WAC 182-538-095 Scope of care for integrated managed care enrollees and managed care organization benefit administration requirements.

Scope of Care.

(1) An enrollee in integrated managed care (IMC) is eligible only for the scope of services that are covered based on the apple health program (eligibility program) in which they are enrolled.

(a) See the chart in WAC 182-501-0060 for category of covered services that are covered based on enrollee's apple health eligibility program, and the program rules to determine which specific services are covered. See WAC 182-501-0065 for a description of the category of covered services.

(b) The apple health eligibility programs for IMC includes the alternative benefit plan (ABP), categorically needy (CN), and medically needy (MN) programs.

(2) The managed care organization (MCO) covers the services included under the IMC medicaid contract for IMC enrollees based on their apple health eligibility program.

(3) If an IMC enrollee is enrolled in behavioral health services only (BHSO):

(a) The MCO will only cover the behavioral health benefit included in the IMC medicaid contract.

(b) The MCO is not responsible for coverage of the physical health benefit in the IMC contract.

(c) See WAC 182-538-190 regarding additional rules related to BHSO.

(4) The agency does not require the MCO to cover any services outside the scope of covered services in the MCO's contract with the agency. At its discretion, an MCO may cover services not required under the IMC medicaid contract.

(5) Services included in enrollees' medicaid eligibility program, and identified as covered based on program rules, may be excluded from coverage by the agency under the managed care contract. These excluded services that are covered based on program rules are available on a fee-for-service basis.

(6) The MCO is not required to authorize or pay for covered services if:

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

(b) Services are excluded from coverage under the managed care contract.

(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.

MCO Benefit Administration Requirements.

(7) 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;

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

(c) MCOs provide covered services to enrollees through their participating providers, unless an exception applies. An MCO covers services from a nonparticipating provider when an enrollee obtains:

(i) Emergency services; or

(ii) Authorization from the MCO to receive services from a nonparticipating provider.

(d) For nonemergency services, MCOs may require:

(i) The enrollee to obtain a referral from the primary care provider (PCP); or

(ii) The provider to obtain authorization from the MCO, according to the requirements of the MCO contract;

(e) 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;

(f) 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;

(g) 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;

(h) 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.

(8)(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.

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

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

(11) A provider may bill an enrollee for services only if the requirements of WAC 182-502-0160 are met.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2019 c 325, 2014 c 225, and 2018 c 201. WSR 19-24-063, § 182-538-095, filed 11/27/19, effective 1/1/20. 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.]