



PROPOSED RULE MAKING

CR-102 (June 2012)

(Implements RCW 34.05.320)

Do NOT use for expedited rule making

Agency: Health Care Authority, Washington Apple Health

Preproposal Statement of Inquiry was filed as WSR 15-05-024; or
 Expedited Rule Making--Proposed notice was filed as WSR _____; or
 Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1).

Original Notice
 Supplemental Notice to WSR _____
 Continuance of WSR _____

Title of rule and other identifying information:

Chapter 182-538 WAC, Managed Care

Hearing location:

Health Care Authority
Cherry Street Plaza Building; Sue Crystal Conf Rm 106A
626 - 8th Avenue, Olympia WA 98504

Metered public parking is available street side around building. A map is available at:
http://www.hca.wa.gov/documents/directions_to_csp.pdf
or directions can be obtained by calling: 360-725-1000

Date: **November 10, 2015** Time: **10:00 a.m.**

Date of intended adoption: Not sooner than **November 11, 2015** (Note: This is NOT the effective date)

Submit written comments to:

Name: HCA Rules Coordinator
Address: PO Box 45504, Olympia WA, 98504-5504
Delivery: 626 – 8th Avenue, Olympia WA 98504
e-mail arc@hca.wa.gov
fax (360) 586-9727

by **5:00 pm on November 10, 2015**

Assistance for persons with disabilities: Contact Amber Lougheed by November 7, 2015

e-mail: amber.lougheed@hca.wa.gov or (360) 725-1349

TTY (800) 848-5429 or 711

Purpose of the proposal and its anticipated effects, including any changes in existing rules: In this WAC chapter, the Agency:

- Removed references to programs that no longer exist.
- Corrected outdated program names.
- Updated citations.
- Restructured sections to improve readability.
- Changed section titles.
- Made style and editorial changes.
- Made changes to conform with federal regulations and the Agency's managed care contracts.
- Wrote a new section regarding the Washington Apple Health Foster Care Program.

Reasons supporting proposal: See "purpose" above.

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Statute being implemented: RCW 41.05.021, 41.05.160

Is rule necessary because of a:

Federal Law? Yes No
 Federal Court Decision? Yes No
 State Court Decision? Yes No
 If yes, CITATION:

DATE
October 6, 2015

NAME
Wendy Barcus

TITLE
HCA Rules Coordinator

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: October 06, 2015

TIME: 11:19 AM

WSR 15-20-104

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters: None

Name of proponent: Health Care Authority

- Private
- Public
- Governmental

Name of agency personnel responsible for:

Name	Office Location	Phone
Drafting..... Sean Sullivan	PO Box 42716, Olympia WA 98504-2716	(360) 725-1344
Implementation.... Alison Robbins	PO Box 42716, Olympia WA 98504-2001	(360) 725-1634
Enforcement.....Alison Robbins	PO Box 42716, Olympia WA 98504-2001	(360) 725-1634

Has a small business economic impact statement been prepared under chapter 19.85 RCW or has a school district fiscal impact statement been prepared under section 1, chapter 210, Laws of 2012?

Yes. Attach copy of small business economic impact statement or school district fiscal impact statement.

A copy of the statement may be obtained by contacting:

Name:

Address:

phone () _____

fax () _____

e-mail _____

No. Explain why no statement was prepared.

The agency has determined that the proposed filing does not impose a disproportionate cost impact on small businesses or nonprofits.

Is a cost-benefit analysis required under RCW 34.05.328?

Yes A preliminary cost-benefit analysis may be obtained by contacting:

Name:

Address:

phone () _____

fax () _____

e-mail _____

No: Please explain:

RCW 34.05.328 does not apply to Health Care Authority rules unless requested by the Joint Administrative Rules Review Committee or applied voluntarily.

NEW SECTION

WAC 182-538-040 Introduction. This chapter governs Washington apple health managed care under the medicaid agency's managed care contracts. Washington apple health managed care services are available through either a managed care organization (MCO) or primary care case management (PCCM) provider.

AMENDATORY SECTION (Amending WSR 13-02-010, filed 12/19/12, effective 2/1/13)

WAC 182-538-050 Definitions. The following definitions and abbreviations and those found in chapter 182-500 WAC, Medical definitions, apply to this chapter. References to managed care in this chapter do not apply to mental health managed care administered under chapter 388-865 WAC.

"Action" means one or more of the following:

~~((1))~~ (a) The denial or limited authorization of a requested service, including the type or level of service;

~~((2))~~ (b) The reduction, suspension, or termination of a previously authorized service;

~~((3))~~ (c) The denial, in whole or in part, of payment for a service;

~~((4))~~ (d) The failure to provide services in a timely manner, as defined by the state; or

~~((5))~~ (e) The failure of a managed care organization (MCO) to act within the time frames provided in 42 C.F.R. 438.408(b).

"Agency" - See WAC 182-500-0010.

~~("Ancillary health services" means health care services that are auxiliary, accessory, or secondary to a primary health care service.)~~

"Appeal" means a request by an enrollee or provider with written permission of an enrollee for reconsideration of an action.

"Apple health foster care (AHFC)" means the managed care program developed by the agency and the department of social and health services to serve children and youth in foster care and adoption support and young adult alumni of the foster care program.

"Assign" or "assignment" means the agency selects an MCO (~~or primary care case management (PCCM) provider~~) to serve a client who has not selected an MCO (~~or PCCM provider~~).

"Auto enrollment" means the agency has automatically enrolled a client into an MCO in the client's area of residence.

~~("Basic health" or "BH" means the health care program authorized by chapter 70.47 RCW and administered by the agency.~~

~~"Basic health plus" - Refer to WAC 182-538-065.)~~

"Client" means, for the purposes of this chapter, an individual eligible for any (~~medical assistance~~) Washington apple health program, including managed care programs, but who is not enrolled with an MCO or PCCM provider. (~~In this chapter, "client" refers to a person before he or she is enrolled in managed care, while "enrollee" refers to an individual eligible for any medical assistance program who is enrolled in managed care.~~)

"Disenrollment" - See "end enrollment."

"Emergency medical condition" means a condition meeting the definition in 42 C.F.R. 438.114(a).

"Emergency services" means services defined in 42 C.F.R. 438.114(a).

"End enrollment" means ending the enrollment of an enrollee for one of the reasons outlined in WAC 182-538-130.

"Enrollee" means an individual eligible for any ~~((medical assistance))~~ Washington apple health program enrolled in managed care with an MCO or PCCM provider that has a contract with the state.

"Enrollee's representative" means ~~((an individual))~~ a person with a legal right or written authorization from the enrollee to act on behalf of the enrollee in making decisions.

"Enrollees with special health care needs" means enrollees having chronic and disabling conditions and the conditions:

~~((1))~~ (a) Have a biologic, psychologic, or cognitive basis;

~~((2))~~ (b) Have lasted or are virtually certain to last for at least one year; and

~~((3))~~ (c) Produce one or more of the following conditions stemming from a disease:

~~((a))~~ (i) Significant limitation in areas of physical, cognitive, or emotional function;

~~((b))~~ (ii) Dependency on medical or assistive devices to minimize limitation of function or activities; or

~~((e))~~ (iii) In addition, for children, any of the following:

~~((i))~~ (A) Significant limitation in social growth or developmental function;

~~((ii))~~ (B) Need for psychological, educational, medical, or related services over and above the usual for the child's age; or

~~((iii))~~ (C) Special ongoing treatments, such as medications, special diet, interventions, or accommodations at home or school.

"Exemption" means agency approval of a client's preenrollment request to remain in the fee-for-service delivery system for one of the reasons outlined in WAC 182-538-130.

"Grievance" means an expression of dissatisfaction about any matter other than an action, as "action" is defined in this section.

"Grievance system" means the overall system that includes grievances and appeals handled at the MCO level and access to the agency's hearing process.

"Health care service" or **"service"** means a service or item provided for the prevention, cure, or treatment of an illness, injury, disease, or condition.

~~((**"Healthy options program"** or **"HO program"** means the agency's prepaid managed care health program for medicaid eligible clients and clients enrolled in the state children's health insurance program (SCHIP).))~~

"Managed care" means a comprehensive health care delivery system that includes preventive, primary, specialty, and ancillary services. These services are provided through either an MCO or PCCM provider.

"Managed care contract" means the agreement between the agency and an MCO to provide prepaid contracted services to enrollees.

"Managed care organization" or **"MCO"** means an organization having a certificate of authority or certificate of registration from the office of insurance commissioner that contracts with the agency under a comprehensive risk contract to provide prepaid health care services to ~~((eligible clients))~~ enrollees under the agency's managed care programs.

"Mandatory enrollment" means the agency's requirement that a client enroll in managed care.

"Mandatory service area" means a service area in which eligible clients are required to enroll in an MCO.

"Nonparticipating provider" means a ~~((health care provider that does not have a written agreement with an MCO but that provides MCO-contracted health care services to managed care enrollees with the MCO's authorization))~~ person, health care provider, practitioner, facility, or entity acting within their scope of practice and licensure that:

(a) Provides health care services to enrollees; and

(b) Does not have a written agreement with the contractor to participate in a managed care organization's provider network.

"Participating provider" means a ~~((health care provider with a written agreement with an MCO to provide health care services to the MCO's managed care enrollees. A participating provider must look solely to the MCO for payment for such services))~~ person, health care provider, practitioner, or entity acting within their scope of practice and licensure with a written agreement with the MCO to provide services to enrollees.

"Primary care case management" or "PCCM" means the health care management activities of a provider that contracts with the agency to provide primary health care services and to arrange and coordinate other preventive, specialty, and ancillary health services.

"Primary care provider" or "PCP" means a person licensed or certified under Title 18 RCW including, but not limited to, a physician, an advanced registered nurse practitioner (ARNP), naturopath, or a physician assistant who supervises, coordinates, and provides health services to a client or an enrollee, initiates referrals for specialist and ancillary care, and maintains the client's or enrollee's continuity of care.

~~((**"Prior authorization" or "PA"** means a process by which enrollees or providers must request and receive agency approval for services provided through the agency's fee for service system, or MCO approval for services provided through the MCO, for certain medical services, equipment, drugs, and supplies, based on medical necessity, before the services are provided to clients, as a precondition for provider reimbursement.))~~

"Timely" ~~((means in relation to))~~ concerning the provision of services, means an enrollee has the right to receive medically necessary health care as expeditiously as the enrollee's health condition requires. ~~((In relation to))~~ Concerning authorization of services and grievances and appeals, "timely" means according to the agency's managed care program contracts and the time frames stated in this chapter.

~~((**"Washington medicaid integration partnership" or "WMIP"** means the managed care program that is designed to integrate medical, mental health, chemical dependency treatment, and long term care services into a single coordinated health plan for eligible aged, blind, or disabled clients.))~~

WAC 182-538-060 Managed care and choice. (1) ~~((This chapter does not apply to the subsidized basic health program found in chapters 182-24 and 182-22 WAC unless allowed by specific program rule.~~

~~(2))~~ Except as provided in subsection ~~((3))~~ (2) of this section, the medicaid agency requires a client to enroll in managed care when that client:

(a) Is eligible for one of the ~~((medical assistance))~~ Washington apple health programs for which enrollment is mandatory;

(b) Resides in an area where enrollment is mandatory; and

(c) Is not exempt from managed care enrollment or the agency has not ended the client's managed care enrollment, consistent with WAC 182-538-130 ~~((, and any related hearing has been held and decided))~~.

~~((3))~~ (2) American Indian and Alaska native (AI/AN) clients ~~((who meet the provisions of 25 U.S.C. 1603 (c) (d) for federally recognized tribal members))~~ and their descendants may choose one of the following:

(a) Enrollment with a managed care organization (MCO) available in their area;

(b) Enrollment with ~~((an Indian or tribal primary care case management (PCCM) provider))~~ a PCCM provider through a tribal clinic or urban Indian center available in their area; or

(c) The agency's fee-for-service system.

~~((4))~~ (3) To enroll with an MCO or PCCM provider, a client may:

(a) Enroll online via the Washington Healthplanfinder at <https://www.wahealthplanfinder.org>;

(b) Call the agency's toll-free enrollment line at 800-562-3022;

~~((b))~~ (c) Go to the ProviderOne client portal at <https://www.waproviderone.org/client> and follow the instructions;

(d) Mail a postage-paid completed managed care enrollment form (HCA 13-862) to the agency's unit responsible for managed care enrollment; or

~~((e))~~ (e) Fax the managed care enrollment form (HCA 13-862) to the agency at the number located on the enrollment form.

~~((5))~~ (4) A client must enroll with an MCO ~~((provider))~~ available in the area where the client resides.

~~((6) All family members of an enrollee placed in the patient review and coordination (PRC) program under WAC 182-501-0135 must enroll with the same MCO but may enroll in a different MCO than the family member placed in the PRC program.)~~ (5) All family members will be enrolled with the same MCO.

(6) If a family member is enrolled in the patient review and coordination (PRC) program, the client must follow the rules in WAC 182-501-0135.

(7) When a client requests enrollment with an MCO or PCCM provider, the agency enrolls a client effective the earliest possible date given the requirements of the agency's enrollment system. ~~((The agency does not enroll clients retrospectively.))~~

(8) The agency assigns a client who does not choose an MCO ~~((or PCCM provider))~~ as follows:

(a) ~~((If the client has a family member or family members enrolled with an MCO, the client is enrolled with that MCO;~~

~~(b))~~ If the client ~~((does not have a family member or family members enrolled with an MCO that is currently under contract with the~~

agency, and the client was previously)) was enrolled with ((the)) an MCO or PCCM provider((, and the agency can identify the previous enrollment)) within the previous six months, the client is reenrolled with the same MCO ((~~or PCCM provider~~));

(b) If the client has a family member enrolled with an MCO, the client is enrolled with that MCO;

(c) If the client cannot be assigned according to (a) or (b) of this subsection, the agency assigns the client as follows:

~~(i) ((If an AI or AN client does not choose an MCO or PCCM provider, the agency assigns the client to a tribal PCCM provider if that client resides in a zip code served by a tribal PCCM provider. If there is no tribal PCCM provider in the client's area, the client continues to be served by the agency's fee for service system. A client assigned under this subsection may request to end enrollment at any time.~~

~~(ii))~~ If a client who is not AI or AN does not choose an MCO ((~~provider~~)), the agency assigns the client to an MCO available in the area where the client resides. The MCO is responsible for primary care provider (PCP) choice and assignment.

~~((iii))~~ (ii) For clients who are ((~~new recipients~~)) newly eligible or who have had a break in eligibility of ((~~greater than two~~)) more than six months, the agency sends a written notice to each household of one or more clients who are assigned to an MCO ((~~or PCCM provider~~)). The assigned client has ten calendar days to contact the agency to change the MCO ((~~or PCCM provider~~)) assignment before enrollment is effective. The notice includes ((~~the~~)):

(A) The agency's toll-free number;

(B) The toll-free number and name of the MCO ((~~or PCCM provider~~)) to which each client has been assigned((~~τ~~));

(C) The effective date of enrollment((~~τ~~)); and

(D) The date by which the client must respond in order to change the assignment((, and the toll-free telephone number of either:

~~(A) The MCO (for enrollees assigned to an MCO); or~~

~~(B) The agency (for enrollees assigned to a PCCM provider).~~

~~(iv))~~.

(iii) If the client has a break in eligibility of less than ((~~two~~)) six months, the client will be automatically reenrolled with his or her previous MCO ((~~or PCCM provider~~)) and no notice will be sent.

~~(9) ((The agency:~~

~~(a) Helps facilitate the choice of a PCP by providing information regarding available providers contracted with the MCOs in the client's service area; and~~

~~(b))~~ Upon request, the agency will assist clients in identifying an MCO with which their provider participates.

(10) An MCO enrollee's selection of a PCP or assignment to a PCP occurs as follows:

(a) An MCO enrollee may choose:

(i) A PCP or clinic that is in the enrollee's MCO and accepting new enrollees; or

(ii) A different PCP or clinic participating with the enrollee's MCO for different family members.

(b) The MCO assigns a PCP or clinic that meets the access standards set forth in the relevant managed care contract if the enrollee does not choose a PCP or clinic.

(c) An MCO enrollee may change PCPs or clinics in an MCO for any reason, with the change becoming effective no later than the beginning of the month following the enrollee's request.

(d) An MCO enrollee may file a grievance with the MCO if the MCO does not approve an enrollee's request to change PCPs or clinics.

(e) MCO enrollees required to participate in the agency's PRC program may be limited in their right to change PCPs (see WAC ((388-501-0135)) 182-501-0135).

AMENDATORY SECTION (Amending WSR 13-02-010, filed 12/19/12, effective 2/1/13)

WAC 182-538-067 ((Managed care provided through)) Qualifications to become a managed care organization((s)) (MCO((s))). ((~~(1) Managed care organizations (MCOs) may contract with the agency to provide pre-paid health care services to eligible clients. The MCOs must meet the qualifications in this section to be eligible to contract with the agency. The MCO must:~~

~~(a) Have a certificate of registration from the office of the insurance commissioner (OIC) that allows the MCO to provide the health care services;~~

~~(b) Accept the terms and conditions of the agency's managed care contract;~~

~~(c) Be able to meet the network and quality standards established by the agency; and~~

~~(d) At the sole option of the agency, be awarded a contract through a competitive process or an application process available to all qualified providers.~~

~~(2) The agency reserves the right not to contract with any other-wise qualified MCO.)~~ (1) A managed care organization (MCO) must meet the following qualifications to be eligible to contract with the med-icaid agency:

(a) Have a certificate of registration from the Washington state office of the insurance commissioner (OIC) that allows the MCO to provide health care services under a risk-based contract;

(b) Accept the terms and conditions of the agency's managed care contract;

(c) Be able to meet the network and quality standards established by the agency; and

(d) Pass a readiness review, including an on-site visit conducted by the agency.

(2) At its discretion, the agency awards a contract to an MCO through a competitive process or an application process available to all qualified providers.

(3) The agency reserves the right not to contract with any other-wise qualified MCO.

AMENDATORY SECTION (Amending WSR 13-02-010, filed 12/19/12, effective 2/1/13)

WAC 182-538-068 (~~((Managed care provided through))~~) Qualifications to become a primary care case management (PCCM) provider. A ~~((provider may contract with the agency as a))~~ primary care case management (PCCM) ~~((provider to coordinate health care services to eligible clients under the agency's managed care program. The PCCM))~~ provider or the individual providers in a PCCM group or clinic must:

- (1) Have a core provider agreement with the medicaid agency;
- (2) Be a recognized urban Indian health center or tribal clinic;
- (3) Accept the terms and conditions of the agency's PCCM contract;
- (4) Be able to meet the quality standards established by the agency; and
- (5) Accept ~~((PCCM))~~ the case management rate~~((s published))~~ paid by the agency.

AMENDATORY SECTION (Amending WSR 13-02-010, filed 12/19/12, effective 2/1/13)

WAC 182-538-070 (~~((Managed care))~~) Payments to managed care organizations (MCOs). (1) The medicaid agency pays apple health managed care organizations (MCOs) monthly capitated premiums that:

- (a) Have been developed ~~((in accordance with))~~ using generally accepted actuarial principles and practices;
 - (b) Are appropriate for the populations to be covered and the services to be furnished under the MCO contract;
 - (c) Have been certified by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board;
 - (d) Are based on ~~((historical))~~ analysis of ~~((financial))~~ historical cost ~~((and/or))~~, rate information, or both; and
 - (e) Are paid based on legislative allocations.
- (2) ~~((The agency pays primary care case management (PCCM) providers a monthly case management fee according to contracted terms and conditions.~~

~~((3))~~) The MCO is solely responsible for payment of MCO-contracted health care services. The agency ~~((does))~~ will not pay ~~((providers under the fee for service system))~~ for a service that is the MCO's responsibility, even if the MCO has not paid the provider for the service ~~((for any reason. The MCO is solely responsible for payment of MCO-contracted health care services)).~~

~~((4))~~) (3) The agency pays an enhancement rate to federally qualified health care centers (FQHC) and rural health clinics (RHC) for each ~~((client enrolled with MCOs through))~~ MCO enrollee assigned to the FQHC or RHC. The enhancement rate from the agency is in addition to the negotiated payments FQHCs and RHCs receive from the MCOs for services provided to MCO enrollees. To ensure that the appropriate amounts are paid to each FQHC or RHC, the agency performs an annual reconciliation of the enhancement payments with the FQHC or RHC.

~~((+5))~~ (4) The agency pays MCOs a delivery case rate, separate from the capitation payment, when an enrollee delivers a child(ren) and the MCO pays for any part of labor and delivery.

NEW SECTION

WAC 182-538-071 Payments for primary care case management (PCCM) providers. (1) The medicaid agency pays PCCM providers a monthly case management fee according to contracted terms and conditions.

(2) The agency pays PCCM providers for health care services under the fee-for-service health care delivery system.

AMENDATORY SECTION (Amending WSR 13-02-010, filed 12/19/12, effective 2/1/13)

WAC 182-538-095 Scope of care for managed care enrollees. (1) A managed care enrollee~~((s-are))~~ is eligible for the scope of services ~~((as-described))~~ in WAC 182-501-0060 for categorically needy clients.

~~((a))~~ ~~((A client is entitled to timely access to medically necessary services as defined in WAC 182-500-0070.~~

~~((b))~~ The managed care organization (MCO) covers the services included in the ~~((MCO))~~ contract for ~~((MCO))~~ its enrollees.

(i) MCOs may, at their discretion, cover ~~((additional))~~ services not required under the MCO contract. ~~((However,))~~

(ii) The agency ~~((may not))~~ cannot require the MCO to cover any ~~((additional))~~ services outside the scope of services ~~((negotiated))~~ in the MCO's contract with the agency.

~~((c))~~ (b) The agency covers ~~((medically necessary))~~ services ~~((described))~~ identified as covered for categorically needy clients in WAC 182-501-0060 and described in WAC 182-501-0065 that are excluded from coverage in the MCO contract.

~~((d))~~ The agency covers services through the fee for service system for enrollees with a primary care case management (PCCM) provider. Except for emergencies, the PCCM provider must either provide the covered services needed by the enrollee, or refer the enrollee to other providers who are contracted with the agency for covered services. The PCCM provider is responsible for instructing the enrollee regarding how to obtain the services that are referred by the PCCM provider. Services that require PCCM provider referral are described in the PCCM contract. The agency informs an enrollee about the enrollee's program coverage, limitations to covered services, and how to obtain covered services.

~~((e))~~ MCO enrollees may obtain specific services described in the managed care contract from either an MCO provider or from a provider with a separate agreement with the agency without needing to obtain a referral from the PCP or MCO. These services are communicated to enrollees by the agency and MCOs as described in ~~((f))~~ of this subsection.

~~((f))~~ The agency sends each client written information about covered services when the client is required to enroll in managed care, and any time there is a change in covered services. This information describes covered services, which services are covered by the agency,

~~and which services are covered by MCOs. In addition, the agency requires MCOs to provide new enrollees with written information about covered services.~~

~~(2) For services covered by the agency through PCCM contracts for managed care:~~

~~(a) The agency covers medically necessary services included in the categorically needy scope of care and rendered by providers who have a current core provider agreement with the agency to provide the requested service;~~

~~(b) The agency may require the PCCM provider to obtain authorization from the agency for coverage of nonemergency services;~~

~~(c) The PCCM provider determines which services are medically necessary;~~

~~(d) An enrollee may request a hearing for review of PCCM provider or agency coverage decisions (see WAC 182-538-110); and~~

~~(e) Services referred by the PCCM provider require an authorization number in order to receive payment from the agency.~~

~~(3) For services covered by the agency through contracts with MCOs:~~

~~(a) The agency requires the MCO to subcontract with a sufficient number of providers to deliver the scope of contracted services in a timely manner. Except for emergency services, MCOs provide covered services to enrollees through their participating providers;~~

~~(b) The agency requires MCOs to provide new enrollees with written information about how enrollees may obtain covered services;~~

~~(c) For nonemergency services, MCOs may require the enrollee to obtain a referral from the primary care provider (PCP), or the provider to obtain authorization from the MCO, according to the requirements of the MCO contract;~~

~~(d) MCOs and their contracted providers determine which services are medically necessary given the enrollee's condition, according to the requirements included in the MCO contract;~~

~~(e) The agency requires the MCO to coordinate benefits with other insurers in a manner that does not reduce benefits to the enrollee or result in costs to the enrollee;~~

~~(f) A managed care enrollee does not need a PCP referral to receive women's health care services, as described in RCW 48.42.100, from any women's health care provider participating with the MCO. Any covered services ordered and/or prescribed by the women's health care provider must meet the MCO's service authorization requirements for the specific service.~~

~~(g) For enrollees temporarily outside their MCO services area, the MCO is required to cover enrollees for emergency care and medically necessary covered benefits that cannot wait until the enrollees return to their MCO services area.~~

~~(4) Unless the MCO chooses to cover these services, or an appeal, or a hearing decision reverses an MCO or agency denial,)) (2) The following services are not covered by the MCO:~~

~~(a) ((For all managed care enrollees:~~

~~(i)) Services that are not medically necessary as defined in WAC 182-500-0070.~~

~~((ii)) (b) Services not included in the categorically needy scope of services.~~

~~((iii)) (c) Services((, other than a screening exam as described in WAC 182-538-100(3),)) received in a hospital emergency department for nonemergency medical conditions, except for a screening exam as described in WAC 182-538-100.~~

~~((b) For MCO enrollees:~~

~~(i))~~ (d) Services received from a participating specialist that require prior authorization from the MCO, but were not authorized by the MCO.

~~((ii) Services received from a nonparticipating provider that require prior authorization from the MCO that were not authorized by the MCO.)~~

(e) All nonemergency services covered under the MCO contract and received from nonparticipating providers ~~((require))~~ that were not prior ((authorization from)) authorized by the MCO.

~~((c) For PCCM enrollees, services that require a referral from the PCCM provider as described in the PCCM contract, but were not referred by the PCCM provider.~~

~~(5))~~ (3) A provider may bill an enrollee for noncovered services as described in subsection ~~((4))~~ (2) of this section, if the requirements of WAC 182-502-0160 are met.

(4) For services covered by the agency through contracts with MCOs:

(a) The agency requires the MCO to subcontract with enough providers to deliver the scope of contracted services in a timely manner. Except for emergency services, MCOs provide covered services to enrollees through their participating providers;

(b) The agency requires MCOs to provide new enrollees with written information about how enrollees may obtain covered services;

(c) For nonemergency services, MCOs may require the enrollee to obtain a referral from the primary care provider (PCP), and/or the provider to obtain authorization from the MCO, according to the requirements of the MCO contract;

(d) MCOs and their contracted providers determine which services are medically necessary given the enrollee's condition, according to the requirements included in the MCO contract;

(e) The agency requires the MCO to coordinate benefits with other insurers in a manner that does not reduce benefits to the enrollee or result in costs to the enrollee;

(f) A managed care enrollee does not need a PCP referral to receive women's health care services, as described in RCW 48.42.100, from any women's health care provider participating with the MCO. Any covered services ordered or prescribed by a women's health care provider must meet the MCO's service authorization requirements for the specific service;

(g) For enrollees outside their MCO services area, the MCO must cover enrollees for emergency care and medically necessary covered benefits that cannot wait until the enrollees return to their MCO services area.

(5)(a) An MCO enrollee may obtain specific services described in the managed care contract from either an MCO-contracted provider or a provider with a separate agreement with the agency without a referral from the PCP or MCO. These services are communicated to enrollees by the agency and MCOs as described in (b) of this subsection.

(b) The agency sends each enrollee written information about covered services when the client must enroll in managed care and any time there is a change in covered services. The agency requires MCOs to provide new enrollees with written information about covered services.

(6) An enrollee is entitled to timely access to covered services that are medically necessary as defined in WAC 182-500-0070.

(7) All nonemergency services covered under the MCO contract and received from nonparticipating providers require prior authorization from the MCO.

NEW SECTION

WAC 182-538-096 Scope of service for PCCM enrollees. (1) A primary care case management (PCCM) enrollee is eligible for the scope of services in WAC 182-501-0060 and 182-501-0065. An enrollee is entitled to timely access to covered services that are medically necessary.

(a) The agency covers services through the fee-for-service system for enrollees with a primary care case management (PCCM) provider. Except for emergencies, the PCCM provider must either provide the covered services or refer the enrollee to other providers who are contracted with the agency for covered services. The PCCM provider is responsible for explaining to the enrollee how to obtain the services for which the PCCM provider is referring the enrollee. Services that require PCCM provider referral are described in the PCCM contract.

(b) The agency sends each enrollee written information about covered services when the client enrolls in managed care and when there is a change in covered services. This information describes covered services, which services are covered by the agency, and how to access services through the PCCM provider.

(2) For services covered by the agency through PCCM contracts for managed care:

(a) The agency covers medically necessary services included in the categorically needy scope of care and furnished by providers who have a current core provider agreement with the agency to provide the requested service;

(b) The agency may require the PCCM provider to obtain authorization from the agency for coverage of nonemergency services;

(c) The PCCM provider determines which services are medically necessary;

(d) Services referred by the PCCM provider require an authorization number to receive payment from the agency; and

(e) An enrollee may request a hearing for review of PCCM provider or agency coverage decisions (see WAC 182-538-110).

(3) The following services are not covered:

(a) Services that are not medically necessary as defined in WAC 182-500-0070.

(b) Services not included in the categorically needy scope of services.

(c) Services, other than a screening exam as described in WAC 182-538-100(3), received in a hospital emergency department for non-emergency medical conditions.

(d) Services that require a referral from the PCCM provider as described in the PCCM contract, but were not referred by the PCCM provider.

AMENDATORY SECTION (Amending WSR 13-02-010, filed 12/19/12, effective 2/1/13)

WAC 182-538-100 Managed care emergency services. (1) A managed care enrollee may obtain emergency services~~((7))~~ for emergency medical conditions from any qualified medicaid provider.

(a) The managed care organization (MCO) covers emergency services for MCO enrollees.

(b) The agency covers emergency services for primary care case management (PCCM) enrollees.

(2) Emergency services for emergency medical conditions do not require prior authorization by the MCO, primary care provider (PCP), PCCM provider, or the agency.

(3) MCOs must cover all emergency services provided to an enrollee by a provider who is qualified to furnish medicaid services, without regard to whether the provider is a participating or nonparticipating provider.

(4) An enrollee who requests emergency services (~~((is entitled to))~~) may receive an exam to determine if the enrollee has an emergency medical condition. What constitutes an emergency medical condition may not be limited on the basis of diagnosis or symptoms.

(5) The MCO must cover emergency services provided to an enrollee when:

(a) The enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an emergency medical condition; and

(b) The plan provider or other MCO representative instructs the enrollee to seek emergency services.

(6) In any disagreement between a hospital and the MCO about whether the enrollee is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the enrollee at the treating facility prevails.

(7) Under 42 C.F.R. 438.114, the enrollee's MCO must cover and pay for:

(a) Emergency services provided to enrollees by an emergency room provider, hospital or fiscal agent outside the managed care system; and

(b) Any screening and treatment the enrollee requires (~~((subsequent to))~~) after the provision of the emergency services.

AMENDATORY SECTION (Amending WSR 13-02-010, filed 12/19/12, effective 2/1/13)

WAC 182-538-110 The grievance system for managed care organizations (MCO). (~~((1) This section contains information about the grievance system for managed care organization (MCO) enrollees, which includes grievances and appeals. See WAC 182-538-111 for information about the grievance system for PCCM enrollees, which includes grievances and appeals.~~)

~~((2) An MCO enrollee may voice a grievance or appeal an action by an MCO to the MCO either orally or in writing.~~

~~(3) MCOs must maintain records of grievances and appeals and must review the information as part of the MCO's quality strategy.~~

~~(4) MCOs must provide information describing the MCO's grievance system to all providers and subcontractors.~~

~~(5) Each MCO must have a grievance system in place for enrollees. The system must comply with the requirements of this section and the regulations of the state office of the insurance commissioner (OIC). If a conflict exists between the requirements of this chapter and OIC regulations, the requirements of this chapter take precedence. The MCO grievance system must include all of the following:~~

~~(a) A grievance process for complaints about any matter other than an action, as defined in WAC 182-538-050. See subsection (6) of this section for this process;~~

~~(b) An appeal process for an action, as defined in WAC 182-538-050. See subsection (7) of this section for the standard appeal process and subsection (8) of this section for the expedited appeal process;~~

~~(c) Access to the agency's hearing process for actions as defined in WAC 182-538-050. The agency's hearing process described in chapter 182-526 WAC applies to this chapter. Where conflicts exist, the requirements in this chapter take precedence.~~

~~(6) The MCO grievance process:~~

~~(a) Only an enrollee may file a grievance with an MCO; a provider may not file a grievance on behalf of an enrollee.~~

~~(b) To ensure the rights of MCO enrollees are protected, each MCO's grievance process must be approved by the agency.~~

~~(c) MCOs must inform enrollees in writing within fifteen days of enrollment about enrollees' rights and how to use the MCO's grievance process, including how to use the agency's hearing process. The MCOs must have agency approval for all written information the MCO sends to enrollees.~~

~~(d) The MCO must give enrollees any assistance necessary in taking procedural steps for grievances (e.g., interpreter services and toll free numbers).~~

~~(e) The MCO must acknowledge receipt of each grievance either orally or in writing, and each appeal in writing, within five working days.~~

~~(f) The MCO must ensure that the individuals who make decisions on grievances are individuals who:~~

~~(i) Were not involved in any previous level of review or decision making; and~~

~~(ii) If deciding any of the following, are health care professionals who have appropriate clinical expertise in treating the enrollee's condition or disease:~~

~~(A) A grievance regarding denial of an expedited resolution of an appeal; or~~

~~(B) A grievance involving clinical issues.~~

~~(g) The MCO must complete the disposition of a grievance and notice to the affected parties within ninety days of receiving the grievance.~~

~~(7) The MCO appeal process:~~

~~(a) An MCO enrollee, or the enrollee's representative with the enrollee's written consent, may appeal an MCO action.~~

~~(b) To ensure the rights of MCO enrollees are protected, each MCO's appeal process must be approved by the agency.~~

~~(c) MCOs must inform enrollees in writing within fifteen days of enrollment about enrollees' rights and how to use the MCO's appeal~~

process and the agency's hearing process. The MCOs must have agency approval for all written information the MCO sends to enrollees.

(d) For standard service authorization decisions, an enrollee must file an appeal, either orally or in writing, within ninety calendar days of the date on the MCO's notice of action. This also applies to an enrollee's request for an expedited appeal.

(e) For appeals for termination, suspension, or reduction of previously authorized services, if the enrollee is requesting continuation of services, the enrollee must file an appeal within ten calendar days of the date of the MCO mailing the notice of action. Otherwise, the time frames in subsection (7)(d) of this section apply.

(f) The MCO's notice of action must:

(i) Be in writing;

(ii) Be in the enrollee's primary language and be easily understood as required in 42 C.F.R. 438.10 (c) and (d);

(iii) Explain the action the MCO or its contractor has taken or intends to take;

(iv) Explain the reasons for the action;

(v) Explain the enrollee's or the enrollee's representative's right to file an MCO appeal;

(vi) Explain the procedures for exercising the enrollee's rights;

(vii) Explain the circumstances under which expedited resolution is available and how to request it (also see subsection (8) of this section);

(viii) Explain the enrollee's right to have benefits continue pending resolution of an appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services (also see subsection (9) of this section); and

(ix) Be mailed as expeditiously as the enrollee's health condition requires, and as follows:

(A) For denial of payment, at the time of any action affecting the claim. This applies only when the client can be held liable for the costs associated with the action.

(B) For standard service authorization decisions that deny or limit services, not to exceed fourteen calendar days following receipt of the request for service, with a possible extension of up to fourteen additional calendar days if the enrollee or provider requests extension. If the request for extension is granted, the MCO must:

(I) Give the enrollee written notice of the reason for the decision for the extension and inform the enrollee of the right to file a grievance if the enrollee disagrees with that decision; and

(II) Issue and carry out the determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

(C) For termination, suspension, or reduction of previously authorized services, ten calendar days prior to such termination, suspension, or reduction, except if the criteria stated in 42 C.F.R. 431.213 and 431.214 are met. The notice must be mailed by a method which certifies receipt and assures delivery within three calendar days.

(D) For expedited authorization decisions, in cases where the provider indicates or the MCO determines that following the standard time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, no later than three calendar days after receipt of the request for service.

~~(g) The MCO must give enrollees any assistance necessary in taking procedural steps for an appeal (e.g., interpreter services and toll-free numbers).~~

~~(h) The MCO must acknowledge receipt of each appeal.~~

~~(i) The MCO must ensure that the individuals who make decisions on appeals are individuals who:~~

~~(i) Were not involved in any previous level of review or decision making; and~~

~~(ii) If deciding any of the following, are health care professionals who have appropriate clinical expertise in treating the enrollee's condition or disease:~~

~~(A) An appeal of a denial that is based on lack of medical necessity; or~~

~~(B) An appeal that involves clinical issues.~~

~~(j) The process for appeals must:~~

~~(i) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal), and must be confirmed in writing, unless the enrollee or provider requests an expedited resolution. Also see subsection (8) for information on expedited resolutions;~~

~~(ii) Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The MCO must inform the enrollee of the limited time available for this in the case of expedited resolution;~~

~~(iii) Provide the enrollee and the enrollee's representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeal process; and~~

~~(iv) Include as parties to the appeal, the enrollee and the enrollee's representative, or the legal representative of the deceased enrollee's estate.~~

~~(k) MCOs must resolve each appeal and provide notice, as expeditiously as the enrollee's health condition requires, within the following time frames:~~

~~(i) For standard resolution of appeals and notice to the affected parties, no longer than forty five calendar days from the day the MCO receives the appeal. This time frame may not be extended.~~

~~(ii) For expedited resolution of appeals, including notice to the affected parties, no longer than three calendar days after the MCO receives the appeal.~~

~~(iii) For appeals for termination, suspension, or reduction of previously authorized services, no longer than forty five calendar days from the day the MCO receives the appeal.~~

~~(l) The notice of the resolution of the appeal must:~~

~~(i) Be in writing. For notice of an expedited resolution, the MCO must also make reasonable efforts to provide oral notice (also see subsection (8) of this section).~~

~~(ii) Include the results of the resolution process and the date it was completed.~~

~~(iii) For appeals not resolved wholly in favor of the enrollee:~~

~~(A) Include information on the enrollee's right to request a agency hearing and how to do so (also see WAC 182-526-0200);~~

~~(B) Include information on the enrollee's right to receive services while the hearing is pending and how to make the request (also see subsection (9) of this section); and~~

~~(C) Inform the enrollee that the enrollee may be held liable for the cost of services received while the hearing is pending, if the~~

hearing decision upholds the MCO's action (also see subsection (10) of this section).

~~(m) If an MCO enrollee does not agree with the MCO's resolution of the appeal, the enrollee may file a request for an agency hearing within the following time frames (see WAC 182-526-0200 for the agency's hearing process for MCO enrollees):~~

~~(i) For hearing requests regarding a standard service, within ninety days of the date of the MCO's notice of the resolution of the appeal.~~

~~(ii) For hearing requests regarding termination, suspension, or reduction of a previously authorized service and the enrollee requests continuation of services pending the hearing, within ten calendar days of the date on the MCO's notice of the resolution of the appeal.~~

~~(n) The MCO enrollee must exhaust all levels of resolution and appeal within the MCO's grievance system prior to requesting a hearing with the agency.~~

~~(8) The MCO expedited appeal process:~~

~~(a) Each MCO must establish and maintain an expedited appeal review process for appeals when the MCO determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request), that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.~~

~~(b) When approving an expedited appeal, the MCO will issue a decision as expeditiously as the enrollee's health condition requires, but not later than three business days after receiving the appeal.~~

~~(c) The MCO must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal.~~

~~(d) If the MCO denies a request for expedited resolution of an appeal, it must:~~

~~(i) Transfer the appeal to the time frame for standard resolution; and~~

~~(ii) Make reasonable efforts to give the enrollee prompt oral notice of the denial, and follow up within two calendar days with a written notice.~~

~~(9) Continuation of previously authorized services:~~

~~(a) The MCO must continue the enrollee's services if all of the following apply:~~

~~(i) The enrollee or the provider files the appeal on or before the later of the following:~~

~~(A) Unless the criteria in 42 C.F.R. 431.213 and 431.214 are met, within ten calendar days of the MCO mailing the notice of action, which for actions involving services previously authorized, must be delivered by a method which certifies receipt and assures delivery within three calendar days; or~~

~~(B) The intended effective date of the MCO's proposed action.~~

~~(ii) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;~~

~~(iii) The services were ordered by an authorized provider;~~

~~(iv) The original period covered by the original authorization has not expired; and~~

~~(v) The enrollee requests an extension of services.~~

~~(b) If, at the enrollee's request, the MCO continues or reinstates the enrollee's services while the appeal is pending, the services must be continued until one of the following occurs:~~

~~(i) The enrollee withdraws the appeal;~~

~~(ii) Ten calendar days pass after the MCO mails the notice of the resolution of the appeal and the enrollee has not requested an agency hearing (with continuation of services until the agency hearing decision is reached) within the ten days;~~

~~(iii) Ten calendar days pass after the state office of administrative hearings (OAH) issues a hearing decision adverse to the enrollee and the enrollee has not requested an appeal to the independent review (IR) organization or petition for review to the agency review judge within the ten days in accordance with the provisions of WAC 182-526-0200;~~

~~(iv) Ten calendar days pass after the IR mails a decision adverse to the enrollee and the enrollee has not requested a review with the board of appeals within the ten days;~~

~~(v) The agency review judge issues a decision adverse to the enrollee; or~~

~~(vi) The time period or service limits of a previously authorized service has been met.~~

~~(c) If the final resolution of the appeal upholds the MCO's action, the MCO may recover the amount paid for the services provided to the enrollee while the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services.~~

~~(10) Effect of reversed resolutions of appeals:~~

~~(a) If the MCO or the final order as defined in chapter 182-526 WAC reverses a decision to deny, limit, or delay services that were not provided while the appeal was pending, the MCO must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires.~~

~~(b) If the MCO or the final order as defined in chapter 182-526 WAC reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO must pay for those services.) (1) This section contains information about the grievance system for managed care organization (MCO) enrollees. See WAC 182-538-111 for information about PCCM enrollees.~~

~~(a) Each MCO must have a grievance system in place for enrollees. The system must comply with the requirements of 42 C.F.R. 438 Subpart F, medicaid agency rules in Title 182 WAC, and the rules of the state office of insurance commissioner (OIC) in chapter 284-43 WAC.~~

~~(b) The agency's hearing rules in chapter 182-526 WAC apply to administrative hearings requested by enrollees to review resolution of an enrollee appeal of an MCO action.~~

~~(c) If a conflict exists between the requirements of this chapter and other rules, the requirements of this chapter take precedence.~~

~~(2) MCO grievance system.~~

~~(a) The MCO grievance system must include:~~

~~(i) A process for addressing complaints about any matter that is not an action, which is called a grievance;~~

~~(ii) An appeals process to address requests for review of an MCO action;~~

~~(iii) Access to an independent review (IR) by an independent review organization (IRO) in accordance with RCW 48.43.535 and WAC 182-526-0200; and~~

~~(iv) Access to the agency's administrative hearing process for review of an MCO's resolution of an appeal.~~

(b) MCOs must provide information describing the MCO's grievance system to all providers and subcontractors.

(c) An MCO must have agency approval for written materials sent to enrollees regarding the grievance system.

(d) MCOs must inform enrollees in writing within fifteen calendar days of enrollment about enrollees' rights with instructions on how to use the MCO's grievance system.

(e) An MCO must give enrollees any reasonable assistance in completing forms and other procedural steps for grievances and appeals (e.g., interpreter services and toll-free numbers).

(f) An MCO must allow enrollees and their authorized representatives to file grievances and appeals orally as well as in writing. MCOs may not require enrollees to provide written follow up for a grievance or an appeal the MCO received orally.

(g) The MCO must resolve each grievance and appeal and provide notice of the resolution as expeditiously as the enrollee's health condition requires, and within the time frames identified in this section.

(h) The MCO must ensure that the individuals who make decisions on grievances and appeals are individuals:

(i) Who were not involved in any previous level of review or decision making; and

(ii) Are health care professionals who have appropriate clinical expertise in treating the enrollee's condition or disease if deciding any of the following:

(A) An appeal of an action concerning medical necessity;

(B) A grievance concerning denial of an expedited resolution of an appeal; or

(C) A grievance or appeal that involves any clinical issues.

(3) The MCO grievance process.

(a) Only an enrollee or enrollee's authorized representative may file a grievance with an MCO. A provider may not file a grievance on behalf of an enrollee without the enrollee's written consent.

(b) An MCO must acknowledge receipt of each grievance filed orally or in writing within two business days.

(c) The MCO must complete the disposition of a grievance and provide notice to the affected parties as expeditiously as the enrollee's health condition requires, but no later than forty-five days after receiving the grievance.

(d) The MCO must notify enrollees of the disposition of grievances within five business days of determination.

(i) Notices of disposition of grievances not involving clinical issues can be oral or in writing.

(ii) Notices of disposition of grievances for clinical issues must be in writing.

(e) Enrollees do not have a right to an administrative hearing in regards to the disposition of a grievance.

(4) The MCO's notice of action.

(a) Language and format requirements. The notice of action must be in writing in enrollee's primary language, and in an easily understood format, in accordance with 42 C.F.R. Sec. 438.404.

(b) Content of notice of action. The notice of MCO action must explain:

(i) The MCO's action or action the MCO intends to take;

(ii) The reasons for the action;

(iii) The enrollee's right to file an appeal;

(iv) The procedures for exercising the enrollee's rights;

(v) The circumstances under which expedited resolution is available and how to request it;

(vi) The enrollee's right to have benefits continued pending resolution of an appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.

(c) Timing of notice of action. The MCO must mail the notice of action within the following time frames:

(i) For termination, suspension, or reduction of previously authorized services, at least ten calendar days prior to such action in accordance with 42 C.F.R. Sec. 438.404 and 431.211. This time period does not apply if the criteria in 42 C.F.R. Sec. 431.213 or 431.214 are met. This notice must be mailed by a method that certifies receipt and assures delivery within three calendar days.

(ii) For denial of payment, at the time of any action affecting the claim. This applies only when the client can be held liable for the costs associated with the action.

(iii) For standard service authorization decisions that deny or limit services, as expeditiously as the enrollee's health condition requires not to exceed fourteen calendar days following receipt of the request for service. An extension of up to fourteen additional days may be allowed if:

(A) The enrollee or enrollee's provider requests the extension.

(B) The MCO determines and justifies to the agency upon request a need for additional information and that the extension is in the enrollee's interest.

(iv) If the MCO extends the time frame for standard service authorization decisions, the MCO must:

(A) Give the enrollee written notice of the reason for the decision to extend and inform the enrollee of the right to file a grievance if the enrollee disagrees with that decision; and

(B) Issue and carry out its determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

(v) For expedited authorization decisions:

(A) In cases where the provider indicates or the MCO determines that following the standard time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice no later than three business days after receipt of the request for service.

(B) The MCO may extend the three business days time frame up to fourteen calendar days if:

(I) The enrollee requests the extension; or

(II) The MCO determines and justifies to the agency upon request a need for additional information and it is in the enrollee's interest.

(5) The MCO appeals process.

(a) An enrollee, the enrollee's authorized representative, or the provider acting with the enrollee's written consent, may appeal an MCO action.

(b) An MCO must treat oral inquiries about appealing an action as an appeal to establish the earliest possible filing date for the appeal. The oral appeal must be confirmed in writing by the MCO, unless the enrollee or provider requests an expedited resolution.

(c) The MCO must acknowledge receipt of each appeal to both the enrollee and the requesting provider within three calendar days. The

appeal acknowledgment letter sent by the MCO serves as written confirmation of an appeal filed orally by an enrollee.

(d) For appeals involving standard service authorization decisions, an enrollee must file an appeal within ninety calendar days of the date on the MCO's notice of action. This time frame also applies to a request for an expedited appeal.

(e) For appeals of actions involving termination, suspension, or reduction of a previously authorized service, and the enrollee is requesting continuation of the service, the enrollee must file an appeal within ten calendar days of the MCO mailing notice of the action.

(f) The MCO appeals process must:

(i) Provide the enrollee a reasonable opportunity to present evidence and allegations of fact or law, both in person and in writing. The MCO must inform the enrollee of the limited time available for this in the case of expedited resolution;

(ii) Provide the enrollee and the enrollee's representative opportunity before and during the appeals process to examine the enrollee's case file, including medical records and any other documents and records considered during the appeals process; and

(iii) Include as parties to the appeal:

(A) The enrollee; and

(B) The enrollee's representative or the legal representative of the deceased enrollee's estate.

(g) Time frames for resolution of appeals. MCOs must resolve each appeal and provide notice as expeditiously as the enrollee's health condition requires, and within the following time frames:

(i) For standard resolution of appeals, including notice to the affected parties, no longer than forty-five calendar days from the day the MCO receives the appeal. This includes appeals involving termination, suspension, or reduction of previously authorized services.

(ii) For expedited resolution of appeals, or appeals of mental health drug authorization decisions, including notice to the affected parties, no longer than three calendar days after the MCO receives the appeal.

(h) Notice of resolution of appeal. The notice of the resolution of the appeal must:

(i) Be in writing and be sent to the enrollee and the requesting provider. For notice of an expedited resolution, the MCO must also make reasonable efforts to provide oral notice.

(ii) Include the results of the resolution process and the date it was completed.

(i) Administrative hearing rights. For appeals not resolved wholly in favor of the enrollee, the notice of resolution of the appeal must:

(i) Include information on the enrollee's right to request an agency administrative hearing and how to do so as provided in the agency hearing rules in WAC 182-526-0200;

(ii) Include information on the enrollee's right to receive services while the hearing is pending and how to make the request as described in the agency hearing rules in WAC 182-526-0200; and

(iii) Inform the enrollee that the enrollee may be held liable for the cost of services received for the first sixty days after an administrative hearing request is received by the agency or the office of administrative hearings (OAH), if the hearing decision upholds the MCO's action.

(6) MCO expedited appeal process.

(a) Each MCO must establish and maintain an expedited appeal review process for appeals when the MCO determines or provider indicates that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

(b) The enrollee may file an expedited appeal either orally or in writing. No additional follow up is required of the enrollee.

(c) The MCO must make a decision on the enrollee's request for expedited appeal and provide written notice as expeditiously as the enrollee's health condition requires and no later than three calendar days after the MCO receives the appeal. The MCO must also make reasonable efforts to orally notify the enrollee of the decision.

(d) The MCO may extend the time frame for decision on the enrollee's request for an expedited appeal up to fourteen days if:

(i) The enrollee requests the extension; or

(ii) The MCO determines there is a need for additional information and the delay is in the enrollee's interest.

(e) The MCO must provide written notice for any extension not requested by the enrollee with the reason for the delay.

(f) If the MCO grants an expedited appeal, the MCO must issue a decision as expeditiously as the enrollee's health condition requires, but not later than three business days after receiving the appeal.

(g) If the MCO denies a request for expedited resolution of an appeal, it must:

(i) Process the appeal based on the time frame for standard resolution;

(ii) Make reasonable efforts to give the enrollee prompt oral notice of the denial; and

(iii) Provide written notice within two calendar days.

(h) The MCO must ensure that punitive action is not taken against a provider who requests an expedited resolution or supports an enrollee's appeal.

(7) Administrative hearing.

(a) Only an enrollee or enrollee's authorized representative may request an administrative hearing. A provider may not request a hearing on behalf of an enrollee.

(b) If an enrollee does not agree with the MCO's resolution of an appeal, the enrollee may file a request for an agency administrative hearing based on the rules in this section and the agency hearing rules in WAC 182-526-0200.

(c) The MCO is an independent party and responsible for its own representation in any administrative hearing, independent review, appeal to the board of appeals, and any subsequent judicial proceedings.

(d) An enrollee must exhaust the appeals process within the MCO's grievance system before requesting an administrative hearing with the agency.

(8) Continuation of previously authorized services during the appeal process.

(a) The MCO must continue the enrollee's services if all of the following apply:

(i) The enrollee or the provider files the appeal on or before the later of the following:

(A) Within ten calendar days of the MCO mailing the notice of action involving services previously authorized; or

(B) The intended effective date of the MCO's proposed action.

(ii) The appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;

(iii) The services were ordered by an authorized provider;
(iv) The original period covered by the original authorization has not expired; and

(v) The enrollee requests an extension of services.

(b) If the MCO continues or reinstates the enrollee's services while the appeal is pending at the enrollee's request, the services must be continued until one of the following occurs:

(i) The enrollee withdraws the appeal;

(ii) Ten calendar days pass after the MCO mails notice of the resolution of the appeal against the enrollee and the enrollee has not requested an agency administrative hearing with continuation of services during the ten day time frame;

(iii) OAH issues a hearing decision adverse to the enrollee;

(iv) The time period or service limits of a previously authorized service has been met.

(c) If the final resolution of the appeal upholds the MCO's action, the MCO may recover from the enrollee the amount paid for the services provided to the enrollee for the first sixty calendar days after the request for hearing was received by the agency or OAH, to the extent that services were provided solely because of the requirement for continuation of services.

(9) Effect of reversed resolutions of appeals.

(a) If the MCO, or a final order as defined in chapter 182-526 WAC, or an independent review organization (IRO) reverses a decision to deny, limit, or delay services that were not provided while the appeal was pending, the MCO must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires.

(b) If the MCO reverses a decision to deny authorization of services or the denial is reversed through an IRO or a final order of OAH or the board of appeals and the enrollee received the disputed services while the appeal was pending, the MCO must pay for those services.

AMENDATORY SECTION (Amending WSR 13-02-010, filed 12/19/12, effective 2/1/13)

WAC 182-538-111 The administrative hearing process for primary care case management (PCCM) ((grievances and appeals)). (1) This section contains information about the ((grievance system)) administrative hearing process for primary care case management (PCCM) enrollees ((, which includes grievances and appeals)). See WAC 182-538-110 for information about the grievance system for managed care organization (MCO) enrollees.

(2) ((A PCCM enrollee may voice a grievance or file an appeal, either orally or in writing. PCCM enrollees use the agency's grievance and appeal processes.

(3) The grievance process for PCCM enrollees;

(a) A PCCM enrollee may file a grievance with the agency. A provider may not file a grievance on behalf of a PCCM enrollee.

(b) The agency provides PCCM enrollees with information equivalent to that described in WAC 182-538-110 (7)(c).

(c) When a PCCM enrollee files a grievance with the agency, the enrollee is entitled to:

- ~~(i) Any reasonable assistance in taking procedural steps for grievances (e.g., interpreter services and toll free numbers);~~
- ~~(ii) Acknowledgment of the agency's receipt of the grievance;~~
- ~~(iii) A review of the grievance. The review must be conducted by an agency representative who was not involved in the grievance issue; and~~
- ~~(iv) Disposition of the grievance and notice to the affected parties within ninety days of the agency receiving the grievance.~~
- ~~(4) The appeal process for PCCM enrollees:~~
 - ~~(a) A PCCM enrollee may file an appeal of an agency action with the agency. A provider may not file an appeal on behalf of a PCCM enrollee.~~
 - ~~(b) The agency provides PCCM enrollees with information equivalent to that described in WAC 182-538-110 (8)(c).~~
 - ~~(c) The appeal process for PCCM enrollees follows that described in chapter 182-526 WAC. Where a conflict exists, the requirements in this chapter take precedence.)) PCCM enrollees follow the same administrative hearing rules and processes as fee-for-service clients under chapter 182-526 WAC.~~

AMENDATORY SECTION (Amending WSR 13-02-010, filed 12/19/12, effective 2/1/13)

WAC 182-538-130 Exemptions and ending enrollment in managed care. ((1) The agency exempts a client from mandatory enrollment in managed care or ends an enrollee's enrollment in managed care as specified in this section.

(2) A client or enrollee, or the client's or enrollee's representative as defined in RCW 7.70.065, may request that the agency exempt or end enrollment in managed care as described in this section.

(a) If a client requests exemption prior to the enrollment effective date, the client is not enrolled until the agency approves or denies the request.

(b) If an enrollee requests to end enrollment, the enrollee remains enrolled pending the agency's final decision, unless staying in managed care would adversely affect the enrollee's health status.

(c) The client or enrollee receives timely notice by telephone or in writing when the agency approves or denies the client's or enrollee's request. The agency follows a telephone denial by written notification. The written notice contains all of the following:

- (i) The action the agency intends to take;
- (ii) The reason(s) for the intended action;
- (iii) The specific rule or regulation supporting the action;
- (iv) The client's or enrollee's right to request a hearing; and
- (v) A translation into the client's or enrollee's primary language when the client or enrollee has limited English proficiency.

(3) A managed care organization (MCO) or primary care case management (PCCM) provider may request that the agency end enrollment. The request must be in writing and be sufficient to satisfy the agency that the enrollee's behavior is inconsistent with the MCO's or PCCM provider's rules and regulations (e.g., intentional misconduct). The agency does not approve a request to remove an enrollee from managed care when the request is solely due to an adverse change in the enrol-

lee's health or the cost of meeting the enrollee's health care needs. The MCO or PCCM provider's request must include documentation that:

(a) The enrollee purposely put the safety and property of the contractor or the contractor's staff, providers, patients, or visitors at risk;

(b) The enrollee refused to follow procedures or treatment recommended by the enrollee's provider and determined by the contractor's medical director to be essential to the enrollee's health and safety and the enrollee has been told by the provider and/or the contractor's medical director that no other treatment is available;

(c) The enrollee engaged in intentional misconduct, including refusing to provide information to the contractor about third party insurance coverage; or

(d) The MCO conducted a clinically appropriate evaluation to determine whether there was a treatable problem contributing to the enrollee's behavior and there was not a treatable problem or the enrollee refused to participate in treatment.

(e) The enrollee received written notice of the provider's intent to request the enrollee's removal, unless the agency has waived the requirement for provider notice because the enrollee's conduct presents the threat of imminent harm to others. The provider's notice must include:

(i) The enrollee's right to use the provider's grievance system as described in WAC 182-538-110 and 182-538-111; and

(ii) The enrollee's right to use the agency's hearing process, after the enrollee has exhausted all grievance and appeals available through the provider's grievance system (see WAC 182-538-110 and 182-538-111 for provider grievance systems, and WAC 182-526-0200 for the hearing process for enrollees).

(4) When the agency receives a request from an MCO or PCCM provider to remove an enrollee from enrollment in managed care, the agency attempts to contact the enrollee for the enrollee's perspective. If the agency approves the request, the agency sends a notice at least ten calendar days in advance of the effective date that enrollment will end. The notice includes:

(a) The reason the agency approved ending enrollment; and

(b) Information about the enrollee's hearing rights.

(5) The agency will exempt a client from mandatory enrollment or end an enrollee's enrollment in managed care when any of the following apply:

(a) The client has or the enrollee becomes eligible for Medicare, CHAMPUS/TRICARE, or any other third party health care coverage comparable to the agency's managed care coverage that would require exemption or involuntarily ending enrollment from:

(i) An MCO, in accordance with the agency's managed care contract; or

(ii) A primary care case management (PCCM) provider, according to the agency's PCCM contract.

(b) The enrollee is no longer eligible for managed care.

(6) The agency will grant a client's request for exemption or an enrollee's request to end enrollment when:

(a) The client or enrollee is American Indian or Alaska native (AI/AN) as specified in WAC 182-538-060(2); or

(b) The client or enrollee is homeless or is expected to live in temporary housing for less than one hundred twenty days from the date of the request.

~~(7) On a case by case basis, the agency will grant a client's request for exemption or an enrollee's request to end enrollment when, in the agency's judgment, the client or enrollee has a documented treatment plan for medically necessary care by a provider who is not available through any contracted MCO and enrollment would likely disrupt that treatment in such a way as to cause an interruption of treatment that could jeopardize the client's or enrollee's life or health or ability to attain, maintain, or regain maximum function.~~

~~(8) Upon request, the agency may exempt the client or end enrollment for the period of time the circumstances or conditions described in subsection (7) of this section are expected to exist. The agency may periodically review those circumstances or conditions to determine if they continue to exist. If the agency approves the request for a limited time, the client or enrollee is notified in writing or by telephone of the time limitation, the process for renewing the exemption or the ending of enrollment.)~~ (1) The agency exempts a client from enrollment or end enrollment from mandatory managed care when any of the following apply:

(a) The client has or the enrollee becomes eligible for medicare, TRICARE, or any other third-party health care coverage comparable to the agency's managed care coverage;

(b) The client or enrollee is not eligible for managed care enrollment, for Washington apple health programs, or both; or

(c) A request for exemption or to end enrollment is received and approved by the agency as described in this section.

(i) If a client requests exemption before the enrollment effective date, the client is not enrolled until the agency approves or denies the request.

(ii) If an enrollee request to end enrollment is received after the enrollment effective date, the enrollee remains enrolled pending the agency's decision.

(2)(a) The following people may request that the agency exempt or end enrollment in managed care as described in this section:

(i) A client or enrollee;

(ii) A client or enrollee's authorized representative under WAC 182-503-0130; or

(iii) A client or enrollee's representative as defined in RCW 7.70.065.

(b) The agency grants a request to exempt or end enrollment in managed care when the client or enrollee:

(i) Is American Indian or Alaska native;

(ii) Lives in an area or is enrolled in a Washington apple health program in which participation in managed care is voluntary; or

(iii) Requires care that meets the criteria in subsection (3) of this section for case-by-case clinical exemptions or ending of enrollment.

(3) Case-by-case clinical exemption for ending of enrollment.

(a) The following criteria must be met:

(i) The care must be medically necessary;

(ii) That medically necessary care is covered under the agency's managed care contracts;

(iii) The client is receiving the medically necessary care from an established provider or providers who is not available through any contracted MCO; and

(iv) It is medically necessary to continue that care from the established provider or providers.

(b) When the agency approves a request for exemption or ending enrollment, the agency will notify the client or enrollee of its decision by telephone or in writing. If the agency approves the request for a limited time, the client or enrollee is notified of the time limitation and the process for renewing the exemption or the ending of enrollment.

(c) When the agency denies a request for exemption or ending enrollment, the agency will notify the client or enrollee of its decision by telephone or in writing and confirms a telephone notification in writing. When a client or enrollee is limited-English proficient, the written notice must be available in the client's or enrollee's primary language under 42 C.F.R. 438.10. The written notice must contain all the following information:

(i) The agency's decision;

(ii) The reason for the decision;

(iii) The specific rule or regulation supporting the decision;

and

(iv) The right to request an agency administrative hearing.

(d) If a client or enrollee does not agree with the agency's decision regarding a request for exemption or to end enrollment, the client or enrollee may file a request for an agency administrative hearing based on RCW 74.09.741, the rules in this chapter, and the agency hearing rules in chapter 182-526 WAC.

(e) A client who appeals an agency decision under this section and requests to remain out of managed care pending their appeal will have their request evaluated according to WAC 182-504-0130.

(4) The agency will grant a request from an MCO to remove an enrollee from enrollment on a case-by-case basis when the request is submitted to the agency in writing and includes sufficient documentation for the agency to determine that the criteria for ending enrollment in this subsection is met.

(a) All of the following criteria must be met to end enrollment:

(i) The enrollee puts the safety or property of the contractor or the contractor's staff, providers, patients, or visitors at risk and the enrollee's conduct presents the threat of imminent harm to others, except for enrollees described in (c) of this subsection;

(ii) A clinically appropriate evaluation was conducted to determine whether there was a treatable problem contributing to the enrollee's behavior and there was not a treatable problem or the enrollee refused to participate; and

(iii) The enrollee's health care needs have been coordinated as contractually required and the safety concerns cannot be addressed.

(b) The agency will not approve a request to end enrollment when the request is solely due to any of the following:

(i) An adverse change in the enrollee's health status;

(ii) The cost of meeting the enrollee's health care needs or because of the enrollee's utilization of services;

(iii) The enrollee's diminished mental capacity; or

(iv) Uncooperative or disruptive behavior resulting from the enrollee's special needs or behavioral health condition, except when continued enrollment in the MCO or PCCM seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees.

(c) When the agency receives a request from an MCO to remove an enrollee from enrollment in managed care, the agency reviews each request on a case-by-case basis. The agency will respond to the MCO in

writing with the decision. If the agency grants the request to end enrollment:

(i) The MCO will notify the enrollee in writing of the decision. The notice must include:

(A) The enrollee's right to use the MCO's grievance system as described in WAC 182-538-110; and

(B) The enrollee's right to use the agency's hearing process (see WAC 182-526-0200 for the hearing process for enrollees).

(ii) The agency will send a written notice to the enrollee at least ten calendar days in advance of the effective date that enrollment will end. The notice to the enrollee includes the information in subsection (3)(c) of this section.

(d) The MCO will continue to provide services to the enrollee until the date the individual is no longer enrolled.

(5) The agency may exempt the client for the period of time the circumstances or conditions described in this section are expected to exist. The agency may periodically review those circumstances or conditions to determine if they continue to exist. Any authorized exemption or ending of enrollment will continue only until the client can be enrolled in managed care.

AMENDATORY SECTION (Amending WSR 13-02-010, filed 12/19/12, effective 2/1/13)

WAC 182-538-140 Quality of care. (1) To assure that managed care enrollees receive quality health care services, the agency requires managed care organizations (MCOs) to comply with quality improvement standards detailed in the agency's managed care contract. MCO's must:

(a) Have a clearly defined quality organizational structure and operation, including a fully operational quality assessment, measurement, and improvement program;

(b) Have effective means to detect over and (~~under utilization~~) underutilization of services;

(c) Maintain a system for provider and practitioner credentialing and recredentialing;

(d) Ensure that MCO subcontracts and the delegation of MCO responsibilities (~~are in accordance~~) align with (~~the~~) agency standards (~~and regulations~~);

(e) Ensure MCO oversight of delegated entities responsible for any delegated activity to include:

(i) A delegation agreement with each entity describing the responsibilities of the MCO and the entity;

(ii) Evaluation of the entity (~~prior to~~) before delegation;

(iii) An annual evaluation of the entity; and

(iv) Evaluation or regular reports and follow-up on issues (~~out of compliance~~) that are not compliant with the delegation agreement or the agency's managed care contract specifications.

(f) Cooperate with an agency-contracted, qualified independent external quality review organization (EQRO) conducting review activities as described in 42 C.F.R. 438.358;

(g) Have an effective mechanism to assess the quality and appropriateness of care furnished to enrollees with special health care needs;

(h) Assess and develop individualized treatment plans for enrollees with special health care needs which ensure integration of clinical and nonclinical disciplines and services in the overall plan of care;

(i) Submit annual reports to the agency on performance measures as specified by the agency;

(j) Maintain a health information system that:

(i) Collects, analyzes, integrates, and reports data as requested by the agency;

(ii) Provides information on utilization, grievances and appeals, enrollees ending enrollment for reasons other than the loss of medic-aid eligibility, and other areas as defined by the agency;

(iii) Collects data on enrollees, providers, and services provided to enrollees through an encounter data system, in a standardized format as specified by the agency; and

(iv) Ensures data received from providers is adequate and complete by verifying the accuracy and timeliness of reported data and screening the data for completeness, logic, and consistency.

(k) Conduct performance improvement projects designed to achieve significant improvement, sustained over time, in clinical care outcomes and services, and that involve the following:

(i) Measuring performance using objective quality indicators;

(ii) Implementing system changes to achieve improvement in service quality;

(iii) Evaluating the effectiveness of system changes;

(iv) Planning and initiating activities for increasing or sustaining performance improvement;

(v) Reporting each project status and the results as requested by the agency; and

(vi) Completing each performance improvement project timely so as to generally allow aggregate information to produce new quality of care information every year.

(l) Ensure enrollee access to health care services;

(m) Ensure continuity and coordination of enrollee care; ((and))

(n) Maintain and monitor availability of health care services for enrollees;

(o) Perform client satisfaction surveys; and

(p) Obtain and maintain national committee on quality assurance (NCQA) accreditation.

(2) The agency may:

(a) Impose intermediate sanctions ((in accordance with)) under 42 C.F.R. 438.700 and corrective action for substandard rates of clinical performance measures and for deficiencies found in audits and on-site visits;

(b) Require corrective action for findings for noncompliance with any contractual state or federal requirements; and

(c) Impose sanctions for noncompliance with any contractual, state, or federal requirements not corrected.

NEW SECTION

WAC 182-538-150 Apple health foster care program. (1) Unless otherwise stated in this section, all of the provisions of chapter 182-538 WAC apply to apple health foster care (AHFC).

(2) The following sections of chapter 182-538 WAC do not apply to AHFC:

- (a) WAC 182-538-068;
- (b) WAC 182-538-071;
- (c) WAC 182-538-096; and
- (d) WAC 182-538-111.

(3) Enrollment in AHFC is voluntary for eligible individuals. The agency will enroll eligible individuals in the single MCO that serves children and youth in foster care and adoption support, and young adult alumni of the foster care system.

(a) The agency will not enroll a client in AHFC or will end an enrollee's enrollment in AHFC when the client has, or becomes eligible for, TRICARE or any other third-party health care coverage that would:

- (i) Require the agency to either exempt the client from enrollment in managed care; or
- (ii) End the enrollee's enrollment in managed care.

(b) An AHFC enrollee may request exemption from enrollment or termination of enrollment in AHFC without cause if the client is in the adoption support or young adult alumni programs under WAC 182-538-130.

(4) In addition to the scope of medical care services in WAC 182-538-095, AHFC coordinates health care services for enrollees with the department of social and health services community mental health system and other health care systems as needed.

(5) The agency sends written information about covered services when the individual becomes eligible to enroll in AHFC and at any time there is a change in covered services. In addition, the agency requires MCOs to provide new enrollees with written information about:

- (a) Covered services;
- (b) The right to grievances and appeals through the MCO; and
- (c) Hearings through the agency.

REPEALER

The following sections of the Washington Administrative Code are repealed:

- | | |
|-----------------|---|
| WAC 182-538-061 | Voluntary enrollment into managed care—
Washington medicaid integration
partnership (WMIP). |
| WAC 182-538-063 | Managed care for medical care services
clients. |
| WAC 182-538-065 | Medicaid-eligible basic health (BH)
enrollees. |