Chapter 182-538 WAC
MANAGED CARE

WAC

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DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

182-538-061 Voluntary enrollment into managed care—Washington medicaid integration partnership (WMIP). [Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-061, filed 12/19/12, effective 2/1/13. WSR 11-14-075, recodified as § 182-538-061, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. WSR 08-15-110, § 388-538-061, filed 7/18/08, effective 8/18/08; WSR 06-03-081, § 388-538-061, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.522, 2003 E1 c 25 § 201(4), 2004 c 276 § 201(4), 42 U.S.C. 1396N (section 1915 (b) and (c) of the Social Security Act of 1924). WSR 05-01-066, § 388-538-061, filed 12/8/04, effective 1/8/05.] Repealed by WSR 15-24-098, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021 and 41.05.160.

182-538-063 Managed care for medical care services clients. [Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-063, filed 12/19/12, effective 2/1/13. Statutory Authority: RCW 41.05.021, 74.09.-035, and 2011 1st sp.s. c 36. WSR 12-19-051, § 182-538-063, filed 9/13/12, effective 10/14/12. WSR 11-14-075, recodified as § 182-538-063, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 2007 c 522 § 209 (13)-(14). WSR 08-10-048, § 388-538-063, filed 5/1/08, effective 6/1/08. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. WSR 06-24-036, § 388-538-063, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090 and 74.09.522. WSR 06-03-081, § 388-538-063, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.522, and 2003 1st sp.s. c 25 § 209(15). WSR 04-15-003, § 388-538-063, filed 7/7/04, effective 8/7/04.] Repealed by WSR 15-24-098, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021 and 41.05.160.

182-538-065 Medicaid-eligible basic health (BH) enrollees. [Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-065, filed 12/19/12, effective 2/1/13. WSR 11-14-075, recodified as § 182-538-065, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. WSR 06-03-081, § 388-538-065, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.522, 2003 E1 c 25 § 201(4), 2004 c 276 § 201(4), 42 U.S.C. 1396N (section 1915 (b) and (c) of the Social Security Act of 1924). WSR 05-01-066, § 388-538-065, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. WSR 02-01-075, § 388-538-065, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. WSR 00-04-080, § 388-538-065, filed 2/1/00, effective 3/3/00.] Repealed by WSR 15-24-098, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021 and 41.05.160.

182-538-112 The department of social and health services' (DSHS) hearing process for enrollee appeals of managed care organization (MCO) actions. [WSR 11-14-075, recodified as § 182-538-112, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. WSR 08-15-110, § 388-538-112, filed 7/18/08, effective 8/18/08; WSR 06-03-081, § 388-538-112, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.522, 2003 E1 c 25 § 201(4), 2004 c 276 § 201(4), 42 U.S.C. 1396N (section 1915 (b) and (c) of the Social Security Act of 1924). WSR 05-01-066, § 388-538-112, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.522, and 74.09.450. WSR 04-13-002, § 388-538-112, filed 6/2/04, effective 7/3/04. Statutory Authority: RCW 74.08.090, 74.09.522. WSR 03-18-110, § 388-538-112, filed 9/2/03, effective 10/3/03.] Repealed by WSR 13-02-010, filed 12/19/12, effective 2/1/13. Statutory Authority: RCW 41.05.021, 42 C.F.R. 438.

WAC 182-538-040 Introduction. This chapter governs services provided under the Washington apple health 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.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-24-098, § 182-538-040, filed 12/1/15, effective 1/1/16.]

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

"Action" means one or more of the following:

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

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

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

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

(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.

"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 to serve a client who has not selected an MCO.

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

"Client" means, for the purposes of this chapter, an individual eligible for any Washington apple health program, including managed care programs, but who is not enrolled with an MCO or PCCM provider.

"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 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 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:

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

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

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

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

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

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

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

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

(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.

"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 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 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 managed care organization (MCO) to participate in the MCO's provider network.

"Participating provider" means a 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.

"Timely" 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. 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.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-24-098, § 182-538-050, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-050, filed 12/19/12, effective 2/1/13. WSR 11-14-075, recodified as § 182-538-050, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. WSR 08-15-110, § 388-538-050, filed 7/18/08, effective 8/18/08; WSR 06-03-081, § 388-538-050, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.522, 2003 E1 c 25 § 201(4), 2004 c 276 § 201(4), 42 U.S.C. 1396N (section 1915 (b) and (c) of the Social Security Act of 1924). WSR 05-01-066, § 388-538-050, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.522. WSR 03-18-109, § 388-538-050, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. WSR 02-01-075, § 388-538-050, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. WSR 00-04-080, § 388-538-050, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. WSR 95-18-046 (Order

3886), § 388-538-050, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. WSR 93-17-039 (Order 3621), § 388-538-050, filed 8/11/93, effective 9/11/93.]

WAC 182-538-060 Managed care choice and assignment. (1) Except as provided in subsection (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 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.

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

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

(b) Enrollment with a PCCM provider through a tribal clinic or urban Indian center available in their area; or

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

(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;

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

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

(5) All family members will be enrolled with the same MCO, except family members of an enrollee placed in the patient review and coordination (PRC) program under WAC 182-501-0135 need not enroll in the same MCO as the family member placed in the PRC program.

(6) A client may be placed into the PRC program by the client's MCO or the agency. The client placed in the PRC program must follow the enrollment requirements 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.

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

(a) If the client was enrolled with an MCO or PCCM provider within the previous six months, the client is reenrolled with the same MCO;

(b) If (a) of this subsection does not apply and 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 a client who is not AI or AN does not choose an MCO, 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.

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

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

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

(C) The effective date of enrollment; and

(D) The date by which the client must respond in order to change the assignment.

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

(9) 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 182-501-0135).

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-24-098, § 182-538-060, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-060, filed 12/19/12, effective 2/1/13. WSR 11-14-075, recodified as § 182-538-060, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. WSR 08-15-110, § 388-538-060, filed 7/18/08, effective 8/18/08; WSR 06-03-081, § 388-538-060, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.522, 2003 E1 c 25 § 201(4), 2004 c 276 § 201(4), 42 U.S.C. 1396N (section 1915 (b) and (c) of the Social Security Act of 1924). WSR 05-01-066, § 388-538-060, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.522. WSR 03-18-109, § 388-538-060, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. WSR 02-01-075, § 388-538-060, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. WSR 00-04-080, § 388-538-060, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. WSR 98-16-044, § 388-538-060, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. WSR 95-18-046 (Order 3886), § 388-538-060, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. WSR 93-17-039 (Order 3621), § 388-538-060, filed 8/11/93, effective 9/11/93.]

WAC 182-538-067 Qualifications to become a managed care organization (MCO). (1) A managed care organization (MCO) must meet the following qualifications to be eligible to contract with the medicaid 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 otherwise qualified MCO.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-24-098, § 182-538-067, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-067, filed 12/19/12, effective 2/1/13. WSR 11-14-075, recodified as § 182-538-067, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.-522. WSR 08-15-110, § 388-538-067, filed 7/18/08, effective 8/18/08; WSR 06-03-081, § 388-538-067, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.522, 2003 E1 c 25 § 201(4), 2004 c 276 § 201(4), 42 U.S.C. 1396N (section 1915 (b) and (c) of the Social Security Act of 1924). WSR 05-01-066, § 388-538-067, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.522. WSR 03-18-112, § 388-538-067, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.09.080, RCW 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. WSR 02-01-075, § 388-538-067, filed 12/14/01, effective 1/14/02.]

WAC 182-538-068 Qualifications to become a primary care case management (PCCM) provider. A primary care case management (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 the case management rate paid by the agency.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-24-098, § 182-538-068, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-068, filed 12/19/12, effective 2/1/13. WSR 11-14-075, recodified as § 182-538-068, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.-522. WSR 08-15-110, § 388-538-068, filed 7/18/08, effective 8/18/08; WSR 06-03-081, § 388-538-068, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. WSR 02-01-075, § 388-538-068, filed 12/14/01, effective 1/14/02.]

WAC 182-538-070 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 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 analysis of historical cost, rate information, or both; and

(e) Are paid based on legislative allocations.

(2) The MCO is solely responsible for payment of MCO-contracted health care services. The agency will not pay for a service that is the MCO's responsibility, even if the MCO has not paid the provider for the service.

(3) The agency pays an enhancement rate to federally qualified health care centers (FQHC) and rural health clinics (RHC) for each 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.

(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.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-24-098, § 182-538-070, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-070, filed 12/19/12, effective 2/1/13. WSR 11-14-075, recodified as § 182-538-070, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.-522. WSR 08-15-110, § 388-538-070, filed 7/18/08, effective 8/18/08; WSR 06-03-081, § 388-538-070, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.522, 2003 E1 c 25 § 201(4), 2004 c 276 § 201(4), 42 U.S.C. 1396N (section 1915 (b) and (c) of the Social Security Act of 1924). WSR 05-01-066, § 388-538-070, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.522. WSR 03-18-109, § 388-538-070, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.09.-080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. WSR 02-01-075, § 388-538-070, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. WSR 00-04-080, § 388-538-070, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090. WSR 96-24-073, § 388-538-070, filed 12/2/96, effective 1/2/97. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. WSR 95-18-046 (Order 3886), § 388-538-070, filed 8/29/95 effective 9/1/95. Statutory Authority: RCW 74.08.090. WSR 93-17-039 (Order 3621), § 388-538-070, filed 8/11/93, effective 9/11/93.]

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.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-24-098, § 182-538-071, filed 12/1/15, effective 1/1/16.]

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

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

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

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

(b) The agency covers services 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.

(2) The following services are not covered by the MCO:

(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 received in a hospital emergency department for nonemergency medical conditions, except for a screening exam as described in WAC 182-538-100.

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

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

(3) A provider may bill an enrollee for noncovered services as described in subsection (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.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-24-098, § 182-538-095, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-095, filed 12/19/12, effective 2/1/13. WSR 11-14-075, recodified as § 182-538-095, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. WSR 08-15-110, § 388-538-095, filed 7/18/08, effective 8/18/08. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. WSR 06-24-036, § 388-538-095, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090 and 74.09.522. WSR 06-03-081, § 388-538-095, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.522, 2003 E1 c 25 § 201(4), 2004 c 276 § 201(4), 42 U.S.C. 1396N (section 1915 (b) and (c) of the Social Security Act of 1924). WSR 05-01-066, § 388-538-095, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.522. WSR 03-18-109, § 388-538-095, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. WSR 02-01-075, § 388-538-095, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090. WSR 01-02-076, § 388-538-095, filed 12/29/00, effective 1/29/01. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. WSR 00-04-080, § 388-538-095, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. WSR 98-16-044, § 388-538-095, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. WSR 95-18-046 (Order 3886), § 388-538-095, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. WSR 93-17-039 (Order 3621), § 388-538-095, filed 8/11/93, effective 9/11/93.]

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 nonemergency 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.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-24-098, § 182-538-096, filed 12/1/15, effective 1/1/16.]

WAC 182-538-100 Managed care emergency services. (1) A managed care enrollee may obtain emergency services 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 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 after the provision of the emergency services.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-24-098, § 182-538-100, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-100, filed 12/19/12, effective 2/1/13. WSR 11-14-075, recodified as § 182-538-100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.-522. WSR 08-15-110, § 388-538-100, filed 7/18/08, effective 8/18/08; WSR 06-03-081, § 388-538-100, filed 1/12/06, effective 2/12/06; WSR 03-18-110, § 388-538-100, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. WSR 02-01-075, § 388-538-100, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. WSR 00-04-080, § 388-538-100, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. WSR 95-18-046 (Order 3886), § 388-538-100, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. WSR 95-04-033 (Order 3826), § 388-538-100, filed 1/24/95, effective 2/1/95; WSR 93-17-039 (Order 3621), § 388-538-100, filed 8/11/93, effective 9/11/93.]

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. 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, including citation to rules or regulations and the MCO criteria that were the basis of the decision;

(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) When the MCO does not reach service authorization decisions within required time frames, it is considered a denial. In this case the MCO sends a formal notice of action, including the enrollee's right to an appeal.

(g) 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 the enrollee's representative; or

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

(h) 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.

(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. 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.

(j) 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.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-24-098, § 182-538-110, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-110, filed 12/19/12, effective 2/1/13. WSR 11-14-075, recodified as § 182-538-110, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. WSR 08-15-110, § 388-538-110, filed 7/18/08, effective 8/18/08; WSR 06-03-081, § 388-538-110, filed 1/12/06, effective 2/12/06; WSR 03-18-110, § 388-538-110, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. WSR 02-01-075, § 388-538-110, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. WSR 00-04-080, § 388-538-110, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090. WSR 97-04-004, § 388-538-110, filed 1/24/97, effective 2/24/97. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. WSR 95-18-046 (Order 3886), § 388-538-110, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. WSR 94-04-038 (Order 3701), § 388-538-110, filed 1/26/94, effective 2/26/94; WSR 93-17-039 (Order 3621), § 388-538-110, filed 8/11/93, effective 9/11/93.]

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

(2) PCCM enrollees follow the same administrative hearing rules and processes as fee-for-service clients under chapter 182-526 WAC.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-24-098, § 182-538-111, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-111, filed 12/19/12, effective 2/1/13. WSR 11-14-075, recodified as § 182-538-111, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. WSR 08-15-110, § 388-538-111, filed 7/18/08, effective 8/18/08; WSR 06-03-081, § 388-538-111, filed 1/12/06, effective 2/12/06; WSR 03-18-110, § 388-538-111, filed 9/2/03, effective 10/3/03.]

WAC 182-538-120 Enrollee request for a second medical opinion. (1) A managed care enrollee has the right to a timely referral for a second opinion upon request when:

(a) The enrollee needs more information about treatment recommended by the provider or managed care organization (MCO); or

(b) The enrollee believes the MCO is not authorizing medically necessary care.

(2) A managed care enrollee has a right to a second opinion from a participating provider. At the MCO's discretion, a clinically appropriate nonparticipating provider who is agreed upon by the MCO and the enrollee may provide the second opinion.

(3) Primary care case management (PCCM) enrollees have a right to a timely referral for a second opinion by another provider who has a core provider agreement with the agency.

[Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-120, filed 12/19/12, effective 2/1/13. WSR 11-14-075, recodified as § 182-538-120, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. WSR 08-15-110, § 388-538-120, filed 7/18/08, effective 8/18/08; WSR 06-03-081, § 388-538-120, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.522, 2003 E1 c 25 § 201(4), 2004 c 276 § 201(4), 42 U.S.C. 1396N (section 1915 (b) and (c) of the Social Security Act of 1924). WSR 05-01-066, § 388-538-120, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. WSR 02-01-075, § 388-538-120, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. WSR 00-04-080, § 388-538-120, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. WSR 95-18-046 (Order 3886), § 388-538-120, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. WSR 93-17-039 (Order 3621), § 388-538-120, filed 8/11/93, effective 9/11/93.]

WAC 182-538-130 Exemptions and ending enrollment in managed care. (1) The agency approves a request to exempt a client from enrollment or to end enrollment from mandatory managed care when any of the following apply:

(a) The client or enrollee is eligible for medicare;

(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 within the notice period stated in WAC 182-538-060, 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, unless continued enrollment creates loss of access to providers for medically necessary care.

(2)(a) The following people may request the agency to approve an exemption or end enrollment in managed care:

(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 to 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 to end enrollment.

(3) Case-by-case clinical criteria to authorize an exemption or to end enrollment.

(a) The agency may approve a request for exemption or to end enrollment when the following criteria are 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 are 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 to end 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.

(c) When the agency denies a request for exemption or to end 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.

(4) 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.

(5) The agency will grant a request from an MCO to end enrollment of an enrollee 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 to end 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;

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

(iv) The enrollee has received written notice from the MCO of its intent to request to end enrollment of the enrollee, unless the requirement for notification has been waived by the agency because the enrollee's conduct presents the threat of imminent harm to others. The MCO's notice to the enrollee includes the enrollee's right to use the MCO's grievance process to review the request to end enrollment.

(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 end enrollment of an enrollee, 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.

(6) 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 will continue only until the client can be enrolled in managed care.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 16-23-021, § 182-538-130, filed 11/4/16, effective 1/1/17; WSR 15-24-098, § 182-538-130, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-130, filed 12/19/12, effective 2/1/13. WSR 11-14-075, recodified as § 182-538-130, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. WSR 08-15-110, § 388-538-130, filed 7/18/08, effective 8/18/08; WSR 06-03-081, § 388-538-130, filed 1/12/06, effective 2/12/06; WSR 03-18-111, § 388-538-130, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. WSR 02-01-075, § 388-538-130, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. WSR 00-04-080, § 388-538-130, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. WSR 98-16-044, § 388-538-130, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. WSR 95-18-046 (Order 3886), § 388-538-130, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. WSR 93-17-039 (Order 3621), § 388-538-130, filed 8/11/93, effective 9/11/93.]

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 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 align with agency standards;

(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 before delegation;

(iii) An annual evaluation of the entity; and

(iv) Evaluation or regular reports and follow-up on issues 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 medicaid 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;

(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 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.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-24-098, § 182-538-140, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-140, filed 12/19/12, effective 2/1/13. WSR 11-14-075, recodified as § 182-538-140, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.-522. WSR 08-15-110, § 388-538-140, filed 7/18/08, effective 8/18/08; WSR 06-03-081, § 388-538-140, filed 1/12/06, effective 2/12/06; WSR 03-18-111, § 388-538-140, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. WSR 02-01-075, § 388-538-140, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. WSR 00-04-080, § 388-538-140, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. WSR 95-18-046 (Order 3886), § 388-538-140, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. WSR 93-17-039 (Order 3621), § 388-538-140, filed 8/11/93, effective 9/11/93.]

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)(a) 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.

(b) An AHFC enrollee may request to end enrollment in AHFC without cause if the client is in the adoption support or young adult alumni programs. WAC 182-538-130 does not apply to these requests.

(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.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 16-23-021, § 182-538-150, filed 11/4/16, effective 1/1/17; WSR 15-24-098, § 182-538-150, filed 12/1/15, effective 1/1/16.]