

Changes to Basic Health & DSHS Medical Assistance Programs

Follow-up from June/July 2009 NoHLA Trainings

In June, Northwest Health Law Advocates coordinated a training on the recent legislative changes to Basic Health, Medicaid, and CHIP. In July, NoHLA presented updates on these changes in a community training. Some questions that arose at the trainings required follow up, and we have worked extensively with the Health Care Authority and Department of Social and Health Services (DSHS) to develop these responses below. We appreciate their assistance.

Thank you for participating in our trainings.

June 25, 2009 Training

Basic Health (BH) Questions

Contacting BH within 30 days of losing other coverage. A person previously on BH who loses other coverage must contact BH within 30 days of that loss in order to return to BH and avoid the waiting list. *This applies to people who left Basic Health due to other DSHS coverage or private (commercial) coverage, including coverage through the individual market, an employer or an association.*

- Meaning of “Contact”
 - Q: What does "contact" mean in the context of contacting BH within 30 days of losing DSHS eligibility? Is it enough that a person contacted BH (e.g. over the phone), or do they have to get in all of their documentation of DSHS ineligibility?
 - A: A person has “contacted” BH if they either call BH at 1-800-660-9840 or use the online chat feature at www.basichealth.hca.wa.gov.

- Pregnant Women returning from DSHS pregnancy medical
 - Q: When does the 30-day notification period begin for BH enrollees whose health coverage during pregnancy transfers to DSHS?
 - A: The 30-day notification period begins on the date the termination of DSHS medical takes effect. DSHS sends out an eligibility review letter approximately 45 days before the two months postpartum end date. The woman would need to notify BH within 30 days of the postpartum end date.
 - Q: Does a pregnant woman who was on Basic Health, but was transferred to DSHS coverage during pregnancy, need to notify BH when DSHS pregnancy coverage ends, in order to have a smooth transition back to BH?
 - A: If the enrollee is in DSHS coverage group P02 and her prenatal/postpartum coverage is ending, she should automatically receive an invoice from Basic Health and does not need to initiate contact with BH when her DSHS coverage ends. However, it is advisable for women who have not received an invoice (all of those in

Changes to Basic Health & DSHS Medical Assistance Programs

Follow-up from June/July 2009 NoHLA Trainings

DSHS coverage group P04, and possibly some on P02) to re-contact BH early in the month that their DSHS coverage is ending.

Dually Enrolled - DSHS Reenrollment Process

- Q: Does the BH deductible restart for those dual enrolled individuals who return to BH after becoming ineligible for DSHS programs?
- A: The BH deductible restarts if a client does not maintain continuous coverage. If a member has more than a one-month break in coverage, they have not maintained continuous coverage.
- Q: What if this disenrollment and reenrollment process happen within the same year?
- A: The BH deductible still restarts if they have had more than a one-month break in coverage.

BH Billing Cycles

- Q: How do the three different BH billing cycles work – for new members, continuing members, and returning members?
- A:
 - *New members:* When people enroll in BH they are sent an offer with a payment due date that may enable them to get coverage the next available month. If they pay but miss that due date, they will begin coverage the following month.
 - *Continuing members:* Premium payments are due by the 5th date of the month before the actual month of coverage; the amount and due date are shown on each month's bill. A client's bill is sent about six weeks before the month to be covered by that payment. For example, the bill for August coverage is sent mid-June and payment is due by July 5.
 - *Returning members:* Returning members are people who left BH for other coverage and have contacted BH within 30 days of the loss of that other coverage, wishing to re-enroll. BH works with the member to re-enroll them depending on their preference. The month of re-enrollment may be the current month or the following month, at the option of the member and consistent with premium payment deadlines. Premium payments for a specific month of coverage are due by the "re-enrollment" date. This date will be noted on the member's invoice and letter. This date varies each month but usually falls around the 24th of each month (due dates are determined by the number of days in each month, taking into consideration any holidays and the requirement to provide a minimum of 10 days notice to members who are losing coverage).

Changes to Basic Health & DSHS Medical Assistance Programs

Follow-up from June/July 2009 NoHLA Trainings

Non-invoiced Premiums

- Q: What is the address for sending non-invoiced premiums to BH?
- A: PO Box 34270, Seattle, WA 98124-1270
 - This is the lockbox address where payments are processed. If no invoice for the current month is available, members may use an older month invoice or they may write their account number on a sheet of paper.

Medically Needy Reenrollment

- Q: Will BH reenroll a DSHS Medically Needy client whose certification period is ending? For example: A former BH member contacts HCA on July 5 to say that her 6-month certification period ends on August 31. She wishes to reenroll in BH effective September 1.
- A: Yes. Depending on the length of time the person has been disenrolled, BH may require verification of eligibility.

July 17, 2009 Training

Basic Health Questions

Personal Care Workers

- Q: Will personal care workers bypass the waiting list? The language on the BH website indicates that they “may” bypass the list, but does not confirm that that HCA *must* allow them to bypass the list.
- A: The BH website indicates “may” because a personal care worker must meet special requirements to be enrolled in the Personal Care Worker (PCW) program; not all personal care workers meet these requirements.
 - The applicant or member must meet all BH eligibility requirements *and*:
 - be contracted with DSHS as a Homecare attendant or PCW
 - Receive at least \$862.58 per month reimbursement from DSHS for providing COPEs, CHORE, or Medicaid Personal Care Services.

Recertification

- Q: How do the changes to the BH recertification process affect people who miss their recertification deadline because of out-of-country travel?
- A: The reason for missing the recertification deadline does not matter; what matters is the timing. There is a new rule (Washington Administrative Code (WAC)) coming out soon will clarify further. In the meantime: there is a one-month grace period after the date the disenrollment letter is mailed. If the BH member submits all of the requested documents within that time and continues to pay their premiums, they will

Changes to Basic Health & DSHS Medical Assistance Programs

Follow-up from June/July 2009 NoHLA Trainings

be re-enrolled in BH without being put on the wait list. Please watch for the new WAC.

- Q: Some advocates report that Social Security Administration (SSA) offices have refused to issue letters/sign BH forms stating that individuals turning 65 are ineligible for Medicare because the individuals lack social security numbers. Other advocates report that they have not had this problem with SSA. What is the proper procedure?
- A: BH verified that its policy has not changed. Under Washington law, individuals who qualify for Medicare are not eligible for BH. BH sends members who are 65 years of age or older a form (available at: <http://www.basicealth.hca.wa.gov/documents/sponsor/25-683.pdf>) and they must respond to BH by July 1. In their response, BH members who have social security numbers must include proof from SSA that they are not eligible for Medicare. Members who do not have social security numbers are not required to submit the form to SSA. Instead, they should check the box on the BH form that states they do not have a social security number and **sign the form** (unsigned forms will be sent back to the members to complete).
BH routinely reviews accounts and if a social security number is discovered, the member will receive a letter requiring them to go to SSA and get proof that they are not eligible for Medicare. They must use the SSN that they have supplied on their BH account. These people may not use their BH member number in place of their SSN, and they may not mark the box stating that they do not have a SSN. If the member had used a false SSN, they should contact an attorney before contacting SSA. If you have a problem getting the form completed by SSA, NoHLA recommends that you contact the SSA Office Director.

Tax ID

- Q: BH Health Plans require that advocates provide their organization's tax ID number in order to discuss client issues with the health plan. What if my organization does not provide its tax ID number to its staff?
- A:
NOTE: We contacted all of the BH health plans. Only Group Health absolutely requires a tax ID number and will make no exceptions. The other plans will accept alternate information such as the client's date of birth, social security number, etc.

BH itself does not require an organization's tax ID number in order to discuss an applicant or member's issues. Instead, the applicant or member can fill out a permission form (available online at <http://www.basicealth.hca.wa.gov/documents/24-137.pdf>) that names the person, organization or clinic who they authorize to help with their BH application and account. This form can be sent to BH and it will become part of the applicant's

Changes to Basic Health & DSHS Medical Assistance Programs

Follow-up from June/July 2009 NoHLA Trainings

record at BH. When an advocate calls BH in the future, the customer service representative can verify the authorization. If a specific organization or clinic has been listed then any advocate who calls from that organization or clinic can discuss the applicant or member's issue with BH.

Medicaid & CHIP Questions

Alien Emergency Medical

- Q: How will the new restrictions to AEM scope of care affect those individuals in adult residential care?
- A: In April 2007, AEM guidelines changed so that the program no longer covered personal care and nursing facility services. Individuals who were in residential care at the time of the change were "grandfathered in" and remained covered. Those individuals will not be affected by the recent changes to AEM. Remember, however, that many lawful residents who are ineligible for Medicaid because of the five-year bar may be eligible for GA-U, which would allow them to access residential care services.

Enteral Nutrition

- Q: Will Basic Food cover those services that were cut out of the DSHS orally administered enteral nutrition benefit?
- A: Yes. Basic Food can be used to pay for enteral nutrition. See DSHS FAQs about enteral nutrition cuts at: <http://maa.dshs.wa.gov/News/DMEChangesFAQ.htm>. Additionally, clients and their providers may request that DSHS pay for a noncovered healthcare service (such as orally administered enteral nutrition) under the "exception to rule" process under WAC 388-501-0160.

Apple Health – Mental Health Benefits

- Q: Do undocumented children receive full mental health benefits under Apple Health?
- A: Mental health services are covered for undocumented children as a fee-for-service benefit when provided by designated mental health providers who have a current Medicaid provider agreement in place. Twenty mental health visits are available annually, with additional visits when authorized by DSHS as medically necessary. Undocumented children may not always be able to access services through the Regional Support Networks due to funding restrictions.

If you have any further questions, please contact Lori Buchsbaum at lori@nohla.org.