Chapter 182-22 WAC
WASHINGTON HEALTH PLAN AND BASIC HEALTH PLAN ADMINISTRATION

WAC

PART 1—AUTHORITY AND DEFINITIONS

WAC 182-22-100 Authority. The administrator's authority to promulgate and adopt rules is contained in RCW 70.47.050.

[Statutory Authority: Chapter 70.47 RCW. 10-24-062 (Order 10-03), § 182-22-100, filed 11/30/10, effective 12/31/10.]

WAC 182-22-110 Definitions. The definitions in this section apply throughout chapters 182-22, 182-23, 182-24, and 182-25 WAC.

"Administrator" means the administrator of the Washington state health care authority (HCA) or designee.

"Appeal procedure" means a formal written procedure for resolution of problems or concerns raised by enrollees or applicants which cannot be resolved in an informal manner to the appellant's satisfaction.

"Basic health plan" or "BHP" means the system of enrollment and payment for subsidized basic health care services administered by the HCA through managed health care systems.

"BHP Plus" means the program of expanded benefits available to children through coordination between the department of social and health services (DSHS) and BHP. Eligibility for BHP Plus is determined by the department of social and health services, based on medicaid eligibility criteria. To be eligible for the program children must be under age nineteen, with a family income at or below two hundred percent of federal poverty level, as defined by the United States Department of Health and Human Services. They must be Washington state residents, not eligible for medicare, and may be required to meet additional DSHS eligibility requirements.

"Copayment" means a payment indicated in the schedule of benefits which is made by an enrollee to a health care provider or to the managed health care system.

"Covered services" means those services and benefits in the applicable BHP or WHP schedule of benefits (as outlined in the member handbook), which an enrollee shall be entitled to receive from a managed health care system in exchange for payment of premium and applicable copayments, coinsurance and deductible.

"Dependent," as it applies to BHP or WHP, means:

(a) The subscriber's lawful spouse, not legally separated, who resides with the subscriber; or

(b) The child of the subscriber or the subscriber's dependent spouse, whether by birth, adoption, legal guardianship, or placement pending adoption, who is younger than age twenty-six, and who has not been relinquished for adoption by the subscriber or the subscriber's dependent spouse; or

(c) A person of any age who is incapable of self-support due to disability, and who is the unmarried child of the subscriber or the subscriber's dependent spouse, whether by birth, adoption, or legal guardianship; or

(d) A child younger than age twenty-six who is residing with the subscriber under an informal guardianship agreement. For a child to be considered a dependent of the subscriber under this provision:

(i) The guardianship agreement must be signed by the child's parent;

(ii) The guardianship agreement must authorize the subscriber to obtain medical care for the child;

(iii) The subscriber must be providing at least fifty percent of the child's support.

"Disenrollment" means the termination of coverage for an enrollee.

"Effective date of enrollment" means the first date, as established by BHP or WHP, on which an enrollee is entitled to receive covered services from the enrollee's respective managed health care system.

"Eligible full-time employee" means an employee who meets all applicable eligibility requirements and who is regularly scheduled to work thirty or more hours per week for an employer. The term includes a self-employed individual (including a sole proprietor or a partner of a partnership, and may include an independent contractor) if the individual:

(a) Is regularly scheduled to work thirty hours or more per week; and

(b) Derives at least seventy-five percent of his or her income from a trade or business that is licensed to do business in Washington state.

Persons covered under a health benefit plan pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 shall not be considered eligible employees for purposes of minimum participation requirements.

"Eligible part-time employee" means an employee who meets all the criteria in definition "eligible full-time employee" of this section, but who is regularly scheduled to work fewer than thirty hours per week for an employer.

"Employee" means one who is in the employment of an employer, as defined under RCW 50.04.080.

"Employer" means an enterprise licensed to do business in Washington state, as defined under RCW 50.04.080, with employees in addition to the employer, whose wages or salaries are paid by the employer.

"Enrollee" means a person who meets all applicable eligibility requirements, who is enrolled in BHP or WHP, and for whom applicable premium payments have been made.

"Family" means an individual or an individual and eligible spouse and dependents. For purposes of eligibility determination and enrollment, an individual cannot be a member of more than one family.

"Financial sponsor" means a person, organization or other entity, approved by the administrator, that is responsible for payment of all or a designated portion of the monthly premiums on behalf of a subscriber and any dependents.

"Health care authority" or "HCA" means the Washington state health care authority.

"Home care agency" means a private or public agency or organization that administers or provides home care services directly or through a contract arrangement to ill, disabled, or infirm persons in places of temporary or permanent residence, and is licensed by the department of social and health services (DSHS) as a home care agency. In order to qualify, the agency must be under contract with one of the following DSHS programs: Chore, medicaid personal care, community options program entry system (COPES) or respite care (up to level three).

"Institution" means a federal, state, county, city or other government correctional or detention facility or government-funded facility where health care historically has been provided and funded through the budget of the operating agency, and includes, but is not limited to: Washington state department of corrections institutions; federal, county and municipal government jail and detention institutions; Washington state department of veterans affairs soldiers' and veterans' homes; department of social and health services state hospitals and facilities and juvenile rehabilitation institutions and group homes. An institution does not include: Educational institutions, government-funded acute health care or mental health facilities except as provided above, chemical dependency facilities, and nursing homes.

"Institutionalized" means to be confined, voluntarily or involuntarily, by court order or health status, in an institution, as defined in this section. This does not include persons on work release or who are residents of higher education institutions, acute health care facilities, alcohol and chemical dependency facilities, or nursing homes.

"Insurance broker" or "agent" means a person who is currently licensed as a disability insurance broker or agent, according to the laws administered by the office of the insurance commissioner under chapter 48.17 RCW.

"Managed health care system" or "MHCS" means:

(a) Any health care organization (including health care providers, insurers, health care service contractors, health maintenance organizations, or any combination thereof) which has entered into a contract with the HCA to provide health care services; or

(b) A self-funded or self-insured method of providing insurance coverage to subsidized enrollees provided under RCW 41.05.140 and subject to the limitations under RCW 70.47.100(7).

"Maternity benefits through medical assistance," also known as S-Medical, means the coordinated program between BHP and DSHS for eligible pregnant women. This program includes all medicaid benefits, including maternity coverage. Eligible members must be at or below one hundred eighty-five percent of the federal poverty level. Eligibility for this program is determined by DSHS, based on medicaid eligibility criteria.

"Medicaid" means the Title XIX medicaid program administered by the department of social and health services, and includes the medical care programs provided to the "categorically needy" and the "medically needy" as defined in chapter 388-503 WAC.

"Medicare" means programs established by Title XVIII of Public Law 89-97, as amended, "Health Insurance for the Aged and Disabled."

"Nonparticipating provider" means a person, health care provider, practitioner, facility, or entity, acting within their scope of practice, that does not have a written contract to participate in a managed health care system's provider network, but provides health care services to enrollees of programs authorized under this chapter whose health care services are provided by the managed health care system.

"Open enrollment" means a time period designated by the administrator during which enrollees may enroll additional dependents or apply to transfer their enrollment from one managed health care system to another.

"Participating employee" means an employee of a participating employer or home care agency who has met all the eligibility requirements and has been enrolled for coverage.

"Participating employer" means an employer who has been approved for enrollment as an employer group.

"Participating provider" means a person, health care provider, practitioner, facility, or entity, acting within their scope of practice, that has a written contract to participate in a managed health care system's provider network.

"Preexisting condition" means any illness, injury or condition for which, in the six months immediately preceding an enrollee's effective date of enrollment:

(a) Treatment, consultation or a diagnostic test was recommended for or received by the enrollee; or

(b) Medication was prescribed or recommended for the enrollee; or

(c) Symptoms existed which would ordinarily cause a reasonably prudent individual to seek medical diagnosis, care or treatment.

"Premium" means a periodic payment, determined under RCW 70.47.060(2), which an individual, an employer, a financial sponsor, or other entity makes for enrollment in BHP or WHP.

"Program" means BHP, WHP, BHP Plus, maternity benefits through medical assistance, or other such category of enrollment specified within chapters 182-22 through 182-24 WAC.

"Provider" or "health care provider" means a health care professional or institution duly licensed and accredited to provide covered services in the state of Washington.

"Rate" means the amount, including administrative charges and any applicable premium and prepayment tax imposed under RCW 48.14.0201, negotiated by the administrator with and paid to a managed health care system, to provide BHP or WHP health care benefits to enrollees.

"Schedule of benefits" means the health care services adopted and from time to time amended by the administrator for BHP or WHP, as applicable, which an enrollee shall be entitled to receive from a managed health care system in exchange for payment of premium and applicable copayments, as described in the member handbook.

"Service area" means the geographic area served by a managed health care system as defined in its contract with HCA.

"Subscriber" is a person who applies for coverage on his/her own behalf or on behalf of his/her dependents, if any, who is responsible for payment of premiums and to whom the administrator sends notices and communications. The subscriber may be an enrollee or the spouse, parent, or guardian of an enrolled dependent and may or may not be enrolled for coverage. Notices to a subscriber and, if applicable, a financial sponsor or employer shall be considered notice to the subscriber and his/her enrolled dependents.

"Washington health program" means the system of enrollment and payment for nonsubsidized basic health care services administered by the HCA through managed health care systems.

"Washington state resident" or "resident" means a person who physically resides and maintains a residence in the state of Washington.

(a) To be considered a Washington resident, enrollees who are temporarily out of Washington state for any reason:

(i) May be required to demonstrate their intent to return to Washington state; and

(ii) May not be out of Washington state for more than three consecutive calendar months.

(b) Dependent children who are attending school out-of-state may be considered to be residents if they are out-of-state during the school year, provided their primary residence is in Washington state and they return to Washington state during holidays and scheduled breaks. Dependent children attending school out-of-state may also be required to provide proof that they pay out-of-state tuition at an accredited secondary school, college, university, technical college, or school of nursing, vote in Washington state and file their federal income taxes using a Washington state address.

(c) "Residence" may include, but is not limited to:

(i) A home the person owns or is purchasing or renting;

(ii) A shelter or other physical location where the person is staying in lieu of a home; or

(iii) Another person's home.

[Statutory Authority: Chapter 70.47 RCW. 11-15-020, § 182-22-110, filed 7/8/11, effective 8/8/11; 10-24-062 (Order 10-03), § 182-22-110, filed 11/30/10, effective 12/31/10.]

PART 2—GROUP PARTICIPATION

WAC 182-22-210 Employer groups. (1) BHP and WHP may accept applications for group enrollment from business owners, their spouses and eligible dependents, and on behalf of their eligible full-time and/or part-time employees, their spouses and eligible dependents.

(2) With the exception of home care agencies, the employer must enroll at least seventy-five percent of all eligible employees within a classification of employees, and the employer must not offer other health care coverage to the same classification of employees. For purposes of this section, a "classification of employees" means a subgroup of employees (for example, part-time employees, full-time employees or bargaining units). Employees who demonstrate in the application process that they have health care coverage from other sources, such as their spouse or a federal program, shall be excluded from the minimum participation calculation.

(3) BHP and WHP may require a minimum financial contribution from the employer for each enrolled employee.

(4) The employer will provide the employees the complete choice of managed health care systems available within the employee's county of residence.

(5) The employer will pay all or a designated portion of the premium, as determined by the administrator, on behalf of the enrollee. It is the employer's responsibility to collect the employee's portion of the premium and remit the entire payment to BHP or WHP, as applicable, and to notify BHP or WHP of any changes in the employee's account.

(6) In the event that an employer group will be disenrolled, all affected employee(s) will be notified prior to the disenrollment, and will be informed of the opportunity to convert their BHP or WHP group membership to individual account(s).

(7) Employees enrolling in BHP or WHP must meet all eligibility requirements.

[Statutory Authority: Chapter 70.47 RCW. 10-24-062 (Order 10-03), § 182-22-210, filed 11/30/10, effective 12/31/10.]

WAC 182-22-220 Home care agencies. BHP and WHP will accept applications from home care agencies under contract with the department of social and health services (DSHS) for group enrollment, with premiums paid by the home care agency or DSHS or a designee, under the provisions for employer groups with the following exceptions or additions:

(1) To qualify for premium reimbursement through DSHS, home care agencies who enroll under the provisions of this section must be under current contract with DSHS as a home care agency, as defined by DSHS.

(2) Home care agencies need not enroll at least seventy-five percent of all eligible employees in BHP or WHP, and home care agencies may offer other coverage to the same classification of employees.

(3) Home care agencies need not make a minimum financial contribution for each enrolled employee.

(4) Home care agencies are not subject to WAC 182-22-210(5).

(5) Individual home care providers may enroll in BHP or WHP as individuals.

[Statutory Authority: Chapter 70.47 RCW. 10-24-062 (Order 10-03), § 182-22-220, filed 11/30/10, effective 12/31/10.]

WAC 182-22-230 Financial sponsors. (1) A third party may, with the approval of the administrator, become a financial sponsor to BHP or WHP enrollees. Financial sponsors may not be a state agency or a managed health care system.

(2) BHP and WHP may require a minimum financial contribution from financial sponsors who are paid to deliver BHP or WHP services. Sponsors who meet the following criteria will be exempt from the minimum contribution:

(a) Organizations that are not paid to perform any function related to the delivery of BHP or WHP services, and do not receive contributions from other organizations paid to deliver BHP or WHP services;

(b) Charitable, fraternal or government organizations (other than state agencies) that are not paid to perform any function related to the delivery of BHP or WHP services, who receive contributions from other individuals or organizations who may be paid to deliver BHP or WHP services, if the organization can demonstrate all of the following:

(i) Organizational autonomy (the organization's governance is separate and distinct from any organization that is paid to deliver BHP services);

(ii) Financial autonomy and control over the funds contributed (contributors relinquish control of the donated funds);

(iii) Sponsored enrollees are selected by the sponsoring organization from all persons within the geographic boundaries established by the sponsor organization who meet the selection criteria agreed upon by the sponsor organization and the HCA; and

(iv) There is no direct financial gain to the sponsoring entity.

(c) Charitable, fraternal, or government organizations (other than state agencies) that are paid to perform a health care function related to the delivery of BHP services, if the organization can demonstrate all of the following:

(i) The organization's primary purpose is not the provision of health care or health care insurance, including activities as a third-party administrator or holding company;

(ii) There is organizational and financial autonomy (the organization's governance and funding of sponsored enrollees is separate and distinct from the function that is paid to deliver BHP services);

(iii) The selection of sponsored enrollees is made by the organization separate and distinct from the function that is paid to deliver BHP services, and sponsored enrollees are selected from all eligible persons who meet the selection criteria agreed upon by the sponsor organization and the HCA, who live within the geographic boundaries established by the sponsor organization; and

(iv) There is no direct financial gain to the sponsoring entity.

(3) The financial sponsor will establish eligibility for participation in that particular financial sponsor group; however, sponsored enrollees must meet all eligibility requirements.

(4) The financial sponsor will pay all or a designated portion of the premium on behalf of the sponsored enrollee. The financial sponsor must collect the enrollee's portion of the premium, if any, and remit the entire payment to BHP or WHP and to notify BHP or WHP of any changes in the sponsored enrollee's account.

(5) A financial sponsor must inform sponsored enrollees and BHP or WHP of the minimum time period for which they will act as sponsor. At least sixty days before the end of that time period, the financial sponsor must notify sponsored enrollees and BHP or WHP if the sponsorship will or will not be extended.

(6) A financial sponsor must not discriminate for or against potential group members based on health status, race, color, creed, political beliefs, national origin, religion, age, sex or disability.

(7) A financial sponsor must disclose to the sponsored enrollee all the managed health care systems within the enrollee's county of residence, the estimated premiums for each of them, and the BHP or WHP toll-free information number.

(8) BHP and WHP may periodically conduct a review of the financial sponsor group members to verify the eligibility of all enrollees.

[Statutory Authority: Chapter 70.47 RCW. 10-24-062 (Order 10-03), § 182-22-230, filed 11/30/10, effective 12/31/10.]

PART 3—ADMINISTRATIVE PROCEDURES

WAC 182-22-310 Where to find instructions for filing an appeal. (1) WAC 182-22-320 and 182-22-330 cover appeals submitted by or on behalf of BHP and WHP enrollees or applicants. To appeal a decision regarding a child enrolled in BHP Plus or a woman receiving maternity benefits through medical assistance, subscribers must contact the Washington state department of social and health services (DSHS) to request a fair hearing under chapter 388-526 WAC.

(2) WAC 182-22-320 covers appeals of decisions made by the health care authority, such as decisions regarding eligibility, premium, premium adjustments or penalties, enrollment, suspension, disenrollment, or a member's selection of managed health care system (MHCS). Decisions which affect an entire group (for example, the disenrollment of an employer group) should be appealed for the entire group by the employer, home care agency, or financial sponsor, using these same rules.

(3) WAC 182-22-330 covers appeals of decisions made by the enrollee's managed health care system (MHCS), such as decisions regarding coverage disputes or benefits interpretation.

[Statutory Authority: Chapter 70.47 RCW. 10-24-062 (Order 10-03), § 182-22-310, filed 11/30/10, effective 12/31/10.]

WAC 182-22-320 How to appeal health care authority (HCA) decisions. (1) HCA decisions regarding the following may be appealed under this section:

(a) Eligibility;

(b) Premiums;

(c) Premium adjustments or penalties;

(d) Enrollment;

(e) Suspension;

(f) Disenrollment; or

(g) Selection of managed health care system (MHCS).

(2) To appeal an HCA decision, enrollees or applicants must send a letter of appeal to the HCA. The letter of appeal should be signed by the appealing party and must be received by the HCA within thirty calendar days of the date of the decision. The letter of appeal should include:

(a) The name, mailing address, and BHP or WHP account number of the subscriber or applicant;

(b) The name and address of the enrollee or applicant affected by the decision, if that person is not the subscriber on the account;

(c) A copy of the HCA notice of the decision that is being appealed or, if the notice is not available, a statement of the decision being appealed;

(d) A statement explaining why the appealing party believes the decision was incorrect, outlining the facts surrounding the decision and including supporting documentation; and

(e) If the appealing party is not an enrollee or the subscriber on the account, a signed agreement from the enrollee, authorizing the appealing party to act on his/her behalf.

(3) When an appeal is received, the HCA will send a notice to the appealing party, confirming that the appeal has been received and indicating when a decision can be expected. If the appealing party is not an enrollee on the affected account, the notice will also be sent to the subscriber.

(4) **Initial HCA decisions:** The HCA will conduct appeals according to RCW 34.05.485. The HCA appeals committee or a single presiding officer designated by the HCA will review and decide the appeal. The appealing party may request an opportunity to be present in person or by telephone to explain his or her view. If the appealing party does not request an opportunity to be present to explain, the HCA appeals committee or presiding officer will review and decide the appeal based on the information and documentation submitted.

(5) The HCA will give priority handling to appeals regarding a loss of coverage for an enrollee with an urgent medical need that could seriously jeopardize the enrollee's life, health, or ability to regain maximum function, provided:

(a) The appeal is received within ten business days of the effective date of the loss of coverage; and

(b) The enrollee has clearly stated in the letter of appeal or has otherwise notified the HCA that he or she has an urgent medical need.

(6) For all other appeals, the HCA will send the appealing party written notice of the initial HCA decision within sixty days of receiving the letter of appeal. If the appealing party is not an enrollee on the affected account, the notice will also be sent to the subscriber. The notice will include the reasons for the initial decision and instructions on further appeal rights.

(7) **Review of initial HCA decision:** The initial HCA decision becomes the final agency decision unless the HCA receives a valid request for a review from the appealing party.

(a) To be a valid request for review, the appealing party's request may be either verbal or in writing, but must:

(i) Be received within thirty days of the date of the initial HCA decision.

(ii) Include a summary of the initial HCA decision being appealed and state why the appealing party believes the decision was incorrect; and

(iii) Provide any additional information or documentation that the appealing party would like considered in the review.

(b) Requests for review of an initial HCA decision regarding a disenrollment for nonpayment will be reviewed by the office of administrative hearings through a hearing conducted under chapter 34.12 RCW and RCW 34.05.488 through 34.05.494.

(c) All other requests for review of an initial HCA decision will be reviewed by a presiding officer designated by the HCA according to the requirements of RCW 34.05.488 through 34.05.494, with the following exception: These review decisions will be based on the record and documentation submitted, unless the presiding officer decides that an in-person or telephone hearing is needed. If an in-person or telephone hearing is needed, the presiding officer will decide whether to conduct the hearing as an informal hearing or formal adjudicative proceeding.

(d) The presiding officer will issue a written notice of the review decision, giving reasons for the decision, within twenty-one days of receiving the request for review, unless the presiding officer finds that additional time is needed for the decision.

(8) Enrollees who appeal a disenrollment decision that was based on eligibility issues and not related to premium payments may remain enrolled during the appeal process, provided:

(a) The appeal was submitted according to the requirements of this section; and

(b) The enrollee:

(i) Remains otherwise eligible;

(ii) Continues to make all premium payments when due; and

(iii) Has not demonstrated a danger or threat to the safety or property of the MHCS or health care authority or their staff, providers, patients or visitors.

(9) Enrollees who appeal a disenrollment decision related to nonpayment of premium or any issue other than eligibility will remain disenrolled during the appeal process.

(10) If the appealing party disagrees with a review decision under subsection (6) of this section, the appealing party may request judicial review of the decision, as provided for in RCW 34.05.542. Request for judicial review must be filed with the court within thirty days of service of the final agency decision.

[Statutory Authority: Chapter 70.47 RCW. 10-24-062 (Order 10-03), § 182-22-320, filed 11/30/10, effective 12/31/10.]

WAC 182-22-330 How to appeal a managed health care system (MHCS) decision nonsubsidized enrollees. (1) Nonsubsidized enrollees who are appealing an MHCS decision, including decisions related to coverage disputes; denial of claims; benefits interpretation; or resolution of complaints must follow their MHCS's complaint/appeals process.

(2) Each MHCS must maintain a complaint/appeals process for enrollees and must provide enrollees with instructions for filing a complaint and/or appeal. This complaint/appeals process must comply with the requirements of chapters 48.43 RCW and 284-43 WAC.

(3) On the request of the enrollee, the HCA may assist an enrollee by:

(a) Attempting to informally resolve complaints against the enrollee's MHCS;

(b) Investigating and resolving MHCS contractual issues; and

(c) Providing information and assistance to facilitate review of the decision by an independent review organization.

[Statutory Authority: Chapter 70.47 RCW. 11-15-020, § 182-22-330, filed 7/8/11, effective 8/8/11; 10-24-062 (Order 10-03), § 182-22-330, filed 11/30/10, effective 12/31/10.]

WAC 182-22-340 How to appeal a managed health care system (MHCS) decision—Subsidized enrollees and federal Health Coverage Tax Credit enrollees. (1) Subsidized enrollees or federal Health Coverage Tax Credit enrollees who are appealing an MHCS decision, including decisions related to coverage disputes; denial of claims; benefits interpretation; or resolution of complaints; may voice a grievance or appeal an action by an MHCS to the MHCS either orally or in writing. For the purposes of this section "managed care organization" (MCO) has the same meaning as "managed health care system" (MHCS).

(2) Each MHCS must maintain a complaint/appeals process for enrollees and must provide enrollees with instructions for filing a complaint and/or appeal. This complaint/appeals process must comply with the requirements of chapters 48.43 RCW and 284-43 WAC.

(3) On the request of the enrollee, the HCA may assist an enrollee by:

(a) Attempting to informally resolve complaints against the enrollee's MHCS;

(b) Investigating and resolving MHCS contractual issues; and

(c) Providing information and assistance to facilitate review of the decision by an independent review organization.

(4) MHCSs must maintain records of subsidized enrollees' grievances and appeals and must review the information as part of the MHCS's quality strategy.

(5) MHCSs must provide information describing the MHCS's grievance system to all providers and subcontractors.

(6) Each MHCS must have a grievance system in place for subsidized enrollees. The system must comply with the requirements of this section and the regulations of the state office of the insurance commissioner (OIC). If a conflict exists between the requirements of this chapter and OIC regulations, the requirements of this chapter take precedence. The MHCS grievance system must include all of the following:

(a) A grievance process for complaints about any matter other than an action, as defined in WAC 388-538-050. See subsection (7) of this section for this process;

(b) An appeal process for an action, as defined in WAC 388-538-050. See subsection (8) of this section for the standard appeal process and subsection (9) of this section for the expedited appeal process;

(c) Access to the HCA's hearing process for actions as defined in WAC 388-538-050. The HCA's hearing process described in chapter 388-02 WAC applies to this chapter. Where conflicts exist, the requirements in this chapter take precedence. See WAC 388-538-112 for the HCA's hearing process for subsidized enrollees;

(d) Access to an independent review (IR) as described in RCW 48.43.535, for actions as defined in WAC 388-538-050; and

(e) Access to the board of appeals (BOA) for actions as defined in WAC 388-538-050.

(7) The MHCS grievance process:

(a) Only a subsidized enrollee may file a grievance with an MHCS; a provider may not file a grievance on behalf of an enrollee.

(b) To ensure the rights of MHCS enrollees are protected, each MHCS's grievance process must be approved by the HCA.

(c) MHCSs must inform enrollees in writing within fifteen days of enrollment about enrollees' rights and how to use the MHCS's grievance process, including how to use the HCA's hearing process. The MHCSs must have HCA approval for all written information the MHCS sends to enrollees.

(d) The MHCS must give enrollees any assistance necessary in taking procedural steps for grievances (e.g., interpreter services and toll-free numbers).

(e) The MHCS must acknowledge receipt of each grievance either orally or in writing, and each appeal in writing, within five working days.

(f) The MHCS must ensure that the individuals who make decisions on grievances are individuals who:

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

(ii) If deciding any of the following, are health care professionals who have appropriate clinical expertise in treating the enrollee's condition or disease:

(A) A grievance regarding denial of an expedited resolution of an appeal; or

(B) A grievance involving clinical issues.

(g) The MHCS must complete the disposition of a grievance and notice to the affected parties within ninety days of receiving the grievance.

(8) The MHCS appeal process:

(a) An enrollee, or the enrollee's representative with the enrollee's written consent, may appeal an MHCS action.

(b) To ensure the rights of enrollees are protected, each MHCS's appeal process must be approved by the HCA.

(c) MHCSs must inform enrollees in writing within fifteen days of enrollment about enrollees' rights and how to use the MHCS's appeal process and the HCA's hearing process. The MHCSs must have HCA approval for all written information the MHCS sends to enrollees.

(d) For standard service authorization decisions, an enrollee must file an appeal, either orally or in writing, within ninety calendar days of the date on the MHCS's notice of action. This also applies to an enrollee's request for an expedited appeal.

(e) For appeals for termination, suspension, or reduction of previously authorized services, if the enrollee is requesting continuation of services, the enrollee must file an appeal within ten calendar days of the date of the MHCS mailing the

notice of action. Otherwise, the time frames in (d) of this subsection apply.

(f) The MHCS's notice of action must:

(i) Be in writing;

(ii) Be in the enrollee's primary language and be easily understood as required in 42 CFR 438.10(c) and (d);

(iii) Explain the action the MHCS or its contractor has taken or intends to take;

(iv) Explain the reasons for the action;

(v) Explain the enrollee's or the enrollee's representative's right to file an MHCS appeal;

(vi) Explain the procedures for exercising the enrollee's rights;

(vii) Explain the circumstances under which expedited resolution is available and how to request it (also see subsection (9) of this section);

(viii) Explain the enrollee's right to have benefits continue 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 (also see subsection (10) of this section); and

(ix) Be mailed as expeditiously as the enrollee's health condition requires, and as follows:

(A) For denial of payment, at the time of any action affecting the claim. This applies only when the client can be held liable for the costs associated with the action.

(B) For standard service authorization decisions that deny or limit services, not to exceed fourteen calendar days following receipt of the request for service, with a possible extension of up to fourteen additional calendar days if the enrollee or provider requests extension. If the request for extension is granted, the MHCS must:

(I) Give the enrollee written notice of the reason for the decision for the extension and inform the enrollee of the right to file a grievance if the enrollee disagrees with that decision; and

(II) Issue and carry out the determination as expeditiously as the enrollee's health condition requires and no later than the date the extension expires.

(C) For termination, suspension, or reduction of previously authorized services, ten days prior to such termination, suspension, or reduction, except if the criteria stated in 42 CFR 431.213 and 431.214 are met. The notice must be mailed by a method which certifies receipt and assures delivery within three calendar days.

(D) For expedited authorization decisions, in cases where the provider indicates or the MHCS 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, no later than three calendar days after receipt of the request for service.

(g) The MHCS must give enrollees any assistance necessary in taking procedural steps for an appeal (e.g., interpreter services and toll-free numbers).

(h) The MHCS must acknowledge receipt of each appeal.

(i) The MHCS must ensure that the individuals who make decisions on appeals are individuals who:

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

(ii) If deciding any of the following, are health care professionals who have appropriate clinical expertise in treating the enrollee's condition or disease:

(A) An appeal of a denial that is based on lack of medical necessity; or

(B) An appeal that involves clinical issues.

(j) The process for appeals must:

(i) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal), and must be confirmed in writing, unless the enrollee or provider requests an expedited resolution. Also see subsection (9) of this section for information on expedited resolutions;

(ii) Provide the enrollee a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The MHCS must inform the enrollee of the limited time available for this in the case of expedited resolution;

(iii) Provide the enrollee and the enrollee's representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeal process; and

(iv) Include as parties to the appeal, the enrollee and the enrollee's representative, or the legal representative of the deceased enrollee's estate.

(k) MHCSs must resolve each appeal and provide notice, as expeditiously as the enrollee's health condition requires, within the following time frames:

(i) For standard resolution of appeals and notice to the affected parties, no longer than forty-five calendar days from the day the MHCS receives the appeal. This time frame may not be extended.

(ii) For expedited resolution of appeals, including notice to the affected parties, no longer than three calendar days after the MHCS receives the appeal.

(iii) For appeals for termination, suspension, or reduction of previously authorized services, no longer than forty-five calendar days from the day the MHCS receives the appeal.

(l) The notice of the resolution of the appeal must:

(i) Be in writing. For notice of an expedited resolution, the MHCS must also make reasonable efforts to provide oral notice (also see subsection (9) of this section).

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

(iii) For appeals not resolved wholly in favor of the enrollee:

(A) Include information on the enrollee's right to request an HCA hearing and how to do so (also see WAC 388-538-112);

(B) Include information on the enrollee's right to receive services while the hearing is pending and how to make the request (also see subsection (10) of this section); and

(C) Inform the enrollee that the enrollee may be held liable for the cost of services received while the hearing is pending, if the hearing decision upholds the MHCS's action (also see subsection (11) of this section).

(m) If an enrollee does not agree with the MHCS's resolution of the appeal, the enrollee may file a request for an HCA hearing within the following time frames (see WAC 388-538-112 for the HCA's hearing process for enrollees):

(i) For hearing requests regarding a standard service, within ninety days of the date of the MHCS's notice of the resolution of the appeal.

(ii) For hearing requests regarding termination, suspension, or reduction of a previously authorized service, within ten days of the date on the MHCS's notice of the resolution of the appeal.

(n) The enrollee must exhaust all levels of resolution and appeal within the MHCS's grievance system prior to requesting a hearing with the HCA.

(9) The MHCS expedited appeal process:

(a) Each MHCS must establish and maintain an expedited appeal review process for appeals when the MHCS determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request), that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

(b) When approving an expedited appeal, the MHCS will issue a decision as expeditiously as the enrollee's health condition requires, but not later than three business days after receiving the appeal.

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

(d) If the MHCS denies a request for expedited resolution of an appeal, it must:

(i) Transfer the appeal to the time frame for standard resolution; and

(ii) Make reasonable efforts to give the enrollee prompt oral notice of the denial, and follow up within two calendar days with a written notice.

(10) Continuation of previously authorized services:

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

(i) The enrollee or the provider files the appeal on or before the later of the following:

(A) Unless the criteria in 42 CFR 431.213 and 431.214 are met, within ten calendar days of the MHCS mailing the notice of action, which for actions involving services previously authorized, must be delivered by a method which certifies receipt and assures delivery within three calendar days; or

(B) The intended effective date of the MHCS's proposed action.

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

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

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

(v) The enrollee requests an extension of services.

(b) If, at the enrollee's request, the MHCS continues or reinstates the enrollee's services while the appeal is pending, the services must be continued until one of the following occurs:

(i) The enrollee withdraws the appeal;

(ii) Ten calendar days pass after the MHCS mails the notice of the resolution of the appeal and the enrollee has not requested an HCA hearing (with continuation of services until the HCA hearing decision is reached) within the ten days;

(iii) Ten calendar days pass after the state office of administrative hearings (OAH) issues a hearing decision adverse to the enrollee and the enrollee has not requested an independent review (IR) within the ten days (see WAC 388-538-112);

(iv) Ten calendar days pass after the IR mails a decision adverse to the enrollee and the enrollee has not requested a review with the board of appeals within the ten days (see WAC 388-538-112);

(v) The board of appeals issues a decision adverse to the enrollee (see WAC 388-538-112); or

(vi) The time period or service limits of a previously authorized service has been met.

(c) If the final resolution of the appeal upholds the MHCS's action, the MHCS may recover the amount paid for the services provided to the enrollee while the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services.

(11) Effect of reversed resolutions of appeals:

(a) If the MHCS or OAH reverses a decision to deny, limit, or delay services that were not provided while the appeal was pending, the MHCS must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires.

(b) If the MHCS or OAH reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MHCS must pay for those services.

[Statutory Authority: Chapter 70.47 RCW. 11-15-020, § 182-22-340, filed 7/8/11, effective 8/8/11.]

PART 4—AGENCY OPERATIONS

WAC 182-22-410 Producers. If specific funding has been appropriated for that purpose, insurance brokers or agents who have met all statutory and regulatory requirements of the office of the insurance commissioner, are currently licensed through the office of the insurance commissioner, and who have completed HCA's training program, will be paid a commission for assisting eligible applicants to enroll.

(1) Individual policy commission: Subject to availability of funds, and as a pilot program, HCA will pay a one-time fee to any currently licensed insurance broker or agent who sells BHP or WHP to an eligible individual applicant if that applicant has not been a BHP or WHP member within the previous five years.

(2) Group policy commission: Subject to availability of funds, and as a pilot program, fees paid for the sale of coverage to an eligible employer will be based on the number of employees in the group for the first and second months of the group's enrollment.

(3) Insurance brokers or agents must provide the prospective applicant with the BHP or WHP toll-free information number and inform them of BHP or WHP benefits, limitations, exclusions, waiting periods, cost sharing, all MHCSs available to the applicant within his/her county of residence and the estimated premium for each of them.

(4) All statutes and regulations of the office of the insurance commissioner will apply to brokers or agents who sell BHP or WHP, except they will not be required to be appointed by the MHCS.

(5) HCA will not pay renewal commissions.

[Statutory Authority: Chapter 70.47 RCW. 10-24-062 (Order 10-03), § 182-22-410, filed 11/30/10, effective 12/31/10.]

WAC 182-22-420 Application processing. Except as otherwise provided, applications for enrollment will be reviewed by HCA within thirty days of receipt and those applicants satisfying the eligibility criteria and who have provided all required information, documentation and premium payments will be notified of their effective date of enrollment.

[Statutory Authority: Chapter 70.47 RCW. 10-24-062 (Order 10-03), § 182-22-420, filed 11/30/10, effective 12/31/10.]

WAC 182-22-430 Open enrollment. An open enrollment period of at least twenty consecutive days will be held annually. During this open enrollment period, enrollees may apply to enroll additional family members or to transfer their enrollment to a different MHCS, provided the MHCS selected is accepting new enrollment for the enrollee's program in the geographic area where the enrollee lives.

[Statutory Authority: Chapter 70.47 RCW. 10-24-062 (Order 10-03), § 182-22-430, filed 11/30/10, effective 12/31/10.]

PART 5—MHCS DUTIES

WAC 182-22-450 MHCS duties. (1) When an MHCS assists applicants in the enrollment process, it must provide them with the toll-free number for BHP or WHP and information on all MHCS available within the applicant's county of residence and the estimated premiums for each available MHCS.

(2) An MHCS shall pay a nonparticipating provider no more than the lowest amount paid for that service under the MHCS's contracts with similar providers in the state.

(a) For services provided to plan enrollees on or after the effective date of this section, nonparticipating providers must accept as payment in full the amount paid by the managed health care system under RCW 70.47.100(2) in addition to any deductible, coinsurance, or copayment that is due from the enrollee under the terms and conditions set forth in the MHCS contract with the administrator.

(b) A plan enrollee is not liable to any nonparticipating provider for covered services, except for amounts due for any deductible, coinsurance, or copayment under the terms and conditions set forth in the managed health care system contract with the administrator.

(3) Pursuant to federal managed care access standards, 42 CFR Sec. 438, MHCS's must maintain a network of appropriate providers that is supported by written agreements sufficient to provide adequate access to all services covered under the contract with the authority, including hospital-based physician services.

[Statutory Authority: Chapter 70.47 RCW. 11-15-020, § 182-22-450, filed 7/8/11, effective 8/8/11; 10-24-062 (Order 10-03), § 182-22-450, filed 11/30/10, effective 12/31/10.]