RULE-MAKING ORDER

CR-103P (May 2009)
(Implements RCW 34.05.360)

Agency: Health Care Authority, Washington Apple Health

Permanent Rule Only

Effective date of rule:

Permanent Rules

☐ 31 days after filing.

☒ Other (specify) April 1, 2016 **(If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)**

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?

☐ Yes ☒ No If Yes, explain:

Purpose:

The agency is creating three WAC chapters to govern the Washington Apple Health Fully Integrated Managed Care Program, which will go into effect April 1, 2016. The program integrates crisis, substance use disorder, physical health, and behavioral health services in Fully Integrated Managed Care Regional Service Areas.

Citation of existing rules affected by this order:

Repealed:
Amended:
Suspended:

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 16-01-173 on December 22, 2015.

Describe any changes other than editing from proposed to adopted version: See Attachment.

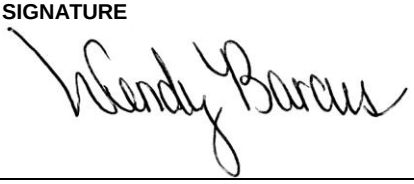
If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name: phone ( ) _____
Address: fax ( ) _____
e-mail _____

Date adopted: February 11, 2016

NAME
Wendy Barcus

SIGNATURE



TITLE
HCA Rules Coordinator

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: February 11, 2016
TIME: 3:51 PM

WSR 16-05-051

(COMPLETE REVERSE SIDE)

Note: If any category is left blank, it will be calculated as zero. No descriptive text.

Count by whole WAC sections only, from the WAC number through the history note. A section may be counted in more than one category.

The number of sections adopted in order to comply with:

Federal statute:	New	_____	Amended	_____	Repealed	_____
Federal rules or standards:	New	_____	Amended	_____	Repealed	_____
Recently enacted state statutes:	New	_____	Amended	_____	Repealed	_____

The number of sections adopted at the request of a nongovernmental entity:

New _____ Amended _____ Repealed _____

The number of sections adopted in the agency's own initiative:

New _____ Amended _____ Repealed _____

The number of sections adopted in order to clarify, streamline, or reform agency procedures:

New 29 Amended __ Repealed _____

The number of sections adopted using:

Negotiated rule making:	New	_____	Amended	_____	Repealed	_____
Pilot rule making:	New	_____	Amended	_____	Repealed	_____
Other alternative rule making:	New	29	Amended	_____	Repealed	_____

ATTACHMENT

182-538A-040

"Mental health professional" means:

(a) A psychiatrist, psychologist, psychiatric nurse, or social worker as defined in chapters 71.05 and 71.34 RCW;

(b) A person who is licensed by the department of health as a mental health counselor, mental health counselor associate, marriage and family therapist, or marriage and family therapist associate;

(c) A person with a master's degree or further advanced degree in counseling or one of the social behavioral sciences from an accredited college or university who has at least two years of experience in direct treatment of persons with mental illness or emotional disturbance that was gained under the supervision of a mental health professional and is recognized by the department of social and health services;

(d) A person who meets the waiver criteria of RCW 71.24.260, which was granted before 1986;

(e) A person who had an approved waiver to perform the duties of a mental health professional that was ~~requested by the regional support network (RSN) and~~ granted by the mental health division before July 1, 2001; or

(f) A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the department of social and health services consistent with WAC 388-865-0265.

182-538A-160

~~(6) See chapter 182-538B WAC and WAC 182-538A-160 for program integrity requirements for substance abuse prevention and treatment (SAPT) block grant funds.~~

182-538B-040

(2) Washington apple health fully integrated managed care (FIMC) behavioral health wraparound services are~~:~~

~~(a) Not covered by medicaid funding and are funded by state-only federal block grant services (CFS/SAPT) funding.~~

~~(b) A~~available only through a managed care organization (MCO) contracted to provide FIMC services or behavioral health services only (BHSO).

(3) The MCO provides contracted nonmedicaid funded behavioral health wraparound services to medicaid enrollees in an FIMC regional service area:

(a) Within available resources;

(b) Based on medical necessity; and

(c) In order of priority to populations as identified by state and federal authorities.

(4) When ~~GFS/SAPT~~ non-medicaid funding is exhausted, behavioral health wraparound services are no longer paid for and cannot be authorized regardless of medical necessity.

182-538B-210

~~WAC 182-538B-210 Program integrity requirements for substance abuse prevention and treatment block grant.~~ ~~(1) The department of social and health services monitors:~~

~~(a) Substance abuse and mental health services administration (SAMHSA) block grant fund expenditures; and~~

~~(b) Substance abuse prevention and treatment (SAPT) block grant funds.~~

~~(2) A managed care organization (MCO) and its contractors work with the medicaid agency and the department to develop:~~

~~(a) Policies;~~

~~(b) Procedures;~~

~~(c) Reporting relationships; and~~

~~(d) Data collection processes and systems.~~

Chapter 182-538A WAC
WASHINGTON APPLE HEALTH FULLY INTEGRATED MANAGED CARE (FIMC)

NEW SECTION

WAC 182-538A-040 Washington apple health fully integrated managed care. (1) This chapter governs the services provided under the medicaid agency's Washington apple health fully integrated managed care (FIMC) medicaid contract.

(a) FIMC provides physical and behavioral health services to medicaid beneficiaries through managed care.

(b) FIMC includes enrollees receiving behavioral health services only (BHSO).

(c) FIMC services are available only through a contracted managed care organization (MCO) and its provider network.

(d) For behavioral health services provided to individuals outside of FIMC regional service areas, see chapters 388-865, 388-877, 388-877A, 388-877B, and 388-877C WAC.

(2) To provide physical and behavioral health services or BHSO under the FIMC medicaid contract, an MCO must contract with the agency.

(3) To be eligible to contract with the agency to provide FIMC services, the MCO must:

(a) Have a certificate of registration from the Washington state 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 contracts;

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

(d) Successfully participate in an on-site readiness review conducted by the agency; and

(e) Be awarded a contract through a competitive process or an application process available to all qualified providers at the discretion of the agency.

(4) The agency reserves the right not to contract with any otherwise qualified MCO.

(5) Chapter 182-538 WAC applies to this chapter. If the rules are in conflict, this chapter takes precedence.

NEW SECTION

WAC 182-538A-050 Definitions. The following definitions and abbreviations and those found in chapters 182-500 and 182-538 WAC apply to this chapter.

"Administrative hearing" means an adjudicative proceeding before an administrative law judge or a presiding officer that is governed by chapters 34.05 RCW and 182-526 WAC.

"Appeal" means a request for review of an action under WAC 182-538-110 and 42 C.F.R. Sec. 438.400(b).

"Apple health adult coverage (AHAC)" means the range of services available to people eligible to receive health care coverage under the Washington apple health modified adjusted gross income (MAGI)-based adult coverage.

"Behavioral health" includes mental health, substance use disorders and conditions, and benefits related to treatment.

"Behavioral health administrative services organization (BH-ASO)" means an entity selected by the agency to administer behavioral health services and programs, including crisis services for all individuals in a defined regional service area, regardless of an individual's insurance status or ability to pay.

"Behavioral health services only (BHSO)" - The program in which enrollees only receive behavioral health benefits through a managed care delivery system.

"Brief intervention treatment" – Solution-focused and outcome-oriented cognitive and behavioral interventions intended to improve symptoms, resolve situational disturbances that are not amenable to resolution in a crisis service model of care, and which do not require long-term treatment to return the individual to previous higher levels of general functioning. This service is provided by or under the supervision of a mental health professional.

"Crisis services" – See WAC 182-538C-150.

"Division of behavioral health and recovery (DBHR)" means the department of social and health services designated state behavioral health authority to administer state-only, federal block grant, and medicaid-funded behavioral health programs.

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

"Fully integrated managed care (FIMC)" means the program covered by this chapter, under which behavioral health services are added to an agency managed care contract.

"Mental health professional" means:

(a) A psychiatrist, psychologist, psychiatric nurse, or social worker as defined in chapters 71.05 and 71.34 RCW;

(b) A person who is licensed by the department of health as a mental health counselor, mental health counselor associate, marriage and family therapist, or marriage and family therapist associate;

(c) A person with a master's degree or further advanced degree in counseling or one of the social behavioral sciences from an accredited college or university who has at least two years of experience in direct treatment of persons with mental illness or emotional disturbance that was gained under the supervision of a mental health professional and is recognized by the department of social and health services;

(d) A person who meets the waiver criteria of RCW 71.24.260, which was granted before 1986;

(e) A person who had an approved waiver to perform the duties of a mental health professional that was granted by the mental health division before July 1, 2001; or

(f) A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the department of social and health services consistent with WAC 388-865-0265.

"Patient days of care" means all voluntary patients and involuntarily committed patients under chapter 71.05 RCW, regardless of where in the state hospital the patients reside. Patients who are committed to the state hospital under chapter 10.77 RCW are not included in the patient days of care. Patients who are committed under RCW 10.77.088 by municipal or district courts after failed competency restoration

and dismissal of misdemeanor charges are not counted in the patient days of care until a petition for ninety days of civil commitment under chapter 71.05 RCW has been filed in court. Patients who are committed under RCW 10.77.086 by a superior court after failed competency restoration and dismissal of felony charges are not counted in the patient days of care until the patient is civilly committed under chapter 71.05 RCW.

"Regional service area (RSA)" means a single county or multi-county grouping formed for the purpose of health care purchasing and designated by the agency and the department of social and health services.

"Wraparound with intensive services (WISe)" is a program that provides comprehensive behavioral health services and support to:

(a) Medicaid-eligible people age twenty or younger with complex behavioral health needs; and

(b) Their families.

NEW SECTION

WAC 182-538A-060 Fully integrated managed care and choice. (1) Except as provided in subsection (2) of this section, the medicaid agency requires a client to enroll in a fully integrated managed care (FIMC) managed care organization (MCO) when that client:

(a) Is eligible;

(b) Resides in a mandatory enrollment FIMC regional service area; and

(c) Is not exempt from FIMC enrollment.

(2)(a) American Indian and Alaska native (AI/AN) clients and their descendants may choose one of the following:

(i) Enrollment with an FIMC MCO available in their regional service area;

(ii) Enrollment with a primary care case management (PCCM) provider through a tribal clinic or urban Indian center available in their area, which includes mandatory enrollment into a behavioral health services only (BHSO) MCO; or

(iii) The agency's fee-for-service system, which includes mandatory enrollment into a BHSO MCO.

(b) To enroll with an FIMC MCO or PCCM provider, an AI/AN client may:

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

(ii) Mail or fax the following to the agency's unit responsible for FIMC enrollment:

(A) Form HCA 13-664; or

(B) Form HCA 13-862 found online at https://www.hca.wa.gov/medicaid/forms/pages/index.aspx.

(iii) Enroll online through the Washington Healthplanfinder at https://www.wahealthplanfinder.org; or

(iv) Go to the ProviderOne client portal at https://www.waproviderone.org/client and follow the prompts.

(3) A client must enroll with an FIMC MCO available in the regional service area where the client resides.

(4) The agency enrolls all family members with the same FIMC MCO, if available.

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

(6) When a client requests enrollment with an FIMC MCO or PCCM provider, the agency enrolls a client effective the first day of the current month a client becomes eligible.

(7) To enroll with an FIMC MCO, a client may:

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

(b) Mail or fax the following to the agency's unit responsible for FIMC enrollment:

(i) Form HCA 13-664; or

(ii) Form HCA 13-862 found online at https://www.hca.wa.gov/medicaid/forms/pages/index.aspx.

(c) Enroll online through the Washington Healthplanfinder at https://www.wahealthplanfinder.org; or

(d) Go to the ProviderOne client portal at https://www.waproviderone.org/client and follow the prompts.

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

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

(b) If the client has a family member or members enrolled with a PCCM provider, the client is enrolled with that PCCM provider;

(c) The client is reenrolled within the previous six months with their prior MCO plan if:

(i) The agency identifies the prior MCO and the program is available; and

(ii) The client does not have a family member enrolled with an agency-contracted MCO or PCCM provider.

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

(e) If the client cannot be assigned according to (a), (b), (c), or (d) of this subsection, the agency assigns the client according to agency policy.

(9) An FIMC enrollee's selection of a primary care provider (PCP) or assignment to a PCP occurs as follows:

(a) An FIMC enrollee may choose:

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

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

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

(c) An FIMC enrollee may change PCPs or clinics for any reason, provided the PCP or clinic is within the enrollee's FIMC MCO's provider network and accepting new enrollees.

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

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

NEW SECTION

WAC 182-538A-067 Qualifications to become a managed care organization (MCO) in fully integrated managed care (FIMC) regional service areas. (1) In addition to subsection (2) of this section, see WAC 182-538A-060 regarding qualifications to become a managed care organization (MCO) in fully integrated managed care (FIMC) regional service areas.

(2) An MCO must contract with an agency-contracted behavioral health administrative service organization (BH-ASO) that maintains an adequate provider network to deliver services to clients in FIMC regional service areas.

NEW SECTION

WAC 182-538A-068 Qualifications to become a primary care case management (PCCM) provider in fully integrated managed care (FIMC) regional service areas. See WAC 182-538-068 regarding qualifications to become a primary care case management (PCCM) provider in fully integrated managed care (FIMC) regional service areas.

NEW SECTION

WAC 182-538A-070 Payments to managed care organizations (MCOs) in fully integrated managed care (FIMC) regional service areas. (1) In addition to the rules in this section, see WAC 182-538-070 regarding payments to managed care organizations (MCOs) in fully integrated managed care (FIMC) regional service areas.

(2) The agency pays MCOs a service-based enhancement rate for wraparound with intensive services (WISe) administered by a certified WISe provider who holds a current behavioral health agency license issued by the division of behavioral health and recovery (DBHR) under chapter 388-877 WAC.

(3) For crisis services, the MCO must determine whether the individual receiving the services is eligible for Washington apple health or if the individual has other insurance coverage.

(4) The MCO pays a reimbursement for each state hospital patient day of care that exceeds the MCO daily allocation of state hospital beds based on a quarterly calculation of the bed usage.

(a) The agency bills the MCO quarterly for state hospital patient days of care exceeding the MCO daily allocation of state hospital beds and the established rate of reimbursement.

(b) An MCO using fewer patient days of care than its quarterly allocation of state hospital beds receives a portion of the reimbursement collected proportional to its share of the total number of patient days of care that were not used at the appropriate state hospital.

(5) The agency may:

(a) Impose intermediate sanctions 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;

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

(d) Apply a monthly penalty assessment associated with poor performance on selected behavioral health performance measures.

NEW SECTION

WAC 182-538A-071 Payments to primary care case management (PCCM) providers in fully integrated managed care (FIMC) regional service areas. See WAC 182-538-071 for rules regarding payments to primary care case management (PCCM) providers in fully integrated managed care (FIMC) regional service areas.

NEW SECTION

WAC 182-538A-095 Scope of care for fully integrated managed care (FIMC) and behavioral health services only (BHSO) enrollees. (1) The rules in WAC 182-538-095 apply to this chapter. If the rules are in conflict, this chapter takes precedence.

(2) An enrollee in fully integrated managed care (FIMC) or behavioral health services only (BHSO) is eligible only for the scope services identified as covered in WAC 182-501-0060 and other program rules based on the enrollee's eligibility program, including the alternative benefit plan (ABP), categorically needy (CN), or medically needy (MN) programs.

(3) The managed care organization (MCO) covers services included under the FIMC medicaid contract for an FIMC or BHSO enrollee. An MCO may, at its discretion, cover services not required under the FIMC medicaid contract.

(4) The agency covers services identified as covered for an FIMC or BHSO enrollee that are not included in the FIMC medicaid contract.

(5) The MCO is not required to pay for services covered under the FIMC medicaid contract for an FIMC or BHSO enrollee if the services are:

(a) Determined not to be medically necessary for the enrollee as defined in WAC 182-500-0070;

(b) Received by the enrollee from a participating specialist that required prior authorization but were not prior authorized by the MCO;

(c) Nonemergency services received by the enrollee from nonparticipating providers that were not prior authorized by the MCO; or

(d) Received by the enrollee in a hospital emergency department for nonemergency medical conditions, except for a screening exam as described in WAC 182-538-100.

(6) The provider may bill the enrollee for noncovered services if the requirements of WAC 182-502-0160 are met.

NEW SECTION

WAC 182-538A-100 Managed care emergency services for fully integrated managed care (FIMC) enrollees. The managed care organization (MCO) covers emergency services for fully integrated managed care (FIMC) enrollees as described in WAC 182-538-100.

NEW SECTION

WAC 182-538A-110 The grievance system for fully integrated managed care (FIMC) managed care organizations (MCOs). Managed care enrollees in fully integrated managed care (FIMC) regional service areas may file grievances or appeal actions through the grievance system of managed care organizations (MCOs) as described in WAC 182-538-110.

NEW SECTION

WAC 182-538A-111 The administrative hearing process for primary care case management (PCCM) enrollees in FIMC regional service areas. See WAC 182-538-111 regarding the administrative hearing process for primary care case management enrollees in fully integrated managed care (FIMC) regional service areas.

NEW SECTION

WAC 182-538A-120 Fully integrated managed care (FIMC) enrollee request for a second medical opinion. Enrollees in fully integrated managed care (FIMC) regional service areas have a right to request a second medical opinion as described in WAC 182-538-120.

NEW SECTION

WAC 182-538A-130 Exemptions and ending enrollment in fully integrated managed care (FIMC). (1) Fully integrated managed care (FIMC) and behavioral health services only (BHSO) are mandatory for individuals in FIMC regional service areas. The medicaid agency enrolls a client into either FIMC or BHSO, depending on eligibility.

(2) WAC 182-538A-060 applies to disenrollment and choice.

(3) A client may end enrollment in FIMC if:

(a) The client has comparable coverage; or

(b) The client's request to end enrollment is approved by the agency under one of the following circumstances:

(i) The enrollee moves out of the FIMC regional service area;

(ii) Medically necessary care is unavailable from the MCO including, but not limited to, when:

(A) The MCO does not, because of moral or religious objections, deliver the service the enrollee seeks; or

(B) The enrollee needs related services performed at the same time and not all related services are available within the network and the enrollee's primary care provider or another provider determines receiving the services separately would subject the enrollee to unnecessary risk.

(4) If an enrollee ends enrollment in FIMC, the agency enrolls the enrollee in BHSO if the enrollee is eligible.

NEW SECTION

WAC 182-538A-140 Fully integrated managed care (FIMC) quality of care. WAC 182-538-140 applies to fully integrated managed care (FIMC) regional service areas.

NEW SECTION

WAC 182-538A-150 Apple health foster care program in fully integrated managed care regional service areas. The following apply to foster care enrollees in fully integrated managed care (FIMC) regional service areas:

(1) WAC 182-538-150; and

(2) WAC 182-538A-190.

NEW SECTION

WAC 182-538A-160 Program integrity requirements. (1) Chapters 182-502A and 182-520 WAC apply to this chapter. If the rules are in conflict, this chapter takes precedence.

(2) To comply with program integrity standards, including fraud and abuse, a managed care organization (MCO) must:

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

(i) Audits;

(ii) Investigations;

(iii) Identifications of improper payments and other program integrity activities;

(iv) Federal reporting (42 C.F.R. Sec. 438.242(b)(1)); and

(v) Service verification.

(b) Perform ongoing analysis of utilization, claims, billing, and encounter data to detect overpayments;

(c) Disclose MCO ownership and control;

(d) Disclose any change in ownership of the MCO's subcontractors or providers that are not individual practitioners or a group of practitioners;

(e) Provide information on persons convicted of crimes through agreements with subcontractors and providers;

(f) Include program integrity requirements in the MCO's provider education program; and

(g) Verify provider compliance with all program integrity requirements in the fully integrated managed care (FIMC) medicaid contract.

(3) When an MCO has concluded a credible allegation of provider fraud has occurred, the MCO must make a referral to the medicaid fraud control unit within five business days of determination.

(4) The MCO must notify the department of social and health services office of fraud and accountability (OFA) of any cases in which the MCO believes there is a serious likelihood of enrollee fraud.

(5) The MCO is prohibited from paying for goods and services furnished by excluded persons with agency funds (see Social Security Act (SSA) Section 1903(i)(2) of the act; 42 C.F.R. Sec. 455.104, 42 C.F.R. Sec. 455.106, and 42 C.F.R. Sec. 1001.1901(b)).

NEW SECTION

WAC 182-538A-170 Notice requirements. The notice requirements in chapter 182-518 WAC apply to fully integrated managed care (FIMC) and behavioral health only (BHSO) enrollees in FIMC regional service areas.

NEW SECTION

WAC 182-538A-180 Rights and protections. (1) Individuals have medicaid-specific rights when applying for, eligible for, or receiving medicaid-funded health care services.

(2) All applicable statutory and constitutional rights apply to all medicaid individuals including, but not limited to:

(a) The participant rights under WAC 388-877-0600;

(b) Applicable necessary supplemental accommodation services including, but not limited to:

(i) Arranging for or providing help to complete and submit forms to the agency;

(ii) Helping individuals give or get the information the agency needs to decide or continue eligibility;

(iii) Helping to request continuing benefits;

(iv) Explaining the reduction in or ending of benefits;

(v) Assisting with requests for administrative hearings; and

(vi) On request, reviewing the agency's decision to terminate, suspend, or reduce benefits.

(c) Receiving the name, address, telephone number, and any languages offered other than English of providers in a managed care organization (MCO);

(d) Receiving information about the structure and operation of the MCO and how health care services are delivered;

(e) Receiving emergency care, urgent care, or crisis services;

(f) Receiving poststabilization services after receiving emergency care, urgent care, or crisis services that result in admittance to a hospital;

(g) Receiving age-appropriate and culturally appropriate services;

(h) Being provided a qualified interpreter and translated material at no cost to the individual;

(i) Receiving requested information and help in the language or format of choice;

(j) Having available treatment options and explanation of alternatives;

(k) Refusing any proposed treatment;

(l) Receiving care that does not discriminate against an individual;

(m) Being free of any sexual exploitation or harassment;

(n) Making an advance directive that states the individual's choices and preferences for health care services under 42 C.F.R., 489 Subpart I;

(o) Choosing a contracted health care provider;

(p) Requesting and receiving a copy of health care records;

(q) Being informed the cost for copying, if any;

(r) Being free from retaliation;

(s) Requesting and receiving policies and procedures of the MCO as they relate to health care rights;

(t) Receiving services in an accessible location;

(u) Receiving medically necessary services in accordance with the early and periodic screening, diagnosis, and treatment (EPSDT) program under WAC 182-534-0100, if the individual is age twenty or younger;

(v) Being treated with dignity, privacy, and respect;

(w) Receiving treatment options and alternatives in a manner that is appropriate to an individual's condition;

(x) Being free from seclusion and restraint;

(y) Receiving a second opinion from a qualified health care professional within an MCO provider network at no cost or having one arranged outside the network at no cost, as provided in 42 C.F.R. Sec. 438.206(3);

(z) Receiving medically necessary health care services outside of the MCO if those services cannot be provided adequately and timely within the MCO;

(aa) Filing a grievance with the MCO if the individual is not satisfied with a service;

(bb) Receiving a notice of action so that an individual may appeal any decision by the MCO that:

(i) Denies or limits authorization of a requested service;

(ii) Reduces, suspends, or terminates a previously authorized service; or

(iii) Denies payment for a service, in whole or in part.

(cc) Filing an appeal if the MCO fails to provide health care services in a timely manner as defined by the state or act within the time frames in 42 C.F.R. Sec. 438.408(b); and

(dd) Requesting an administrative hearing if an appeal is not resolved in an individual's favor.

NEW SECTION

WAC 182-538A-190 Behavioral health services only (BHSO). This section applies to enrollees receiving behavioral health services only (BHSO) under the fully integrated managed care (FIMC) medicaid contract.

(1) The medicaid agency requires eligible clients in FIMC regional service areas to enroll in the BHSO program.

(2) A BHSO enrollee in an FIMC regional service area may change managed care organizations (MCOs) but may not disenroll from the BHSO program.

(3) For BHSO enrollees, the MCO covers the behavioral health benefit included in the FIMC medicaid contract.

(4) WAC 182-538-110 applies to BHSO enrollees in FIMC regional service areas.

(5) The agency assigns the BHSO enrollee to an MCO available in the area where the client resides.

(6) A BHSO enrollee may change MCOs for any reason with the change becoming effective according to the agency's managed care policy.

(7) The agency ends enrollment in BHSO managed care when the enrollee becomes eligible for any third-party health care coverage comparable to BHSO.

Chapter 182-538B WAC
BEHAVIORAL HEALTH WRAPAROUND SERVICES

NEW SECTION

WAC 182-538B-040 Behavioral health wraparound services. (1) This chapter governs nonmedicaid funded behavioral health services provided under the medicaid agency's behavioral health services wrap-around contract.

(2) Washington apple health fully integrated managed care (FIMC) behavioral health wraparound services are available only through a managed care organization (MCO) contracted to provide FIMC services or behavioral health services only (BHSO).

(3) The MCO provides contracted nonmedicaid funded behavioral health wraparound services to medicaid enrollees in an FIMC regional service area:

(a) Within available resources;

(b) Based on medical necessity; and

(c) In order of priority to populations as identified by state and federal authorities.

(4) When nonmedicaid funding is exhausted, behavioral health wraparound services are no longer paid for and cannot be authorized regardless of medical necessity.

NEW SECTION

WAC 182-538B-050 Definitions. The following definitions and those found in chapters 182-500, 182-538, and 182-538A WAC apply to this chapter, unless otherwise stated.

"Action" means the denial or limited authorization of a service covered under the behavioral health services wraparound contract based on medical necessity.

"Available resources" means funds appropriated for the purpose of providing behavioral health wraparound services.

(a) This includes:

(i) Federal funds, except those provided according to Title XIX of the Social Security Act; and

(ii) State funds appropriated by the legislature for the purpose of providing services under the behavioral health administrative services organization contract.

(b) This does not include funds appropriated for the purpose of operating and administering the state psychiatric hospitals.

NEW SECTION

WAC 182-538B-110 Grievance system. (1) This section contains information about the managed care organization (MCO) grievance system

for enrollees under the behavioral health services wraparound contract in fully integrated managed care (FIMC) regional service areas.

(a) The MCO must have a grievance system to allow enrollees to file grievances and seek review of an MCO action as defined in this chapter.

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

(d) The MCO's policies and procedures regarding the grievance system must be approved by the agency.

(e) The MCO must maintain records of grievances and appeals.

(2) MCO grievance system. The MCO grievance system includes:

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

(b) An appeals process to address an enrollee's request for review of an MCO action;

(c) Access to an independent review by an independent review organization (IRO) under RCW 48.43.535 and WAC 182-526-0200;

(d) Access to the agency's administrative hearing process for review of an MCO's resolution of an appeal; and

(e) Allowing enrollees and their authorized representatives to file grievances and appeals orally or in writing. An MCO cannot require enrollees to provide written follow up for a grievance or an appeal the MCO received orally.

(3) The MCO grievance process.

(a) 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 enrollee does not have a right to an administrative hearing in regards to the disposition of a grievance.

(c) The MCO must acknowledge receipt of each grievance either orally or in writing within two business days.

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

(4) The MCO appeals process.

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

(b) An MCO treats oral inquiries about appealing an action as an appeal to establish the earliest possible filing date for the appeal. The MCO confirms the oral appeal in writing.

(c) An 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) An appeal of an MCO action must be filed within ninety calendar days of the date on the MCO's notice of action.

(e) The MCO will not be obligated to continue services pending the results of an appeal or subsequent administrative hearing.

(f) The MCO appeals process:

(i) Provides the enrollee a reasonable opportunity to present evidence and allegations of fact or law, both in person and in writing;

(ii) Provides the enrollee and the enrollee's authorized 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) Includes as parties to the appeal:

(A) The enrollee and the enrollee's authorized representative; and

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

(g) The MCO ensures that the individuals making decisions on appeals:

(i) 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 either of the following:

(A) An appeal of an action involving medical necessity; or

(B) An appeal that involves any clinical issues.

(h) Time frames for resolution of appeals.

(i) An MCO resolves each appeal and provides notice as expeditiously as the enrollee's health condition requires and no longer than three calendar days after the day the MCO receives the appeal.

(ii) The MCO may extend the time frame by an additional fourteen calendar days if:

(A) The enrollee requests the extension; or

(B) The MCO determines additional information is needed and delay is in the interests of the enrollee.

(i) 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;

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

(iii) 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, if the appeal is not resolved wholly in favor of the enrollee.

(5) 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) An 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.

(6) Effect of reversed resolutions of appeals. If an MCO, a final order as defined in chapter 182-526 WAC, or an independent review organization (IRO) reverses a decision to deny or limit services, the MCO must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires.

(7) Grievance system termination. When available resources are exhausted, any appeals process, independent review, or administrative hearing process related to a request to authorize a service will be

terminated, since services cannot be authorized without funding regardless of medical necessity.

NEW SECTION

WAC 182-538B-170 Notice requirements. Chapter 182-518 WAC applies to notice requirements in fully integrated managed care (FIMC) regional service areas.

Chapter 182-538C WAC
CRISIS-RELATED BEHAVIORAL HEALTH SERVICES

NEW SECTION

WAC 182-538C-040 Behavioral health services. (1) This chapter governs crisis-related and other behavioral health services provided under the medicaid agency's behavioral health administrative services organization (BH-ASO) contract.

(2) The BH-ASO contracts with the agency to provide behavioral health services within a fully integrated managed care (FIMC) regional service area.

(a) The BH-ASO provides the following services to all individuals, regardless of insurance status, income level, ability to pay, and county of residence:

(i) Mental health crisis services; and

(ii) Operation of a behavioral health ombuds.

(b) The BH-ASO may provide substance use disorder crisis services within available resources to all individuals, regardless of the individual's insurance status, income level, ability to pay, and county of residence.

(c) The BH-ASO provides the following services to individuals who are not eligible for medicaid coverage and are involuntarily or voluntarily detained under chapter 71.05 or 71.34 RCW, RCW 70.96A.140, or a less restrictive alternative (LRA) court order:

(i) Evaluation and treatment services;

(ii) Substance use disorder residential treatment services; and

(iii) Outpatient behavioral services, under an LRA court order.

(d) To be eligible to contract with the agency, the BH-ASO must:

(i) Accept the terms and conditions of the agency's contracts; and

(ii) Be able to meet the network and quality standards established by the agency.

(e) Services related to the administration of chapters 71.05 and 71.34 RCW and RCW 70.96A.140.

(3) The BH-ASO may provide contracted noncrisis behavioral health services to individuals in an FIMC regional service area:

(a) Within available resources;

(b) Based on medical necessity; and

(c) In order of priority to populations as identified by state and federal authorities.

(4) Within an FIMC regional service area, the BH-ASO is a subcontractor with all FIMC managed care organizations (MCOs) to provide crisis services for medicaid enrollees and the administration of involuntary treatment acts under RCW 70.96A.140 or chapter 71.05 or 71.34 RCW.

(5) For medicaid funded services subcontracted for by FIMC managed care organizations (MCOs) to the BH-ASO:

(a) Grievances and appeals must be filed with the FIMC MCO; and

(b) The grievance system rules in chapter 182-538 WAC apply instead of the grievance system rules in this chapter.

NEW SECTION

WAC 182-538C-050 Definitions. The definitions and abbreviations in this section and those found in chapter 182-500 WAC apply to this chapter. If conflict exists, this chapter takes precedence.

"Action" means the denial or limited authorization of a service covered under the behavioral health administrative services organization (BH-ASO) contract based on medical necessity.

"Available resources" means funds appropriated for the purpose of providing community behavioral health programs.

(a) This includes:

(i) Federal funds, except those provided according to Title XIX of the Social Security Act; and

(ii) State funds appropriated by the legislature for the purpose of providing services under the BH-ASO contract.

(b) This does not include funds appropriated for the purpose of operating and administering the state psychiatric hospitals.

"Behavioral health" means mental health and substance use disorder conditions and related benefits.

"Behavioral health administrative services organization (BH-ASO)" means an entity selected by the medicaid agency to administer behavioral health programs, including crisis services for individuals in a fully integrated managed care regional service area. The BH-ASO administers crisis services for all individuals in its defined regional service area, regardless of an individual's ability to pay.

"Complaint" - See "grievance."

"Crisis" means an actual or perceived urgent or emergent situation that occurs when:

(a) An individual's stability or functioning is disrupted; and

(b) There is an immediate need to resolve the situation to prevent:

(i) A serious deterioration in the individual's mental or physical health; or

(ii) The need for referral to a significantly higher level of care.

"Fully integrated managed care (FIMC)" means the program under which a managed care organization provides:

(a) Physical health services funded by medicaid; and

(b) Behavioral health services funded by other available resources as defined in this chapter.

"Grievance" means an expression of dissatisfaction made by or on behalf of an individual and referred to a behavioral health administrative services organization (BH-ASO) about any matter other than an action.

"Less restrictive alternative (LRA)" means court-ordered outpatient treatment in a setting less restrictive than total confinement.

"Noncrisis services" means services funded by nonmedicaid funding sources that are provided to individuals who are not enrolled in Washington apple health or otherwise eligible for medicaid. These services may be provided at the discretion of the behavioral health administrative services organization (BH-ASO) within available resources, such as:

(a) Crisis stabilization;

(b) Outpatient mental health or substance use disorder services; and

(c) Withdrawal management.

"Patient days of care" means all voluntary patients and involuntarily committed patients under chapter 71.05 RCW, regardless of where in the state hospital the patients reside. Patients who are committed to the state hospital under chapter 10.77 RCW are not included in the patient days of care. Patients who are committed under RCW 10.77.088 by municipal or district courts after failed competency restoration and dismissal of misdemeanor charges are not counted in the patient days of care until a petition for ninety days of civil commitment under chapter 71.05 RCW has been filed in court. Patients who are committed under RCW 10.77.086 by a superior court after failed competency restoration and dismissal of felony charges are not counted in the patient days of care until the patient is civilly committed under chapter 71.05 RCW.

"Regional service area" means a single county or multi-county grouping formed for the purpose of health care purchasing and designated by the agency and the department of social and health services.

NEW SECTION

WAC 182-538C-070 Payment. (1) For crisis services, the behavioral health administrative services organization (BH-ASO) must determine whether the individual receiving the services is eligible for Washington apple health or if the individual has any other form of insurance coverage.

(2) For individuals receiving crisis services who do not have other insurance coverage, the BH-ASO is responsible for the cost of those services.

(3) The BH-ASO administers and pays for the evaluation of involuntary detention or involuntary treatment under chapters 71.05 and 71.34 RCW and RCW 70.96A.140.

(4) The BH-ASO pays a reimbursement for each state hospital patient day of care that exceeds the BH-ASO daily allocation of state hospital beds based on a quarterly calculation of the bed usage by the BH-ASO.

(a) The medicaid agency bills the BH-ASO quarterly for state hospital patient days of care exceeding the BH-ASO daily allocation of state hospital beds and the established rate of reimbursement.

(b) The BH-ASO using fewer patient days of care than its quarterly allocation of state hospital beds will receive a portion of the reimbursement collected proportional to its share of the total number of patient days of care that were not used at the appropriate state hospital.

NEW SECTION

WAC 182-538C-110 Grievance system for behavioral health administrative services organizations (BH-ASOs). (1) This section applies to the behavioral health administrative service organization (BH-ASO) grievance system for individuals within fully integrated managed care (FIMC) regional service areas.

(a) The BH-ASO must have a grievance system to allow an individual to file a grievance and seek review of a BH-ASO action as defined in this chapter.

(b) The agency's hearing rules in chapter 182-526 WAC apply to administrative hearings requested by an individual to review resolution of an appeal of a BH-ASO action.

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

(d) The BH-ASO must maintain records of grievances and appeals.

(2) The BH-ASO grievance system. The BH-ASO grievance system includes:

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

(b) An appeals process to address an individual's request for review of a BH-ASO action as defined in this chapter; and

(c) Access to the agency's administrative hearing process for an individual to seek review of a BH-ASO's resolution of an appeal.

(3) The BH-ASO grievance process.

(a) An individual or an individual's authorized representative may file a complaint with a BH-ASO. A provider may not file a complaint on behalf of an individual without written consent.

(b) There is no right to an administrative hearing in regards to the disposition of a complaint.

(c) The BH-ASO must notify individuals of the disposition of grievances within five business days of determination.

(4) The BH-ASO appeals process.

(a) An individual, the individual's authorized representative, or the provider acting with the individual's written consent may appeal a BH-ASO action.

(b) A BH-ASO 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 BH-ASO.

(c) The BH-ASO must acknowledge receipt of each appeal to both the individual and the provider requesting the service within three calendar days. The appeal acknowledgment letter sent by the BH-ASO serves as written confirmation of an appeal filed orally by an individual.

(d) An appeal of a BH-ASO action must be filed within ninety calendar days of the date of the notice of action.

(e) The BH-ASO will not be obligated to continue services pending the results of an appeal or subsequent administrative hearing.

(f) The BH-ASO appeals process:

(i) Provides the individual a reasonable opportunity to present evidence and allegations of fact or law, both in person and in writing;

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

(iii) Includes as parties to the appeal:

(A) The individual;

(B) The individual's legal representative; or

(C) The authorized representative of the deceased individual's estate.

(g) The BH-ASO ensures the individuals making decisions on appeals:

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

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

(A) An appeal of an action; or

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

(h) Time frames for resolution of appeals.

(i) A BH-ASO resolves each appeal and provides notice as expeditiously as the individual's health condition requires and no longer than three calendar days after the BH-ASO receives the appeal.

(ii) The BH-ASO may extend the time frame by fourteen additional calendar days if:

(A) The individual requests the extension; or

(B) The BH-ASO determines additional information is needed and the delay is in the interests of the individual.

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

(i) Be in writing and be sent to the individual and the provider requesting the services;

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

(iii) Include notice of the right to request an administrative hearing and how to do so as provided in the agency hearing rules in chapter 182-526 WAC, if the appeal is not resolved wholly in favor of the individual.

(5) Administrative hearings.

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

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

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

(d) An individual must exhaust the appeals process within the BH-ASO's grievance system before requesting an administrative hearing with the agency.

(6) Effect of reversed resolutions of appeals. If the BH-ASO's decision not to provide services is reversed by the BH-ASO on appeal or through a final order from the administrative hearing process, the BH-ASO must authorize or provide the disputed services promptly and as expeditiously as the individual's health condition requires.

(7) Grievance system termination. When available resources are exhausted, any appeals or administrative hearing process related to a request for authorization of a noncrisis service will be terminated, since noncrisis services cannot be authorized without funding regardless of medical necessity.

NEW SECTION

WAC 182-538C-220 Covered crisis mental health services. (1) Crisis mental health services are intended to stabilize an individual in crisis to:

(a) Prevent further deterioration;

(b) Provide immediate treatment and intervention in a location best suited to meet the needs of the individual; and

(c) Provide treatment services in the least restrictive environment available.

(2) Crisis mental health services include:

(a) Crisis telephone support under WAC 388-877A-0230;

(b) Crisis outreach services under WAC 388-877A-0240;

(c) Crisis stabilization services under WAC 388-877A-0260;

(d) Crisis peer support services under WAC 388-877A-0270; and

(e) Emergency involuntary detention services under WAC 388-877A-0280.

(3) A facility providing any crisis mental health service to an individual must:

(a) Be licensed by the department of social and health services as a behavioral health agency;

(b) Be certified by the department of social and health services to provide crisis mental health services;

(c) Have policies and procedures to support and implement the:

(i) Program-specific requirements in WAC 388-877A-0230 through 388-877A-0280 for each crisis mental health service provided; and

(ii) Department of corrections access to confidential mental health information requirements in WAC 388-865-0600 through 388-865-0640.

(4) A BH-ASO or its subcontractor providing crisis mental health services only is not required to meet the initial assessment, individual service plan, and clinical record requirements in WAC 388-877-0610, 388-877-0620, and 388-877-0640.

(5) A BH-ASO or its subcontractor must ensure crisis mental health services:

(a) Are, with the exception of stabilization services, available twenty-four hours a day, seven days a week;

(b) Include family members, significant others, and other relevant treatment providers, as necessary, to provide support to the individual in crisis; and

(c) Are provided in a setting that is safe for the individual and staff members of the BH-ASO and its subcontractor.

NEW SECTION

WAC 182-538C-230 Covered substance use disorder detoxification services. (1) Chemical dependency detoxification services are provided to an individual to assist in the process of withdrawal from psychoactive substances in a safe and effective manner.

(2) A facility providing detoxification services to an individual must:

(a) Be a facility licensed by the department of health under one of the following:

(i) Chapter 246-320 WAC;
(ii) Chapter 246-322 WAC;
(iii) Chapter 246-324 WAC; or
(iv) Chapter 246-337 WAC.

(b) Be licensed by the department of social and health services as a behavioral health agency;

(c) Meet the applicable behavioral health agency licensure, certification, administration, personnel, clinical requirements, and behavioral health services administrative requirements; and

(d) Have policies and procedures to support and implement the applicable requirements in WAC 388-877B-0110 through 388-877B-0130.

(3) A BH-ASO or its subcontractor agency must:

(a) Provide counseling to each individual that addresses the individual's:

(i) Chemical dependency and motivation; and

(ii) Continuing care needs and need for referral to other services.

(b) Maintain a list of resources and referral options that can be used by staff members to refer an individual to appropriate services.

(c) Post any rules and responsibilities for individuals receiving treatment, including information on potential use of increased motivation interventions or sanctions, in a public place in the facility.

(d) Provide tuberculosis screenings to individuals for the prevention and control of tuberculosis.

(e) Provide HIV/AIDS information and include a brief risk intervention and referral as indicated.