP) in the Washington State Department of Health (DOH). DOH is responsible for screening and eligibility, while HCA administers enrollment and provider payment. Coverage continues through the full course of treatment as certified by the BCCHP.

A woman is eligible if she meets all of the following criteria:

- Screened for breast or cervical cancer under the BCCHP.
- Requires treatment for either breast or cervical cancer or for a related pre-cancerous condition.
- Is under age 65.
- Is not covered for another CN (Categorically Needy) Apple Health program.
- Has no insurance or has insurance that is not creditable coverage.
- Meets residency requirements.
- Meets social security number requirements.
- Meets citizenship or immigration status requirements.
- Meets income limits set by the BCCHP.

For further information, go to the DOH website:

www.doh.wa.gov/YouandYourFamily/IllnessandDisease/Cancer/BreastCervicalandColonHealth.aspx

Foster Care/Adoption Support/Former Foster Care (D01, D02, D26):

This program provides CN coverage to children receiving foster care or adoption support services. This program also provides CN coverage to individuals from the age of 18 up to 26 who age out of foster care in Washington State.

Medical Care Services (A01, A05):

This state-funded program provides limited health care coverage to adults who are not eligible for Apple Health programs with CN, ABP, or MN scope of care and meet the eligibility criteria for either the Aged, Blind or Disabled–cash or the Housing Essential Needs (HEN) program.

Refugee (R02, R03):

The Refugee Medical Assistance program (RMA) provides CN coverage to refugees who are not eligible for Apple Health programs with CN or ABP scope of care and who meet the income and resource standards for this program. RMA is a 100 percent federally funded program for persons granted asylum in the U.S. as refugees or asylees. Individuals enrolled in RMA are covered from the date they entered the U.S.

Eligibility for refugees/asylees that have been in the United States for more than eight months is determined the same as for U.S. citizens.

Immigrants from Iraq and Afghanistan who were granted Special Immigrant status under Section 101(a)(27) of the Immigration and Nationality Act (INA) are eligible for Medicaid and Refugee Medical Assistance (RMA) the same as refugees.





Non-Citizen Programs

Alien Emergency Medical (AEM) (K03, L04, L24, N21, N25, S07):

This program covers health care services to treat qualifying emergency medical conditions. To be eligible for AEM, an individual must:

- Be categorically relatable to a Medicaid program but not eligible for the Medicaid program solely due to immigration status requirements (which program an individual is related to determines whether they follow the MAGI or Classic Medicaid eligibility rules and application processing); and
- Have a qualifying emergency medical condition as described in WAC 182-507-0115, 182-507-0120, or 182-507-0125 that is approved by HCA's medical consultant team.

Below is a summary of the 3 WACs that cover Alien Medical Programs:

- **182-507-0115:** Alien Emergency Medical (AEM) – The qualifying services must be provided in a hospital setting (inpatient, outpatient surgery, emergency room) that includes evaluation and management visits by a physician and be needed to treat the emergency medical condition. Certification is limited to the dates on which the qualifying services were provided.
- **182-507-0120:** Alien Medical for Dialysis and Cancer Treatment – The qualifying services must be needed to treat the qualifying condition of cancer, acute renal failure, or end stage renal disease, or be anti-rejection medication. These services do not need to be provided in a hospital setting.
- **182-507-0125:** Alien Nursing Facility Program – The applicant must meet all other eligibility factors for nursing home placement and receive prior authorization by the Aging & Long-Term Support Administration (AL TSA). This program is subject to caseload limits.

Income and resource limits are the same as for the program to which the AEM applications are categorically relatable.





Supplemental Security Income (SSI) Related Programs

SSI Program (S01):

This program provides CN coverage to individuals receiving SSI (Supplemental Security Income) cash benefits.

SSI-Related Program (S02):

Effective January 1, 2017

Household Size	Monthly Income Limit	Resource Limit
1	\$735	\$2,000
2	\$1,103	\$3,000

This program provides CN coverage to individuals who meet the SSI income and resource limits and at least one of the following requirements:

- 65 years old or older (aged).
- Blind (as defined by the Social Security Administration and determined by DSHS).
- Disabled (as defined by the Social Security Administration and determined by DSHS).

SSI-Related MN Program (S95, S99):

Effective January 1, 2017

Household Size	Monthly Income Limit
1	\$735
2	\$735
3	\$735
4	\$742
5	\$858
6	\$975

This program provides MN coverage to individuals with income above the SSI income and resource limits. Individuals who qualify and enroll in the Apple Health SSI-Related MN Program become eligible for MN coverage after incurring medical costs equal to the amount of the household income that is above the SSI income standard.

Healthcare for Workers with Disabilities (HWD) (S08):

This program provides CN coverage to people with disabilities (aged 16 through 64) with earned income who purchase health care coverage based on a sliding income scale.

HWD has no asset test and the net income limit is based on 220 percent of the Federal Poverty Level (FPL).

Effective April 1, 2017

Household Size	Income Limit - 220% FPL
1	\$2,211
2	\$2,978

To be eligible, an individual must meet federal disability requirements, be employed (including self-employment) full or part time, and pay the monthly premium. To receive HWD benefits, enrollees pay a monthly premium determined as a percentage of their income. The premium will never exceed 7.5 percent of total income and may be less. American Indians and Alaska Natives are exempt from paying premiums for HWD.





Medically Needy (MN) and Spenddown

Medically Needy (F99, G95, G99, K95, K99, L95, L99, P99, S95, S99):

The Medically Needy (MN) program is a federal and state-funded Medicaid program for individuals who are aged, blind, disabled, pregnant, or a child with income above the applicable CN limits. MN provides slightly less health care coverage than CN and requires greater financial participation by the individual.

Spenddown

An individual with income above the limits for the applicable CN program may enroll in the MN program. An enrollee is given a base period, typically three or six months, to spend down excess income—in other words, to incur financial obligations for medical expenses equal to his or her spenddown amount. (Spenddown is the amount of the individual's income minus the income limit for his/her particular program.) The enrollee is responsible for paying these medical expenses.

The enrollee receives MN health care coverage for the selected base period once the spenddown is met.



Example: Martha is 67 years of age and applies for Apple Health for MN coverage in April. Her monthly Social Security benefit is \$1,166. She is over the SSI monthly income limit of \$735 by \$411 (\$20 is disregarded from her Social Security benefits).

Martha is found eligible for the MN spenddown program for the aged. She selects a six-month spenddown base period. Her spenddown amount is \$2,466 ($\411×6 months) for April through September. This means that Martha is responsible for the first \$2,466 in medical costs she incurs.

On May 12, Martha has surgery. After Medicare pays the eligible 80 percent of the bill, there remains a balance of \$5,200 that Martha is responsible to pay. Based on her participation in the MN spenddown program, she is liable for \$2,466. Once her spenddown has been met, Apple Health will pay the remaining amount of the bill. Her certification period is May 12 to September 30.

If Martha's monthly income were below \$735, she would have qualified for the no-cost Apple Health for the Aged program for 12 months coverage.



Medicare Savings Program (MSP)

The Medicare Savings Program (MSP) can provide assistance with premium costs, copayments, deductibles, and co-insurance for individuals who are entitled to Medicare and meet program requirements.

Qualified Medicare Beneficiary (QMB) (S03)

- Pays Part A and Part B premiums.
- Pays deductibles.
- Pays copayments except for prescriptions.

Specified Low-Income Medicare Beneficiary (SLMB) (S05)

- Pays Part B premiums.

Qualified Individual (QI-1) (S06)

- Pays Part B premiums.

Qualified Disabled Working Individual (QDWI) (S04)

- Pays Part A premiums.

Income Limits—Effective April 1, 2017

Medicare Savings Program	Federal Poverty Level (FPL)	Monthly Income Limit – One Person	Monthly Income Limit – Two Persons
QMB	100%	\$1,005	\$1,354
SLMB	120%	\$1,206	\$1,624
QI-1	135%	\$1,357	\$1,827
QDWI	200%	\$2,010	\$2,707

Resource Limits—Effective April 1, 2017

Medicare Savings Program	Resource Limit – One Person	Resource Limit – Two Persons
QMB	\$7,280	\$10,930
SLMB	\$7,280	\$10,930
QI-1	\$7,280	\$10,930
QDWI	\$4,000	\$6,000





Long-Term Services and Supports (LTSS) and Hospice

Long-term Services and Supports (LTSS)

Long-term Services and Supports programs are tailored to fit individual needs and situations. Home and Community Based (HCB) services, authorized by Home and Community Services or Developmental Disabilities Administration (DDA) in the Department of Social and Health Services, enable people to continue living in their homes with help to meet their physical, medical, and social needs. When these needs cannot be met at home, care in a residential or nursing facility is available.

A person who is eligible for a categorically needy (CN), alternative benefit plan (ABP), or medically needy (MN) Apple Health program is eligible for hospice services because these services are included in the benefits offered under those programs. If a person is not eligible under any of the programs listed above, an alternative program is available, called the Hospice program (special rules apply). The Hospice program pays for hospice care in a client's own home, hospice care center, or a nursing facility.

Different income standards are used to determine eligibility for CN or MN coverage for LTSS. To be eligible for most LTSS programs, a person must meet the financial eligibility rules and functional eligibility criteria (based on a comprehensive assessment).

For information about home and community-based services through DDA, go to <https://www.dshs.wa.gov/dda>.

For information about financial eligibility on the Hospice program, MAGI Institutional or DDA HCB services, contact the LTC Specialty Unit at 1-855-873-0642.

For all other programs, contact a local Home and Community Services Office for more information at www.alsa.dshs.wa.gov/Resources/clickmap.htm.

LTSS services include the following programs:

- Community Options Program Entry System (COPEs) (L21, L22)
- Community First Choice (CFC) (L51, L52)
- New Freedom (L21, L22)
- Roads to Community Living (RCL) (L41, L42)
- Developmental Disabilities Administration (DDA) Waivers (L21, L22)
- Program of All-inclusive Care for the Elderly (PACE) (L31, L32)
- Hospice (L31, L32)
- MAGI Institutional (K01, K95, K99)
- Nursing Facility LTC (L01, L02, L95, L99)
- DDA Residential Habitation Centers and Intermediate Care Facilities (L01, L02, L95, L99)



Covered services—scope of service

Apple Health provides access to a wide range of medical services. Not all eligibility groups receive all services. Coverage is broadest under the Categorically Needy (CN) and Alternative Benefits Plan (ABP) programs.

The scope of services covered for any individual depends on the Apple Health program in which the individual is enrolled. The table on pages 12-13 lists specific health care services and shows which scope of service category covers which services. An individual's age is also a factor. Some services may require prior authorization from HCA, the individual's Apple Health Managed Care plan, or DSHS as applicable.

This table is provided for general information only and does not in any way guarantee that any service will actually be covered at the time of inquiry, because benefits, coverage, and interpretation of benefits and coverage may change at any time. Coverage limitations can be found in federal statutes and regulations, state statutes and regulations, state budget provisions, and Medicaid provider guides. Individuals with questions regarding coverage should call the 800 number on the back of their Services Card.

Benefit packages by program

Service	ABP 20-	ABP 21+	CN 20-	CN 21+	MN 20-	MN 21+	MCS	FP/TC
Ambulance (Ground/Air)	Y	Y	Y	Y	Y	Y	Y	R ¹
Ambulatory Surgery (Center Based)	Y	Y	Y	Y	Y	Y	Y	R ¹
Applied Behavior Analysis (ABA)	R ³	N	Y	N	Y	N	N	N
Blood/Blood Administration	Y	Y	Y	Y	Y	Y	Y	R ¹
Behavioral Health Services								
Mental health (MH) inpatient care	Y	Y	Y	Y	Y	Y	Y	N
MH outpatient community care	Y	Y	Y	Y	Y	Y	R	N
MH psychiatric visits	Y	Y	Y	Y	Y	Y	R	N
MH medication management	Y	Y	Y	Y	Y	Y	Y	N
Substance use disorder (SUD) detoxification	Y	Y	Y	Y	Y	Y	Y	N
SUD diagnostic assessment	Y	Y	Y	Y	Y	Y	Y	N
SUD residential treatment	Y	Y	Y	Y	Y	Y	Y	N
SUD outpatient treatment	Y	Y	Y	Y	Y	Y	Y	N
Chiropractic	R ³	R ³	Y	N	Y	N	N	N
Dental	Y	Y	Y	Y	Y	Y	R	N
Dentures	Y	Y	Y	Y	Y	Y	N	N
Detoxification	Y	Y	Y	Y	Y	Y	R	N
Diabetes Education	Y	Y	Y	Y	Y	Y	Y	N
Dialysis	Y	Y	Y	Y	Y	Y	Y	N
Early Periodic Screening Diagnosis & Treatment (EPSDT)	R ³	N	Y	N	Y	N	N	N
Family Planning Services	Y	Y	Y	Y	Y	Y	Y	Y
Habilitative Services	R	R	N	N	N	N	N	N
Hearing Aid	R ³	N	Y	N	Y	N	N	N
Hearing Evaluations	Y	Y	Y	Y	Y	Y	Y	N
HIV/AIDS Case Management	Y	Y	Y	Y	Y	Y	N	N
Home Health Services	Y	Y	Y	Y	Y	Y	Y	N
Home Infusion Therapy/Parental Nutrition	Y	Y	Y	Y	Y	Y	Y	N
Hospice	Y	Y	Y	Y	Y	Y	N	N
Pediatric Palliative Care Services	R ³	R ³	Y	N	Y	N	N	N
Hospital Services - Inpatient and Outpatient	Y	Y	Y	Y	Y	Y	Y	R ¹
Intermediate care facility/services for persons with intellectual disabilities	Y	Y	Y	Y	Y	Y	Y	N
Maternity Care & Delivery Services	Y	Y	Y	Y	Y	Y	N	N

Benefit packages by program

Service	ABP 20-	ABP 21+	CN 20-	CN 21+	MN 20-	MN 21+	MCS	FP/ TC
Medical Equipment								
Enteral Nutrition Services	R ³	R ³	Y	R	Y	R	R	N
Nondurable Medical Supplies and Equipment (MSE)	Y	Y	Y	Y	Y	Y	Y	N
Wheelchairs, Durable Medical Equipment and Supplies (DME), Complex Rehabilitation Technology	Y	Y	Y	Y	Y	Y	Y	N
Medical Nutrition Program (RD Consult)	R ³	R ³	R ²	R	R ²	N	R ²	N
Nursing Facility Services	Y	Y	Y	Y	Y	Y	Y	N
Organ Transplants	Y	Y	Y	Y	Y	Y	Y	N
Orthodontics	R ³	N	Y	N	Y	N	N	N
Out of State Services (Excludes Border Cities)	Y	Y	Y	Y	Y	Y	N ⁴	N
Oxygen Respiratory Services	Y	Y	Y	Y	Y	Y	Y	N
Personal Care Services	R	R	R	R	R	R	N	N
Physician Related Services	Y	Y	Y	Y	Y	Y	Y	R ¹
Prenatal Diagnosis Genetic Counseling	Y	Y	Y	Y	Y	Y	N	N
Prescription Drugs ⁶	Y	Y	Y	Y	Y	Y	Y	R ¹
Private Duty Nursing for Children	R ³	R ³	Y	N	Y	N	N	N
Prosthetic/Orthotic Devices	Y	Y	Y	Y	Y	Y	Y	N
School Based Health Care Services	R ³	N	Y	N	Y	N	N	N
Smoking Cessation	Y	Y	Y	Y	Y	Y	Y	N
Substance Abuse Services (Chemical Dependency)	Y	Y	Y	Y	Y	Y	Y ⁵	N
Therapy (Outpatient Rehab)- Occupational, Physical, Speech	R	R	Y	Y	Y	N	Y	N
Vaccinations	Y	R	Y	R	Y	R	R	R ¹
Vision hardware	Y	N	Y	N	Y	N	N	N

Abbreviations:

20- age 20 and younger

21+ age 21 and older

ABP Alternative Benefits Plan

CN Categorically Needy Program

FP/TC Family Planning Only/TAKE CHARGE

MCS Medical Care Services

MN Medically Needy Program

Legend:

Y = Yes, service is usually included.

N = No, service is not included.

R = Restricted with coverage limitations (see footnotes).

Footnotes:

1. Services limited by program (i.e., TAKE CHARGE, Family Planning sterilization services).

2. Coverage limited to children age 20 years old and younger if done through an EPSDT screening referral, or as required by the enteral nutrition program.

3. Coverage limited to recipients age 19 through 20 years of age.

4. Border cities are considered "in state" for MCS coverage.

5. Service is covered directly through DSHS' Division of Behavioral Health and Recovery (DBHR).

6. Medicare recipients receive outpatient prescriptions through their Medicare Part D plan.



Other services

Non-Emergency Medical Transportation (Brokered Transport)

HCA covers non-emergency medical transportation for eligible clients to or from covered services through contracted brokers. The brokers arrange and pay for trips for qualifying clients. Currently, eligible clients are those in Apple Health (Medicaid & CHIP) and other state-funded medical assistance programs that include a transportation benefit. Transportation may be authorized for individuals who have no other means to access medical care.

The most common types of transportation available include: public transit bus, gas vouchers, client and volunteer mileage reimbursement, taxi, wheelchair van or accessible vehicle, commercial bus and air, and ferry tickets. More information is

available online at: www.hca.wa.gov/medicaid/transportation/pages/index.aspx. Comments and questions may be directed to HCA Transportation Services at hcanemttrans@hca.wa.gov.

Interpreter Services – Sign Language

HCA covers the cost of sign language interpreters for eligible clients. This service must be requested by Medicaid providers, HCA staff or HCA-authorized DSHS staff, and must be provided by the HCA-approved contractor.

Interpreter Services – Spoken language

HCA covers interpreter service for eligible clients through the HCA approved contractor. Requests for this service must be submitted by Medicaid providers, HCA staff, or HCA-authorized DSHS staff.



Where to apply for health care coverage

Modified Adjusted Gross Income (MAGI) programs

- **Online:** www.wahealthplanfinder.org.
- **Phone:** 1-855-923-4633
- **Paper:** HCA Form 18-001P (Application for Health Care Coverage) available at www.hca.wa.gov/assets/free-or-low-cost/18-001P.pdf.

To submit a completed application by mail:
Washington Healthplanfinder
P.O. Box 946, Olympia, WA 98507

Or send it by fax to: 1-855-867-4467

If you want help applying, you can work with an in-person assister or call Healthplanfinder Customer Support at 1-855-923-4633.

Aged, Blind, Disabled Coverage

Disability-based Washington Apple Health, refugee coverage, coverage for seniors 65+, and programs that help pay for Medicare premiums and expenses:

- **Online:** www.washingtonconnection.org
- **Paper:** HCA Form 18-005 (Application for ABD/LTC) available at www.hca.wa.gov/assets/free-or-low-cost/18-005.pdf.

To submit a completed application by mail:
DSHS – Community Services Division
P.O. Box 11699, Tacoma, WA 98411-6699

Or send it by fax to: 1-888-338-7410

- **In-person:** Visit a local Community Service Office. For locations, go to www.dshs.wa.gov/esa/community-services-find-an-office.

Questions? Call 1-877-501-2233

Long-Term Care

Nursing home care, in-home personal care, assisted-living facilities, and adult family home programs:

- **Online:** www.washingtonconnection.org.
- **Paper:** HCA Form 18-005 (Application for ABD/LTC) available at www.hca.wa.gov/assets/free-or-low-cost/18-005.pdf.

To submit a completed application by mail:
DSHS – Home & Community Services
P.O. Box 45826, Olympia, WA 98504-5826
Or send it by fax to: 1-855-635-8305

- **In-person:** Visit a local HCS office. For locations, go to www.dshs.wa.gov/AL TSA/resources.

Questions? Call a local HCS office. For locations, go to www.dshs.wa.gov/AL TSA/resources.



Resources

Telephone	
Apple Health Medical Assistance Customer Service Center (MACSC) Open 7 a.m. – 5 p.m. (weekdays)	Clients 1-800-562-3022 (option 6) or https://fortress.wa.gov/hca/p1contactus/ Providers 1-800-562-3022 (option 5) or https://fortress.wa.gov/hca/p1contactus/ Orders for large print or Braille 1-800-562-3022 (option 1, option 6, option 2) TRS: 711
Apple Health Medical Eligibility Determination Services (MEDS) Open 8 a.m. – 5 p.m. (weekdays)	1-800-562-3022 or https://fortress.wa.gov/hca/magiccontactus/ContactUs.aspx TRS: 711
Online	
Apple Health (Medicaid)	www.hca.wa.gov/free-or-low-cost-health-care/apple-health-medicaid-coverage
Apple Health (Medicaid) Manual	www.hca.wa.gov/free-or-low-cost-health-care/program-administration/apple-health-eligibility-manual
Access to rules	
Washington Administrative Code (WAC) sections pertaining to “scope of care”	Healthcare general coverage: http://apps.leg.wa.gov/WAC/default.aspx?cite=182-501-0050 Healthcare coverage Scope of covered categories of service: http://apps.leg.wa.gov/WAC/default.aspx?cite=182-501-0060 Healthcare coverage Description of covered categories of service: http://apps.leg.wa.gov/WAC/default.aspx?cite=182-501-0065

HCA complies with all applicable federal and Washington state civil rights laws and is committed to providing equal access to our services.

If you need an accommodation, or require documents in another format or language, please call 1-800-562-3022 (TRS: 711).

[Russian] ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-562-3022 (TRS: 711).

[Spanish] ATENCIÓN: Si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-562-3022 (TRS: 711).



Definitions

Apple Health

See Washington Apple Health

Managed Care

The majority of individuals enrolled in Apple Health receive their health services through a designated health care plan that contracts with the Health Care Authority. This prepaid comprehensive system of medical and health care services is usually called managed care.

Classic Medicaid

The term used to describe the Medicaid health care programs administered by the Department of Social and Health Services (DSHS). These are Long-Term Care services and Aged, Blind or Disabled coverage. The Modified Adjusted Gross Income (MAGI) health care programs are not Classic Medicaid.

Federal Poverty Level (FPL)

A guideline for determining eligibility for a governmental program based on the Consumer Price Index guide from the year just completed. Many health care coverage programs determine eligibility based on a percentage of the FPL.

Fee-for-Service

This is a health care service delivery system where health care providers are paid for each service (such as an office visit, test, or procedure). Individuals who are not covered by Apple Health Managed Care are covered by Apple Health Fee-for-Service.

Health Care Authority (HCA)

HCA is a Washington State agency that administers a number of programs related to health and wellness, including most Washington Apple Health programs.

Medicaid

The federally matched medical aid programs under Title XIX of the Social Security Act (and Title XXI of the Social Security Act for the Children's Health Insurance Plan) that cover the Categorically Needy (CN) and Medically Needy (MN) programs.

Modified Adjusted Gross Income (MAGI)

The methodology used for calculating income and determining household composition to determine eligibility for Apple Health for Adults, Kids, Families and Caretaker Relatives, and Pregnant Women. This method follows federal income tax filing rules with a few exceptions and has no resource or asset limits.

ProviderOne

The online payment system for health care providers serving individuals enrolled in an Apple Health program.

Scope of Care

Scope of care describes which medical and health care services are covered by a particular Apple Health program. There are four categories of scope of care: Categorically Needy (CN), Alternative Benefits Plan (ABP), Medically Needy (MN), and Medical Care Services (MCS).

Spenddown

This process allows individuals with income above the limits for the applicable CN program to spend down excess income within a specified period of time to become eligible for coverage.

Washington Apple Health

The brand name for all Washington State medical assistance programs, including Medicaid. The brand name may be shortened to "Apple Health."



Washington State
Health Care Authority

HCA administers Washington Apple Health (Medicaid).

Calling the HCA/Medicaid phone system to check Medicaid and MSP enrollment

TIPS for 1-800-562-3022 (available 24/7):

- You need client’s **zip code** and one of the following:
 - Social Security Number **or**
 - Provider One Number (on the front of a client’s Provider One card)
- Have a pen ready to write what you hear
- For best results, mute your phone and use the keypad (not your voice) for all choices in [brackets]. The system may interpret background noises as responses. You may key ahead at any time.

SAY	OR	PRESS
“English”		[1]
“Spanish”		[2]
“Client Services”		[6]
“Check Eligibility”		[4]
Disclaimer will play about applications		
“Continue”		[2]
“DSHS Services Card”		[1]
“Social Security Card”		[2]
State the Number		[enter the number]
Say your zip code		[enter the zip code]
“Yourself”		[1]

“Other Family Member”	[2]
“Today” Say the date you want	[1] [ddmmyyyy]
Available Eligibility Information will play. Select the option you want. Press [9] to repeat.	
Medicaid	[10]
Managed Care (i.e. Healthy Options)	[11]
Medicare Part A	[12]
Medicare Part B	[13]
Medicare Part D	[15]
Other Insurance	[16]
Hospice	[17]
Long Term Care	[18]
Restrictions	[19]
Note: If you choose an Eligibility Option that isn't available to the client, the system will transfer you to the call center.	

MEDICARE SAVINGS PROGRAMS – REFERENCE GUIDE

General Information

Medicare Savings Programs pay for cost sharing expenses for Medicare beneficiaries and include the following programs:

- QMB (S03)
- SLMB (S05)
- QI-1 (S06)
- QDWI (S04)
- State buy-in (not in ACES)

Cost sharing expenses include:

- Medicare Part A and Part B premiums
- Coinsurance charges
- Deductibles
- Some copayments under Part B

Eff: 04/2017 The income limits are :

	1 person	2 person
QMB	1005	1354
SLMB	1206	1624
QI-1	1357	1827
QDWI	2010	2707

Eff: 04/2017 The resource limits are:

	1 person	2 person
QMB		
SLMB	\$7,390	\$11,090
QI-1		
QDWI	\$4000	\$6000
Buy-In	No limit	No limit

What are the different parts to Medicare?

Part A – Inpatient hospital insurance
 Part B – Outpatient physicians insurance
 Part C (optional) – Medicare services delivered via a managed care plan
 Part D – Prescription drug coverage

FAQ's

1. What do the Medicare Savings programs pay for?

PROGRAM	COVERAGE
QMB	Part A premiums, Part B premiums, coinsurance, deductibles and Part B copayments
SLMB	Part B premiums
QI-1	Part B premiums for non-medicaid clients
QDWI	Part A premiums
Buy-In	Part B premiums, coinsurance and deductibles (if not eligible for QMB,SLMB,QI-1 or QDWI)

2. What is the Buy-In program and who is eligible?

Buy-In is a state-funded program that pays for Part B premiums, coinsurance and deductibles for Medicaid clients who are not eligible for a federally-funded MSP (QMB, SLMB,QI-1, QDWI). A dual eligible client active on CN or MN coverage is automatically approved for the State to pay their Part B premiums until the Medicaid coverage ends. There is no coverage group for this in ACES as it happens behind the scenes. It takes approx. 60 days for the State to start paying the premiums and for SSA to reimburse clients for monies withheld from their SSA checks. When clients call about reductions in a recent SSA check or loss of Medicare B coverage, check to see if there has been a recent loss of CN/MN eligibility, especially S99 cases.

3. What about Medicare Part D premiums – who pays these?

The federal government (CMS) pays Part D premiums for low-income individuals.

Part D pays for prescription drug coverage for clients who are entitled to receive Medicare. DSHS does NOT cover the costs of prescription drugs for Medicare clients regardless of whether they have chosen to elect Part D coverage.

4. How does a client apply for help paying Part D premiums?

- The client may apply at the Social Security Administration for the LIS (low-income subsidy).
- All Medicaid-eligible clients are automatically enrolled into a Part D plan via a monthly interface with the federal government (CMS).

5. What about Part D copayments?

Clients who are eligible for the low-income subsidy pay a reduced amount for their drug copayments. Until 12/31/2010, these state-funded copayment charges were paid by the State of Washington for Medicaid-eligible clients. Effective 1/1/2011, these costs are now the responsibility of the client since the optional Part D copayment program was cut by the legislature due to budget reductions.

6. What is the 'donut hole' or coverage gap?

The 'donut hole' is a period during which a client bears the full cost of their prescription drugs. DSHS Medicaid clients and clients who receive coverage under an MSP, do NOT have a donut hole.

7. I've heard there is a penalty if a client does not accept Medicare when they are first eligible?

There is a penalty for non-DSHS individuals. However, DSHS clients who are eligible for Medicaid/MSP are not subject to the penalty or restricted to set enrollment periods. They can enroll in Medicare at any time.

**For Medicare Buy-In questions or issues relating to payment for Medicare premiums, please contact:
 Medicare Buy-In unit at 1-800-562-3022, Ext: 16129**