

WSR 22-07-107

PERMANENT RULES

HEALTH CARE AUTHORITY

[Filed March 23, 2022, 9:49 a.m., effective April 23, 2022]

Effective Date of Rule: Thirty-one days after filing.

Purpose: The agency is amending these rules to permit children with special health care needs to request an exemption from, or an end to enrollment in, managed care. The agency is making this amendment to align the rule with the medicaid state plan and federal regulation (42 C.F.R. 438.50 (d) (3)).

Citation of Rules Affected by this Order: Amending WAC 182-538-050 and 182-538-130.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Other Authority: 42 C.F.R. 438.50.

Adopted under notice filed as WSR 22-05-055 on February 10, 2022.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 2, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 2, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: March 23, 2022.

Wendy Barcus
Rules Coordinator

OTS-3554.1

AMENDATORY SECTION (Amending WSR 19-24-063, filed 11/27/19, effective 1/1/20)

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

"Administrative hearing" means an evidentiary adjudicative proceeding before an administrative law judge or presiding officer that is available to an enrollee under chapter 182-526 WAC according to RCW 74.09.741.

"Adverse benefit determination" means one or more of the following:

(a) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

(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;

(e) The failure of a managed care organization (MCO) to act within the time frames provided in 42 C.F.R. Sec. 438.408 (a), (b) (1) and (2) for standard resolution of grievances and appeals; or

(f) For a resident of a rural area with only one MCO, the denial of an enrollee's request to exercise the enrollee's right to obtain services outside the network under 42 C.F.R. Sec. 438.52 (b) (2) (ii).

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

"Appeal" means a review by an MCO of an adverse benefit determination.

"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.

"Behavioral health" - See WAC 182-538D-0200.

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

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

"Child or youth with special health care needs" means a client under age 19 who is:

(a) Eligible for supplemental security income under Title XVI of the Social Security Act;

(b) Eligible for medicaid under section 1902 (e) (3) of the Social Security Act;

(c) In foster care or other out-of-home placement;

(d) Receiving foster care or adoption assistance; or

(e) Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501 (a) (1) (D) of Title V of the Social Security Act.

"Client" - See WAC 182-500-0020.

"Disenrollment" - See "end enrollment."

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

"Emergency services" means services defined in 42 C.F.R. Sec. 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 a person 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.

"Fully integrated managed care (FIMC)" - See integrated managed care.

"Grievance" means an expression of dissatisfaction about any matter other than an adverse benefit determination.

"Grievance and appeal system" means the processes the MCO implements to handle appeals of adverse benefit determinations and grievances, as well as the processes to collect and track information about them.

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

"Integrated managed care (IMC)" means the program under which a managed care organization provides:

- (a) Physical health services funded by medicaid; and
- (b) Behavioral health services funded by medicaid, and other available resources provided for in chapters 182-538B, 182-538C, and 182-538D WAC.

"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.

"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~~)) 90 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.

"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.

"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.

"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.

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

- (a) Medicaid-eligible people age ((~~twenty~~)) 20 or younger with complex behavioral health needs; and
- (b) Their families.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2019 c 325, 2014 c 225, and 2018 c 201. WSR 19-24-063, § 182-538-050, filed 11/27/19, effective 1/1/20. Statutory Authority: RCW 41.05.021, 41.05.160 and 42 C.F.R. Parts 431, 433, 438, 440, 457, and 495. WSR 17-23-199, § 182-538-050, filed 11/22/17, effective 12/23/17. 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.]

OTS-3555.1

AMENDATORY SECTION (Amending WSR 19-24-063, filed 11/27/19, effective 1/1/20)

WAC 182-538-130 Exemptions and ending enrollment in managed care. The medicaid agency enrolls clients into integrated managed care (IMC) based on the rules in WAC 182-538-060. IMC is mandatory in all regional service areas.

(1) **Authority to request.** The following people may request that the agency approve an exemption or end enrollment in managed care:

- (a) A client or enrollee;
- (b) A client or enrollee's authorized representative under WAC 182-503-0130; or
- (c) A client or enrollee's representative as defined in RCW 7.70.065.

(2) **Standards to exempt or end enrollment.**

(a) The agency exempts or ends enrollment from mandatory managed care when any of the following apply:

- (i) The client or enrollee is eligible for medicare;
- (ii) The client or enrollee is not eligible for managed care enrollment, for Washington apple health programs, or both.
- (b) The agency grants a request to exempt or to end enrollment in managed care, with the change effective the earliest possible date given the requirements of the agency's enrollment system, when the client or enrollee:
 - (i) Is American Indian or Alaska native or is a descendant of an AI/AN client and requests not to be in managed care;
 - (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; or
 - (iv) Is a child or youth with special health care needs as defined in WAC 182-538-050.

(3) **Case-by-case clinical criteria.** Clinical criteria for an enrollee or client to be exempted or end enrollment in IMC.

(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) The medically necessary care at issue is covered under the agency's managed care contracts and is not a benefit under the behavioral health services only (BHSO) program;
- (iii) The client is receiving the medically necessary care at issue 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) If a client requests exemption prior to enrollment, the client is not enrolled until the agency approves or denies the request.

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

(4) **Approved request.**

(a) 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.

(b) For clients who are not AI/AN, the following rules apply:

(i) 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.

(ii) The agency limits the period of time based on the circumstances or how long the conditions described are expected to exist.

(iii) The agency may periodically review those circumstances or conditions to determine if they continue to exist.

(iv) Any authorized exemption will continue only until the client can be enrolled in managed care.

(5) **BHSO.**

(a) When a client is exempt from mandatory IMC or their enrollment in the mandatory IMC program ends, the exemption is for the physical health benefit only. The client remains enrolled in behavioral health services only (BHSO) for the behavioral health benefit.

(b) AI/AN clients are an exception in that they can choose to receive their behavioral health benefit on a fee-for-service basis.

(6) **Denied request.** When the agency denies a request for exemption or to end enrollment:

(a) The agency will notify the client or enrollee of its decision by telephone or in writing and confirms a telephone notification in writing.

(b) 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.

(c) 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.

(7) **Administrative hearing request.** 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.

(8) **MCO request.** The agency will grant a request from an MCO to end enrollment of an enrollee 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) The agency will not approve a request to end enrollment of an enrollee's behavioral health services. The agency may determine to transition the enrollee to behavioral health services only (BHSO).

(d) 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)~~ 10 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.

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

(f) The agency may exempt the client for the period of time the circumstances are expected to exist. The agency may periodically review those circumstances to determine if they continue to exist. Any

authorized exemption will continue only until the client can be enrolled in IMC.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2019 c 325, 2014 c 225, and 2018 c 201. WSR 19-24-063, § 182-538-130, filed 11/27/19, effective 1/1/20. 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.]