Apple Health Managed Care and Your Rights
* Formerly called "Healthy Options"

What is Apple Health "Managed Care," "Medicaid Managed Care," and "Healthy Options?"

Washington State's Medicaid program, along with other state health programs, is now called "Apple Health." The state agency that runs these programs is called the Health Care Authority, or "HCA."

HCA contracts with health insurance companies to provide medical services for most Apple Health clients. These managed care plans were called "Healthy Options" plans until 2014. Now they are called "Apple Health Managed Care" plans.

Some clients are not in managed care plans. For these clients, the agency pays providers directly for medical services. This is called "Apple Health Fee for Service (FFS)."

The health plans available to you depend on the county where you live. The plans available in Washington are Amerigroup, Community Health Plan of Washington (this plan includes "CUP" providers in Clark County), Coordinated Care Corporation, United Healthcare Community Plan, and Molina Healthcare of Washington, Inc. (this plan may include Group Health providers – check with the plan and providers to find out who is available to you).

Health plans work in the following way:

- Generally you must use clinics, providers' offices, and pharmacies that have contracts with your plan. (There are some exceptions.)
- You must choose a **primary care provider (PCP)** who gives you care for routine health needs. The PCP can be a doctor or nurse practitioner. If you need care from a specialist (such as a neurologist, cardiologist, or orthopedist), generally you must get a referral from the PCP. There are some exceptions. See pages 5-6 of this publication.
- Your doctor or pharmacist must sometimes get approval from the health plan for the care or medications they think you need.
- You can get help from the plan to find providers. The plan is legally responsible to give you access to the care covered in the plan's contract with the Medicaid agency.

Most, but not all, Apple Health-covered services are available through your health plan. Other covered services not part of the health plan contract are paid by Apple Health directly to the provider. This is called a "Fee for Service" service arrangement. An example of this is dental care.

Who Must Enroll in Apple Health Managed Care?

With some exceptions (see below), you must enroll in a managed care plan if you receive Apple Health in Washington State.

Exceptions:

You are **not** required to be in Apple Health Managed Care and are covered on a fee-for-service basis if you are:

- On Medicare
- On the "Medically Needy" Apple Health Program (also called "spenddown program")
- Covered by other health insurance with benefits comparable to Apple Health Managed Care. If your coverage begins after you enroll in Apple Health Managed Care, call Customer Service at 1-800-562-3022, extension 16134.
- Disabled or blind and living in a nursing home or an ICF/ID institution for people with developmental disabilities (such as Fircrest School, Lakeland Village, Rainier School)
- Receiving hospice care before enrollment in managed care (if you are enrolled and start receiving hospice, you stay enrolled)
- An adult getting private duty nursing services through Apple Health
- Approved by HCA for an "exemption" or disenrollment from Apple Health Managed Care (see page 4).

Voluntary Enrollment:

You can be in managed care or can choose not to be if you are:

- An American Indian or Alaska Native
- A child receiving "Medically Intensive" Apple Health services (private duty nursing). A foster child or child receiving adoption support (NOTE: In 2014 these children may participate in Apple Health Managed Care but are not required to. HCA may require them to enroll in a special managed care plan beginning in 2015.)
- Certain immigrant children
- Living in a county that does not have at least two Apple Health Managed Care health plans with adequate networks (if there is only one plan, you may get Apple Health services from a managed care plan, but don't have to).

Other HCA managed care programs:

Besides Apple Health Managed Care, HCA recently had or will soon have several other managed care programs:

- The Washington Medicaid Integration Partnership (WMIP) was a managed care program in Snohomish County. The WMIP program ended June 30, 2014. Former WMIP clients have now been transferred to Apple Health Managed Care or to Apple Health Fee for Service.
- In 2015, HCA proposes to start another voluntary managed care program called "HealthPath Washington" for clients who receive both Medicare and Apple Health. Only residents of King and Snohomish Counties will be able to enroll. Two insurance companies, CHPW and United Healthcare, will offer HealthPath Washington health plans. These plans will cover mental health, chemical dependency, and long-term care in addition to medical services.

- PACE is a managed care program in King County. It is a voluntary program. People over age 55 with COPES level of care are eligible.

How Do I Choose a Plan and Primary Care Provider?

If you are new to Apple Health Managed Care or your plan is no longer participating, HCA will assign you to a plan. **You must respond to the notice from HCA if you want to choose a different plan.** HCA is working on a way for individuals to pick their plan when they apply for Apple Health coverage through the HealthPlanFinder website. This choice is supposed to be available beginning in the Spring of 2015.

If you think you might qualify for an exemption (described in next section),you should ask for it **as soon as possible** after you are told that you will be enrolled in an Apple Health Managed Care plan.

Here are things to consider in choosing a plan and PCP:

My Primary Care Provider (PCP):
In what plan or plans are my family's health care providers? Each family member can have a different, PCP or you can choose one PCP to care for all family members enrolled in Apple Health Managed Care. To be absolutely sure your provider is in an Apple Health Managed Care plan , call their office. If you want to pick a new PCP, make sure to ask the provider if (s)he is taking new Apple Health Managed Care patients. Each plan should have a list of participating providers, but they may not know which ones are currently taking new patients.

My Specialist, Hospital and Pharmacy:
Will the PCP I choose be able to refer me to the specialist I want to see? Call the PCP's office before you enroll, to ask whether the specialist(s) would be available to you. You can also contact the specialist directly and ask whether you can access them through the Apple Health Managed Care plan and PCP you are considering. Call the Plan you are considering for a list of pharmacies and hospitals you may use.

There may also be differences in the medications you can get in each plan. The list of medications that are covered by a health plan is called a formulary. Check with the plans you are considering to find out if your medications are covered by the plan's formulary and if there is anything you need to do before you can get your medications. Ask the plan if their formulary is online, or ask for a written copy of the formulary.

Location:
Where is the PCP's office? Is it convenient?

Quality of Care:
What have you heard from others about the plan, the PCP, and other providers? Talk with friends, family members or others and ask the following questions: How does the PCP deal with Apple Health clients? Is it hard to reach the PCP or an on-call doctor or nurse after hours? Have you heard complaints that people can't get appointments or the referrals they need?

Special Needs and Equal Access

Providers are required to provide bilingual staff or interpreters to help speak with patients who prefer to speak in a language other than English. The providers also have to have offices and equipment that is accessible to persons with disabilities. Ask the provider for help if you prefer to speak in a language other than English, have a disability for which you want an accommodation, or have other concerns

about receiving care that suits your individual needs.

Once you enroll, your health plan will send you a health plan ID card that has the health plan's toll-free telephone number. Call this number if you have any questions about health care services or medications, want to change primary care providers, or want to file a complaint or appeal.

Who Can Be Exempt from Apple Health Managed Care?

An "exemption" from Apple Health Managed Care means you are not in any managed care plan. Instead, Apple Health pays your providers on a fee-for-service basis. Fee-for-service works best if you already have healthcare providers to give you care and your providers are not all available to you in one health plan.

If you are **exempt**:

- You can see any provider who is willing to give you care and be paid by Apple Health on a fee-for-service basis.
- You are not enrolled in an insurance company's health plan.
- You do not have to see only one PCP.
- You do not have a health plan responsible for making sure you have access to providers when you need care.

You May Qualify for an **exemption** or **disenrollment** from Apple Health Managed Care if:

- you are homeless or are in temporary housing for 120 days or less, or
- you have been getting medically necessary treatment that will be interrupted by enrollment in a plan, and the interruption will jeopardize your life, health or ability to attain, maintain, or regain maximum function.

If you have another reason for concern about enrolling in Apple Health Managed Care, ask for an exemption. HCA may exempt you for a reason not on the above list, such as being unable to get to medical appointments.

If you are in a plan and wish to disenroll, you can work with your plan both to resolve any concerns and to get help completing the medical justification form for disenrollment.

> ◈ To ask for an exemption or disenrollment, call HCA Customer Service at **1-800-562-3022.** Customer service staff will review your reasons for asking to leave or stay out of managed care to see if you qualify for disenrollment/exemption.

If possible, submit a request for exemption before the effective date of your enrollment. Then if the request is denied, and you appeal quickly, you may be kept in the fee-for-service program while you wait for your appeal. If you wait until after your enrollment is effective to ask for an exemption, the Health Care Authority refuses to disenroll you, and you appeal that decision, you generally will stay in managed care while you wait for your appeal.

If the Health Care Authority denies your exemption request, it must send you a

notice explaining the reasons and your appeal rights. (See "What if I Disagree with My Health Plan?") You may wish to seek legal help for your appeal through CLEAR (see below).

What if I Want To See a Different Provider for My Women's Health Care Services?

You may see a nurse practitioner, obstetrician-gynecologist, nurse, midwife or other women's health care doctor for your women's health services, without a referral from your PCP. Washington State law requires all health plans, including Apple Health Managed Care, to allow you to go to the provider of your choice to get women's health services, without referral from a PCP. These include prenatal and maternity care, birth control, gynecological exams, PAP smears, etc. You may go to different types of providers to receive this care, such as a doctor, physician's assistant, nurse practitioner or nurse midwife. For many of these services, the provider you choose must be a member of your health plan. For family planning services, you can go outside your health plan to a local health department or a family planning clinic that takes Apple Health.

If I Have an Ongoing Need to See a Specialist, Do I Need a Referral for Every Appointment?

If you need to see a specialist frequently, as part of a course of treatment, or for regular monitoring, your health plan should let you see one in its network without a referral for each specialist appointment. You can also ask the specialist to be your PCP. To do either of these things, you will need to have your provider create a treatment plan that says you need to see a specialist on a frequent or ongoing basis. Call your health plan's customer service number or ask your provider how to do this. If your plan refuses to let you do this, you can ask to appeal that decision.

Which Services Are Covered by My Plan?

You can get some medical services in your Apple Health Managed Care plan and other services outside your plan without a referral from the provider or permission from the plan. Some services, such as immunizations, are covered both by the plan and outside it. Information on benefits is available in the Benefits Book that HCA sends to Apple Health Managed Care enrollees. (Save this booklet for your reference. The current booklet is available at http://www.hca.wa.gov/medicaid/publications/documents/22-542.pdf .

What If I Disagree with My Health Plan? What Are My Rights?

If you disagree with something you are being told by someone in your health plan, if you feel something is not right, if you want to stay with a doctor who is dropping out of your plan, if you feel you have been treated unfairly, or if there's anything about your plan or your health care you are not satisfied with, here are some of your options:

Ask for a second opinion:
Plans are required to give you a second opinion from another provider in the plan when you ask for it. If you have a good reason for getting a second opinion from a health care provider outside of the plan, you can ask your plan for one. Call your health plan. If your plan refuses, a fair hearing judge might authorize a second

opinion outside the plan. To get that, you must first ask for a hearing (see below).

Contact your plan's customer service office: Every plan is required to help its members with grievances (complaints) and appeals. Contact customer service to ask for help. Sometimes the plan's customer service office can help solve your problem. Generally, the health plan must treat your call as a grievance or appeal and follow the appropriate rules.

File a grievance or an appeal: Health plans have policies and procedures for reviewing their decisions. Every plan must give you a copy of its grievance and appeal process. We recommend filing a grievance or appeal in writing, though the plan must accept them orally too. Contact your plan to make a complaint/grievance or ask to appeal something the plan did that affects your health care.

File a grievance

A grievance is any expression of dissatisfaction about anything that is not considered an appeal. You can file a grievance any time you are dissatisfied with the services you are receiving or not receiving from a health plan or a doctor, pharmacy, or other provider with your health plan. Your health plan is supposed to make a decision about your grievance within 90 days of learning that you made the complaint, unless you

Ask for an appeal

An appeal is a request that the health plan change a decision or action it has made that affects your health care. You can make an appeal in writing or orally, but we suggest you send your health plan a written appeal. Make sure to explain the reason for your appeal, such as denial of a request for you to get an appointment with a specialist or to get medical equipment you need. You can appeal if:

- The health plan has said that it will deny, end, or change a service;
- The health plan has denied payment for a service;
- The health plan has not provided services in a timely manner;
- The health plan has not made a decision on an appeal or grievance you made by the time required;

If you appeal because the plan has said it will stop or change a service, you have the right to continue getting the service, during the appeal process, as often as you were getting the service and in the amount you were getting it before the plan decided to change your service. This is called continued benefits. To get continued benefits you must let your plan know that you are appealing its decision to change your care and ask for continued benefits either: a) within 10 days of when your plan mails you a letter telling you that your care may be stopped or changed; or b) by the date your care is scheduled to change, whichever time is later. If you appeal a change in your health care and do not ask for continued benefits, you can appeal up to 90 days after the date on the letter from your plan telling you about the change. When you appeal, you have the right to: 1) review the health plan's file on you and any other written materials the health plan will consider in your appeal; 2) give evidence that your health plan must consider when it decides your appeal; and 3) argue to your health plan in person or in writing why they should agree with your appeal.

If your appeal is unsuccessful, you may have to pay the health plan for part or all of the continued benefits you got during the first 60 days of the appeal process. You can also ask to have someone outside of your plan decide whether the plan's decision that you appealed was wrong, as described below.

Ask for a fair hearing

If you do not agree with the final outcome of your appeal, you can ask for a fair hearing. In a fair hearing, a neutral judge considers the case and makes the decision. The judge does not work for your health plan and usually does not work for HCA or DSHS. You may ask for a hearing at your local DSHS office or by calling HCA or your DSHS community services office. You may also ask for a fair hearing by writing to:

Office of Administrative Hearings
P.O. Box 42489
Olympia, WA 98504
1-800-583-8270

If you had continued benefits during your appeal and you want to keep getting them during the fair hearing process, you must ask for a fair hearing and continued benefits within 10 days of the date of the letter you get from your health plan giving you their decision in your appeal. If you are not asking for continued benefits during the fair hearing process, you have up to 90 days from when you receive your plan's appeal decision to ask for a fair hearing.

Ask for an Independent Review

If you don't agree with the decision in the fair hearing, you have a right to independent review (IR). This is a review by an Independent Review Organization, a committee outside your health plan. You have to ask for IR within 21 days of the day that the decision in your fair hearing was mailed to you. You can also ask for independent review without going through the fair hearing process first.

To request an independent review, contact your health plan in writing and send a copy of the request to the Office of Administrative Hearings.

Ask for a Board of Appeals Review

If the Independent Review does not resolve the issue, or if you decide to skip the Independent Review, you have the right to ask the Board of Appeals to review the fair hearing or independent review decision. You must ask for review by the Board of Appeals in writing. You should send your request, including your explanation of why the fair hearing decision or independent review decision was wrong. Mail your letter asking for review to:

Board of Appeals – Health Care Authority
P.O. Box 45803
Olympia, WA 98504-5803
1-877-351-0002

Can your health plan ask the Board of Appeals to review an Independent Review Decision they don't like?

You can ask for Board of Appeals review of an Independent Review decision against you. But, the law is not clear whether your health plan can appeal an Independent Review organization's decision. The law that sets up the Independent Review process says that health plans have to follow Independent Review organizations' decisions. However, a Health Care Authority rule (WAC 182-526-0200(9)) says that a health plan can appeal a decision by an Independent Review organization. If they do, you can ask your health plan to follow the Independent Review organization's decision based on a law in the Revised

Code of Washington, RCW 48.43.535(8). If your plan refuses to follow the Independent Review organization's decision and asks the Board of Appeals to review the decision, you can object to this based on this law.

We have given you some of the deadlines for asking for appeals, fair hearings, independent review decisions and reviews by the Board of Appeals. But some of the timeframes for these procedures are a little unclear in the law. So, you may want to contact CLEAR (888-201-1014) to get help with the process.

Expedited Appeals and Review

If you need a quick decision at any time in the appeal and review process, you can ask for an "expedited" decision. If you know you want an expedited decision when you make your appeal or ask for review, make sure you ask for both at the same time. When you ask for an expedited decision, you should explain why your health, life or ability to function will be hurt or put at risk if you don't get a quick decision in your appeal or review. If your plan, the fair hearing judge, the IR organization or the Board of Appeals agrees to give you an expedited decision, you should get it within 3 business days of when they get your request for the expedited appeal or review. If your plan refuses to give you an expedited appeal decision, you can file a grievance about this.

Ask for an Exception to Rule or Limitation Extension

If your plan refuses to pay for or authorize health care you asked for, you can ask for an "Exception to Rule" (ETR) to get the coverage. If your plan will only approve care in an amount that is less than what you requested, or for a shorter period of time or less frequently than what you asked for, you can ask for a "Limitation Extension" (LE) to get the full amount of care your provider says you need. To ask for an ETR or LE, you or your health care provider must explain in writing why you need the care that was partly or completely denied by your health plan. At least until the end of 2014, you or your provider should send a letter asking for an ETR or LE to your health plan. Your health plan will send you a written letter telling you whether they agree to give you the ETR or LE.

Asking for an ETR or LE does not shorten the time you have to ask for an appeal of a decision by your health plan that affects your health care. You can ask for an appeal AND for an ETR or LE. That way, if you get the ETR or LE, you may decide to drop the appeal. But, if you don't get the ETR or LE, you have not lost your ability to appeal the change in your care.

At the time this brochure is being written, the Health Care Authority is considering whether to take over making decisions about ETR and LE requests from the plans, beginning in 2015. After 2014, call your health plan or Medical Assistance Customer Service Center to find out where you should send a letter asking for an ETR or LE.

Change Plans:

You may change plans as often as you like. The change will take effect the next month, as long as you ask for the change before the 2nd to last business day in the month. However, you should try to get your change in by the 15th of the month. To change your health plan, you can visit the ProviderOne Client Portal at https://www.waproviderone.org/client or call the Medical Assistance Customer Service Center at 1-800-562-3022, press 6

for client services, and then press 2 for health plan enrollment. Instructions on how to change your plan through Provider One are at http://www.hca.wa.gov/Documents/managed_care/ChangePlanEnrollment.pdf. You can also change health plans by filling out HCA's "Enrollment Form" at http://www.hca.wa.gov/medicaid/forms/Documents/13_862.pdf. You can fax the form to HCA at 1-866-668-1214 or mail it to the address printed on the form.

Change primary care providers:
You may change your primary care provider (PCP) for any reason. Call your health plan to switch. The change will become effective at the beginning of the next month.

Contact Medical Assistance Customer Service Center:
They are interested in hearing about problems with your health plan, and they may be able to help solve your complaint. Contact information for the Medical Assistance Customer Service Center is at the end of this publication.

Contact Legal Services:
You may be able to get free advice or representation from legal services, including information to help you represent yourself in a fair hearing. See contact information below.

What are My Other Rights?

What if I do not speak English well or I am deaf or hearing impaired?
Plan providers must arrange for interpreter services for medical visits at no cost to you. If they refuse or you have problems, contact the Medical Assistance Customer Service Center (contact information below).

Do I have to pay for Apple Health Managed Care?
No. There is no charge for any Apple Health Managed Care service, or any other Apple Health service. If a service is not covered by Apple Health, or determined to be not "medically necessary," you may only be billed for it if you first sign an agreement to pay for it (with limited exceptions). You can also be billed if you are in managed care and use a provider not contracted or approved by your plan. If you are not in managed care, or the service you get is a service paid for by Apple Health directly instead of through the plan, you must use a provider who has a contract with Apple Health to avoid getting a bill.

If you do get a bill, contact your health plan first. If that does not solve the problem, contact the HCA Customer Service at **1-800-562-3022.** If the bill is sent to a collection agency, if you are sued, or if your wages are being garnished as a result of a medical bill, contact legal services (see below).

What if I have no way to get to any PCP or other health visits?
Call your regional Apple Health transportation broker. Contact information is posted on the Internet at: http://www.hca.wa.gov/medicaid/transportation/pages/newrequest.aspx. They will ask you about your provider and your medical care. Have your Medical Services Card with you. They should arrange the most appropriate and least costly transportation, at no charge. If you are denied transportation, you can appeal.

Is there a limit on when I can receive care?
You have the right to receive needed medical care without discrimination of any kind, 24 hours a day, seven days a week. See your Medical Benefit Book, which can

be found at http://www.hca.wa.gov/medicaid/publications/documents/22-542.pdf, for more information.

Will Apple Health Managed Care plans respect my privacy?

Yes. Health plans and providers are required to keep your health information strictly confidential. See the privacy section of your Medical Benefit Book more information.

After Apple Health …How is My Health Care Covered?

You will stay on Apple Health Managed Care as long as family income stays below a certain level (look for our brochures about how to qualify for Apple Health medical programs). Income levels for children and pregnant women are higher than for adults.

If you are a parent or relative caring for children and you start working, Healthy Options will cover you for a year or more after your income exceeds a certain level. After that, even if your income remains above Apple Health levels, your children may remain eligible up to a much higher income level.

If you go off Apple Health because of income or other changes, new health insurance options are available. As of January 1, 2014, low-cost coverage is available through national health reform ("Obamacare"). For information about this health coverage, see http://nohla.org/infoAnalysis/coverOps.php (NoHLA website).

Contact Information for Medical Assistance Customer Service Center

Phone: 1-800-562-3022

Email: askmedicaid@hca.wa.gov

TTD: Dial 711 through Washington Relay

The "Contact Us" webform: https://fortress.wa.gov/hca/p1contactus/Client_WebForm.aspx

General Information about Apple Health Managed Care

http://www.hca.wa.gov/medicaid/healthyoptions/Pages/index.aspx

Regulations:

Washington Administrative Code (WAC) Chapter 182-538. Internet link is: http://apps.leg.wa.gov/wac/default.aspx?cite=182-538

Contact Information for Legal Services

- Apply online with CLEAR*Online - http://nwjustice.org/get-legal-help or
- If outside King County, call CLEAR at 1-888-201-1014. CLEAR is Washington's toll-free, centralized intake, advice and referral service for low-income people seeking free legal assistance with civil legal problems. Call 1-888-201-1014 weekdays from 9:10 a.m. until 12:25 p.m. CLEAR works with a language line to provide interpreters as needed at no cost to callers. If you are deaf, hard of hearing, or have difficulty speaking, please call 1-888-201-1014 using your preferred TTY or Video relay service.
- If inside King County, call 211 for information and referral to an appropriate legal services provider Monday through Friday from 8:00

am – 6:00 pm. You may also call (206) 461-3200, or the toll-free number, which may be useful when calling from a pay phone, 1-877-211-WASH (9274). 211 works with a language line to provide interpreters as needed at no cost to callers. Callers who are deaf, hearing-impaired, or have difficulty speaking can call 1-800-833-6384 or 711 to be connected to a relay operator at no cost, who will then connect them with 211. Information on legal service providers in King County may also be accessed through 211's website at www.resourcehouse.com/win211/.

- If you are age 60 or over, anywhere in the state, you may call CLEAR*Sr at 1-888-387-7111, regardless of income. If you are deaf, hard of hearing or have difficulty speaking, you may call CLEAR *Sr using the relay service of your choice. CLEAR*Sr phone lines are open Monday through Friday starting at 9:10 a.m. but close when they meet their capacity. If you get a busy signal or a message stating all circuits are busy, please try again later. When you get through, leave a message so the screener can call you back. Be sure to leave your name and phone number, including area code.

NoHLA
Northwest Health Law Advocates

This publication provides general information concerning your rights and responsibilities. It is not intended as a substitute for specific legal advice.
This information is current as of November 2014.