WSR 24-21-064
EMERGENCY RULES
HEALTH CARE AUTHORITY

[Filed October 11, 2024, 8:05 a.m., effective October 11, 2024, 8:05 a.m.]

Effective Date of Rule: Immediately upon filing.

Purpose: The health care authority (agency) is developing rules under ESSB 5187, section 211(83), 68th legislature, 2023 regular session. This legislation directed the agency to implement a program that began on July 1, 2024, with coverage comparable to the categorically needy medicaid program for certain adults age 19 and older who: (a) Have an immigration status making them ineligible for medicaid or federal subsidies through the health benefit exchange; and (b) are not eligible for another full scope federally funded medical assistance program.

Citation of Rules Affected by this Order: New chapters 182-525, 182-525A and 182-525B WAC; and amending WAC 182-500-120, 182-501-0060, 182-503-0510, 182-503-0515, 182-509-0220, and 182-526-0005.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Other Authority: ESSB 5187, section 211(83), 68th legislature, regular session.

Under RCW 34.05.350 the agency for good cause finds that immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.

Reasons for this Finding: These rules are necessary to implement the agency's apple health expansion program, as directed in ESSB 5187, to provide health care coverage for adults who qualify. The program took effect on July 1, 2024.

The agency previously filed emergency rules under WSR 24-13-067 on June 14, 2024. Those rules are expiring. This filing continues the emergency rules while the permanent rule process is completed. This emergency filing includes additional housekeeping changes and the following revisions:

- Distinguished between MAGI and non-MAGI rules in WAC 182-525-0200.
- Removed the reference to WAC 182-504-0035 in WAC 182-525-0600 (5)(b).
- Identified chapter 182-512 WAC as applicable to apple health expansion (with noted exceptions) in WAC 182-525-0700.
- Removed WAC 182-525-0900(3).
- Added a requirement that providers accept a fee-for-service payment from the agency as payment in full in WAC 182-525-1100(3).
- Removed WAC 182-525A-0200 (1)(d).
- Removed language regarding people age 64 and younger in WAC 182-509-0220 (2)(d)(viii).
- Added subsection WAC 182-503-0510 (3)(a)(vi) to include people age 65 and older.

The agency shared two versions of the draft rules with interested parties in February and May of this year and received substantial comments on each of the drafts. After the agency filed the emergency rules, staff subsequently asked stakeholders to comment on a permanent enrollment process for the apple health expansion program. The agency has created a draft policy, based on stakeholders' input, and staff

are preparing proposed rules that include the permanent enrollment process.

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 30, Amended 6, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 30, Amended 6, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 0, Repealed 0.

Date Adopted: October 11, 2024.

Wendy Barcus
Rules Coordinator

OTS-5177.3

AMENDATORY SECTION (Amending WSR 13-14-019, filed 6/24/13, effective 7/25/13)

WAC 182-500-0120 Medical assistance definitions—W. "Washington apple health" means the public health insurance programs for eligible Washington residents. Washington apple health is the name used in Washington state for medicaid, the children's health insurance program (CHIP), and state-only funded health care programs.

"Washington apple health expansion" means the state-funded health care program for individuals age 19 and older who do not meet the citizenship or immigration requirements to receive benefits under federally funded programs. Eligibility for this program is limited and is subject to available funds.

"Washington Healthplanfinder" is a marketplace for individuals, families, and small businesses in Washington state to compare and enroll in health insurance coverage and gain access to premium tax credits, reduced cost sharing, and public programs such as Washington apple health. Washington Healthplanfinder is administered by the Washington health benefit exchange.

OTS-5178.3

AMENDATORY SECTION (Amending WSR 23-07-132, filed 3/22/23, effective 4/22/23)

WAC 182-501-0060 Health care coverage—Program benefit packages—Scope of service categories. (1) This rule provides a table that lists:

(a) The following Washington apple health programs:

(i) The alternative benefits plan (ABP) medicaid;

(ii) Categorically needy (CN) medicaid;

(iii) Medically needy (MN) medicaid; ((~~and~~))

(iv) Medical care services (MCS) programs (includes incapacity-based and aged, blind, and disabled medical care services), as described in WAC 182-508-0005; and

(v) Washington apple health expansion (AHE); and

(b) The benefit packages showing what service categories are included for each program.

(2) Within a service category included in a benefit package, some services may be covered and others noncovered.

(3) Services covered within each service category included in a benefit package:

(a) Are determined in accordance with WAC 182-501-0050 and 182-501-0055 when applicable.

(b) May be subject to limitations, restrictions, and eligibility requirements contained in agency rules.

(c) May require prior authorization (see WAC 182-501-0165), or expedited prior authorization when allowed by the agency.

(d) Are paid for by the agency or the agency's designee and subject to review both before and after payment is made. The agency or the client's managed care organization may deny or recover payment for such services, equipment, and supplies based on these reviews.

(4) The agency does not pay for covered services, equipment, or supplies that:

(a) Require prior authorization from the agency or the agency's designee, if prior authorization was not obtained before the service was provided;

(b) Are provided by providers who are not contracted with the agency as required under chapter 182-502 WAC;

(c) Are included in an agency or the agency's designee waiver program identified in chapter 182-515 WAC; or

(d) Are covered by a third-party payor (see WAC 182-501-0200), including medicare, if the third-party payor has not made a determination on the claim or has not been billed by the provider.

(5) Programs not addressed in the table:

(a) Medical assistance programs for noncitizens (see chapter 182-507 WAC); and

(b) Family planning only programs (see WAC 182-532-500 through 182-532-570);

(c) Postpartum and family planning extension (see WAC 182-523-0130(4) and 182-505-0115(5));

(d) Eligibility for pregnant minors (see WAC 182-505-0117); and

(e) Kidney disease program (see chapter 182-540 WAC).

(6) Scope of service categories. The following table lists the agency's categories of health care services.

(a) Under the ABP, CN, and MN headings, there are two columns. One addresses clients 20 years of age and younger, and the other addresses clients 21 years of age and older.

(b) The letter **"Y"** means a service category is included for that program. Services within each service category are subject to limitations and restrictions listed in the specific medical assistance program rules and agency issuances.

(c) The letter **"N"** means a service category is not included for that program.

(d) Refer to WAC 182-501-0065 for a description of each service category and for the specific program rules containing the limitations and restrictions to services.

Service Categories	ABP 20-	ABP 21+	CN[1] 20-	CN 21+	MN 20-	MN 21+	MCS	AHE
Ambulance (ground and air)	Y	Y	Y	Y	Y	Y	Y	Y
Applied behavior analysis (ABA)	Y	Y	Y	Y	Y	Y	N	Y
Behavioral health services	Y	Y	Y	Y	Y	Y	Y	Y
Blood/blood products/related services	Y	Y	Y	Y	Y	Y	Y	Y
Dental services	Y	Y	Y	Y	Y	Y	Y	Y
Diagnostic services (lab and X-ray)	Y	Y	Y	Y	Y	Y	Y	Y
Early and periodic screening, diagnosis, and treatment (EPSDT) services	Y	N	Y	N	Y	N	N	N
Enteral nutrition program	Y	Y	Y	Y	Y	Y	Y	Y
Habilitative services	Y	Y	N	N	N	N	N	N
Health care professional services	Y	Y	Y	Y	Y	Y	Y	Y
Health homes	Y	Y	Y	Y	N	N	N	N
Hearing evaluations	Y	Y	Y	Y	Y	Y	Y	Y
Hearing aids	Y	Y	Y	Y	Y	Y	Y	Y
Home health services	Y	Y	Y	Y	Y	Y	Y	Y
Home infusion therapy/parenteral nutrition program	Y	Y	Y	Y	Y	Y	Y	Y
Hospice services	Y	Y	Y	Y	Y	Y	N	Y
Hospital services Inpatient/outpatient	Y	Y	Y	Y	Y	Y	Y	Y
Intermediate care facility/services for persons with intellectual disabilities	Y	Y	Y	Y	Y	Y	Y	N
Maternity care and delivery services	Y	Y	Y	Y	Y	Y	Y	Y
Medical equipment, supplies, and appliances	Y	Y	Y	Y	Y	Y	Y	Y
Medical nutrition therapy	Y	Y	Y	Y	Y	Y	Y	Y
Nursing facility services	Y	Y	Y	Y	Y	Y	Y	Y*
Organ transplants	Y	Y	Y	Y	Y	Y	Y	Y
Orthodontic services	Y	N	Y	N	Y	N	N	Y**
Out-of-state services	Y	Y	Y	Y	Y	Y	N	Y
Outpatient rehabilitation services (OT, PT, ST)	Y	Y	Y	Y	Y	((N)) Y	Y	Y
Personal care services	Y	Y	Y	Y	N	N	N	N
Prescription drugs	Y	Y	Y	Y	Y	Y	Y	Y
Private duty nursing	Y	Y	Y	Y	Y	Y	N	N
Prosthetic/orthotic devices	Y	Y	Y	Y	Y	Y	Y	Y
Reproductive health services	Y	Y	Y	Y	Y	Y	Y	Y
Respiratory care (oxygen)	Y	Y	Y	Y	Y	Y	Y	Y
School-based medical services	Y	N	Y	N	Y	N	N	Y**
Vision care Exams, refractions, and fittings	Y	Y	Y	Y	Y	Y	Y	Y
Vision hardware Frames and lenses	Y	N	Y	N	Y	N	N	Y**

[1] Clients enrolled in the Washington apple health for kids and Washington apple health for kids with premium programs, which includes the children's health insurance program (CHIP), receive CN-scope of health care services.

* Medically necessary nursing facility services are covered when the enrollee's condition meets the criteria for rehabilitative or skilled care.

** Only for age 20 and younger.

OTS-5179.5

AMENDATORY SECTION (Amending WSR 23-11-007, filed 5/4/23, effective 6/4/23)

WAC 182-503-0510 Washington apple health—Program summary. (1) The agency categorizes Washington apple health programs into three groups based on the income methodology used to determine eligibility:

(a) Those that use a modified adjusted gross income (MAGI)-based methodology described in WAC 182-509-0300, called MAGI-based apple health programs;

(b) Those that use an income methodology other than MAGI, called non-MAGI-based apple health programs, which include:

(i) Supplemental security income (SSI)-related apple health programs;

(ii) Temporary assistance for needy families (TANF)-related apple health programs; and

(iii) Other apple health programs not based on MAGI, SSI, or TANF methodologies.

(c) Those that provide coverage based on a specific status or entitlement in federal rule and not on countable income, called deemed eligible apple health programs.

(2) MAGI-based apple health programs include the following:

(a) Apple health parent and caretaker relative program described in WAC 182-505-0240;

(b) MAGI-based apple health adult medical program described in WAC 182-505-0250, for which the scope of coverage is called the alternative benefits plan (ABP) described in WAC 182-500-0010;

(c) Apple health ((~~for pregnant women program~~)) pregnancy and after-pregnancy coverage described in WAC 182-505-0115;

(d) Apple health for kids program described in WAC 182-505-0210 (3)(a);

(e) Premium-based apple health for kids described in WAC 182-505-0215;

(f) Apple health long-term care for children and adults described in chapter 182-514 WAC; ((~~and~~))

(g) Apple health alien emergency medical program described in WAC 182-507-0110 through 182-507-0125 when the person is eligible based on criteria for a MAGI-based apple health program; and

(h) Apple health expansion program for people who are age 64 or younger as described in chapter 182-525 WAC.

(3) Non-MAGI-based apple health programs include the following:

(a) SSI-related programs which use the income methodologies of the SSI program (except where the agency has adopted more liberal rules than SSI) described in chapter 182-512 WAC to determine eligibility:

(i) Apple health for workers with disabilities (HWD) described in chapter 182-511 WAC;

(ii) Apple health SSI-related programs described in chapters 182-512 and 182-519 WAC;

(iii) Apple health long-term care and hospice programs described in chapters 182-513 and 182-515 WAC;

(iv) Apple health medicare savings programs described in chapter 182-517 WAC; ((~~and~~))

(v) Apple health alien emergency medical (AEM) programs described in WAC 182-507-0110 and 182-507-0125 when the person meets the age, blindness or disability criteria specified in WAC 182-512-0050; and

(vi) Apple health expansion program for people who are age 65 and older as described in chapter 182-512 WAC.

(b) TANF-related programs which use the income methodologies based on the TANF cash program described in WAC 388-450-0170 to determine eligibility, with variations as specified in WAC 182-509-0001(5) and program specific rules:

(i) Refugee medical assistance (RMA) program described in WAC 182-507-0130; and

(ii) Apple health medically needy (MN) coverage for pregnant ((~~women~~)) people and children who do not meet SSI-related criteria.

(c) Other programs:

(i) Breast and cervical cancer program described in WAC 182-505-0120;

(ii) Family planning only programs described in chapter 182-532 WAC;

(iii) Medical care services described in WAC 182-508-0005;

(iv) Apple health for pregnant minors described in WAC 182-505-0117;

(v) Kidney disease program described in chapter 182-540 WAC; and

(vi) Tailored supports for older adults described in WAC 182-513-1610.

(4) Deemed eligible apple health programs include:

(a) Apple health SSI medical program described in chapter 182-510 WAC, or a person who meets the medicaid eligibility criteria in 1619b of the Social Security Act;

(b) Newborn medical program described in WAC 182-505-0210(2);

(c) Foster care program described in WAC 182-505-0211;

(d) Medical extension program described in WAC 182-523-0100; and

(e) Family planning extension described in WAC 182-505-0115(5).

(5) A person is eligible for categorically needy (CN) health care coverage when the household's countable income is at or below the categorically needy income level (CNIL) for the specific program.

(6) If income is above the CNIL, a person is eligible for the MN program if the person is:

(a) A child;

(b) A pregnant ((~~woman~~)) person; or

(c) SSI-related (aged 65, blind or disabled).

(7) MN health care coverage is not available to parents, caretaker relatives, or adults unless they are eligible under subsection (6) of this section.

(8) A person who is eligible for the apple health MAGI-based adult program listed in subsection (2)(b) of this section is eligible for ABP health care coverage as defined in WAC 182-500-0010. Such a person may apply for more comprehensive coverage through another apple health program at any time.

(9) For the other specific program requirements a person must meet to qualify for apple health, see chapters 182-503 through 182-527 WAC.

AMENDATORY SECTION (Amending WSR 21-19-142, filed 9/22/21, effective 10/23/21)

WAC 182-503-0515 Washington apple health—Social Security number requirements. (1) To be eligible for Washington apple health (medicaid), or tailored supports for older adults (TSOA) described in WAC 182-513-1610, you (the applicant or recipient) must provide your valid Social Security number (SSN) or proof of application for an SSN to the medicaid agency or the agency's designee, except as provided in subsections (2) and (6) of this section.

(2) An SSN is not required if you are:

(a) Not eligible to receive an SSN or may only be issued an SSN for a valid nonwork reason described in 20 C.F.R. 422.104;

(b) A household member who is not applying for apple health coverage, unless verification of that household member's resources is required to determine the eligibility of the client;

(c) Refusing to obtain an SSN for well-established religious objections as defined in 42 C.F.R. 435.910 (h)(3); or

(d) Not able to obtain or provide an SSN because you are a victim of domestic violence.

(3) If you are receiving coverage because you meet an exception under either subsection (2)(c) or (d) of this section, we (the agency) will confirm with you at your apple health renewal, consistent with WAC 182-503-0050, that you still meet the exception.

(4) If we ask for confirmation that you continue to meet an exception in subsection (2) of this section and you do not respond in accordance with subsection (3) of this section, or if you no longer meet an exception and do not provide your SSN, we will terminate your apple health coverage according to WAC 182-518-0025.

(5) If you are not able to provide your SSN, either because you do not know it or it has not been issued, you must provide:

(a) Proof from the Social Security Administration (SSA) that you turned in an application for an SSN; and

(b) The SSN when you receive it.

(i) Your apple health coverage will not be delayed, denied, or terminated while waiting for SSA to send you your SSN. If you need help applying for an SSN, assistance will be provided to you.

(ii) We will ask you every 90 days if your SSN has been issued.

(6) An SSN is not required for the following apple health programs:

(a) Refugee medical assistance program described in WAC 182-507-0130;

(b) Alien medical programs described in WAC 182-507-0115, 182-507-0120, and 182-507-0125;

(c) Newborn medical program described in WAC 182-505-0210 (2)(a);

(d) Foster care program for a child age 18 and younger as described in WAC 182-505-0211(1);

(e) Medical programs for children and pregnant women who do not meet citizenship or immigration status described in WAC 182-503-0535 (2)(e)(ii) and (iii); ((~~or~~))

(f) Family planning only program described in WAC 182-532-510 if you do not meet citizenship or immigration status for Washington apple health or you have made an informed choice to apply for family planning services only; or

(g) Washington apple health expansion program described in chapter 182-525 WAC.

(7) If you are required to provide an SSN under this section, and you do not meet an exception under subsection (2) of this section, failure to provide your SSN may result in:

(a) Denial of your application or termination of your coverage because we cannot determine your household's eligibility; or

(b) Inability to apply the community spouse resource allocation (CSRA) or monthly maintenance needs allowance (MMNA) for a client of long-term services and supports (LTSS).

OTS-5234.3

AMENDATORY SECTION (Amending WSR 24-03-050, filed 1/10/24, effective 2/10/24)

WAC 182-509-0220 Washington apple health—How resources are considered. (1) A resource is any cash, other personal property, or real property that a person:

(a) Owns;

(b) Has the right, authority, or power to convert to cash (if not already cash); and

(c) Has the legal right to use for ((~~his or her~~)) their support and maintenance.

(2) There is no resource limit for an applicant or recipient of the following Washington apple health (medicaid) programs:

(a) Apple health for workers with disabilities (HWD) program, as described in chapter 182-511 WAC;

(b) Apple health foster care program (see WAC 182-505-0211);

(c) Medicare savings programs (see WAC 182-517-0100);

(d) All programs that are based on modified adjusted gross income (MAGI) methodologies, as described in WAC 182-503-0510. This includes the following:

(i) Apple health for parents and caretaker relatives (see WAC 182-505-0240);

(ii) Apple health pregnancy coverage (see WAC 182-505-0115);

(iii) Apple health for kids (see WAC 182-505-0210);

(iv) Premium-based apple health for kids (see WAC 182-505-0215);

(v) Apple health long-term care for children and adults (see WAC 182-514-0230);

(vi) Apple health for MAGI-based adult coverage (see WAC 182-505-0250); ((~~and~~))

(vii) Apple health MAGI-based adult alien emergency medical (see WAC 182-507-0110); and

(viii) Apple health expansion coverage.

(3) For all other apple health programs, the resource limits and exclusions can be found in the following chapters:

(a) Apple health SSI-related medical (see chapter 182-512 WAC) with the exception of programs listed in subsection (2) of this section;

(b) Apple health long-term care (see chapters 182-513 and 182-515 WAC);

(c) SSI-related apple health alien medical program (see chapter 182-507 WAC);

(d) Apple health for refugees (see WAC 182-507-0130); and

(e) Medical care services (see WAC 182-508-0005).

(4) The agency or its designee determines how trusts, annuities and life estates affect eligibility for apple health coverage for the programs listed in subsection (3)(a) through (e) of this section by following the rules described in chapter 182-516 WAC.

(5) Receipt of money by a member of a federally recognized tribe from exercising federally protected rights or extraction of protected resources, such as fishing, shell-fishing, or selling timber, is considered conversion of an exempt resource during the month of receipt. Any amounts remaining from the conversion of this exempt resource on the first of the month after the month of receipt will remain exempt if the funds were used to purchase another exempt resource. Any amounts remaining in the form of countable resources (such as in checking or savings accounts) on the first of the month after receipt, will be added to other countable resources for eligibility determinations when a resource determination is required by the specific apple health program. If no resource determination is required by the specific apple health program, eligibility is not affected.

OTS-5226.7

Chapter 182-525 WAC
WASHINGTON APPLE HEALTH EXPANSION—COVERAGE BENEFITS

NEW SECTION

WAC 182-525-0100 Overview. This program began on July 1, 2024.

(1) The rules in this chapter and in chapters 182-525A and 182-525B WAC are specific to Washington apple health expansion and govern the administration of apple health expansion benefits.

(2) Apple health expansion benefits are state-funded physical and behavioral health services identified as covered in WAC 182-501-0060 and 182-525-0700.

(a) Coverage of apple health expansion services may be limited or modified based on program rules relating to those services. Information related to noncovered or excluded services may be contained in the program rules applicable to apple health expansion.

(b) An apple health expansion enrollee may receive only those apple health expansion services that are specifically identified as a covered benefit in the apple health expansion program rules.

(c) Services administered or authorized by the department of social and health services are not covered under the apple health expansion benefit package.

(d) The exception to rule process in WAC 182-501-0160 applies only to services that are specified as part of the apple health expansion benefit package in WAC 182-501-0060 and pursuant to the rules of this chapter, and chapters 182-525A and 182-525B WAC.

(3) Health plans, as defined in WAC 182-525-0400, administer apple health expansion benefits under the apple health expansion contract based on the rules in this chapter and chapters 182-525A and 182-525B WAC.

(4) If a service is covered under the apple health expansion program but excluded from administration under the apple health expansion contract, the service is administered by the agency on a fee-for-service basis according to the agency rules for that service.

(5) In order to provide services and receive payments, an apple health expansion provider must be an enrolled provider in accordance with chapter 182-502 WAC and meet the requirements of this chapter and other applicable program rules.

(6) The agency deems that providers enrolled in apple health under chapter 182-502 WAC are enrolled providers for purposes of apple health expansion.

NEW SECTION

WAC 182-525-0200 Applying for the program and income limits. (1) **How to apply.** A person may apply for Washington apple health expansion coverage by following the process described in WAC 182-503-0005.

(2) **Income.** The agency follows the modified adjusted gross income (MAGI) rules in chapter 182-509 WAC to determine a person's apple health expansion eligibility for people age 19 through 64. For people age 65 and older, the agency follows the non-MAGI rules in chapter 182-512 WAC, with the following exceptions:

(a) The person must have a countable income equal to or below 138 percent of the federal poverty level; and

(b) A resource or asset test is not required.

(3) **Insurance affordability programs.** A person may apply for the insurance affordability programs offered through the agency as described in WAC 182-503-0001.

NEW SECTION

WAC 182-525-0300 Available resources exhausted. (1) Unlike the medicaid program under Title XIX of the Social Security Act and chapter 74.09 RCW, Washington apple health expansion is not an entitlement program with an open-ended right to services and benefits. The provision of services and benefits under apple health expansion is strictly limited by the funding that the legislature appropriates to the agency for the program.

(2) The agency does not have the legal right to spend money on apple health expansion coverage or benefits unless specifically appropriated by the legislature.

(3) The agency determines, in its sole discretion, if and when the available funding for apple health expansion has been or will be exhausted. Upon making any such determination, the agency notifies enrollees, providers, health plans, and the general public through a posting on its website or in any other manner that the agency considers appropriate. The notice will specify the date on which available funding has been or will be exhausted.

(4) A determination by the agency that available funding for apple health expansion is exhausted results in the automatic termination of any authorization, appeals process, independent review, or agency administrative hearing process related to a request to authorize a service or benefit. This is because services and benefits cannot be authorized or paid for without available funding, regardless of medical necessity.

NEW SECTION

WAC 182-525-0400 Definitions. The definitions from chapters 182-500 and 182-538 WAC apply to Washington apple health expansion, along with the following definitions:

• "Enrollment cap" – means the maximum number of people who may be enrolled in apple health expansion.

• "Health plan" – means the same as the term "managed care organization" in WAC 182-538-050.

NEW SECTION

WAC 182-525-0500 Enrollment cap for services. (1) Enrollment in Washington apple health expansion is subject to available funds, as described in this section and in WAC 182-525-0300.

(2) The agency caps apple health expansion enrollment if it determines that accepting additional enrollees would exceed funding appropriated by the legislature. Once the enrollment cap is reached, all applications for apple health expansion will be denied.

(3) If the agency denies a person apple health expansion coverage due to an enrollment cap, that person will be considered for other apple health programs. The person may be eligible for other programs if they:

(a) Meet immigration requirements for other apple health programs;

(b) Qualify due to pregnancy as identified in WAC 182-505-0115; or

(c) Have a qualifying medical emergency for which federal funding is available.

(4) If apple health expansion enrollment closes due to a cap on enrollment, the agency notifies applicants that their applications are denied.

(5) Applicants who are denied based on the enrollment cap may not appeal the agency's decision to apply the enrollment cap.

(6)(a) If the agency reopens apple health expansion enrollment because enrollment has fallen below the cap and funding is available, the agency fills the available openings as described in (b) and (c) of this subsection.

(b) If the agency determines that additional individuals can be enrolled into apple health expansion, the agency will identify the number of openings available. To fill the available number of openings, the agency selects from the following categories:

(i) Individuals who submitted a completed application and were denied enrollment due to the cap;

(ii) Individuals who were enrolled in the children's health program (CHP), alien emergency medical (AEM), or after-pregnancy coverage programs who met eligibility requirements for apple health expansion and whose coverage ended while the cap was in effect; and

(iii) Individuals who are enrolled in a qualified health plan under the health benefit exchange's section 1332 waiver.

(c) The agency randomly selects individuals from (b) of this subsection to fill the openings, striving to ensure that 90 percent of these individuals are eligible under modified adjusted gross income (MAGI) standards, and 10 percent are non-MAGI.

(d) If the agency is unable to fill the openings available based on (b) and (c) of this subsection, the agency conducts outreach efforts to inform the public of the opportunity to apply.

NEW SECTION

WAC 182-525-0600 Termination of enrollees based on available funds. (1)(a) When the agency determines that available funds are exhausted as described in WAC 182-525-0300, the agency terminates Washington apple health expansion coverage of all enrollees.

(b) The agency sends notice to enrollees in accordance with WAC 182-518-0025 (1), (2), and (3). Continued coverage of apple health expansion benefits is not available.

(2)(a) When the agency determines that available funds are at risk of being exhausted, the agency terminates coverage of enrollees necessary to maintain funding for the program until the number of enrollees receiving coverage is sustainable based on the appropriated funds. The agency terminates apple health expansion enrollees beginning with the people most recently enrolled in apple health expansion, based on the date the agency approved a person for enrollment.

(b) The agency sends notice to enrollees in accordance with WAC 182-518-0025 (1), (2), and (3). Continued coverage of apple health expansion benefits is not available.

(3) Applicants who are denied based on the enrollment cap may not appeal the agency's decision to apply the enrollment cap.

(4) If the cap has been met and the agency denies enrollment due to agency error, the agency may choose not to apply the enrollment cap and enroll or provide coverage if there are available funds.

(5) If the cap has been met and the agency terminates an enrollee due to their failure to submit a completed renewal, the agency may choose not to apply the cap if:

(a) There are available funds to reinstate the enrollee's coverage; and

(b) The enrollee completes their renewal within 90 calendar days of their coverage end date.

NEW SECTION

WAC 182-525-0700 Washington apple health rules applicable to Washington apple health expansion. Agency rules applicable to other Washington apple health programs may also be applicable to Washington apple health expansion. The following agency rules apply to apple health expansion, with any modifications or exceptions as noted:

(1) Chapter 182-500 WAC;

(2) Chapter 182-501 WAC, except that the rules relating to early periodic screening, diagnosis, and treatment (EPSDT) services do not apply to apple health expansion.

(3) Chapter 182-512 WAC, with the exception of WAC 182-512-0600 and 182-512-0960;

(4) WAC 182-501-0165 applies only to the fee-for-service benefits available under apple health expansion and as noted in the apple health expansion contract.

(5) Chapter 182-502 WAC, except that WAC 182-525-1100 replaces WAC 182-502-0160;

(6) Chapter 182-502A WAC;

(7) Chapter 182-503 WAC, except that the general eligibility requirements in WAC 182-503-0505 and 182-503-0055 do not apply to apple health expansion. (See WAC 182-525-0900.)

(8) Chapter 182-504 WAC, except that WAC 182-504-0015 does not apply regarding the certification period for apple health expansion.

(9) Chapter 182-505 WAC;

(10) Chapter 182-506 WAC;

(11) Chapter 182-509 WAC;

(12) Chapter 182-518 WAC, except as otherwise noted in the apple health expansion rules;

(13) Chapter 182-520 WAC;

(14) Chapter 182-523 WAC;

(15) Chapter 182-525 WAC;

(16) Chapter 182-525A WAC;

(17) Chapter 182-525B WAC;

(18) Chapter 182-526 WAC;

(19) Chapter 182-530 WAC does not apply to apple health expansion, except for the definitions from WAC 182-530-1050 that are incorporated by reference into chapter 182-525B WAC as identified in WAC 182-525B-0300. See chapter 182-525B WAC for the apple health expansion pharmacy benefit and outpatient drug program rules; and

(20) Chapters 182-531 through 182-537 WAC and chapters 182-539 through 182-560 WAC may be applicable to apple health expansion if the services are provided on a fee-for-service basis or if incorporated by reference in the apple health expansion contract.

NEW SECTION

WAC 182-525-0800 Certification period. (1) A certification period is the length of time the agency determines a person is eligible for Washington apple health expansion coverage, which may be reduced or terminated under WAC 182-525-0600.

(2) The certification period for apple health expansion coverage is 12 months, as long as the person remains eligible according to program rules.

(3) The certification period begins on the first day of the month the person is approved and continues through the end of the 12th month.

(4) If, during a person's certification period, apple health expansion funding is exhausted, as described in WAC 182-525-0300, the agency terminates enrollment for a person based on funding availability according to WAC 182-525-0600.

(5) The agency considers an enrollee's eligibility for all other Washington apple health programs, as well as qualified health plans, health insurance premium tax credits (as defined in WAC 182-500-0045), and cost sharing reductions (as defined in WAC 182-500-0020) before ending the enrollee's apple health expansion coverage.

(6) A person may be eligible for retroactive coverage through the medical assistance programs for noncitizens, as described in WAC 182-507-0110.

NEW SECTION

WAC 182-525-0900 General eligibility requirements. (1) A person must meet the following eligibility criteria for Washington apple health expansion coverage:

(a) Be age 19 or older (see WAC 182-503-0050);

(b) Be a resident of Washington state (see WAC 182-503-0520 and 182-503-0525);

(c) Have net countable income that is at or below 138 percent of the federal poverty level for a household of the applicable size;

(d) Is not entitled to or enrolled in medicare benefits under Part A or B of Title XVIII of the Social Security Act; and

(e) Is not eligible for another full scope medical assistance program.

(2) A person in a public institution, including a correctional facility, is not eligible for apple health expansion coverage until released, unless the person:

(a) Is age 21 or younger or age 65 or older and is a patient in an institution for mental disease (see WAC 182-513-1317(5)); or

(b) Receives inpatient hospital services outside of the public institution or correctional facility.

NEW SECTION

WAC 182-525-1000 Application processing times. Application processing times for Washington apple health expansion follow the application processing times described in WAC 182-503-0060.

NEW SECTION

WAC 182-525-1100 Billing an enrollee. (1) This section specifies the limited circumstances in which:

(a) Washington apple health expansion enrollees can choose to self-pay for health care services; and

(b) Providers, as defined in WAC 182-500-0085, have the authority to bill apple health expansion enrollees for health care services furnished to those enrollees.

(2) The provider is responsible for:

(a) Verifying whether a person is eligible to receive health care services on the date the services are provided;

(b) Verifying whether the person is enrolled with an agency-contracted health plan;

(c) Knowing the limitations of the services within the scope of apple health expansion coverage (see WAC 182-501-0050 (4)(a), 182-501-0060, 182-501-0065, and chapters 182-525, 182-525A, and 182-525B WAC);

(d) Informing the enrollee of those limitations;

(e) Exhausting all applicable agency or agency-contracted health plan processes necessary to obtain authorization for requested service(s);

(f) Ensuring that translation or interpretation is provided to enrollees with limited-English proficiency (LEP) who agree to be billed for services in accordance with this section; and

(g) Retaining all documentation which demonstrates compliance with this section.

(3) Unless otherwise specified in this section, providers must accept as payment in full the amount paid by either:

(a) The agency health plan, for health care services furnished to enrollees; or

(b) The agency, for services provided on a fee-for-service basis.

(4)(a) A provider must not bill an enrollee, or anyone on the enrollee's behalf, for any services until the provider has completed all requirements of this section, including the conditions of payment described in the agency's rules, the agency's fee-for-service billing instructions, and the requirements for billing the enrollee's health plan, and until the provider has then fully informed the enrollee of their coverage options.

(b) A provider must not bill an enrollee for:

(i) Any services for which the provider failed to satisfy the conditions of payment described in the agency's rules, the agency's fee-for-service billing instructions, and the requirements for billing the enrollee's health plan;

(ii) A covered service even if the provider has not received payment from the agency or the enrollee's health plan; or

(iii) A covered service when the agency or the enrollee's health plan denies an authorization request for the service because the required information was not received from the provider or the prescriber within 30 calendar days.

(5) If the requirements of this section are satisfied, then a provider may bill an enrollee for a covered service or a noncovered service. The enrollee and provider must sign and date the HCA form 13-879, Agreement to Pay for Healthcare Services, before the service is furnished. Form 13-879, including translated versions, is available to download at https://www.hca.wa.gov/assets/billers-and-providers/13_879.pdf. The requirements for this subsection are as follows:

(a) The agreement must:

(i) Indicate the anticipated date the service will be provided, which must be no later than 90 calendar days from the date of the signed agreement;

(ii) List each of the services that will be furnished;

(iii) List treatment alternatives that may have been covered by the agency or the enrollee's health plan;

(iv) Specify the total amount the enrollee must pay for the service;

(v) Specify what items or services are included in this amount (such as preoperative care and postoperative care). See WAC 182-501-0070(3) for payment of ancillary services for a noncovered service;

(vi) Indicate that the enrollee has been fully informed of all available medically appropriate treatment, including services that may be paid for by the agency or the enrollee's health plan, and that the enrollee chooses to get the specified service(s);

(vii) Specify that the enrollee may request an exception to rule (ETR) in accordance with WAC 182-501-0160 when the agency or the enrollee's health plan denies a request for a noncovered service and that the enrollee may choose not to do so;

(viii) Specify that the enrollee may request an administrative hearing in accordance with chapter 182-526 WAC to appeal the agency's denial of a request for prior authorization of a covered service and that the enrollee may choose not to do so;

(ix) Be completed only after the provider and the enrollee have exhausted all applicable agency or health plan processes necessary to obtain authorization of the requested service, except that the enrollee may choose not to request an ETR or an administrative hearing regarding agency or health plan denials of authorization for requested service(s); and

(x) Specify which reason in (b) of this subsection applies.

(b) The provider must select on the agreement form one of the following reasons (as applicable) why the enrollee agrees to be billed for the service(s). The service(s) is:

(i) Not covered by apple health expansion, the ETR process as described in WAC 182-501-0160 has been exhausted, and the service(s) is denied;

(ii) Not covered by apple health expansion and the enrollee has been informed of their right to an ETR and has chosen not to pursue an ETR as described in WAC 182-501-0160;

(iii) Covered by apple health expansion, requires authorization, and the provider completes all the necessary requirements; however, the agency or health plan denied the service as not medically necessary (this includes services denied as a limitation extension under WAC 182-501-0169); or

(iv) Covered by apple health expansion and does not require authorization, but the enrollee has requested a specific type of treatment, supply, or equipment based on personal preference which the agency or health plan does not pay for and the specific type is not medically necessary for the enrollee.

(c) For enrollees with limited-English proficiency, the agreement must be the version translated in the enrollee's primary language and interpreted if necessary. The translator or interpreter must sign the agreement regardless of whether the agreement is translated in writing or orally interpreted;

(d) The provider must give the enrollee a copy of the agreement and maintain the original and all documentation which supports compliance with this section in the enrollee's file for six years from the date of service. The agreement must be made available to the agency for review upon request; and

(e) If the service is not provided within 90 calendar days of the signed agreement, the provider must complete a new agreement, which must be signed by both the provider and the enrollee.

(6) The following are the limited circumstances in which a provider may bill an enrollee without executing form 13-879, Agreement to Pay for Healthcare Services, as specified in subsection (5) of this section:

(a) The enrollee, the enrollee's legal guardian, or the enrollee's legal representative:

(i) Was reimbursed for the service directly by a third party (see WAC 182-501-0200); or

(ii) Refused to complete and sign insurance forms, billing documents, or other forms necessary for the provider to bill the third-party insurance carrier for the service.

(b) The person represented that they were paying privately and not enrolled in apple health expansion when they were already enrolled in and receiving benefits under apple health expansion. In this circumstance, the provider must:

(i) Keep documentation of the enrollee's declaration of medical coverage. The declaration must be signed and dated by the enrollee, the enrollee's legal guardian, or the enrollee's legal representative; and

(ii) Give a copy of the document to the enrollee and maintain the original for six years from the date of service, for agency review upon request.

(c) The enrollee is placed in the agency's or a health plan's patient review and coordination (PRC) program and obtains nonemergency services from a nonpharmacy provider that is not an assigned or appropriately referred provider as described in WAC 182-501-0135;

(d) The service is within a service category excluded from the enrollee's benefits package. See WAC 182-501-0060;

(e) The services were noncovered ambulance services (see WAC 182-546-0250(2));

(f) An enrollee chooses to receive nonemergency services from a provider who is not contracted with the agency after being informed by the provider that they are not contracted with the agency and that the services offered will not be paid by apple health expansion; and

(g) An enrollee chooses to receive nonemergency services from providers outside of the health plan's network without authorization from the health plan, i.e., a nonparticipating provider.

(7) There are situations in which a provider must refund the full amount of a payment previously received from or on behalf of an enrollee and then bill the agency for the covered service that had been furnished. This occurs when the enrollee becomes eligible for a covered service that was already furnished. Providers must then accept as payment in full the amount paid by the agency or the enrollee's health plan for medical services furnished to enrollees. These situations include, but are not limited to, the following:

(a) The person was not enrolled in apple health expansion on the day the service was furnished. The person applies for apple health expansion later in the same month in which the service was provided and the agency makes the person eligible for apple health expansion from the first day of that month;

(b) The enrollee receives a delayed certification for apple health expansion as defined in WAC 182-500-0025; or

(c) The enrollee receives apple health expansion certification for a retroactive period as defined in WAC 182-500-0095.

(8) Regardless of any written and signed agreement to pay, a provider may not bill, demand, collect, or accept payment or a deposit from an enrollee, anyone on the enrollee's behalf, or the agency for:

(a) Copying, printing, or otherwise transferring health care information, as the term health care information is defined in chapter 70.02 RCW, to another health care provider. This includes, but is not limited to:

(i) Medical/dental charts;

(ii) Radiological or imaging films; and

(iii) Laboratory or other diagnostic test results.

(b) Missed, canceled, or late appointments;

(c) Shipping and/or postage charges;

(d) "Boutique," "concierge," or enhanced service packages (e.g., newsletters, 24/7 access to provider, health seminars) as a condition for access to care; or

(e) The price differential between an authorized service or item and an "upgraded" service or item (e.g., a wheelchair with more features; brand name versus generic drugs).

OTS-5227.5

Chapter 182-525A WAC
WASHINGTON APPLE HEALTH EXPANSION—HEALTH PLAN ADMINISTRATION OF BENEFITS

NEW SECTION

WAC 182-525A-0100 Health plan rules—General. The rules in this chapter govern the administration of benefits under Washington apple health expansion by health plans, as defined in WAC 182-525-0400. Chapter 182-538 WAC is not applicable to apple health expansion, except for the definitions found in WAC 182-538-050, which are incorporated by reference into this chapter.

NEW SECTION

WAC 182-525A-0200 Health plan choice and assignment. The agency requires people enrolled in Washington apple health expansion to enroll in a health plan.

(1) To enroll with a health plan, a person 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; or

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

(2) A person enrolled in apple health expansion must enroll with a health plan available in the regional service area where the person resides.

(3) All family members must be enrolled with the same health plan if contracted to serve apple health expansion enrollees. However, family members of an apple health expansion enrollee placed in the patient review and coordination (PRC) program under WAC 182-501-0135 need not enroll in the same health plan as the family member placed in the PRC program.

(4) An apple health expansion enrollee may be placed into the PRC program by the health plan or the agency. An enrollee placed in the PRC program must follow the enrollment requirements of the program as stated in WAC 182-501-0135.

(5) When a person requests enrollment with a health plan, the agency enrolls them with the earliest possible effective date, based on the requirements of the agency's enrollment system.

(6) The agency assigns a person who does not choose a health plan as follows:

(a) If the person was enrolled with a health plan within the previous six months, the person is reenrolled with the same health plan if:

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

(ii) The person does not have a family member enrolled with a health plan;

(b) If (a) of this subsection does not apply and the person has a family member enrolled with a health plan, the person is enrolled with that health plan;

(c) If the person has a break in eligibility of less than two months, that person will be automatically reenrolled with their previous health plan and no notice will be sent;

(d) If the person cannot be assigned according to (a), (b), or (c) of this subsection, the agency:

(i) Assigns the person based on agency policy, or this rule, or both;

(ii) Does not assign people to any health plan that has a total statewide market share of 40 percent or more of people who are enrolled in apple health expansion coverage. On a quarterly basis, the agency reviews enrollment data to determine each health plan's statewide market share in apple health expansion coverage; and

(iii) Applies performance measures associated with increasing or reducing assignment consistent with this rule and agency policy and its contracts with health plans; or

(e) If the person cannot be assigned to a health plan under (a), (b), or (c) of this subsection, the agency assigns the person as follows:

(i) If a person does not choose a health plan, the agency assigns the person to a health plan available in the regional service area where the person resides. The health plan is responsible for primary care provider (PCP) choice and assignment.

(ii) For people 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 people who are assigned to a health plan. The assigned person has 10 calendar days to contact the agency, if desired, to change the health plan assignment before enrollment is effective. The notice includes the:

(A) Agency's toll-free number;

(B) Toll-free number and name of the health plan to which each person has been assigned;

(C) Effective date of enrollment; and

(D) Date by which the person must respond to change the assignment.

(7) An apple health expansion enrollee's selection of a PCP or assignment to a PCP occurs as follows:

(a) An apple health expansion enrollee may choose:

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

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

(b) If the enrollee does not choose a PCP or clinic, the health plan assigns a PCP or clinic that meets the access standards in the health plan contract.

(c) An apple health expansion enrollee may change from one PCP or clinic to a different PCP or clinic participating in the enrollee's health plan for any reason, with the change taking effect no later than the beginning of the month following the enrollee's request.

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

(e) Apple health expansion enrollees required to participate in the agency's PRC program may be limited in their right to change PCPs. (See WAC 182-501-0135.)

NEW SECTION

WAC 182-525A-0300 Qualifications to become an agency-contracted health plan for Washington apple health expansion coverage. (1) To provide services under the Washington apple health expansion contract, a health plan must:

(a) Contract with the agency; and

(b) Contract with an agency-contracted behavioral health administrative service organization (BH-ASO) that maintains an adequate provider network to deliver services to enrollees in the apple health expansion regional service areas.

(2) A health plan must meet the following qualifications to be eligible to contract with the agency:

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

(b) Accept the terms and conditions of the agency's apple health expansion contract;

(c) 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.

(3) The agency may periodically conduct a procurement for new apple health expansion health plans or to reduce or expand the use of existing apple health expansion health plans.

(a) The agency may conduct a procurement when the agency determines in its sole discretion there is a need to:

(i) Expand or reduce current health plan contracts;

(ii) Enhance current health plan provider networks;

(iii) Establish new contracts for apple health expansion coverage in one or more regional services areas; or

(iv) Adjust the program to ensure adherence to state and federal law.

(b) The agency gives significant weight to the following factors in any procurement process:

(i) Demonstrated commitment to, and experience in, serving low-income populations;

(ii) Demonstrated commitment to, and experience in, serving people who have mental illness, substance use disorders, or co-occurring disorders;

(iii) Demonstrated commitment to, and experience in, serving immigrant populations and populations with limited-English proficiency;

(iv) Demonstrated commitment to, and experience with, partnerships with county and municipal criminal justice systems, housing services, and other critical support services necessary to achieve the outcomes established in RCW 70.320.020, 71.24.435, and 71.36.025;

(v) Recognition that meeting apple health expansion enrollees' physical and behavioral health care needs is a shared responsibility of contracted behavioral health administrative services organizations, health plans, service providers, the state, and communities;

(vi) Consideration of past and current performance and participation in other state or federal behavioral health programs as a contractor;

(vii) Quality of services provided to enrollees under previous contracts with the state of Washington or other states;

(viii) Accessibility, including appropriate utilization, of services offered to enrollees;

(ix) Demonstrated capability to perform contracted services, including the ability to supply an adequate provider network; and

(x) The ability to meet any other requirements established by the agency.

(c) The agency may define and consider additional factors as part of any procurement including, but not limited to:

(i) Timely processing of, and payments to, providers in the health plan networks, including reconciliation of outstanding payments; and

(ii) The optimal number of health plans per regional services area, based on population and in the manner that the agency determines most beneficial for the program, enrollees, and providers.

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

NEW SECTION

WAC 182-525A-0400 Health plan payments, corrective action, and sanctions. (1) The agency pays Washington apple health expansion health plans monthly capitated premiums that:

(a) Were developed using generally accepted actuarial principles and practices;

(b) Are appropriate for the covered populations and the services to be furnished under the apple health expansion contract;

(c) Are 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) Health plans are solely responsible for payment of apple health expansion-contracted health care services. The agency does not pay for a service that is the health plan's responsibility, even if the health plan has not paid the provider for the service.

(3) The agency pays health plans a service-based enhancement rate for wraparound with intensive services (WISe) administered by a certified WISe provider who holds a current behavioral health agency license issued by the department of health under chapter 246-341 WAC.

(4) For crisis services, the health plan must determine whether the person receiving the services is eligible for apple health expansion or if the person has other insurance coverage.

(5) The agency may require corrective action for:

(a) Substandard rates of clinical performance measures;

(b) Deficiencies found in audits and on-site visits; or

(c) Findings of noncompliance with any contractual, state, or federal requirements.

(6) The agency may:

(a) Impose sanctions for a health plan's noncompliance with any contractual or state requirement; and

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

(7) If a health plan fails to meet any material obligation under the apple health expansion contract, the agency may impose the maximum allowable sanction on a per-occurrence, per-day basis until the agency determines the health plan has:

(a) Corrected the violation; and

(b) Remedied any harm caused by the noncompliance.

NEW SECTION

WAC 182-525A-0500 Scope of care. (1) A person enrolled in Washington apple health expansion is eligible only for the scope of services identified in WAC 182-501-0060, which may be modified by other agency rules pertinent to apple health expansion.

(2) The agency does not require the health plan to cover any services outside the scope of covered services in the agency's health plan contract. At its discretion, a health plan may cover services not required under the apple health expansion contract.

(3) Some services included in apple health expansion coverage may be provided on a fee-for-service basis rather than through a health plan.

(4) The health plan is not required to authorize or pay for covered services if services:

(a) Are determined not to be medically necessary, as defined in WAC 182-500-0070, in accordance with the apple health expansion contract;

(b) Are excluded from coverage under the apple health expansion contract;

(c) Are received in a hospital emergency department for nonemergency medical conditions, except for a screening exam;

(d) Are received from a participating provider that require prior authorization from the health plan; or

(e) Are nonemergency services covered under the apple health expansion contract and received from nonparticipating providers that were not prior authorized by the health plan.

NEW SECTION

WAC 182-525A-0600 Health plan administration requirements. For covered services administered through the Washington apple health expansion contracts:

(1) Health plans must subcontract with enough providers to deliver the scope of contracted services in a timely manner.

(2) Health plans must provide new enrollees with written information about how enrollees may obtain covered services.

(3) Health plans must provide covered services to enrollees through their participating providers unless an exception applies. A health plan covers services from a nonparticipating provider when an apple health expansion enrollee obtains:

(a) Emergency services; or

(b) Authorization from the health plan to receive services from a nonparticipating provider.

(4) For nonemergency services, health plans may require:

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

(b) The provider to obtain authorization from the enrollee's health plan.

(5) Health plans and their contracted providers must determine whether a requested service is medically necessary, as described in WAC 182-500-0070, given the enrollee's condition, according to the requirements included in the apple health expansion contract.

(6) The health plan must coordinate benefits with other insurers in a manner that does not reduce benefits to the enrollee or result in costs to the enrollee.

(7) A health plan enrollee does not need a PCP referral to receive reproductive health services, as described in chapter 182-532 WAC, from any reproductive health care provider participating with the health plan. Any covered services ordered or prescribed by a reproductive health care provider must meet the health plan's service authorization requirements for the specific service.

(8) For enrollees outside their health plan service area, the health plan must cover enrollees for emergency care and medically necessary covered benefits that cannot wait until the enrollees return to their health plan service area.

(9) A health plan enrollee may obtain specific services described in the apple health expansion contract from either a health plan-contracted provider or a provider with a separate agreement with the agency without a referral from the PCP or health plan.

(10) Health plans must provide new enrollees with written information about covered services. Additionally, the agency sends each enrollee written information about covered services when there is a change in covered services.

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

(12) All nonemergency services covered under the apple health expansion contract and received from nonparticipating providers require prior authorization from the health plan.

(13) A provider may bill an apple health expansion enrollee for services only if the requirements of WAC 182-525-1100 are met.

NEW SECTION

WAC 182-525A-0700 Telemedicine and store and forward technology. The agency's rules related to the authorized use of telemedicine and store and forward technology are found in WAC 182-501-0300 and are applicable to Washington apple health expansion benefits, including those administered by the health plan.

NEW SECTION

WAC 182-525A-0800 The grievance and appeal system and agency administrative hearings. (1) **Introduction.** This section contains information about the grievance and appeal system and the right to an agency administrative hearing for Washington apple health expansion health plan enrollees.

(2) **Statutory basis and framework.**

(a) Each health plan must have a grievance and appeal system in place for enrollees.

(b) Once a health plan enrollee has completed the health plan appeals process, the enrollee has the option of requesting an agency administrative hearing regarding any adverse benefit determination (as defined in WAC 182-538-050) upheld by the health plan. See chapter 182-526 WAC.

(3) **Health plan grievance and appeal system - General requirements.**

(a) The health plan grievance and appeal system must include:

(i) A process for addressing complaints about any matter that is not an adverse benefit determination, which is a grievance;

(ii) An appeal process to address enrollee requests for review of a health plan's adverse benefit determination; and

(iii) Access to the agency's administrative hearing process for review of a health plan's resolution of an appeal.

(b) Health plans must provide information describing the health plan's grievance and appeal system to all providers and subcontractors.

(c) A health plan must have agency approval for written materials sent to enrollees regarding the grievance and appeal system and the agency's administrative hearing process under chapter 182-526 WAC.

(d) Health plans must inform enrollees in writing within 15 calendar days of enrollment about enrollees' rights with instructions on how to use the health plan's grievance and appeal system and the agency's administrative hearing process.

(e) A health plan 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) A health plan must allow enrollees and their authorized representatives to file grievances and appeals orally as well as in writing.

(g) Methods to file either a grievance or appeal include, but are not limited to, U.S. mail, commercial delivery services, hand delivery, fax, telephone, and email.

(h) Health plans may not require enrollees to provide written follow-up for a grievance the health plan received orally.

(i) The health plan 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.

(j) The health plan must ensure that the people who make decisions on grievances and appeals:

(i) Were neither involved in any previous level of review or decision making nor a subordinate of any person who was so involved;

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

(A) An appeal of an adverse benefit determination 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; and

(iii) Consider all comments, documents, records, and other information submitted by the enrollee or the enrollee's representative without regard to whether the information was submitted or considered in the initial adverse benefit determination.

(4) **The health plan grievance process.**

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

(b) The health plan must acknowledge receipt of each grievance within two business days. Acknowledgment may be orally or in writing.

(c) The health plan must complete the resolution of a grievance and provide notice to the affected parties as expeditiously as the enrollee's health condition requires, but no later than 45 calendar days after receiving the grievance.

(d) The health plan must notify enrollees of the resolution of grievances within five business days of determination.

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

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

(e) Enrollees do not have a right to an agency administrative hearing to dispute the resolution of a grievance unless the health plan fails to adhere to the notice and timing requirements for grievances.

(f) If the health plan fails to adhere to the notice and timing requirements for grievances, the enrollee is deemed to have completed the health plan's appeals process and may initiate an agency administrative hearing.

(5) **Health plans' notice of adverse benefit determination.**

(a) **Language and format requirements.** The notice of adverse benefit determination must be in writing in the enrollee's primary language and in an easily understood format.

(b) **Content of notice.** The notice of health plan adverse benefit determination must explain:

(i) The adverse benefit determination the health plan has made or intends to make, and any pertinent effective date;

(ii) The reasons for the adverse benefit determination, including citation to legal authority and the health plan criteria that were the basis of the decision;

(iii) The enrollee's right to receive upon request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the adverse benefit determination, in-

cluding medical necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits;

(iv) The enrollee's right to file an appeal of the adverse benefit determination, including information on the health plan appeal process and the right to request an agency administrative hearing;

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

(vi) The circumstances under which an appeal can be expedited and how to request it; and

(vii) 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.** The health plan must mail the notice of adverse benefit determination within the following time frames:

(i) For termination, suspension, or reduction of previously authorized services, at least 10 calendar days prior to the effective date of the adverse benefit determination. 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 adverse benefit determination affecting the claim. This applies only when the enrollee can be held liable for the costs associated with the adverse benefit determination.

(iii) For standard service authorization decisions that deny or limit services, as expeditiously as the enrollee's health condition requires, but not to exceed 14 calendar days following receipt of the request for service. An extension of up to 14 additional calendar days may be allowed if:

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

(B) The health plan 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 health plan extends the time frame for standard service authorization decisions, the health plan 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 involving mental health drug authorization decisions, or where the provider indicates or the health plan 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 health plan must make an expedited authorization decision and provide notice no later than 72 hours after receipt of the request for service.

(B) The health plan may extend the 72-hour time frame up to 14 calendar days if:

(I) The enrollee requests the extension; or

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

(6) **The health plan appeal process.**

(a) **Authority to appeal.** An enrollee, the enrollee's authorized representative, or the provider acting with the enrollee's written

consent may appeal an adverse benefit determination from the health plan.

(b) **Oral appeals.** A health plan must treat oral inquiries about appealing an adverse benefit determination as an appeal to establish the earliest possible filing date for the appeal.

(c) **Acknowledgment letter.** The health plan must acknowledge in writing receipt of each appeal to both the enrollee and the requesting provider within five calendar days of receiving the appeal request. The appeal acknowledgment letter sent by the health plan serves as written confirmation of an appeal filed orally by an enrollee.

(d) **Standard service authorization - 60-day deadline.** For appeals involving standard service authorization decisions, an enrollee must file an appeal within 60 calendar days of the date on the health plan's notice of adverse benefit determination. This time frame also applies to a request for an expedited appeal.

(e) **Previously authorized service - 10-day deadline.** For appeals of adverse benefit determinations involving termination, suspension, or reduction of a previously authorized service, and when the enrollee is requesting continuation of the service, the enrollee must file an appeal within 10 calendar days of the health plan mailing notice of the adverse benefit determination.

(f) **Untimely service authorization decisions.** When the health plan does not make a service authorization decision within required time frames, it is considered a denial. In this case, the health plan sends a formal notice of adverse benefit determination, including the enrollee's right to an appeal.

(g) **Appeal process requirements.** The health plan appeal process must:

(i) Provide the enrollee a reasonable opportunity to present evidence and allegations of fact or law, in person, by telephone, or in writing. The health plan 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 the opportunity before and during the appeal process to examine the enrollee's case file, including medical records, other relevant documents and records, and any new or additional evidence considered, relied upon, or generated by the health plan (or at health plan's direction) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution time frame for appeals as specified in this section; 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) **Level of appeal.** There is only one level of review in the health plan's appeals process.

(i) **Time frames for resolution of appeals and notice to the enrollee.** Health plans 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 30 calendar days from the day the health plan receives the appeal. This includes appeals involving termination, suspension, or reduction of previously authorized services.

(ii) For expedited resolution of appeals, including notice to the affected parties, no longer than 72 hours after the health plan re-

ceives the appeal. The health plan may extend the 72-hour time frame up to 14 calendar days if:

(A) The enrollee requests the extension; or

(B) The health plan determines and shows to the satisfaction of the agency, upon request, there is a need for additional information and it is in the enrollee's interest.

(iii) If the health plan fails to adhere to the notice and timing requirements for appeals, the enrollee is deemed to have completed the health plan's appeals process and may request an agency administrative hearing.

(j) **Language and format requirements - Notice of resolution of appeal.**

(i) The notice of the resolution of the appeal must be in writing in the enrollee's primary language and in an easily understood format.

(ii) The notice of the resolution of the appeal must be sent to the enrollee and the requesting provider.

(iii) For notice of an expedited resolution, the health plan must also make reasonable efforts to provide oral notice.

(k) **Content of resolution of appeal.**

(i) The notice of resolution must include the results of the resolution process and the date it was completed.

(ii) For appeals not resolved wholly in favor of the enrollee, the notice of resolution must include:

(A) The right to request an agency administrative hearing under chapter 182-526 WAC, and how to request the hearing;

(B) The right to request and receive benefits while an agency administrative hearing is pending, and how to make the request in accordance with subsection (9) of this section and the agency's administrative hearing rules in chapter 182-526 WAC; and

(C) That the enrollee may be held liable for the cost of those benefits received for the first 60 calendar days after the agency or the office of administrative hearings (OAH) receives an agency administrative hearing request if the hearing decision upholds the health plan's adverse benefit determination.

(7) **Health plan expedited appeal process.**

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

(b) The enrollee may file an expedited appeal either orally, according to WAC 182-526-0095, or in writing. No additional follow-up is required of the enrollee.

(c) The health plan 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 but no later than two calendar days after the health plan receives the appeal. The health plan must also make reasonable efforts to orally notify the enrollee of the decision.

(d) The health plan may extend the time frame for decision on the enrollee's request for an expedited appeal up to 14 calendar days if:

(i) The enrollee requests the extension; or

(ii) The health plan determines and shows to the satisfaction of the agency, upon its request, that there is a need for additional information and the delay is in the enrollee's interest.

(e) The health plan must make reasonable efforts to provide the enrollee prompt verbal notice and provide written notice for any extension not requested by the enrollee with the reason for the delay.

(f) If the health plan grants an expedited appeal, the health plan must issue a decision as expeditiously as the enrollee's physical or behavioral health condition requires, but not later than 72 hours after receiving the appeal. The health plan may extend the time frame for a decision and to provide notice to the enrollee for an expedited appeal, up to 14 days, if:

(i) The enrollee requests the extension; or

(ii) The health plan determines and shows to the satisfaction of the agency, upon its request, that there is a need for additional information and the delay is in the enrollee's interest.

(g) The health plan must provide written notice for any extension not requested by the enrollee within two calendar days of the decision and inform the enrollee of the reason for the delay and the enrollee's right to file a grievance.

(h) If the health plan 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.

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

(8) **The right to an agency administrative hearing for health plan enrollees.**

(a) **Authority to file.** Only an enrollee, the enrollee's authorized representative, or a provider with the enrollee's or authorized representative's written consent may request an administrative hearing. See WAC 182-526-0095 and 182-526-0155.

(b) **Right to agency administrative hearing.** If an enrollee has completed the health plan appeal process and does not agree with the health plan's resolution of the appeal, the enrollee may file a request for an agency administrative hearing based on the rules in this section and in chapter 182-526 WAC.

(c) **Deadline – 120 days.** An enrollee's request for an agency administrative hearing must be filed no later than 120 calendar days from the date of the written notice of resolution of appeal from the health plan.

(d) **Independent party.** The health plan is an independent party and responsible for its own representation in any agency administrative hearing, appeal to the board of appeals, and any subsequent judicial proceedings.

(e) **Applicable rules.** The agency's administrative hearing rules in chapter 182-526 WAC apply to agency administrative hearings requested by enrollees to review the resolution of an enrollee appeal of a health plan adverse benefit determination.

(9) **Continuation of previously authorized services.**

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

(i) The enrollee, or enrollee's authorized representative, or provider with written consent files the appeal on or before the later of the following:

(A) Within 10 calendar days of the health plan mailing the notice of adverse benefit determination; or

(B) The intended effective date of the health plan's proposed adverse benefit determination;

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

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

(iv) The original period covered by the original authorization has not expired.

(b) If the health plan 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 health plan appeal;

(ii) The enrollee fails to request an agency administrative hearing within 10 calendar days after the health plan sends the notice of an adverse resolution to the enrollee's appeal;

(iii) The enrollee withdraws the request for an agency administrative hearing; or

(iv) The office of administrative hearings (OAH) issues a hearing decision adverse to the enrollee.

(c) If the final resolution of the appeal upholds the health plan's adverse benefit determination, the health plan may recover from the enrollee the amount paid for the services provided to the enrollee for the first 60 calendar days after the agency or the office of administrative hearings (OAH) received a request for an agency administrative hearing, to the extent that services were provided solely because of the requirement for continuation of services.

(d) Expenditures for continued enrollee services under this section are subject to legislative funding provided specifically for apple health expansion coverage and the health plan's obligation to continue the services will terminate when available funding for apple health expansion is exhausted.

(10) **Effect of reversed resolutions of appeals.**

(a) **Services not furnished while an appeal is pending.** If the health plan or a final order entered by the agency's board of appeals, 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 health plan must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires, but not later than 72 hours from the date it receives notice reversing the determination.

(b) **Services furnished while the appeal is pending.** If the health plan 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 health plan must pay for those services.

(11) **Available resources exhausted.** Any appeals, independent review, or agency administrative hearing process related to a request to authorize or pay for a service will terminate when the available funding for apple health expansion coverage is exhausted, since services cannot be authorized or paid for without funding, regardless of medical necessity.

NEW SECTION

WAC 182-525A-0900 Enrollee request for a second medical opinion. (1) A health plan 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 health plan; or

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

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

NEW SECTION

WAC 182-525A-1000 Quality of care. To assure that health plan enrollees receive quality health care services, the agency requires health plans to comply with quality improvement standards detailed in the agency's health plan contract. Health plans must:

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

(2) Have effective means to detect overutilization and underutilization of services;

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

(4) Ensure that health plan subcontracts and the delegation of health plan responsibilities align with agency standards;

(5) Ensure health plan oversight of delegated entities responsible for any delegated activity to include:

(a) A delegation agreement with each entity describing the responsibilities of the health plan and the entity;

(b) Evaluation of the entity before delegation;

(c) An annual evaluation of the entity; and

(d) Evaluation or regular reports and follow-up on issues that are not compliant with the delegation agreement or the agency's health plan contract specifications;

(6) Cooperate with an agency-contracted, qualified independent external quality review organization (EQRO) conducting review activities;

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

(8) 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;

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

(10) Maintain a health information system that:

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

(b) Provides information on utilization, grievances and appeals, and other areas as defined by the agency;

(c) Retains enrollee grievance and appeal records for a period of no less than 10 years;

(d) 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

(e) 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.

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

(a) Measuring performance using objective quality indicators;

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

(c) Evaluating the effectiveness of system changes;

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

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

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

(12) Ensure enrollee access to health care services;

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

(14) Maintain and monitor availability of health care services for enrollees.

NEW SECTION

WAC 182-525A-1100 Notice requirements. The notice requirements in chapter 182-518 WAC apply to Washington apple health expansion. However, when available funds are exhausted, benefits are terminated, and the agency sends notice to enrollees in accordance with WAC 182-518-0025 (1), (2), and (3). Continued coverage of apple health expansion benefits is not available.

NEW SECTION

WAC 182-525A-1200 Enrollee rights. Washington apple health expansion enrollees have the rights described in WAC 182-503-0100, as applicable, and WAC 182-538-180, as applicable.

OTS-5228.3

Chapter 182-525B WAC
WASHINGTON APPLE HEALTH EXPANSION OUTPATIENT DRUG PROGRAM

NEW SECTION

WAC 182-525B-0100 Introduction. The rules in this chapter are applicable to the Washington apple health expansion outpatient drug program. Chapter 182-530 WAC is not applicable to apple health expansion, except for the definitions from WAC 182-530-1050 that are incorporated by reference into this chapter as identified in WAC 182-525B-0300.

NEW SECTION

WAC 182-525B-0200 Overview. (1) The Washington apple health expansion outpatient drug program provides medically necessary outpatient drugs, drug-related supplies, and devices to apple health expansion enrollees based on agency rules.

(2) The agency determines the outpatient drugs, vitamins, minerals, drug-related supplies, and devices that are covered under apple health expansion.

(3) The apple health expansion outpatient drug program covers outpatient drugs, vitamins, minerals, drug-related supplies, and devices when:

(a) The items are designated as covered for apple health expansion on the agency's apple health expansion preferred drug list. For covered outpatient drugs, vitamins, minerals, drug-related supplies, and devices, refer to WAC 182-525B-0500. For noncovered outpatient drugs, vitamins, minerals, drug-related supplies, and devices, refer to WAC 182-525B-0600; or

(b) The items are prescribed by a practitioner with prescriptive authority (also known as "prescriber," as defined in WAC 182-525B-0300), unless covered without a prescription as described in WAC 182-525B-0500 for family planning and emergency contraception; and

(c) When the prescriber is a provider:

(i) With an approved core provider agreement;

(ii) Who is enrolled as a servicing provider on an approved core provider agreement; or

(iii) Who is enrolled as a nonbilling provider.

NEW SECTION

WAC 182-525B-0300 Definitions. In addition to the definitions and abbreviations found in chapter 182-500 WAC, the following definitions apply to this chapter:

"Apple health expansion preferred drug list (PDL)" - The list of all drugs in drug classes and each drug's preferred or nonpreferred status as approved by the agency director or designee.

"Compendia of drug information" - See WAC 182-530-1050.

"Drug-related supplies and devices" - See WAC 182-530-1050.

"Medically accepted indication" - See WAC 182-530-1050.

"National drug code (NDC)" - See WAC 182-530-1050.

"Nonpreferred drug" - A drug within a therapeutic class of drugs on the apple health expansion PDL that has not been selected as a preferred drug.

"Obsolete NDC" - See WAC 182-530-1050.

"Outpatient drug" - A prescription or OTC drug, vitamin, mineral, enzyme, or supplement. Covered outpatient drugs will be listed on the apple health expansion PDL.

"Over-the-counter (OTC) drugs" - Outpatient drugs that do not by any applicable federal or state law or regulation require a prescription before they can be sold or dispensed.

"Pharmacist" - See WAC 182-530-1050.

"Pharmacy" - See WAC 182-530-1050.

"Practice of pharmacy" - The practice of and responsibility for:

(a) Accurately interpreting prescription orders;

(b) Compounding drugs;

(c) Dispensing, labeling, administering, and distributing drugs and devices;

(d) Providing drug information to the enrollee that includes, but is not limited to, the advising of therapeutic values, hazards, and the uses of drugs and devices;

(e) Monitoring of drug therapy and use;

(f) Proper and safe storage of drugs and devices;

(g) Documenting and maintaining records;

(h) Initiating or modifying drug therapy in accordance with written guidelines or protocols previously established and approved for a pharmacist's practice by a practitioner authorized to prescribe drugs; and

(i) Participating in drug use reviews and drug product selection.

"Practitioner" - See WAC 182-530-1050.

"Preferred drug" - A drug within a therapeutic class of drugs on the apple health expansion PDL that has been selected as a preferred drug.

"Prescriber" - A physician, osteopathic physician/surgeon, dentist, nurse, physician assistant, optometrist, pharmacist, or other person authorized by law or rule to prescribe drugs. See WAC 246-945-350 for pharmacists' prescriptive authority.

"Prescription" - An order for drugs, vitamins, minerals, enzymes or devices issued by a prescriber, in the course of the prescriber's professional practice, for a legitimate medical purpose.

"Prescription drugs" - Drugs, vitamins, minerals, or enzymes required by any applicable federal or state law or regulation to be dispensed by prescription only or that are restricted to use by practitioners only.

"Terminated NDC" - See WAC 182-530-1050.

NEW SECTION

WAC 182-525B-0400 Requirements for prescribing and dispensing controlled substances—Prescription monitoring program (PMP). This section identifies the steps prescribers must take before prescribing a controlled substance. This includes the steps pharmacists must take when dispensing a controlled substance from an outpatient pharmacy to check a Washington apple health expansion enrollee's prescription drug history in the prescription monitoring program (PMP) described in chapter 246-470 WAC.

(1) **PMP review required.** Except as identified in subsection (4) of this section, a prescriber, before prescribing, and a pharmacist, when dispensing, must check all the apple health expansion enrollee's

current prescriptions in the PMP, including any prescriptions not paid for under apple health expansion.

(2) **Retrieval by delegates allowed.** A prescriber or pharmacist may delegate the retrieval of the apple health expansion enrollee's PMP information to anyone in their practice setting with authorization to access the PMP, so long as the prescriber or pharmacist reviews all the enrollee's current prescriptions in the PMP before prescribing or when dispensing a controlled substance.

(3) **Documentation.** The prescriber and pharmacist must document in the apple health expansion enrollee's record the date and time of the:

(a) Retrieval of information from the PMP; and

(b) Review of information from the PMP.

(4) **Good faith effort exception.**

(a) If a prescriber, pharmacist, or their delegate is unable to access the apple health expansion enrollee's record in the PMP after a good faith effort, that attempt must be documented in the enrollee's record.

(b) A prescriber or pharmacist must document the reason or reasons they were unable to conduct the check in the apple health expansion enrollee's medical record.

NEW SECTION

WAC 182-525B-0500 Covered drugs, drug-related supplies, and devices. (1) The Washington apple health expansion outpatient drug program covers:

(a) Prescription and over-the-counter (OTC) drugs, vitamins, and minerals as defined in WAC 182-525B-0300, subject to the limitations and requirements in this chapter, when:

(i) The item is approved by the Food and Drug Administration (FDA);

(ii) The item is for a medically accepted indication as defined in WAC 182-525B-0300;

(iii) The manufacturer has a signed drug rebate agreement with the federal Department of Health and Human Services (DHHS) or the agency has exempted the drug from the rebate requirement based on a determination that the nonrebateable product is medically necessary and essential to the health of the enrollees; and

(iv) The item is not excluded from coverage under WAC 182-525B-0600.

(b) Drugs and drug-related supplies and devices used for family planning per chapter 182-532 WAC are as follows:

(i) OTC drugs, devices, and drug-related supplies used for family planning without a prescription when the agency determines it necessary for enrollee access and safety;

(ii) Contraceptive patches, contraceptive rings, and oral contraceptives, excluding emergency contraception, when dispensed in no less than a one-year supply, unless:

(A) A smaller supply is directed by the prescriber;

(B) A smaller supply is requested by the enrollee; or

(C) The pharmacy does not have adequate stock.

(iii) Family planning drugs that do not meet the federal drug rebate requirement in (a)(iii) of this subsection, on a case-by-case basis.

(c) Prescription or OTC vitamins, minerals, and enzymes listed as preferred on the apple health expansion preferred drug list (PDL) that are:

(i) Prenatal vitamins, iron replacement, or folic acid, when prescribed and dispensed to a pregnant person;

(ii) Recommended by the United States Preventive Services Task Force with an A or B rating;

(iii) Fluoride for enrollees under age 21; or

(iv) Taken for a clinically documented medical condition that causes vitamin, mineral, or enzyme deficiencies, and the deficiency cannot be treated through other dietary interventions.

(d) OTC drugs listed on the apple health expansion PDL that the agency determines to be the least costly therapeutic alternative for a medically accepted indication;

(e) Drug-related supplies and devices that are:

(i) Essential for the administration of an outpatient drug;

(ii) Not excluded from coverage under WAC 182-525B-0600; and

(iii) Medical equipment and supplies covered under chapter 182-543 WAC and available at retail pharmacies, when published on the apple health expansion PDL.

(f) Preservatives, flavoring, or coloring agents, only when used as a suspending agent in a compound;

(g) Prescription drugs and OTC drugs listed as preferred on the apple health expansion PDL to promote tobacco/nicotine cessation; and

(h) Drugs approved by the FDA under an emergency use authorization during a public health emergency.

(2) Apple health expansion does not cover or pay for any drug, vitamin, mineral, enzyme, or drug-related supply or device not meeting the coverage requirements under this section.

NEW SECTION

WAC 182-525B-0600 Noncovered outpatient drugs, drug-related supplies, and devices. (1) The agency does not cover a drug that is:

(a) Not approved by the Food and Drug Administration (FDA);

(b) Prescribed for a condition that is not a medically accepted indication, including a dose or dosage schedule that is not FDA-approved or supported in the Compendia;

(c) Prescribed for:

(i) Weight loss or gain;

(ii) Infertility, frigidity, or impotency;

(iii) Cosmetic purposes or hair growth; or

(iv) Sexual or erectile dysfunction, unless such drugs are used to treat a condition other than sexual or erectile dysfunction and approved by the FDA.

(d) Designated by the FDA as a less-than-effective drug;

(e) An outpatient drug for which the manufacturer requires as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or manufacturer's designee;

(f) An outpatient drug, drug-related supply, or device:

(i) With an obsolete National Drug Code (NDC) for more than two years;

(ii) With a terminated NDC;

(iii) Whose shelf life has expired; or

(iv) Which does not have a valid NDC approved by the FDA.

(g) A prescription or OTC drug, vitamin, mineral, or enzyme except as allowed under WAC 182-525B-0500 (1)(h);

(h) A drug regularly supplied by other public agencies as an integral part of program activity (e.g., immunization vaccines for children);

(i) Listed as not covered on the Washington apple health expansion preferred drug list (PDL); or

(j) A free pharmaceutical sample.

(2) A noncovered drug may be requested through the exception to rule process as described in WAC 182-501-0160.

NEW SECTION

WAC 182-525B-0700 Washington apple health expansion preferred drug list (PDL). (1) Outpatient drugs in a drug class on the Washington apple health expansion preferred drug list (PDL) may be designated as preferred, nonpreferred, or not covered drugs.

(2) The agency director or designee makes the final selection of drugs or drug classes included on the apple health expansion PDL.

(3) The agency determines the preferred, nonpreferred, and not covered status of outpatient drugs on the apple health expansion PDL.

(4) A nonpreferred drug may:

(a) Require trial and failure of one or more preferred drugs before the nonpreferred drug will be considered for authorization; or

(b) Require authorization for medical necessity as established by the agency or health plan criteria for the nonpreferred drug instead of the preferred drug.

(5) Drugs in a drug class on the apple health expansion PDL may require authorization regardless of preferred or nonpreferred status.

(6) When a preferred innovator drug or biological product on the apple health expansion PDL loses its patent, the agency may:

(a) Designate an available, equally effective, generic equivalent, or biosimilar biological product as a preferred drug; and

(b) Make the innovator drug or biological product nonpreferred.

OTS-5180.3

AMENDATORY SECTION (Amending WSR 21-11-039, filed 5/12/21, effective 6/12/21)

WAC 182-526-0005 Purpose and scope. (1) This chapter:

(a) Describes the general hearing rules and procedures that apply to((~~:~~

~~(i)~~)) the resolution of disputes between an appellant and the health care authority (HCA), an agency designee, or an HCA-contracted managed care organization (MCO) or health plan, or a dispute involving an assessed overpayment by HCA against an HCA-contracted MCO or health plan, involving:

(i) Medical services programs established under chapter 74.09 RCW including, but not limited to, Washington apple health fee-for-service, integrated managed care ((~~in~~)) (see chapters 182-538((~~,~~

~~182-538A,~~)) and 182-538B WAC), and crisis and noncrisis services ((~~in~~)) (see chapter 182-538C WAC); ((~~and~~))

(ii) ((~~The resolution of disputes between an appellant and the health care authority (HCA) arising from~~)) Washington apple health expansion (see chapters 182-525, 182-525A, and 182-525B WAC); and

(iii) The prescription drug pricing transparency program in chapter 182-51 WAC and the all payer health care claims database rules in chapter 182-70 WAC.

(b) Supplements the Administrative Procedure Act (APA), chapter 34.05 RCW, and the model rules, chapter 10-08 WAC, adopted by the office of administrative hearings (OAH).

(c) Establishes rules encouraging informal dispute resolution between HCA, its authorized agents, or an HCA-contracted ((~~managed care organization (~~))MCO((~~)~~)) or health plan, and people or entities who disagree with its actions.

((~~(d)~~)) (2) Unless specifically excluded by this chapter or program rules, this chapter regulates all hearings involving:

(a) Medical services programs established under chapter 74.09 RCW including, but not limited to, apple health fee-for-service, managed care in chapters 182-538((~~, 182-538A,~~)) and 182-538B WAC((~~,~~)) and crisis and noncrisis services in chapter 182-538C WAC((~~, unless specifically excluded by this chapter or program rules~~));

(b) Apple health expansion eligibility or services as described in chapters 182-525, 182-525A, and 182-525B WAC; and

(c) Prescription drug pricing transparency program in chapter 182-51 WAC and the all payer health care claims database rules in chapter 182-70 WAC.

((~~(2)~~)) (3) Nothing in this chapter is intended to affect the constitutional rights of any person or to limit or change additional requirements imposed by statute or other rule. Other laws or rules determine if a hearing right exists, including the APA and program rules or laws.

((~~(3)~~)) (4) If there is a conflict between this chapter and specific program rules, the specific program rules prevail. HCA's hearing rules and program rules prevail over the model hearing rules in chapter 10-08 WAC.

((~~(4)~~)) (5) The hearing rules in this chapter do not apply to the public employees benefits board or the school employees benefits board programs (see chapters 182-16 and 182-32 WAC).