Chapter 182-538A WAC

WASHINGTON APPLE HEALTH FULLY INTEGRATED MANAGED CARE (FIMC)

WAC

WAC 182-538A-040 Washington apple health fully integrated managed care. (1) This chapter governs the services provided under the medicaid agency's Washington apple health fully integrated managed care (FIMC) medicaid contract.

(a) FIMC provides physical and behavioral health services to medicaid beneficiaries through managed care.

(b) FIMC includes enrollees receiving behavioral health services only (BHSO).

(c) FIMC services are available only through a contracted managed care organization (MCO) and its provider network.

(d) For behavioral health services provided to individuals outside of FIMC regional service areas, see chapters 388-865, 388-877, 388-877A, 388-877B, and 388-877C WAC.

(2) To provide physical and behavioral health services or BHSO under the FIMC medicaid contract, an MCO must contract with the agency.

(3) To be eligible to contract with the agency to provide FIMC services, the MCO must:

(a) Have a certificate of registration from the Washington state office of the insurance commissioner (OIC) that allows the MCO to provide the health care services;

(b) Accept the terms and conditions of the agency's contracts;

(c) Be able to meet the network and quality standards established by the agency;

(d) Successfully participate in an on-site readiness review conducted by the agency; and

(e) Be awarded a contract through a competitive process or an application process available to all qualified providers at the discretion of the agency.

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

(5) Chapter 182-538 WAC applies to this chapter. If the rules are in conflict, this chapter takes precedence.

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-05-051, § 182-538A-040, filed 2/11/16, effective 4/1/16.]

WAC 182-538A-050 Definitions. The following definitions and abbreviations and those found in chapters 182-500 and 182-538 WAC apply to this chapter.

"Administrative hearing" means an adjudicative proceeding before an administrative law judge or a presiding officer that is governed by chapters 34.05 RCW and 182-526 WAC.

"Appeal" means a request for review of an action under WAC 182-538-110 and 42 C.F.R. Sec. 438.400(b).

"Apple health adult coverage (AHAC)" means the range of services available to people eligible to receive health care coverage under the Washington apple health modified adjusted gross income (MAGI)-based adult coverage.

"Behavioral health" includes mental health, substance use disorders and conditions, and benefits related to treatment.

"Behavioral health administrative services organization (BH-ASO)" means an entity selected by the agency to administer behavioral health services and programs, including crisis services for all individuals in a defined regional service area, regardless of an individual's insurance status or ability to pay.

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

"Brief intervention treatment" - Solution-focused and outcome-oriented cognitive and behavioral interventions intended to improve symptoms, resolve situational disturbances that are not amenable to resolution in a crisis service model of care, and which do not require long-term treatment to return the individual to previous higher levels of general functioning. This service is provided by or under the supervision of a mental health professional.

"Crisis services" - See WAC 182-538C-150.

"Division of behavioral health and recovery (DBHR)" means the department of social and health services

designated state behavioral health authority to administer state-only, federal block grant, and medicaid-funded behavioral health programs.

"End enrollment" means ending the enrollment of an enrollee for one of the reasons outlined in WAC 182-538A-130.

"Fully integrated managed care (FIMC)" means the program covered by this chapter, under which behavioral health services are added to an agency managed care contract.

"Mental health professional" means:

(a) A psychiatrist, psychologist, psychiatric nurse, or social worker as defined in chapters 71.05 and 71.34 RCW;

(b) A person who is licensed by the department of health as a mental health counselor, mental health counselor associate, marriage and family therapist, or marriage and family therapist associate;

(c) A person with a master's degree or further advanced degree in counseling or one of the social behavioral sciences from an accredited college or university who has at least two years of experience in direct treatment of persons with mental illness or emotional disturbance that was gained under the supervision of a mental health professional and is recognized by the department of social and health services;

(d) A person who meets the waiver criteria of RCW 71.24.260, which was granted before 1986;

(e) A person who had an approved waiver to perform the duties of a mental health professional that was granted by the mental health division before July 1, 2001; or

(f) A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the department of social and health services consistent with WAC 388-865-0265.

"Patient days of care" means all voluntary patients and involuntarily committed patients under chapter 71.05 RCW, regardless of where in the state hospital the patients reside. Patients who are committed to the state hospital under chapter 10.77 RCW are not included in the patient days of care. Patients who are committed under RCW 10.77.088 by municipal or district courts after failed competency restoration and dismissal of misdemeanor charges are not counted in the patient days of care until a petition for ninety days of civil commitment under chapter 71.05 RCW has been filed in court. Patients who are committed under RCW 10.77.086 by a superior court after failed competency restoration and dismissal of felony charges are not counted in the patient days of care until the patient is civilly committed under chapter 71.05 RCW.

"Regional service area (RSA)" means a single county or multi-county grouping formed for the purpose of health care purchasing and designated by the agency and the department of social and health services.

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

(a) Medicaid-eligible people age twenty or younger with complex behavioral health needs; and

(b) Their families.

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-05-051, § 182-538A-050, filed 2/11/16, effective 4/1/16.]

WAC 182-538A-060 Fully integrated managed care and choice. (1) Except as provided in subsection (2) of this section, the medicaid agency requires a client to enroll in a fully integrated managed care (FIMC) managed care organization (MCO) when that client:

(a) Is eligible;

(b) Resides in a mandatory enrollment FIMC regional service area; and

(c) Is not exempt from FIMC enrollment.

(2)(a) American Indian and Alaska native (AI/AN) clients and their descendants may choose one of the following:

(i) Enrollment with an FIMC MCO available in their regional service area;

(ii) Enrollment with a primary care case management (PCCM) provider through a tribal clinic or urban Indian center available in their area, which includes mandatory enrollment into a behavioral health services only (BHSO) MCO; or

(iii) The agency's fee-for-service system, which includes mandatory enrollment into a BHSO MCO.

(b) To enroll with an FIMC MCO or PCCM provider, an AI/AN client may:

(i) Call the agency's toll-free enrollment line at 800-562-3022;

(ii) Mail or fax the following to the agency's unit responsible for FIMC enrollment:

(A) Form HCA 13-664; or

(B) Form HCA 13-862 found online at https://www.hca.wa.gov/medicaid/forms/pages/index.aspx.

(iii) Enroll online through the Washington Healthplanfinder at https://www.wahealthplanfinder.org; or

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

(3) A client must enroll with an FIMC MCO available in the regional service area where the client resides.

(4) The agency enrolls all family members with the same FIMC MCO, if available.

(5) If a family member is enrolled in the patient review and coordination (PRC) program, that family member must follow the rules in WAC 182-501-0135.

(6) When a client requests enrollment with an FIMC MCO or PCCM provider, the agency enrolls a client effective the first day of the current month a client becomes eligible.

(7) To enroll with an FIMC MCO, a client may:

(a) Call the agency's toll-free enrollment line at 800-562-3022;

(b) Mail or fax the following to the agency's unit responsible for FIMC enrollment:

(i) Form HCA 13-664; or

(ii) Form HCA 13-862 found online at https://www.hca.wa.gov/medicaid/forms/pages/index.aspx.

(c) Enroll online through the Washington Healthplanfinder at https://www.wahealthplanfinder.org; or

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

(8) The agency assigns a client who does not choose an FIMC MCO or PCCM provider as follows:

(a) If the client has a family member or members enrolled with an FIMC MCO, the client is enrolled with that FIMC MCO;

(b) If the client has a family member or members enrolled with a PCCM provider, the client is enrolled with that PCCM provider;

(c) The client is reenrolled within the previous six months with their prior MCO plan if:

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

(ii) The client does not have a family member enrolled with an agency-contracted MCO or PCCM provider.

(d) If the client has a break in eligibility of less than two months, the client will be automatically reenrolled with his or her previous MCO or PCCM provider and no notice will be sent; or

(e) If the client cannot be assigned according to (a), (b), (c), or (d) of this subsection, the agency assigns the client according to agency policy.

(9) An FIMC enrollee's selection of a primary care provider (PCP) or assignment to a PCP occurs as follows:

(a) An FIMC enrollee may choose:

(i) A PCP or clinic that is in the enrollee's FIMC MCO's provider network and accepting new enrollees; or

(ii) A different PCP or clinic participating with the enrollee's FIMC MCO's provider network for different family members.

(b) The FIMC MCO assigns a PCP or clinic that meets the access standards described in the relevant managed care contract if the enrollee does not choose a PCP or clinic.

(c) An FIMC enrollee may change PCPs or clinics for any reason, provided the PCP or clinic is within the enrollee's FIMC MCO's provider network and accepting new enrollees.

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

(e) Enrollees required to participate in the agency's PRC program may be limited in their right to change PCPs (see WAC 182-501-0135).

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-05-051, § 182-538A-060, filed 2/11/16, effective 4/1/16.]

WAC 182-538A-067 Qualifications to become a managed care organization (MCO) in fully integrated managed care (FIMC) regional service areas. (1) In addition to subsection (2) of this section, see WAC 182-538A-060 regarding qualifications to become a managed care organization (MCO) in fully integrated managed care (FIMC) regional service areas.

(2) An MCO must contract with an agency-contracted behavioral health administrative service organization (BH-ASO) that maintains an adequate provider network to deliver services to clients in FIMC regional service areas.

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-05-051, § 182-538A-067, filed 2/11/16, effective 4/1/16.]

WAC 182-538A-068 Qualifications to become a primary care case management (PCCM) provider in fully integrated managed care (FIMC) regional service areas. See WAC 182-538-068 regarding qualifications to become a primary care case management (PCCM) provider in fully integrated managed care (FIMC) regional service areas.

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-05-051, § 182-538A-068, filed 2/11/16, effective 4/1/16.]

WAC 182-538A-070 Payments to managed care organizations (MCOs) in fully integrated managed care (FIMC) regional service areas. (1) In addition to the rules in this section, see WAC 182-538-070 regarding payments to managed care organizations (MCOs) in fully integrated managed care (FIMC) regional service areas.

(2) The agency pays MCOs 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 division of behavioral health and recovery (DBHR) under chapter 388-877 WAC.

(3) For crisis services, the MCO must determine whether the individual receiving the services is eligible for Washington apple health or if the individual has other insurance coverage.

(4) The MCO pays a reimbursement for each state hospital patient day of care that exceeds the MCO daily allocation of state hospital beds based on a quarterly calculation of the bed usage.

(a) The agency bills the MCO quarterly for state hospital patient days of care exceeding the MCO daily allocation of state hospital beds and the established rate of reimbursement.

(b) An MCO using fewer patient days of care than its quarterly allocation of state hospital beds receives a portion of the reimbursement collected proportional to its share of the total number of patient days of care that were not used at the appropriate state hospital.

(5) The agency may:

(a) Impose intermediate sanctions under 42 C.F.R. 438.700 and corrective action for substandard rates of clinical performance measures and for deficiencies found in audits and on-site visits;

(b) Require corrective action for findings for noncompliance with any contractual, state, or federal requirements;

(c) Impose sanctions for noncompliance with any contractual, state, or federal requirements not corrected; and

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

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-05-051, § 182-538A-070, filed 2/11/16, effective 4/1/16.]

WAC 182-538A-071 Payments to primary care case management (PCCM) providers in fully integrated managed care (FIMC) regional service areas. See WAC 182-538-071 for rules regarding payments to primary care case management (PCCM) providers in fully integrated managed care (FIMC) regional service areas.

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-05-051, § 182-538A-071, filed 2/11/16, effective 4/1/16.]

WAC 182-538A-095 Scope of care for fully integrated managed care (FIMC) and behavioral health services only (BHSO) enrollees. (1) The rules in WAC 182-538-095 apply to this chapter. If the rules are in conflict, this chapter takes precedence.

(2) An enrollee in fully integrated managed care (FIMC) or behavioral health services only (BHSO) is eligible only for the scope services identified as covered in WAC 182-501-0060 and other program rules based on the enrollee's eligibil-

ity program, including the alternative benefit plan (ABP), categorically needy (CN), or medically needy (MN) programs.

(3) The managed care organization (MCO) covers services included under the FIMC medicaid contract for an FIMC or BHSO enrollee. An MCO may, at its discretion, cover services not required under the FIMC medicaid contract.

(4) The agency covers services identified as covered for an FIMC or BHSO enrollee that are not included in the FIMC medicaid contract.

(5) The MCO is not required to pay for services covered under the FIMC medicaid contract for an FIMC or BHSO enrollee if the services are:

(a) Determined not to be medically necessary for the enrollee as defined in WAC 182-500-0070;

(b) Received by the enrollee from a participating specialist that required prior authorization but were not prior authorized by the MCO;

(c) Nonemergency services received by the enrollee from nonparticipating providers that were not prior authorized by the MCO; or

(d) Received by the enrollee in a hospital emergency department for nonemergency medical conditions, except for a screening exam as described in WAC 182-538-100.

(6) The provider may bill the enrollee for noncovered services if the requirements of WAC 182-502-0160 are met.

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-05-051, § 182-538A-095, filed 2/11/16, effective 4/1/16.]

WAC 182-538A-100 Managed care emergency services for fully integrated managed care (FIMC) enrollees. The managed care organization (MCO) covers emergency services for fully integrated managed care (FIMC) enrollees as described in WAC 182-538-100.

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-05-051, § 182-538A-100, filed 2/11/16, effective 4/1/16.]

WAC 182-538A-110 The grievance system for fully integrated managed care (FIMC) managed care organizations (MCOs). Managed care enrollees in fully integrated managed care (FIMC) regional service areas may file grievances or appeal actions through the grievance system of managed care organizations (MCOs) as described in WAC 182-538-110.

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-05-051, § 182-538A-110, filed 2/11/16, effective 4/1/16.]

WAC 182-538A-111 The administrative hearing process for primary care case management (PCCM) enrollees in FIMC regional service areas. See WAC 182-538-111 regarding the administrative hearing process for primary care case management enrollees in fully integrated managed care (FIMC) regional service areas.

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-05-051, § 182-538A-111, filed 2/11/16, effective 4/1/16.]

WAC 182-538A-120 Fully integrated managed care (FIMC) enrollee request for a second medical opinion. Enrollees in fully integrated managed care (FIMC) regional service areas have a right to request a second medical opinion as described in WAC 182-538-120.

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-05-051, § 182-538A-120, filed 2/11/16, effective 4/1/16.]

WAC 182-538A-130 Exemptions and ending enrollment in fully integrated managed care (FIMC). (1) Fully integrated managed care (FIMC) and behavioral health services only (BHSO) are mandatory for individuals in FIMC regional service areas. The medicaid agency enrolls a client into either FIMC or BHSO, depending on eligibility.

(2) WAC 182-538A-060 applies to disenrollment and choice.

(3) A client may end enrollment in FIMC if:

(a) The client has comparable coverage; or

(b) The client's request to end enrollment is approved by the agency under one of the following circumstances:

(i) The enrollee moves out of the FIMC regional service area;

(ii) Medically necessary care is unavailable from the MCO including, but not limited to, when:

(A) The MCO does not, because of moral or religious objections, deliver the service the enrollee seeks; or

(B) The enrollee needs related services performed at the same time and not all related services are available within the network and the enrollee's primary care provider or another provider determines receiving the services separately would subject the enrollee to unnecessary risk.

(4) If an enrollee ends enrollment in FIMC, the agency enrolls the enrollee in BHSO if the enrollee is eligible.

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-05-051, § 182-538A-130, filed 2/11/16, effective 4/1/16.]

WAC 182-538A-140 Fully integrated managed care (FIMC) quality of care. WAC 182-538-140 applies to fully integrated managed care (FIMC) regional service areas.

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-05-051, § 182-538A-140, filed 2/11/16, effective 4/1/16.]

WAC 182-538A-150 Apple health foster care program in fully integrated managed care regional service areas. The following apply to foster care enrollees in fully integrated managed care (FIMC) regional service areas:

(1) WAC 182-538-150; and

(2) WAC 182-538A-190.

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-05-051, § 182-538A-150, filed 2/11/16, effective 4/1/16.]

WAC 182-538A-160 Program integrity requirements. (1) Chapters 182-502A and 182-520 WAC apply to this chapter. If the rules are in conflict, this chapter takes precedence.

(2) To comply with program integrity standards, including fraud and abuse, a managed care organization (MCO) must:

(a) Collect data on enrollees, providers, and services provided to enrollees through an encounter data system in a standardized format as specified by the agency for:

(i) Audits;

(ii) Investigations;

(iii) Identifications of improper payments and other program integrity activities;

(iv) Federal reporting (42 C.F.R. Sec. 438.242 (b)(1)); and

(v) Service verification.

(b) Perform ongoing analysis of utilization, claims, billing, and encounter data to detect overpayments;

(c) Disclose MCO ownership and control;

(d) Disclose any change in ownership of the MCO's subcontractors or providers that are not individual practitioners or a group of practitioners;

(e) Provide information on persons convicted of crimes through agreements with subcontractors and providers;

(f) Include program integrity requirements in the MCO's provider education program; and

(g) Verify provider compliance with all program integrity requirements in the fully integrated managed care (FIMC) medicaid contract.

(3) When an MCO has concluded a credible allegation of provider fraud has occurred, the MCO must make a referral to the medicaid fraud control unit within five business days of determination.

(4) The MCO must notify the department of social and health services office of fraud and accountability (OFA) of any cases in which the MCO believes there is a serious likelihood of enrollee fraud.

(5) The MCO is prohibited from paying for goods and services furnished by excluded persons with agency funds (see Social Security Act (SSA) Section 1903 (i)(2) of the act; 42 C.F.R. Sec. 455.104, 42 C.F.R. Sec. 455.106, and 42 C.F.R. Sec. 1001.1901(b)).

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-05-051, § 182-538A-160, filed 2/11/16, effective 4/1/16.]

WAC 182-538A-170 Notice requirements. The notice requirements in chapter 182-518 WAC apply to fully integrated managed care (FIMC) and behavioral health only (BHSO) enrollees in FIMC regional service areas.

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-05-051, § 182-538A-170, filed 2/11/16, effective 4/1/16.]

WAC 182-538A-180 Rights and protections. (1) Individuals have medicaid-specific rights when applying for, eligible for, or receiving medicaid-funded health care services.

(2) All applicable statutory and constitutional rights apply to all medicaid individuals including, but not limited to:

(a) The participant rights under WAC 388-877-0600;

(b) Applicable necessary supplemental accommodation services including, but not limited to:

(i) Arranging for or providing help to complete and submit forms to the agency;

(ii) Helping individuals give or get the information the agency needs to decide or continue eligibility;

(iii) Helping to request continuing benefits;

(iv) Explaining the reduction in or ending of benefits;

(v) Assisting with requests for administrative hearings; and

(vi) On request, reviewing the agency's decision to terminate, suspend, or reduce benefits.

(c) Receiving the name, address, telephone number, and any languages offered other than English of providers in a managed care organization (MCO);

(d) Receiving information about the structure and operation of the MCO and how health care services are delivered;

(e) Receiving emergency care, urgent care, or crisis services;

(f) Receiving poststabilization services after receiving emergency care, urgent care, or crisis services that result in admittance to a hospital;

(g) Receiving age-appropriate and culturally appropriate services;

(h) Being provided a qualified interpreter and translated material at no cost to the individual;

(i) Receiving requested information and help in the language or format of choice;

(j) Having available treatment options and explanation of alternatives;

(k) Refusing any proposed treatment;

(l) Receiving care that does not discriminate against an individual;

(m) Being free of any sexual exploitation or harassment;

(n) Making an advance directive that states the individual's choices and preferences for health care services under 42 C.F.R., 489 Subpart I;

(o) Choosing a contracted health care provider;

(p) Requesting and receiving a copy of health care records;

(q) Being informed the cost for copying, if any;

(r) Being free from retaliation;

(s) Requesting and receiving policies and procedures of the MCO as they relate to health care rights;

(t) Receiving services in an accessible location;

(u) Receiving medically necessary services in accordance with the early and periodic screening, diagnosis, and treatment (EPSDT) program under WAC 182-534-0100, if the individual is age twenty or younger;

(v) Being treated with dignity, privacy, and respect;

(w) Receiving treatment options and alternatives in a manner that is appropriate to an individual's condition;

(x) Being free from seclusion and restraint;

(y) Receiving a second opinion from a qualified health care professional within an MCO provider network at no cost or having one arranged outside the network at no cost, as provided in 42 C.F.R. Sec. 438.206(3);

(z) Receiving medically necessary health care services outside of the MCO if those services cannot be provided adequately and timely within the MCO;

(aa) Filing a grievance with the MCO if the individual is not satisfied with a service;

(bb) Receiving a notice of action so that an individual may appeal any decision by the MCO that:

(i) Denies or limits authorization of a requested service;

(ii) Reduces, suspends, or terminates a previously authorized service; or

(iii) Denies payment for a service, in whole or in part.

(cc) Filing an appeal if the MCO fails to provide health care services in a timely manner as defined by the state or act within the time frames in 42 C.F.R. Sec. 438.408(b); and

(dd) Requesting an administrative hearing if an appeal is not resolved in an individual's favor.

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-05-051, § 182-538A-180, filed 2/11/16, effective 4/1/16.]

WAC 182-538A-190 Behavioral health services only (BHSO). This section applies to enrollees receiving behavioral health services only (BHSO) under the fully integrated managed care (FIMC) medicaid contract.

(1) The medicaid agency requires eligible clients in FIMC regional service areas to enroll in the BHSO program.

(2) A BHSO enrollee in an FIMC regional service area may change managed care organizations (MCOs) but may not disenroll from the BHSO program.

(3) For BHSO enrollees, the MCO covers the behavioral health benefit included in the FIMC medicaid contract.

(4) WAC 182-538-110 applies to BHSO enrollees in FIMC regional service areas.

(5) The agency assigns the BHSO enrollee to an MCO available in the area where the client resides.

(6) A BHSO enrollee may change MCOs for any reason with the change becoming effective according to the agency's managed care policy.

(7) The agency ends enrollment in BHSO managed care when the enrollee becomes eligible for any third-party health care coverage comparable to BHSO.

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 16-05-051, § 182-538A-190, filed 2/11/16, effective 4/1/16.]