WAC 182-557-0350 Health home—Grievance and appeals. (1) Qualified health homes must have a grievances and appeals process in place that complies with the requirements of this section and must maintain records of all grievances and appeals.

(a) This section contains information about the grievance system for fee-for-service clients, including full dual eligible clients, for health home services. These participants must follow the process in chapter 182-526 WAC for appeals.

(b) Participants who are enrolled in an agency-contracted managed care organization must follow the process in WAC 182-538-110 to file a grievance or an appeal for health home services.

(2) **Grievance process.**

(a) Only a participant or the participant's authorized representative may file a grievance with the qualified health home orally or in writing. A health home care coordinator may not file a grievance for the participant unless the participant gives the health home care coordinator written consent to act on the participant's behalf.

(b) The qualified health home must:

(i) Accept, document, record, and process grievances that it receives from the participant, the participant's representative, or the agency;

(ii) Acknowledge receipt of each grievance, either orally or in writing, within two business days of receiving the grievance;

(iii) Assist the participant with all grievance processes;

(iv) Cooperate with any representative authorized in writing by the participant;

(v) Ensure that decision makers on grievances were not involved in the activity or decision being grieved, or any review of that activity or decision by qualified health home staff;

(vi) Consider all information submitted by the participant or the participant's authorized representative;

(vii) Investigate and resolve all grievances;

(viii) Complete the disposition of a grievance and notice to the affected parties as quickly as the participant's health condition requires, but no later than forty-five calendar days from receipt of the grievance;

(ix) Notify the participant, either orally or in writing, of the disposition of grievances within five business days of determination. Notification must be in writing if the grievance is related to a quality of care issue.

(3) **Appeal process.**

(a) The qualified health home must give the participant written notice of an action.

(b) The written notice must:

(i) State what action the qualified health home intends to take and the effective date of the action;

(ii) Explain the specific facts and reasons for the decision to take the intended action;

(iii) Explain the specific rule or rules that support the decision, or the specific change in federal or state law that requires the action;

(iv) Explain the participant's right to appeal the action according to chapter 182-526 WAC;

(v) State that the participant must request a hearing within ninety calendar days from the date that the notice of action is mailed.

(c) The qualified health home must send the written notice to the participant no later than ten days before the date of action. The written notice may be sent by the qualified health home no later than the date of the action it describes only if:

(i) The qualified health home has factual information confirming the death of a participant; or

(ii) The qualified health home receives a written statement signed by a participant that:

(A) The participant no longer wishes to receive health home services; or

(B) Provides information that requires termination or reduction of health home services and which indicates that the participant understands that supplying the information will result in health home services being ended or reduced.

(d) A health home care coordinator may not file an appeal for the participant.

(e) If the agency receives a request to appeal an action of the qualified health home, the agency will provide the qualified health home notice of the request.

(f) The agency will process the participant's appeal in accordance with chapter 182-526 WAC.

(g) Continued coverage. If a participant appeals an action by a qualified health home, the participant's health home services will continue consistent with WAC 182-504-0130.

(h) Reinstated coverage. If the agency ends or changes the participant's qualified health home coverage without advance notice, the agency will reinstate coverage consistent with WAC 182-504-0135.

(i) If the participant requests a hearing, the qualified health home must provide to the agency and the participant, upon request, and within three working days, all documentation related to the appeal.

(j) The qualified health home is an independent party and is responsible for its own representation in any administrative hearing, subsequent review process, and judicial proceedings.

(k) If a final order, as defined in WAC 182-526-0010, requires a qualified health home to provide the participant health home services that were not provided while the appeal was pending, the qualified health home must authorize or provide the participant those health home services promptly. A qualified health home cannot seek further review of a final order issued in a participant's administrative appeal of an action taken by the qualified health home.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-17-065, § 182-557-0350, filed 8/14/15, effective 9/14/15.]