Chapter 22a: Apple Health Managed Care (MCO) and Apple Health Medicare Connect (DSNP)

Ask the Expert

If you have questions or need clarification about the content in this chapter, please contact:

Kelli Emans — Senior Strategic Integration Advisor
(360)725-3213 Kelli.emans@dshs.wa.gov

Brendy Visintainer — Duals Integration Unit Manager
(360)725-2640 Brendy.Visintainer@dshs.wa.gov

Ethan Leon — Managed Care Data and Policy Analyst
(360)725-3566 Ethan.Leon@dshs.wa.gov

Vanessa Sherrill — Advancing Medicare-Medicaid Integration (AMMI) Program Manager
(360)725-3477 Vanessa.Sherrill@dshs.wa.gov

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OVERVIEW OF MANAGED CARE

The purpose of the managed care service delivery model is to integrate services an individual may need in one delivery system with one payment called a capitated payment. The managed care plan must furnish all of an individual's services included in the managed care contract using this capitated payment. This puts the managed care plan at risk for high cost services as well as creates incentives to use prevention and pro-active techniques to keep a person well.

The Health Care Authority (HCA), the Department of Social and Health Services (DSHS), and the Centers for Medicare and Medicaid Services (CMS) have contracts with managed care entities. The contract between HCA, DSHS and/or CMS and the Managed Care entity details what services are covered in the contract and what the Managed Care Organization (MCO) is responsible for. Contract examples include:

- Apple Health (Medicaid)
- Program for all Inclusive Care for the Elderly (PACE) (DSHS & CMS)
- Medicare Advantage and Dual eligible – Special Needs Plan (DSNP) (CMS)

APPLE HEALTH (AH) MANAGED CARE AND APPLE HEALTH MEDICARE CONNECT (AHMC)

Apple Health (AH) Managed Care

See WAC 182-538 Washington State Health Care Authority Managed Care for full details.

HCA is the single state Medicaid agency and is responsible for managing Medicaid medical benefits for eligible recipients. HCA also manages the medical benefits of state employees known as the Public Employees Benefits Board (PEBB) program.

HCA has transitioned to mostly contracting with plans to administer the Medicaid benefits, some of the most relevant programs for our clients are:

1. **Fully Integrated Managed Care (FIMC)**
   HCA contracts with MCOs who are responsible for the full scope of Medicaid physical, mental and substance use disorder services. For more information, please see the HCA publication: "Welcome to Washington Apple Health: Managed Care" benefits book.

2. **Behavioral Health Services Only (BHSO)**
   HCA contracts with MCOs who are responsible for mental and substance use disorder services. Clients who are eligible for BHSO benefits are not eligible for FIMC due to having another Third Party Liability (TPL) for their physical health benefits. This is most commonly Medicare and are referred to as Dual Eligible clients. For more information, please see the HCA publication: "Welcome to Washington Apple Health: Behavioral Health Services Only" benefits book.

3. **Fee for Service (FFS) (See Special Populations for more information)**
   Provider is paid directly by HCA for services provided. All dual eligible (those on both Medicare & Medicaid) are FFS for their medical but enrolled in managed care for behavioral health services only. For more information, please see the HCA publication: "Welcome to Washington Apple Health: Coverage without a managed care plan" benefits book**.**

4. **Apple Health Managed Foster Care (AHFC) (See Special Populations for more information)**
   HCA contracts with Coordinated Care (an MCO) to provide medical services and coordination to foster children, foster care alumni and individuals who receive adoption support services.

5. **Primary Care Case Management (PCCM) (See Special Populations for more information)**
   Mostly tribal clinics. Providers are paid FFS, clinic is given a monthly per member per month payment to fund care coordination activities.

Apple Health Medicare Connect (AHMC), seen as a D-SNP segment in CARE and ProviderOne, is not an Apple Health (Medicaid) service. For more information see the section "What is a D-SNP".

Identifying clients who are enrolled in managed care via ACES Online, Provider One, and CARE:

Staff may need to explore further with a client to determine the client's actual coverage. Here are the ways staff can find a client's managed care plan and eligibility:

ACES Online:

First pull up a client by entering name or ACES ID. Hover over the Details drop down and select Medical Information.

ProviderOne:

First hover over the Client dropdown and select Benefit Inquiry. Search the client by their ProviderOne ID number. Click the Ok button. You will now be on the screen that shows Managed Care information.

CARE:

First open the client's file in CARE. Expand the Client Details section. Click on the ProviderOne option. Click the View ProviderOne Details. This will open a web browser and click on the Managed Care hyperlink. This will display their managed care plan.

If the client is enrolled in managed care, the health plan name, program and start and end dates will be visible. You can view managed care information, Primary Care Case Management, Health Home, and PACE enrollments on this screen. Clients who are Fee-For-Service (FFS) will not show any managed care enrollment plan but will be active on a Medicaid program in ACES.

Please see the Resources section for screenshots.

Integrated Managed Care

Additional web resources for benefits and eligibility can be found in the Resources section at the end of this manual.

Benefits:

Please see the HCA Benefit Matrix for more detail. Coverage includes:

- Outpatient care such as: Wellness exams, immunizations, maternity care
- Pharmacy, including over the counter (OTC) and prescription medications
- Laboratory services
- Inpatient Hospital/Emergency Room
- Nursing facility for rehab/skilled nursing services
- Outpatient Mental Health

Eligibility:

Eligibility for Apple Health Medical coverage is handled through:

- The Health Benefit Exchange www.WAHealthPlanFinder.org
- The local DSHS community service office for SSI-eligible aged, blind, and disabled clients.
- www.washingtonconnection.org

Mandatory AH Integrated Managed Care enrollees include:

- Parents, children & pregnant women
- SSI Categorically Needy Blind and Disabled
- CFC, CFC+COPES & institutional clients
- Medicaid Expansion adults without children (MAGI)
- Foster Care (if they do not elect Fee-For-Service [FFS] coverage)
- Clients with Third Party Liability

Enrollment

Medicaid clients will be enrolled into an MCO in the month they are determined eligible for Medicaid. This means they will be enrolled back to the first of the month in which they are determined eligible. This reduces gaps in managed care coverage and increases care coordination for individuals who are newly eligible or have lost eligibility and are reestablishing their Medicaid eligibility.

Fully Integrated Managed Care (AH-FIMC)

FIMC for **Medicaid Only** includes the full scope of Medicaid physical plus mental health and substance use disorder services. Clients with physical health and pharmacy coverage will be enrolled in FIMC Apple Health.

- Apple Health Family (Healthy Options)
- Apple Health Blind Disabled
- Apple Health Adult Coverage
- State Children's Health Insurance Program

Dual eligible clients will not be enrolled in FIMC.

Benefits:

- Medicaid clients have a choice of at least two managed care organizations in an IMC region.
- Medicaid State Plan services will remain the same and clients will continue to a have access to block grant or state-funded behavioral health services that complement the Medicaid benefits.
- Clients will now have one point of contact for medical and behavioral health services instead of navigating up to three systems.

Services covered include:

- Outpatient care such as: Wellness exams, immunizations, maternity care
- Pharmacy, including OTC and prescription medications
- Laboratory services
- Inpatient Hospital/Emergency Room
- Nursing facility for rehab/skilled nursing services
- Mental Health services with the exception of crisis services
- Substance Use Disorder treatment

Behavioral Health Services Only (BHSO)

The **BHSO** program for **Dual Eligible clients** provides specialty mental health and substance use disorder services ONLY and is a separate product than FIMC that is offered by the same MCOs.

Clients who are typical FFS populations can access behavioral health services through the BHSO program (For example: Medicare coverage or someone exempt from managed care). They will get physical health services through the FFS system.

Apple Health – BHSO = FFS Medical and Managed Care for behavioral health services.

- Medicare/Medicaid duals
- PCCM
- Foster Care clients that elect to have FFS benefits

Exceptions

- Dually eligible and otherwise managed care exempt individuals will not be enrolled in FIMC but will be required to be enrolled in a managed care plan for BHSO
- An undocumented person (as defined by WAC 182-503-0535 (1)(e) will not be enrolled in either program and will remain in FFS medical except undocumented pregnant women, during their pregnancy will be enrolled in BHSO.

Special Populations

There are clients who can be enrolled in programs outside of the five managed care programs or may not be enrolled in a managed care plan at all, known as Fee-For-Service (FFS). These special populations are:

- American Indian/Alaskan Native (AI/AN)
  - Eligible for Primary Care Case Management (PCCM)
  - Eligible for FFS
- Foster Care
  - Eligible for Apple Health Foster Care
  - Eligible for FFS
- Non-Citizen Clients, specifically:
  - Qualified aliens who have not met the five-year bar
    - Only eligible for FFS
  - Non-Qualified aliens
    - Only eligible for FFS
  - Undocumented person
    - Only eligible for FFS

American Indian/Alaskan Native and Foster Care clients may elect to be part of the FFS program.

Per WAC 182-503-0535 Non-Citizen Clients as defined in the above section are not eligible for Managed Care Plans and are only eligible for FFS benefits if found eligible for a State Funded Medicaid Program.

Click to return to Apple Health Managed Care

My client should be enrolled in managed care but isn't?

There are several reasons a client should be enrolled in a managed care plan but they are not. For example, the exemptions section shows groups of clients that are eligible Fee-For-Service (FFS) program. However, there are clients that can be approved on a program in ACES, but not be eligible for FIMC or BHSO. These programs are:

- Unmet Spenddowns (Any program that ends in 95 or 99)
- QMB (S03)
- SLMB (S05)
- QI-1 (S06)

Also there can be situations when a client has been determined functionally and financially eligible for a LTSS program (L-Program in ACES) but due to being in an Acute or State Hospital setting they are still pending in ACES due to the client's residence needing to be in a Long-Term Care facility before the program can be made active in ACES.

Finally, per WAC 182-503-0535, there are clients that may have State-Funded FFS Medicaid eligibility due to their Citizenship or Immigration status. Those individuals are:

- Qualified aliens who have not met the five-year bar
- Non-Qualified aliens
- Undocumented person

Health Plan Service Areas & Network

For the most up to date service area map detailing what plans are available in each county and RSA please visit HCA's website.

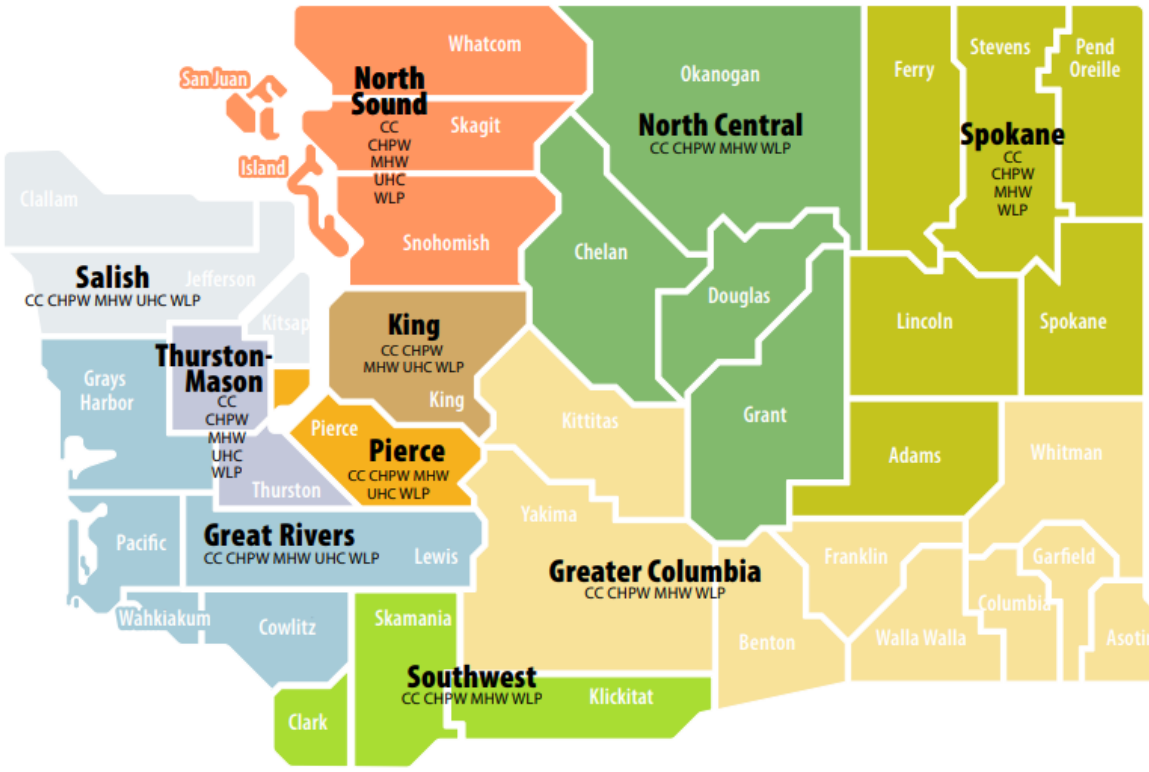
Regional Service Areas (RSA):

RSAs are the new geographical boundaries or service areas for Medicaid purchasing of physical and behavioral health care through managed care contracts.

- Authorized by legislation in 2014
- Regions on a map, not an organization that oversees services

Apple Health managed care

Service area map - January 2026



Integrated managed care regions

Greater Columbia	Pierce	Salish	North Central
King	Spokane	Great Rivers	
North Sound	Thurston-Mason	Southwest Washington	

Apple Health Foster Care (statewide)†

† Apple Health Foster Care is a statewide program. Integrated managed care is provided through Apple Health Core Connections (Coordinated Care of Washington - CC).

Health plans offered

CC	–	Coordinated Care
CHPW	–	Community Health Plan of Washington
MHW	–	Molina Healthcare of Washington
UHC	–	UnitedHealthcare Community Plan of Washington
WLP	–	Wellpoint Washington (previously Amerigroup)

HCA 19-0036 (11/25)

Health Plan Contact Information (for Clients/Providers)

Wellpoint	Customer Service Website Provider Line Provider Website	1-800-600-4441 www.wellpoint.com 1-800-454-9790 https://www.provider.wellpoint.com/washington-provider/home
COMMUNITY HEALTH PLAN of Washington	Customer Service Website Provider Line Provider Website	1-800-440-1561 www.chpw.org 1-800-440-1561 www.chpw.org/for-providers
coordinatedcare	Customer Service Website Provider Line Provider Website	1-877-644-4613 www.coordinatedcarehealth.com 1-877-644-4613 https://www.coordinatedcarehealth.com/providers.html
MOLINA HEALTHCARE	Customer Service Website Provider Line Provider Website	1-800-869-7165 www.molinahealthcare.com 1-800-869-7165 https://www.molinahealthcare.com/providers/wa/medicaid/pages/home.aspx
UnitedHealthcare Community Plan	Customer Service Website Provider Line Provider Website	1-877-542-8997 www.uhccommunityplan.com 1-877-542-9231 www.uhcprovider.com/en/health-plans-by-state/washington-health-plans/wa-comm-plan-home.html

Changing Plans

Apple Health enrollees may change plans every month (effective the 1st of the following month):

- Via telephone at 1-800-562-3022 ext. 16131. Clients may either wait for a customer services representative or use automated telephone Individual Voice Recognition (IVR)
- Online at www.waproviderone.org/client
- Via paper enrollment form mailed to HCA

- The Health Benefit Exchange www.WAHealthPlanFinder.org (MAGI and Family medical-not SSI [S-programs] or Long-Term Care [L-programs])

~~Community Behavioral Health Support (CBHS) Services formerly Behavioral Health Personal Care (BHPC) Residential~~ Moved to Chapter 22d

MCO Funded Behavioral Health Wraparound Support previously Behavioral Health Personal Care (BHPC) In-Home

Beginning July 1st, 2024, a Managed Care Organization (MCO) will only fund the following Behavioral Health Wraparound Support (BHWS) formerly, Behavioral Health Personal Care (BHPC) for additional personal care hours reflected in an increase beyond the CARE generated hours.

To be eligible for BHWS funding, a client must meet the criteria outlined in all three boxes.

> If a client does not meet the three criteria boxes, do **NOT** submit a BHWS request.

Criteria for BHWS funding

The client must meet criteria below for a request of BHWS funding to be made:

Box #1 – Psychiatric Disability Criteria:

1. The client has a primary diagnosis of a serious mental illness (schizophrenia, bi-polar disorder, major depressive disorder); and that psychiatric diagnosis is the primary reason for client's need for assistance with personal care.

   Please note: If the client has the following diagnoses: intellectual disabilities, Alzheimer's/dementia, traumatic brain injury, substance use disorder, and these are the primary reason the client requires assistance with personal care, do not submit this form.

   However, if the client has these **diagnoses but the mental health diagnosis/behaviors are the primary reason the client needs personal care**, still submit the request.

OR

2. The client has behaviors or symptoms of a mental illness that cause impairment and functional limitations in self-care/self-management activities; and it is these behaviors or symptoms of mental illness that are the primary reason for client's need for assistance with personal care.

AND

Box #2 – Involvement with Mental Health Services Criteria:

In addition to the above criteria being met, the client should also engage with mental health services in **one** of the three ways below:

1. The client is currently receiving mental health services;
   OR
2. The client is transitioning from an inpatient setting and will be receiving mental health services in the community;

AND

Box #3 – Needs wraparound support beyond the CARE generated hours:

The client meets the criteria in both Box #1 and Box #2, **AND** needs wraparound support (additional personal care hours) beyond the CARE generated hours. Follow the instructions below for requesting MCO funding for wraparound support.

Are you unsure if your client meets the criteria above?

If so, request a care conference with your supervisor and the designated Care Coordination Contact listed on the Medicaid and Medicare Managed Care Coordination Contacts Lists. Review the client's care plan, including diagnoses, treatments, behaviors, etc., and why you think this client's need for BHWS funding is because of behaviors or symptoms of a mental illness.

Is this a new request for BHWS funding?

If so, and the client is currently receiving mental health services covered under their medical benefit (i.e. Apple Health), please contact the client's local mental health professional/case manager to coordinate the care plan and ensure the CARE assessment has accurate information (diagnoses, treatments, behaviors, etc.). If the client is receiving behavior support services through an ALTSA paid provider, and is not currently receiving mental health services through their medical benefit, then coordinate with the ALTSA paid behavior support provider to ensure accuracy of the assessment.

1. Fax client's signed/completed Consent form (DSHS 14-012) to the client's local mental health professional/agency or ALTSA paid behavior support provider.

2. Call the client's local mental health professional/agency (or ALTSA paid behavior support provider) and discuss the following information:
    a. An assessment has been completed and you are calling to discuss the case, review the care plan, and client's need for BHWS support.
    b. Inform them of client's planned living setting
    c. Review client's mental health diagnoses and treatment plan for accuracy.
    d. Review what services are being provided by the local mental health professional/agency (or ALTSA paid behavior support provider) as well as what services are being provided through long-term care services. At this time, discuss if there are any service(s) missing in the client's care plan and what types of services or supports may be available to address these gaps. The goal of this conversation is to develop a coordinated care plan to meet the client's needs.
    e. Incorporate any information from the local mental health professional/agency (or ALTSA paid behavior support provider) into the CARE assessment.
3. Add the contact information for the local mental health professional/agency or ALTSA paid behavior support provider on the BHWS Request to the MCO (DSHS form 13-712).

Request BHWS funding from the MCO

Within 2-5 days of completing a CARE assessment (moving it to current) in which the criteria in the boxes above are reflected and described, a BHWS request for funding should be submitted to the MCO. A timely request for funding is vital to ensure care plan coordination is achieved. In addition, this process ensures the social services authorization and ETR (if needed) are done timely.

1. Complete the BHWS request form (DSHS form 13-712) to the MCO and include the CARE Assessment Details, CARE Service Summary.

    Detail the behaviors and caregiver interventions on this form, and what BHWS support is needed. This information helps the MCO quickly determine how the client's mental health is impacting their need for the BHWS request.

    Please note: if the additional support hours requested is unusually high, prior to submitting the request for funding, staff the case with your supervisor, your regional Managed Care Systems Consultant (MCSC), and consider a care conference with the designated Care Coordination Contact listed on the Medicaid and Medicare Managed Care Coordination Contacts Lists. This step allows the MCO to ask clarifying questions and ensures collaboration of the care plan.

2. Send DSHS form 13-712, CARE Assessment Details, and CARE Service Summary (also known as the packet) to the Funding Request Contact listed on the Medicaid and Medicare Managed Care Coordination Contacts Lists via secure email using the **template emails and subject line language provided**.



Behavioral Health Wraparound Suppo

3. The MCO will review the packet and determine if the established criteria listed above has been met.
   i. The MCO should confirm receipt of request within 2 business days of receiving, and must respond with a decision to approve, counter-offer, or deny the request within 5 business days of receiving a complete packet. If decision will exceed 5 business days, the MCO representative will contact the Case Manager (CM). If you do not receive a response within 5 business days you should escalate the communication through the assigned escalation contact listed on the Medicaid and Medicare Managed Care Coordination Contacts Lists.

      The MCO may review additional information, as necessary, in deciding whether the above criteria are met, reviewing PRISM, conversation with the provider, conversation with the HCS/AAA worker, conversation with the Enrollee's Mental Health Provider and other involved providers.

   ii. If the request is denied, a clear rationale for why the request did not meet criteria and/or what services will be provided to the client by the MCO to meet the client's need should be written on the form by the MCO representative.

      When the MCO denies BHWS funding based on the provision of other services, a plan (e.g., Individual Service Plan) must be developed by the MCO and implemented to meet the service needs identified.

4. Once the MCO signs, completes and returns the DSHS form 13-712:
   i. Document the approval or denial from the MCO in a SER.
      1. Approvals,
         a. notify the provider of the BHWS approval and document this conversation in a SER, including the name of the person you spoke with. Explain that this approved BHWS rate is a wraparound rate above the CARE generated rate/hours. Language to be used when notifying the client's provider:

            <CLIENT'S MCO> has approved a Behavioral Health Wraparound Support of <MCO APPROVED HOURS> for the dates of <Approved Funding Dates on 13-712>. This is only a portion of the client's funding and is in addition to the CARE generated hours. The Managed Care Organization (MCO) is the sole decision maker for ongoing funding beyond the approved funding dates. Future requests to the MCO for ongoing funding beyond the approval dates must include documentation supporting the need for ongoing services.

         b. In CARE Web, include the following approval information on the Comments screen, under the General Comments.

<CLIENT'S MCO> has approved a BHWS for the dates of <Approved Funding Dates on 13-712>. The following supports will be provided: **COPY (Ctrl + C) and PASTE (Ctrl + V) the comments from the section that states what the caregiver does (or will do) as an intervention.**

2. Denials,
   a. notify the provider of the BHWS denial. Document this conversation in a SER, including the name of the person you spoke with. Language to be used when notifying the client's provider:

<CLIENT'S MCO> has denied the Behavioral Health Wraparound Support of <REQUESTED HOURS FROM MCO>. The Managed Care Organization (MCO) is the sole decision maker for determinations on these requests. Continue to staff any changes in the client's condition with the client's assigned case manager.

ii. Scan and email a copy of the completed DSHS form 13-712 (approved or denied) to: MCOBHOforms@dshs.wa.gov. Please scan/email only ONE client's form per email.

iii. Submit completed DSHS form 13-712 to the Document Management Systems (DMS) via HOTMAIL to be included in client's electronic case record (ECR).

i. **For In-home clients**,
   1. The wraparound support hours approved by the MCO will be incorporated into the personal care service code T1019.
   2. Select reason code "MCO_BHO Client/ MCO_BHO Funded" for that service line.
   3. The start and end date of the service code should be the same dates approved on DSHS form 13-712.

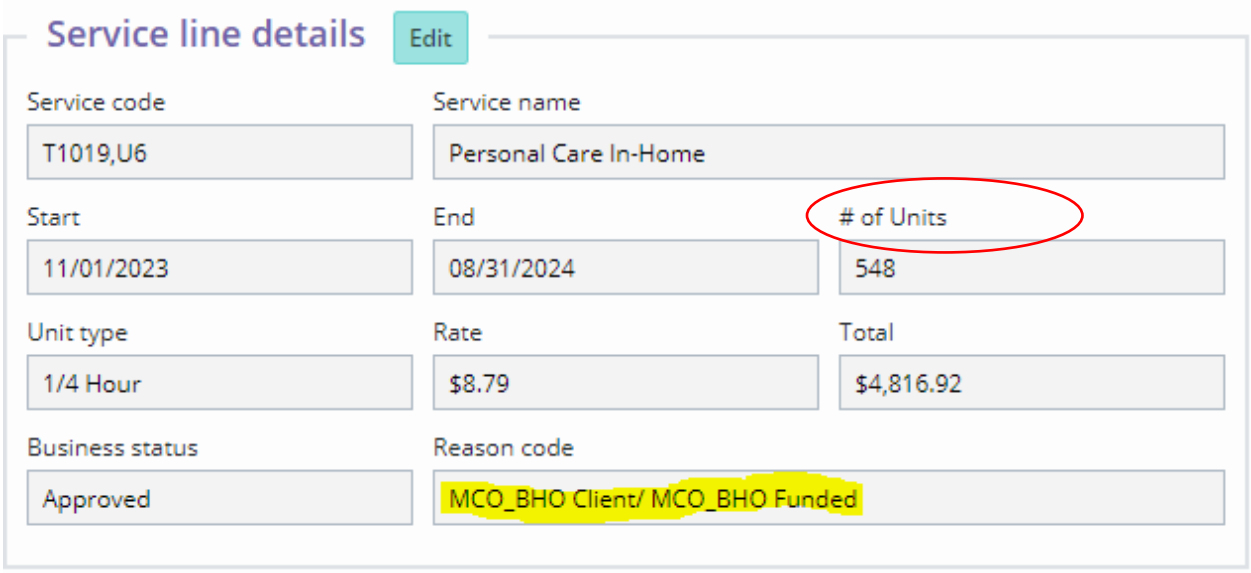
Example of in-home personal care with wraparound support:

DSHS form 13-712 – approved amount by MCO:

For In-Home Clients	
CARE generated hours per month:	**92**
Wraparound Support additional hours:	**45**
Total hours per month requested:	**137**
Monthly estimated cost of care:	**$ 4,816.92**

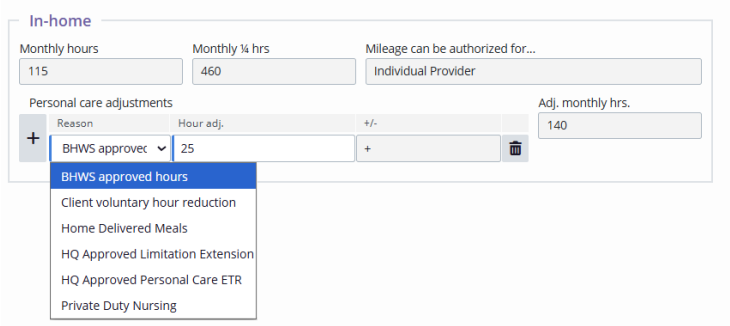
Authorization to in-home care provider (137 hours = 548 units):

#	Status	Service code	Service name	Start date	End date	# Units	Unit type	Rate
1.10	Approved	T1019,U6	Personal Care In-Home	11/01/2023	08/31/2024	548	1/4 Hour	$8.79



5. On the Behavior screen select the following options:
    i. To the question, "Was a referral sent to the MCO or HCA?" Select "No"
    ii. Select "other" for the reason no referral was made.
        i. Document the reason the CBHS referral was not made in the required comment box.
            1. Case manager will type "Client's Care Plan is for in-home."

6. On the Care Plan screen in the In-home section for the personal care adjustments enter the Reason "BHWS approved hours".



7. Set a reminder for at least a week before the end of the MCO funded approval period (or CARE plan period) so that another request for BHWS support can be made to the MCO if the client continues to meet the criteria listed above.

8. If the client's case is transferred to another office/agency, ensure the next CM/agency is aware of the MCO's approval of BHWS support and when another BHWS request will be due if necessary.

9. At next assessment, if client meets the criteria in the boxes above, request funding from the MCO for BHWS support services following the same process noted above.

Another BHWS request to the MCO for funding is necessary when:

- An annual assessment is completed
- A significant change assessment is completed
- An interim assessment is completed and there is a change in client's in-home care hours (e.g. informal support change, QA correction)
- Client changes from one MCO (for example Wellpoint) to another MCO (for example Molina)

Behavioral Health Administrative Services Organization (BH-ASO)

Some services, such as response services for individuals experiencing a mental health crisis, must be available to all individuals regardless of their insurance status or income level. For this reason, the HCA will have a contract with an organization known as a Behavioral Health Administrative Service Organization (BH-ASO) to provide these services in integrated regions.

BH-ASO

The BH-ASO is only responsible for a subset of crisis-related services for Medicaid clients in integrated region and is responsible for providing limited services to individuals who are not eligible for Medicaid, as well as managing certain administrative functions.

Services Provided – Regardless Insurance Status or Income

The following services may be provided by the BH-ASO to anyone in an integrated region who is experiencing a mental health or substance use disorder crisis:

- A 24/7/365 regional crisis hotline to triage, refer and dispatch calls for mental health and substance use disorder crises;
- Mental health crisis services, including the dispatch of mobile crisis outreach teams staffed by mental health professionals and certified peer counselors;

- Short-term substance use disorder crisis services for people intoxicated or incapacitated in public;
- Designated Mental Health Professionals (DMHPs) who can apply the Mental Health Involuntary Treatment Act, available 24/7 to conduct Involuntary Treatment Act assessments and file detention petitions;
- Chemical dependency specialist who can apply the substance use disorder involuntary commitment statute, including services to identify and evaluate alcohol and drug involved individuals who may need protective custody, detention, etc. The chemical dependency specialist will also manage case findings and legal proceedings for substance use disorder involuntary commitment cases.

Services Provided – Uninsured and Low-Income

The BH-ASO may provide certain mental health and substance use disorder services to people who are not enrolled in or otherwise eligible for Medicaid. For some services, like those funded through the federal Substance Abuse Prevention and Treatment (SAPT) block grant, individuals may need to meet other priority population requirements to be considered eligible.

The BH-ASO may provide the following services to individuals who are not eligible for Medicaid:

- Mental health evaluation and treatment services for individuals who are involuntarily detained or agree to a voluntary commitment;
- Residential substance use disorder treatment services for individuals involuntarily detained as described in state law;
- Outpatient mental health or substance use disorder treatment services, in accordance with a Less Restrictive Alternative court order;
- Within available resources, the BH-ASO may provide non-crisis behavioral health services, such as outpatient substance use disorder and/or mental health services or residential substance use disorder and/or mental health services, to low-income individuals who are not eligible for Medicaid and meet other eligibility criteria.

What is a D-SNP

A Dual-Eligible Special Needs Plan (D-SNP) is a special kind of Medicare Advantage plan for dual-eligible individuals. A D-SNP combines Medicare and Apple Health (Medicaid) services under one managed care plan. In Washington, D-SNPs have been branded as Apple Health Medicare Connect (AHMC) to better communicate that AHMC is only available who are enrolled in Apple Health (Medicaid) and Medicare.

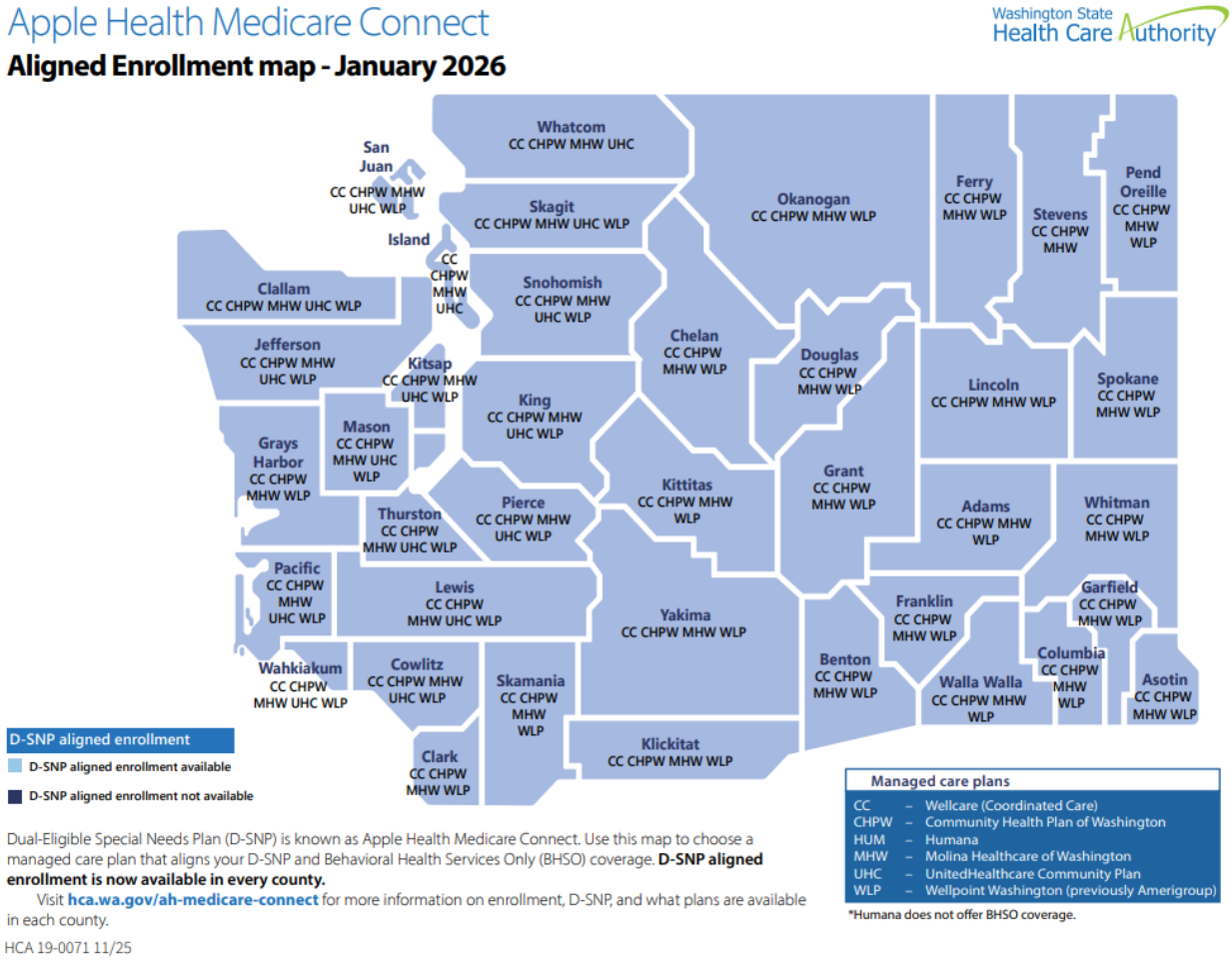
Who is a dual-eligible individual

A dual-eligible individual has both Medicare coverage and Apple Health coverage. This includes physical and behavioral health care coverage. If a client is a dual-eligible client, Medicare is the primary coverage

for their physical health care needs. They also have Apple Health as secondary coverage. Dual-eligible clients also have behavioral health coverage through an Apple Health managed care plan. This is a Behavioral Health Services Only (BHSO) plan. Behavioral health includes mental health and substance use disorder treatment.

AHMC Health Plan Service Areas & Network

For the most up to date service area map detailing what plans are available in each county please visit HCA's website or use the service area guide found in the attachments.



Care Coordination

Apple Health Managed Care & Nursing Facilities

Managed care, like Medicare, covers a rehabilitative/skilled nursing benefit if the authorization criteria is met. When a managed care enrollee is hospitalized and needs to be discharged to a nursing facility, the plan must be contacted for nursing facility authorization.

MCOs have transitional care requirements for moves from the hospital to the nursing facility and home. Once it has been determined that the rehab/skilled stay will end or an enrollee does not meet authorization criteria, that enrollee should be referred to Home and Community Services (HCS) for a nursing facility level of care (NFLOC) assessment. HCS should also review available options with the client.

Contacted Regarding Discharges:

- If contacted by a hospital/facility for the NFLOC assessment or for discharge options
  - Staff must ask if the hospital stay is covered by an MCO ***and*** if the client is enrolled in Medicaid managed care.
- If the client is enrolled in Medicaid managed care (Apple Health):
  - The facility must have a denial from the MCO before the stay can be covered by HCS.

Assisting with Coordination (Case Managers)

- If you receive billing questions, refer the provider to the health plan the client is enrolled in.
- Assist clients who have Apple Health medical coverage by knowing the health plan contact phone numbers.
- Find out which plan(s) contract with doctors and specialists in their area. This will help you assist the client in choosing the right Apple Health managed care plan. It will also help when the client has a provider/plan coordination issue.
- If you need assistance with acute hospital or skilled nursing facility transitional care activities, please use the plan contacts in the Medicaid and Medicare Managed Care Coordination Contacts list.
- Report issues to the plan, the HCS HQ Managed Care Data and Policy Analyst Ethan Leon at Ethan.Leon@dshs.wa.gov
- For additional information regarding Nursing Facility coordination, see the Nursing Facility Case Management Chapter, Chapter 10.

For additional information on Nursing Facility billing see the HCA Nursing Facility Provider billing Guide

Managed Care Organization (MCO) Assistance with Transition of Care

MCOs, who are responsible for physical health benefits, should offer the following support to clients, HCS and/or the hospital when clients are discharging from inpatient hospital settings:

- Coordinate medically necessary services, supplies, and resources. For example:
  - Transition planning:
    - Arranging for DME (Durable Medical Equipment) approval and delivery
    - Assigning a PCP (Primary Care Provider) for the client to see post discharge
    - Assisting in community transition setting searches
    - Negotiating contracts with SNFs and paying for Enrollees' SNF stays that meet rehabilitative or skilled criteria
    - Completing a written discharge plan, including scheduled follow-up appointments, provided to the Enrollee and all treating providers; Formal or informal caregivers shall be included in this process when requested by the Enrollee to ensure timely access to follow-up care post discharge and to identify and re-engage Enrollees who do not receive post discharge care
  - Post Discharge care:
    - Organized post-discharge skilled and rehabilitative services, such as home health care services, after-treatment services, and occupational and physical therapy service
    - Telephonic reinforcement of the discharge plan and problem-solving two (2) to three (3) business days following discharge
    - For Enrollees at high risk of re-hospitalization, the Contractor shall ensure the Enrollee has an in-person assessment by the Enrollee's PCP or Care Coordinator for post-discharge support within seven (7) calendar days of hospital discharge. The assessment must include follow-up of: discharge instructions, assessment of environmental safety issues, medication reconciliation, an assessment of support network adequacy and services, and linkage to appropriate referrals
    - Scheduled outpatient Behavioral Health and/or primary care visits within seven (7) calendar days of discharge and/or physical or mental health home health care services delivered within seven (7) calendar days of discharge
    - Follow-up to ensure the Enrollee saw his/her provider
    - Planning that actively includes the patient and family caregivers and support network in assessing needs.
- Assist with facilitating authorizations for covered medical services and behavioral health services.
- Ensure continuity of care for enrollees transitioning to the MCO during an active course of treatment for an acute or chronic health condition

MCOs should offer the following care coordination to enrollees who meet criteria:

- Individual needs support coordinating access to service with their primary/private insurance provider
- Individual encounters difficulty accessing prescribed treatment, services, or supplies
- Individual has complex healthcare needs and could otherwise benefit from assistance in coordinating care. For example:
  - An individual receives a new diagnosis and they or their guardian feel like they "don't know where to start"
  - An individual has had frequent or long-term hospitalizations
  - An individual has had frequent emergency department use

All HCS and AAA case managers should use the MCO Transitions of Care Contact List found at http://intra.altsa.dshs.wa.gov/hcs/ on the right side of the webpage, under Contractors for the most current Transitions of Care contacts. When corresponding please use the Transitions of Care (discharge) email attachment found at the end of this chapter to frame HCS and AAA emails to the MCO for Initial Contacts, Follow Up, and Day of Discharge coordination.

If you experience any issues with this process, please contact to HQ Managed Care Data and Policy Analyst.

Managed Care Assistance with Care Coordination

When an HCS/AAA client enrolled in managed care needs assistance to coordinate their health care services and access to appropriate treatment, the CM must assist the client and their guardian, if applicable, to request "care coordination" from the client's Apple Health MCO or Medicare Advantage (MA) Health Plan (including clients who have managed care only for behavioral health services).

We have a document in the Apple Health & Managed Care section titled MCO Care Coordination at a Glance which will help answer questions about the role of Managed Care Organizations in Care Coordination, why it can be helpful to coordinate with the MCOs and how to coordinate with the MCOs. We also have a Care Coordination contact list can be found on the HCS/AAA intranet website at http://intra.altsa.dshs.wa.gov/hcs/ on the right side of the webpage, under Contractors. For D-SNP Coordination please use the Medicaid and Medicare Managed Care Coordination Contacts Lists on the D-SNP CM-TOC tab. Finally we also have a decision tree that will help you determine what program a client is on titled Managed Care Coordination Decision Tree 5.14.25. (Please see the Attachment section at the end of this chapter.)

1. To request care coordination, the CM may send a secure email* to the client's MCO to request care coordination and assistance to address barriers the client is experiencing to access medically necessary care covered by Apple Health. Email addresses for the five Apple Health plans are:
   a. Molina Healthcare of Washington, Inc. (MHW)
   b. Community Health Plan of Washington (CHPW)
   c. Coordinated Care of Washington (CCW)
   d. Wellcare (for Dual Special Needs Population [D-SNP] operated by CCW)
   e. United Healthcare Community Plan (UHC)

f. Wellpoint (WLP) (for Dual Special Needs Population [D-SNP])
g. Humana/Arcadian Health Plan (for Dual Special Needs Population [D-SNP])

*Emails from the DSHS URL (@dshs.wa.gov) identifies the requestor as a DSHS employee and meets HIPAA requirements to request care coordination on behalf of an HCS/AAA client.

2. When making a care coordination request include the following in your email:
   a. In the Email "Subject" line, provide the reason for care coordination request. For example:
      i. Mental health treatment
      ii. Durable medical equipment
      iii. Needs Primary Care Provider
   b. In the body of the email, provide the following information:
      i. Client Name
      ii. Client ProviderOne ID: (9-digit number ending in WA)
      iii. Date of Birth
      iv. Residence Type
      v. CM Name and Contact Information
      vi. Summary of client barrier/issue/need

3. If you do not receive a response or assistance with your request timely, the CM should discuss the case with their supervisor to determine if escalation is needed. Sent a second email to the MCO with 'escalation' in the title of the email.

4. If the CM and supervisor do not receive a response, they may determine escalation to HCS HQ is needed when issues are not resolved.

   a. If the CM supervisor determines that escalation to HQ is appropriate, the CM supervisor will submit the original email communication and escalation with the MCO to Ethan.Leon@dshs.wa.gov

Once the request for escalation is received, HCS HQ will outreach with HCA to discuss the identified barrier to access. Based upon the type of request, the case manager and supervisor will be notified regarding next steps.

If you experience any issues with this process, please contact the HQ Managed Care Data and Policy Analyst Ethan.Leon@dshs.wa.gov.

RESOURCES

Related WACs & eCFRs

WAC 182-526-0155	HCA & Appellant's Representation
WAC 182-538	Washington State Health Care Authority Managed Care
WAC 182-538-130	Exemption

CFR 42-438 Managed Care

Acronyms

AAA	Area Agency on Aging
ACES	Automated Client Eligibility System
AH	Apple Health
AHFC	Apple Health Foster Care
AHMC	Apple Health Medicare Connect
AI/AN	American Indian/Alaskan Native
BH-ASO	Behavioral Health Administrative Services Organization
BHSO	Behavioral Health Services Only
CARE	Comprehensive Assessment Reporting & Evaluation
CCC/CCW	Coordinated Care of Washington
CFC	Community First Choice
CFR	Code of Federal Regulations
CHP/CHPW	Community Health Plan of Washington
CM	Case Manager
CMS	Centers for Medicare and Medicaid Services
COPES	Community Options Program Entry System
DME	Durable Medical Equipment
DMHP	Designated Mental Health Professionals
DSHS	Department of Social and Health Services
D-SNP/DSNP	Dual-Eligible Special Needs Plan
eCFR	Electronic Code of Federal Regulations
FFS	Fee For Service
FIMC	Fully Integrated Managed Care
HCA	Health Care Authority
HCS	Home and Community Services
HUM	Humana
IVR	Individual Voice Recognition
LTSS	Long Term Services and Supports
MAGI	Modified Adjusted Gross Income
MCO	Managed Care Organization
MHC/MHW	Molina Health Care of Washington
NFLOC	Nursing Facility Level of Care
OTC	Over the Counter

PACE	Program for all Inclusive Care for the Elderly
PCCM	Primary Care Case Management
PCP	Primary Care Provider
PEBB	Public Employees Benefits Board
QI-1	Qualified Individual Program
QMB	Qualified Medicare Beneficiary
RSA	Regional Service Area
SAPT	Substance Abuse Prevention and Treatment
SLMB	Specified Low-Income Medicare Beneficiary
SNF	Skilled Nursing Facility
SSI	Supplemental Security Income
TPL	Third Party Liability
UHC	United Health Care
WAC	Washington Administrative Code
WLC	Wellcare
WLP	Wellpoint

Glossary

Care Coordination	An approach to healthcare in which all of a patient's needs are coordinated with the assistance of a primary point of contact. The point of contact provides information to the patient and the patient's caregivers and works with the patient to make sure that the patient gets the most appropriate treatment, while ensuring that health care is not duplicated.
Disenrollment	The process by which an enrollee's participation in a managed care program is terminated. Reasons for disenrollment include death, loss of eligibility, or choice not to participate, if applicable.
Fee-For-Service	A service delivery system where health care providers are paid for each service separately (e.g. an office visit, test, or procedure).
Long-Term Services and Supports	A wide variety of services and supports that help people with functional impairments meet their daily needs for assistance in qualified settings and attain the highest level of independence possible. LTSS includes both Home and Community-Based Waiver Services and Medicaid Personal Care Services.
Managed Care	A prepaid, comprehensive system of medical and health care delivery. - *Medical*: Includes preventive, primary, specialty care and ancillary health services - *Integrated***:** Includes Medical services PLUS behavioral health and long term services and supports.
Third Party Liability	Refers to the legal obligation of third parties (e.g., entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a state plan. By law, all other available third party resources must meet their legal

	obligation to pay claims before the Medicaid program pays for the care of an individual eligible for Medicaid. States are required to take all reasonable measures to ascertain the legal liability of third parties to pay for care and services available under the state plan.

REVISION HISTORY

DATE	MADE BY	CHANGE(S)	MB #
8/2/19	Integration Unit	Updated into new template	
5/9/23	Office of Policy and Integration	Split Chapter 22 into three parts: Chapter 22a, 22b, and 22c	

Web Resources

Return to Identifying clients who are enrolled in managed care via ACES Online, Provider One, and CARE
Return to Integrated Managed Care
Return to AHMC Health Plan Service Areas & Network

Apple Health & Managed Care

MCO care coordination at a glance

Behavioral Health Wraparound Support (BHWS) – email templates

How to Identify Managed Care Plans

Managed Care Coordination Decision Tree

Medicaid and Medicare Managed Care Coordination Contacts

HCA Managed Care webpage

Regional Information Spreadsheet

Fee-For-Service (FFS)/Apple Health Coverage without managed care

ProviderOne Find a Provider List for FFS

Washington Healthplanfinder

"Welcome to Washington Apple Health: Managed Care" benefits book

"Welcome to Washington Apple Health: Behavioral Health Services Only" benefits book

"Welcome to Washington Apple Health: Coverage without a managed care plan" benefits book

Apple Health Enrollment Form

HCA Apple Health Medicare Connect (Dual-Eligible Special Needs Plan [D-SNP]) Website

D-SNP Service Area Guide

Chapter 22d CBHS Community Behavioral Health Support

HCA Community Behavioral Health Support website