Washington State Department of Social & Health Services

BHSIA Behavioral Health and Service Integration Administration

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Frequently Asked Questions
Medicaid Expansion and Publicly-funded Chemical Dependency Treatment

Introduction

As a result of the Affordable Care Act, health care coverage, including Medicaid, will be available to more people. Beginning January 1, 2014, Medicaid eligibility limits will increase, so that adults earning up to 138% of the federal poverty level (FPL) will be eligible. Washington's Medicaid program is also getting a new name: **Washington Apple Health.**

The federal government will fund 100% of Apple Health expansion for the first three years of the program. This support will gradually decrease to 90% by 2020. Washington State must continue to cover 50% of Apple Health costs for those who currently qualify. The costs for those who are newly eligible for Apple Health will be covered 100% by federal funds, except for those who are Presumptive SSI. Federal funding will cover 75% of the costs for these individuals.

People who need free or reduced-cost health coverage will apply online to our state's new Health Benefits Exchange at Washington Healthplanfinder www.wahealthplanfinder.org. People with income between 139% and 400% of FPL can buy private insurance on a sliding scale through subsidies and tax credits. At this website, people will compare available health plans, find out if they are eligible for free coverage or tax credits, and enroll in a plan that best fits their needs.

General Information

- **What are the key changes for people seeking publicly funded chemical dependency services?**
- **What is the definition of the "newly eligible" group?**
- **Will people who were on Basic Health be considered Classic or Newly-Eligible?**
- **What is the new process for individuals to seek financial eligibility for treatment services or additional health care coverage?**
- **When HealthPlanFinder advises a person that they are eligible for Apple Health (Medicaid), do they know immediately? Or is there a lapse in eligibility for processing?**
- **Will youth under the age of 19 all be considered Classic Apple Health (Medicaid)? Or are there circumstances where a person under 18 could be considered a New Apple Health (Medicaid)?**
- **How will minors apply for state-funded behavioral health services?**
- **How will providers verify health insurance coverage for Apple Health clients?**
- **Can an agency serve only "newly eligible" clients who are 100% federally funded?**
- **How can providers help people enroll in health coverage?**
- **Can a client still receive services if they miss the enrollment period?**
- **Will coverage be retroactive?**
- **Can providers or clients call the Washington Recovery Helpline to verify eligibility?**
- **Is there a "waiting list" requirement imposed for Medicaid clients?**
- **Is Apple Health managed care available in each county?**
- **Who should I contact if have other Apple Health questions?**

Chemical Dependency Services

- **Will CD providers continue to serve Apple Health clients?**
- **Will the processes and/or criteria for outpatient assessments change?**
- **Will the processes and/or criteria for residential assessments change?**
- **Will clients who are Dually-Eligible (Medicare/Apple Health) be able to receive CD services since Medicare does not cover CD services? There is a currently a long wait for denial letters from Medicare in order to get Apple Health treatment services.**
- **Will CD providers need to contract with Healthy Options' Managed Care Organizations (MCO's)?**
- **Will there be a requirement in the DSHS county contracts to monitor all publicly-funded providers to ensure all Apple Health clients are being served? If so, will they be supported financially to do this?**
- **For new clients who are transitioning from ADATSA/DL to Apple Health, will providers need to stop admitting people to treatment until January 1?**
- **Will there be a requirement to report to DSHS Community Services Offices on ADATSA/TANF-clients?**
- **Can counties pay for premiums with other funds?**
- **Are Health Exchanges considered Private Pay for TARGET reporting?**
- **Will DBHR funds be used to provide treatment to individuals who are below the 220% FPL but can't afford deductible?**
- **Is it necessary for individuals who needing CD treatment services to apply for coverage through the HealthPlanFinder?**
- **Is substance abuse parity included in the discussion of mental health parity**
- **Can treatment be provided to individuals who are below the 220% FPL but can't afford deductible?**

Billing/Match

- **Currently providers must have a Core Provider Agreement contract with the county to bill Apple Health through Provider One. Will that continue?**
- **Will the current Apple Health billing practice continue for CD agencies?**
- **Will counties receive state-funding to cover match for Classic/Welcome Mat Apple Health-eligible clients?**
- **How will providers and counties identify clients who are Newly Eligible, Presumptive SSI, or Classic Apple Health to determine funding match amounts?**
- **How will Presumptive-SSI clients be tracked since they won't look any different than other newly eligible clients with a 100% match?**
- **Will CD Providers still be paid on a fee for service basis? If so will the rates remain the same?**
- **If a person is in chemical dependency treatment that has been paid by the county when they apply, will that trigger retroactive coverage?**
- **If there is a lapse, is there a way a treatment provider can determine the date of eligibility so they don't inadvertently provide services before the plan is open?**
- **Will counties/agencies be able to use their DSHS contract funding to cover people who are low income, but not financially eligible for Washington Apple Health?**
- **Is there a new process for billing when a client is low-income and on SSI spend-down requirement?**

General Information

What are the key changes for people seeking publicly funded chemical dependency services?

- Beginning January 1, 2014, Apple Health eligibility limits will be increased.
- There are three new client groups:
  - **Newly eligible** – Clients who were previously not financially eligible.
  - **Welcome Mat** – Client who are currently eligible but may not realize it.

- **Classic** - Clients currently receiving services under the traditional Medicaid/Apple Health system.

- The ADATSA program for state-funded chemical dependency treatment will end on December 31, 2013. **Clients currently receiving ADATSA will be automatically converted to Apple Health as "newly eligible."** They will be notified of this change in writing from their DSHS Community Services Office (CSO) during October and November of 2013. Providers are encouraged to notify current ADATSA clients of the pending change.
- Treatment for behavioral health conditions will now be covered in all qualified health plans as an essential health benefit. For publicly-funded (Apple Health) chemical dependency treatment services, the Washington State Department of Social and Health Services will continue to contract with counties, tribes and residential providers.
- This change will open publicly-funded coverage to many childless adults who were not eligible before. The DSHS Division of Research and Data Analysis estimates 380,000 more clients could be added to the monthly Apple Health caseload, with 40,000 engaging in chemical dependency treatment in a typical fiscal year.
- Those who are approved online for Washington Apple Health will see a message referring them to the Washington Connection website where they can apply for other public assistance.
- Most adults with incomes below 138% of FPL will now be eligible for Apple Health. This income level is about $15,864 for an individual and $32,508 for a family of four. For more details, see the Washington State health Care Authority's Apple Health (Medicaid) Expansion fact sheet.
- Clients can apply for Apple Health without the assistance of CSO staff. Kiosks and phones will be available at CSOs and other locations to apply for coverage.
  - The Classic Apple Health population (aged, blind and disabled) will apply online through www.washingtonconnection.org.
  - For services beginning **after** January 1, 2014 applications can be submitted online through Washington's Health Benefits Exchange: www.wahealthplanfinder.org. .

What is the definition of the "newly eligible" group?

This new group is made up of individuals who:

- Are age 19 through 64 who are not eligible for a current Medicaid program
- Have income up to and including 138% FPL
- Meet citizenship/immigration requirements
- Are not incarcerated
- Are not entitled to Medicare

Will people who were on Basic Health be considered Classic or Newly-Eligible?

Individuals enrolled in the current Basic Health program have been requested to go through WAHealthplanfinder to determine what coverage they are eligible for on 1/1/14. We anticipate that most will be eligible for Medicaid, and many have already been enrolled in Medicaid for coverage beginning January 1, 2014. Others have the option to purchase coverage in the Exchange, and many have already done that.

What is the new process for individuals to seek financial eligibility for treatment services or additional health care coverage?

There are a number of ways a person can receive treatment services. For instance, most people will find that treatment services are part of their Apple Health or other health insurance. Any Washington resident can apply through the WAHealthPlanfinder to find coverage to meet their needs.

When HealthPlanFinder advises a person that they are eligible for Apple Health, do they know immediately? Or is there a lapse in eligibility for processing?

The system is designed to provide a response within minutes of the completion of the application. Clients will need to contact the Health Benefits Exchange customer service center if they have any questions. 1-855-WAFINDER (923-4633).

Will youth under the age of 19 all be considered Classic Apple Health? Or are there circumstances where a person under 19 could be considered a New Apple Health?
Individuals under 19, if eligible, will receive coverage in the Apple Health for Kids program, some funded through Medicaid, some through CHIP, and some funded by the State. This is not a change from eligibility prior to 10/1/13.

How will minors apply for state-funded behavioral health services?
Youth under the age of 19, or their parents/guardians, must call the Customer Support Network to apply: 1-855-WAFINDER (923-4633).

How will providers verify health insurance coverage for Apple Health clients?
Providers will continue to use ProviderOne to verify coverage. Clients will also receive an insurance card verifying their coverage. Real time eligibility will be determined for clients using the www.wahealthplanfinder.org.

Can an agency serve only "newly eligible" clients who are 100% federally funded?
No. All providers must be ready to support all Apple Health clients. See Core Provider Agreement for complete list of requirements.

How can providers help people enroll in health coverage?
Anyone can help with the online application process. Help is available from Navigator/In-Person Assister agencies, or the Customer Support Network: 1-855-WAFINDER (923-4633). Providers are encouraged to help clients enroll in Washington Apple Health.

Can a client still receive services if they miss the enrollment period?
Yes. The enrollment period does not apply to Apple Health coverage. They can apply anytime.

Will coverage be retroactive*?*
Yes. There is a retro medical question on both the on-line and paper application. Coverage will back date to the first of the month they apply if an applicant marks that they have incurred medical bills in the 3 months prior to their application. For the "newly eligible" adult group, retro-active coverage will be available, but not prior to 1/1/14 because "newly eligible" adults are not eligible for Medicaid coverage prior to that date. For example, if an individual applies in February but have had medical expenses in January the coverage could back date to January 1 or, a person could apply in April and have medical bills in January and as long as they check the appropriate boxes identifying they have medical expenses when applying their coverage would backdate to January 1, 2014.

Can providers or clients call the Washington Recovery Helpline to verify eligibility?
No. Only the Health Benefits Exchange can determine eligibility for health coverage, either online or by phone. The Washington Recovery Helpline provides referrals to treatment and recovery services for problem gambling, mental health and substance use disorders, and emotional support for people in crisis.

Is there a "waiting list" requirement imposed for Medicaid clients?
No. However, you MUST schedule an appointment for an assessment. It is not required to provide "wait list" services to Medicaid clients waiting for an assessment.

Is Apple Health managed care available in each county?
Yes. Enrollment is mandatory in all counties except in Clallam, Skamania and Klickitat counties. Mandatory enrollment means that eligible beneficiaries must enroll in managed care unless they meet exemption criteria because there are two or more plans in a county with a network that meets contract requirements.

Enrollment in Skamania and Klickitat counties is voluntary because the managed care plans in those counties do not have provider networks that meet contract requirements. Enrollment is voluntary in Clallam County because only one Apple Health plan is available.

All Apple Health managed care plans provide the same benefits, including a mental health benefit (in addition to the mental health benefit provided by Regional Support Networks). Not all counties have included the plans that support Suboxone. The list of plans by county, and the map of plans by county are available at: Apple Health (Managed Care) Service Area Maps effective 1/1/14 and Apple Health (Managed Care) Service Area Matrix effective 1/1/14

Who should I contact if have other Apple Health questions?
Providers should follow their standard process for questions. Contact Health Care Authority at 1-800-562-3022 or through their website: www.hca.wa.gov.

Chemical Dependency

Will CD providers continue to serve Apple Health clients?
Yes. All providers must be ready to support all Apple Health clients. The County should encourage CD service providers to help eligible individuals enroll.

Will the processes and/or criteria for outpatient assessments change?
No. Clinical assessments and the criteria for eligibility will not change

Will the processes and/or criteria for residential assessments change?
Yes. CSO financial eligibility and ADATSA assessments will no longer be necessary. People will be referred to residential treatment under the same process that is currently in place for Apple Health clients.

Will clients who are Dually-Eligible (Medicare/Apple Health) be able to receive CD services since Medicare does not cover CD services? There is a currently a long wait for denial letters from Medicare in order to get Apple Health treatment services.
It is not necessary to wait for a denial letter for CD services. Dually-eligible clients will automatically be considered an Apple Health-eligible client for CD Services.

Will CD providers need to contract with Healthy Options' Managed Care Organizations (MCO's)?
No. Not at this time. Money for publicly-funded CD services will continue to be reimbursed through ProviderOne, or direct contracting with the residential programs.

Will there be a requirement in the DSHS county contracts to monitor all publicly-funded providers to ensure all Apple Health clients are being served? If so, will they be supported financially to do this?
Yes, counties will continue to be required to monitor providers. Counties may use their DSHS administrative funding to monitor services.

For new clients who are transitioning from ADATSA/DL to Apple Health, will providers need to stop admitting people to treatment until January 1?
No. People who are currently receiving services through ADATSA will be automatically converted to Apple Health before January 1, 2014. People who apply for ADATSA prior to January 1, 2014 must use one of the following methods:

1) Apply online: www.washingtonconnection.org.
2) Mail/drop-off the DSHS Application for Benefits (14-001) and mark the box for "cash" to get an interview with a financial specialist to see which programs they are eligible for.

Will TANF clients be converted to “newly eligible”?
No. TANF-eligible adult clients will remain “Classic” Apple Health; however, they will be converted to a NO1 code in ProviderOne. Youth TANF-eligible clients will use codes N10 – N13.

Will there be a requirement to report to DSHS Community Services Offices on ADATSA/TANF-clients?
It depends. Reports are no longer required on ADATSA (Newly Eligible) clients. TANF reporting requirements will remain. Both services will continue to be reported to TARGET and ProviderOne.

Can counties pay for premiums with other funds?
No. Counties may not pay for individual premiums with either state or block grant funding. Funding is to support treatment and/or prevention services only.

Are Health Exchanges considered Private Pay for TARGET reporting?
Yes, but ONLY for TARGET reporting. Health Benefits Exchange and Private Pay are different. Health Benefits refers to a commercial insurance while private pay implies that the individual pays.

Will DBHR funds be used to provide treatment to individuals who are below the 220% FPL but can’t afford deductible?
No, low-income funding cannot be used to support individuals who chose not to apply for coverage

Is it necessary for individuals who needing CD treatment services to apply for coverage through the HealthPlanFinder?
No, however, it is at a risk of not receiving treatment. It is not a requirement that treatment services be provided to those who refuse to sign up for Medicaid or Exchanges if they are eligible to do so. Even if a client is mandated to get services the provider is not obligated provide treatment.

Is substance abuse parity included in the discussion of mental health parity?
Yes, substance use parity will be a part of our mental health parity rulemaking (since they are both required under the federal MHPEA regulations and our goal is to align our state law with the new federal guidance).

Can treatment be provided to individuals who are below the 220% FPL but can’t afford deductible?
Anybody can get care they just need to be able to pay either through private insurance, health exchange, or Medicaid.

Billing/Match

Currently providers must have a Core Provider Agreement contract with the county to bill Apple Health through Provider One. Will that continue?
Yes. Non-Tribal Providers must be contracted through a county to receive Apple Health reimbursement for outpatient services. Tribal programs must have a Core Provider Agreement directly with Health Care Authority and do not need to contract through the county.

Will the current Apple Health billing practice continue for CD agencies?
Yes. Providers will continue to use current billing practices for treatment services, including Methadone clinics. Outpatient and non-IMD Residential facilities will bill using the ProviderOne system. Beginning January 1, 2014 new billing codes will be used. (See Washington Apple Health ProviderOne Codes by Coverage Type document) Residential IMD facilities will use the current RSVP process.

Will counties receive state-funding to cover match for Classic/Welcome Mat Apple Health-eligible clients?
Yes. Counties will receive state-funding to support:

- 50% match for services provided to Classic-Apple Health and Welcome Mat eligible clients, and
- 25% for services provided to Presumptive SSI clients.

How will providers and counties identify clients who are Newly Eligible, Presumptive SSI, or Classic Apple Health to determine funding match amounts?
Counties will be required to set aside the amount necessary to meet demand for services for clients who are Classic Apple Health and/or Welcome Mat.

The Health Care Authority will use a new coding system in Provider One to identify these Apple Health clients. (See Washington Apple Health ProviderOne Codes by Coverage Type document):

1. Newly Eligible clients, who will be funded 100% by federal Apple Health.
2. Classic Apple Health and Welcome Mat clients, who will be funded 50% by DSHS.
3. DBHR will notify counties on a quarterly basis as to who the presumptive SSI population is. They will no longer be identified in ProviderOne.

How will Presumptive-SSI clients be tracked since they won't look any different than other newly eligible clients with a 100% match?
We are still in discussion with Health Care Authority (HCA) on how this will happen. In the meantime, providers will need to keep track of Presumptive-SSI Clients.

Will CD providers still be paid on a fee for service basis? If so will the rates remain the same?
Yes. The reimbursement method and rates will remain the same at this time.

If a person is in chemical dependency treatment that has been paid by the county when they apply, will that trigger retroactive coverage?
The client must ask for a retro determination when they apply through HealthPlanFinder. "Newly eligible" adults are not eligible for coverage prior to 1/1/14. Prior to 1/1/14 they must have applied for and received coverage through the existing ADATSA program.

If there is a lapse, is there a way a treatment provider can determine the date of eligibility so they don't inadvertently provide services before the plan is open?
Yes. Full eligibility details can be determined through Provider 1.

Will counties/agencies be able to use their DSHS contract funding to cover people who are low income, but not financially eligible for Washington Apple Health?
On a limited basis. Individuals who are not eligible for Apple Health must go to HealthPlanFinder to see if they qualify for other insurance coverage, DSHS funding, within available funding, will only cover people with incomes that fall within 138%-220% of FPL and who do not qualify for other insurance. It is anticipated that Apple Health expansion will reduce the numbers of individuals requiring low income funding.

Is there a new process for billing when a client is low-income and on SSI with a spend-down requirement?
There is no change in how spend down is processed. The provider should always bill Medicare first. Once Medicare has paid the provider can bill HCA for the Medicaid wrap around. If a client is on spend down, HCA can allow the amount not paid by Medicare towards the individuals spend down. The individual needs to provide medical expenses to the DSHS financial worker so that they can be applied toward the spend-down amount. It is helpful if the treatment provider can provide a statement of what part of the bill will remain owing after Medicare has paid. Typically, providers know how much Medicare will pay on the bill. We can use this statement to apply the remaining amount against the spend-down obligation. Once the spend-down obligation has been met by the client, the provider can bill HCA for services