Frequently asked questions – Health Care Authority (HCA) Earlier Enrollment

Beginning in April 2016, the HCA implemented Earlier Enrollment. This is a mechanism that allows clients to be enrolled into a plan the very same month they become eligible for Medicaid, as opposed to waiting until at least the next month to be enrolled. Currently, newly or returning eligible Medicaid clients wait up to six weeks to be enrolled in a managed care plan. Earlier Enrollment significantly reduces the amount of time that clients receive services via fee-for-service while waiting to be enrolled into a plan.

Q1. What is the change?
A1. Enrollments will be backdated to the first day of the current month for new Washington Apple Health clients and those who have had a break in coverage and are now returning to Washington Apple Health coverage.

Q2. What members are affected by this?
A2. New members initially applying for benefits or those with changes in their existing program that consequently make them eligible for Washington Apple Health.

Renewing clients are those who have been enrolled with a managed care organization (MCO) but have had a break in enrollment and have subsequently renewed their eligibility.

Q3. How do members know if their eligibility is retroactively effective?
A3. All members will receive a letter from HCA, advising them of their effective date.

Q4. Does this change the assignment and enrollment cutoff dates?
A4. No, these are not changed.

Q5. Are clients who enroll after the cutoff date eligible for earlier enrollment?
A5. Yes, if they meet the eligibility criteria, their eligibility can be retroactive to the first of the month in which they apply, even though they normally would have had to wait over a full month to be eligible because of missing the cutoff date.

Q6. If a member doesn't select an MCO when they first apply through Washington Health Plan Finder, but they don't want the plan to which HCA assigns them, can they change retroactively?
A6. Yes, the member must contact HCA in the same month they applied on Washington Health Plan Finder to request the change.

Q7. What if a member who is already in an MCO wants to retroactively switch to another MCO?

A7. Retroactive changes for members already in an MCO are not allowed; these changes are effective the first of the following month as long as the member makes the request in accordance with HCA's cutoff date.

Q8. How does Amerigroup Washington, Inc. know when a member is retroactively eligible?

A8. Amerigroup receives an 834 file daily from HCA. New members will appear on the daily files with their retroactive effective date listed.

Q9. How soon can providers see members' eligibility changes in ProviderOne?

A9. Eligibility is populated to ProviderOne the day after the change is made and will show the retroactive effective date. Also, members are advised to take their eligibility letter from HCA with them to provider visits until they receive their ID card from the MCO.

Q10. How soon can providers see members' eligibility change in Availity?

A10. Eligibility is populated to Availity the day after the change is made and will show the retroactive effective date.

Q11. How will Amerigroup inform providers that a member's eligibility is retroactively effective or changed to another MCO?

A11. Providers should check ProviderOne before rendering services to any MCO members.

Q12. What if an Amerigroup contracted provider rendered services to the member between the dates of the member applying for eligibility and their retroactive eligibility date with Amerigroup, when the services require prior authorization (PA) under Amerigroup rules?

A12. Providers should contact Amerigroup to request a retrospective authorization. Claims submitted without the authorization will deny. Providers will need to appeal if the claim has already been adjudicated.

Q13. What if an Amerigroup noncontracted provider provided services to the member between the dates of the member applying for eligibility and their retroactive eligibility date with Amerigroup, when the services require PA under Amerigroup rules?

A13. Provider should contact Amerigroup to request a retrospective authorization. Claims submitted without the authorization will deny. Providers will need to appeal if the claim has already been adjudicated.

Q14. Will Amerigroup pay for all services for which it authorizes, even if the member is later retroactively moved to another MCO?

A14. No, Amerigroup will recoup claims paid if the member is moved, with an explanation to the provider. Providers will need to secure payment from the new MCO.

Q15. Will Amerigroup pay for services authorized by another MCO when the member is retroactively moved to Amerigroup?

A15. Yes, for covered services, if provider submits the other MCO's authorization to our PA team, Amerigroup will pay participating providers at Amerigroup rates and nonparticipating providers at Medicaid rates.

Q16. Will HCA apply early enrollment to clients who are already inpatient?
A16. Yes, and these members may also elect to change their assigned MCO retroactive to the first of the month of their eligibility.

Q17. Does this mean inpatient facilities must check eligibility every day for their Medicaid patients?
A17. This is a safe practice to identify changes promptly; facilities should at least check upon admit and discharge.

Q18. How far back will Amerigroup backdate inpatient authorizations?
A18. We will backdate to the member's date of admission up to the first of the current month. Facilities need to request retrospective review prior to submitting their claim to Amerigroup or the claim will deny and provider will be required to submit a claims appeal.

Q19. Have all of the Medicaid MCOs agreed on any standard practices for managing this change?
A19. Not at this time.

Q20. When was this change effective?
A20. April 1, 2016.

Q21. Is this part of the Early Adopter Program?
A21. No, this is about general Washington Apple Health eligibility. The Early Adopter Program is about the integration of behavioral health and physical health services.

Q22. Why did HCA make this change?
A22. This is intended to fill the fee-for-service gap so the client is continuously enrolled in managed care from the first of their eligibility instead of starting with fee-for-service and then being moved to managed care.

Q23. Who do members call if they have questions or concerns about their eligibility?
A23. Members should call HCA at 1-800-562-3022 or TTY/TDD 1-800-848-5429.