WSR 22-24-005
PROPOSED RULES
HEALTH CARE AUTHORITY
[Filed November 28, 2022, 12:11 p.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 22-18-069.

Title of Rule and Other Identifying Information: WAC 182-538-070 Payments, corrective action, and sanctions for managed care organizations (MCOs) and 182-538-140 Quality of care.

Hearing Location(s): On January 10, 2023, 10:00 a.m. In response to the coronavirus disease 2019 (COVID-19) public health emergency, the health care authority (HCA) continues to hold public hearings virtually without a physical meeting place. This promotes social distancing and the safety of the residents of Washington state. To attend the virtual public hearing, you must register in advance https://us02web.zoom.us/webinar/register/WN_uzi3CSJ5TjaOjrSSuttwUA. If the link above opens with an error message, please try using a different browser. After registering, you will receive a confirmation email containing information about joining the public hearing.

Date of Intended Adoption: January 11, 2023.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, by January 10, 2023, by 11:59 p.m.

Assistance for Persons with Disabilities: Contact Johanna Larson, phone 360-725-1349, fax 360-586-9727, telecommunication[s] relay service 711, email Johanna.Larson@hca.wa.gov, by December 30, 2022.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The agency is amending these rules to allow it to be flexible in its approach to sanctions with managed care organizations (MCOs), as authorized by 42 C.F.R. 438.702(b). The proposed rules allow the agency to impose the maximum allowable sanction on a daily, per-occurrence basis for an MCO's violation of any material obligation under the MCO's contract.

Reasons Supporting Proposal: See purpose.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Statute Being Implemented: RCW 41.05.021, 41.05.160.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: HCA, governmental.

Name of Agency Personnel Responsible for Drafting: Melinda Froud, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-1408; Implementation and Enforcement: Michael Brown, P.O. Box 45503, Olympia, WA 98504-5503, 360-725-0913.

A school district fiscal impact statement is not required under RCW 28A.305.135.

A cost-benefit analysis is not required under RCW 34.05.328. RCW 34.05.328 does not apply to HCA rules unless requested by the joint administrative rules review committee or applied voluntarily.

This rule proposal, or portions of the proposal, is exempt from requirements of the Regulatory Fairness Act because the proposal:

Is exempt under RCW 19.85.025(4).

Scope of exemption for rule proposal:

Is fully exempt.

November 28, 2022
Wendy Barcus
Rules Coordinator

OTS-4206.1

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

WAC 182-538-070 Payments ((~~and~~)), corrective action, and sanctions for managed care organizations (MCOs) ((~~in integrated managed care regional service areas~~)). (1) The medicaid agency pays apple health managed care organizations (MCOs) monthly capitated premiums that:

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

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

(c) Have been 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) The MCO is solely responsible for payment of MCO-contracted health care services. The agency will not pay for a service that is the MCO's responsibility, even if the MCO has not paid the provider for the service.

(3) 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 department of health under chapter 246-341 WAC.

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

(5) The agency may((~~:~~

~~(a) Impose intermediate sanctions under 42 C.F.R. Sec. 438.700 and~~)) require corrective action for:

(a) Substandard rates of clinical performance measures ((~~and for~~));

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

((~~(b) Require corrective action for~~)) (c) Findings ((~~for~~)) of noncompliance with any contractual, state, or federal requirements((~~;~~

~~(c)~~)).

(6) The agency may:

(a) Impose sanctions for an MCO's noncompliance with any contractual, state, or federal requirements ((~~not corrected~~)) including, but not limited to, intermediate sanctions as described in 42 C.F.R. Sec. 438.700 and 42 C.F.R. Sec. 438.702; and

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

((~~(6)~~)) (7) As authorized by 42 C.F.R. Sec. 438.702(b), if an MCO fails to meet any material obligation under the MCO contract including, but not limited to, the items listed in 42 C.F.R. Sec. 438.700(b), (c), or (d), the agency may impose the maximum allowable sanction on a per-occurrence, per-day basis until the agency determines the MCO has:

(a) Corrected the violation; and

(b) Remedied any harm caused by the noncompliance.

(8) The agency pays an enhancement rate for each MCO enrollee assigned to a federally qualified health center ((~~(FQHC)~~)) or rural health clinic ((~~(RHC) according to~~)), as authorized under chapters 182-548 and 182-549 WAC.

((~~(7)~~)) (9) The agency pays MCOs a delivery case rate, separate from the capitation payment, when an enrollee delivers a ((~~child(ren)~~)) child or children and the MCO pays for any part of labor and delivery.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2019 c 325, 2014 c 225, and 2018 c 201. WSR 19-24-063, § 182-538-070, filed 11/27/19, effective 1/1/20. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 18-08-035, § 182-538-070, filed 3/27/18, effective 4/27/18; WSR 15-24-098, § 182-538-070, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-070, filed 12/19/12, effective 2/1/13. WSR 11-14-075, recodified as § 182-538-070, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. WSR 08-15-110, § 388-538-070, filed 7/18/08, effective 8/18/08; WSR 06-03-081, § 388-538-070, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.522, 2003 E1 c 25 § 201(4), 2004 c 276 § 201(4), 42 U.S.C. 1396N (section 1915 (b) and (c) of the Social Security Act of 1924). WSR 05-01-066, § 388-538-070, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.522. WSR 03-18-109, § 388-538-070, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. WSR 02-01-075, § 388-538-070, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. WSR 00-04-080, § 388-538-070, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090. WSR 96-24-073, § 388-538-070, filed 12/2/96, effective 1/2/97. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. WSR 95-18-046 (Order 3886), § 388-538-070, filed 8/29/95 effective 9/1/95. Statutory Authority: RCW 74.08.090. WSR 93-17-039 (Order 3621), § 388-538-070, filed 8/11/93, effective 9/11/93.]

OTS-4207.1

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

WAC 182-538-140 Quality of care. ((~~(1)~~)) To assure that managed care enrollees receive quality health care services, the agency requires managed care organizations (MCOs) to comply with quality improvement standards detailed in the agency's managed care contract. MCOs must:

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

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

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

((~~(d)~~)) (4) Ensure that MCO subcontracts and the delegation of MCO responsibilities align with agency standards;

((~~(e)~~)) (5) Ensure MCO oversight of delegated entities responsible for any delegated activity to include:

((~~(i)~~)) (a) A delegation agreement with each entity describing the responsibilities of the MCO and the entity;

((~~(ii)~~)) (b) Evaluation of the entity before delegation;

((~~(iii)~~)) (c) An annual evaluation of the entity; and

((~~(iv)~~)) (d) Evaluation or regular reports and follow-up on issues that are not compliant with the delegation agreement or the agency's managed care contract specifications((~~.~~
~~(f)~~));

(6) Cooperate with an agency-contracted, qualified independent external quality review organization (EQRO) conducting review activities as described in 42 C.F.R. Sec. 438.358;

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

((~~(h)~~)) (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;

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

((~~(j)~~)) (10) Maintain a health information system that:

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

((~~(ii)~~)) (b) Provides information on utilization, grievances and appeals, enrollees ending enrollment for reasons other than the loss of medicaid eligibility, and other areas as defined by the agency;

((~~(iii)~~)) (c) Retains enrollee grievance and appeal records described in 42 C.F.R. Sec. 438.416, base data as required by 42 C.F.R. Sec. 438.5(c), MLR reports as required by 42 C.F.R. Sec. 438.8(k), and the data, information, and documentation specified in 42 C.F.R. Secs. 438.604, 438.606, 438.408, and 438.610 for a period of no less than ((~~ten~~)) 10 years;

((~~(iv)~~)) (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

((~~(v)~~)) (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((~~.~~
~~(k)~~));

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

((~~(i)~~)) (a) Measuring performance using objective quality indicators;

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

((~~(iii)~~)) (c) Evaluating the effectiveness of system changes;

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

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

((~~(vi)~~)) (f) Completing each performance improvement project timely so as to generally allow aggregate information to produce new quality of care information every year((~~.~~
~~(l)~~));
(12) Ensure enrollee access to health care services;
((~~(m)~~)) (13) Ensure continuity and coordination of enrollee care;
((~~(n)~~)) (14) Maintain and monitor availability of health care services for enrollees;
((~~(o)~~)) (15) Perform client satisfaction surveys; and
((~~(p)~~)) (16) Obtain and maintain national committee on quality assurance (NCQA) accreditation.
((~~(2) The agency may:~~
~~(a) Impose intermediate sanctions under 42 C.F.R. Sec. 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; and~~
~~(c) Impose sanctions for noncompliance with any contractual, state, or federal requirements not corrected.~~))

[Statutory Authority: RCW 41.05.021, 41.05.160, 2019 c 325, 2014 c 225, and 2018 c 201. WSR 19-24-063, § 182-538-140, filed 11/27/19, effective 1/1/20. Statutory Authority: RCW 41.05.021, 41.05.160 and 42 C.F.R. Parts 431, 433, 438, 440, 457, and 495. WSR 17-23-199, § 182-538-140, filed 11/22/17, effective 12/23/17. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-24-098, § 182-538-140, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-140, filed 12/19/12, effective 2/1/13. WSR 11-14-075, recodified as § 182-538-140, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. WSR 08-15-110, § 388-538-140, filed 7/18/08, effective 8/18/08; WSR 06-03-081, § 388-538-140, filed 1/12/06, effective 2/12/06; WSR 03-18-111, § 388-538-140, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. WSR 02-01-075, § 388-538-140, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. WSR 00-04-080, § 388-538-140, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. WSR 95-18-046 (Order 3886), § 388-538-140, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. WSR 93-17-039 (Order 3621), § 388-538-140, filed 8/11/93, effective 9/11/93.]