WSR 24-19-061
PROPOSED RULES
HEALTH CARE AUTHORITY
[Filed September 16, 2024, 8:31 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 24-14-064.

Title of Rule and Other Identifying Information: WAC 182-538-110 The grievance and appeal system and agency administrative hearing for managed care organization (MCO) enrollees.

Hearing Location(s): On October 22, 2024, at 10:00 a.m. The health care authority (HCA) holds public hearings virtually without a physical meeting place. To attend the virtual public hearing, you must register in advance https://us02web.zoom.us/webinar/register/WN_icWpKqAQTxyCXgTcltuVgA. 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: Not sooner than October 23, 2024.

Submit Written Comments to: HCA Rules Coordinator, P.O. Box 42716, Olympia, WA 98504-2716, email arc@hca.wa.gov, fax 360-586-9727, beginning September 17, 8:00 a.m., by October 22, 2024, by 11:59 p.m.

Assistance for Persons with Disabilities: Contact Johanna Larson, phone 360-725-1349, fax 360-586-9727, telecommunication relay service 711, email Johanna.Larson@hca.wa.gov, by October 11, 2024.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: HCA is amending WAC 182-538-110 to align it with applicable federal government regulations and simplify the MCO appeal process.

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: Brian Jensen, P.O. Box 42716, Olympia, WA 98504-2716, 360-725-0815; Implementation and Enforcement: Jodie Arneson, P.O. Box 45506, Olympia, WA 98504-5506, 360-725-1410.

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).

Explanation of exemptions: The proposed rule applies to medicaid MCOs, which are not small businesses.

Scope of exemption for rule proposal:

Is fully exempt.

September 16, 2024
Wendy Barcus
Rules Coordinator

OTS-5710.1

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

WAC 182-538-110 The grievance and appeal system and agency administrative hearing for managed care organization (MCO) enrollees. (1) **Introduction.** This section contains information about the grievance and appeal system and the right to an agency administrative hearing for MCO enrollees. See WAC 182-538-111 for information about PCCM enrollees.

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

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

(b) Once an MCO enrollee has completed the MCO appeals process, the MCO enrollee has the option of requesting an agency administrative hearing regarding any adverse benefit determination upheld by the MCO. See chapter 182-526 WAC.

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

(a) The MCO grievance and appeal system must include:

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

(ii) An appeal process to address enrollee requests for review of an MCO adverse benefit determination; and

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

(b) MCOs must provide information describing the MCO's grievance and appeal system to all providers and subcontractors.

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

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

(e) An MCO must give enrollees any reasonable assistance in completing forms and other procedural steps for grievances and appeals (e.g., interpreter services and toll-free numbers).

(f) An MCO must allow enrollees and their authorized representatives to file grievances and appeals orally as well as in writing.

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

(h) MCOs may not require enrollees to provide written follow-up for a grievance the MCO received orally.

(i) The MCO must resolve each grievance and appeal and provide notice of the resolution as expeditiously as the enrollee's health condition requires, and within the time frames identified in this section.

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

(i) Neither were involved in any previous level of review or decision making, nor a subordinate of any person who was so involved; and

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

(A) An appeal of an adverse benefit determination concerning medical necessity;

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

(C) A grievance or appeal that involves any clinical issues.

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

(4) **The MCO grievance process.**

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

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

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

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

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

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

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

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

(5) **MCO's notice of adverse benefit determination.**

(a) **Language and format requirements.** The notice of adverse benefit determination must be in writing in the enrollee's primary language, and in an easily understood format, in accordance with 42 C.F.R. Sec. 438.404.

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

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

(ii) The reasons for the adverse benefit determination, including citation to rules or regulations and the MCO criteria that were the basis of the decision;

(iii) The enrollee's right to receive upon request, free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination, including medical necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits;

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

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

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

(vii) The enrollee's right to have benefits continued pending resolution of an appeal, how to request that benefits be continued, and the circumstances under which the enrollee may be required to pay the costs of these services.

(c) **Timing of notice.** The MCO must mail the notice of adverse benefit determination within the following time frames:

(i) For termination, suspension, or reduction of previously authorized services, at least ((~~ten~~)) 10 calendar days prior to the effective date of the adverse benefit determination in accordance with 42 C.F.R. Sec. 438.404 and 431.211. This time period does not apply if the criteria in 42 C.F.R. Sec. 431.213 or 431.214 are met. This notice must be mailed by a method that certifies receipt and assures delivery within three calendar days.

(ii) For denial of payment, at the time of any adverse benefit determination affecting the claim. This applies only when the enrollee can be held liable for the costs associated with the adverse benefit determination.

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

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

(B) The MCO determines and justifies to the agency upon request, a need for additional information and that the extension is in the enrollee's interest.

(iv) If the MCO extends the time frame for standard service authorization decisions, the MCO must:

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

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

(v) For expedited authorization decisions:

(A) In cases involving mental health drug authorization decisions, or where the provider indicates or the MCO determines that following the standard time frame could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function, the MCO must make an expedited authorization decision and provide notice no later than ((~~seventy-two~~)) 72 hours after receipt of the request for service.

(B) The MCO may extend the ((~~seventy-two~~)) 72-hour time frame up to ((~~fourteen~~)) 14 calendar days if:

(I) The enrollee requests the extension; or

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

(6) **The MCO appeal process.**

(a) **Authority to appeal.** An enrollee, the enrollee's authorized representative, or the provider acting with the enrollee's written consent may appeal an adverse benefit determination from the MCO.

(b) **Oral appeals.** An MCO must treat oral inquiries about appealing an adverse benefit determination as an appeal to establish the earliest possible filing date for the appeal. ((~~The oral appeal must~~

~~be confirmed in writing by the MCO, unless the enrollee or provider requests an expedited resolution.~~))

(c) **Acknowledgment letter.** The MCO must acknowledge in writing receipt of each standard appeal to both the enrollee and the requesting provider within five calendar days of receiving the appeal request. The appeal acknowledgment letter sent by the MCO serves as written confirmation of ((~~an~~)) a standard appeal filed orally by an enrollee. The MCO must acknowledge receipt of each expedited appeal either orally or in writing within two business days

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

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

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

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

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

(ii) Provide the enrollee and the enrollee's representative opportunity before and during the appeal process to examine the enrollee's case file, including medical records, other relevant documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO (or at the direction of the MCO) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and sufficiently in advance of the resolution time frame for appeals as specified in this section; and

(iii) Include as parties to the appeal:

(A) The enrollee and the enrollee's representative; or

(B) The legal representative of the deceased enrollee's estate.

(h) **Level of appeal.** There will only be one level of review in the MCO appeals process.

(i) Time frames for resolution of appeals and notice to the enrollee. MCOs must resolve each appeal and provide notice as expeditiously as the enrollee's health condition requires, and within the following time frames:

(i) For standard resolution of appeals, including notice to the affected parties, no longer than ((~~thirty~~)) 30 calendar days from the day the MCO receives the appeal. This includes appeals involving termination, suspension, or reduction of previously authorized services.

(ii) For expedited resolution of appeals, including notice to the affected parties, no longer than ((~~seventy-two~~)) 72 hours after the MCO receives the appeal. The MCO may extend the ((~~seventy-two~~)) 72-hour time frame up to ((~~fourteen~~)) 14 calendar days if:

(A) The enrollee requests the extension; or

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

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

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

(i) The notice of the resolution of the appeal must be in writing in the enrollee's primary language and in an easily understood format, in accordance with 42 C.F.R. Sec. 438.10.

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

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

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

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

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

(A) The right to request an agency administrative hearing under RCW 74.09.741 and chapter 182-526 WAC, and how to request the hearing;

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

(C) That the enrollee may be held liable for the cost of those benefits received for the first ((~~sixty~~)) 60 days after the agency or the office of administrative hearings (OAH) receives an agency administrative hearing request, if the hearing decision upholds the MCO's adverse benefit determination. See RCW 74.09.741 (5)(g).

(7) **MCO expedited appeal process.**

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

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

(c) The MCO must make a decision on the enrollee's request for expedited appeal and provide written notice as expeditiously as the enrollee's health condition requires and no later than two calendar days after the MCO receives the appeal. The MCO must also make reasonable efforts to orally notify the enrollee of the decision.

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

(i) The enrollee requests the extension; or

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

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

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

(i) The enrollee requests the extension; or

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

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

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

(i) Process the appeal based on the time frame for standard resolution;

(ii) Make reasonable efforts to give the enrollee prompt oral notice of the denial; and

(iii) Provide written notice within two calendar days.

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

(8) **The right to an agency administrative hearing for managed care (MCO) enrollees.**

(a) **Authority to file.** Only an enrollee, the enrollee's authorized representative, or a provider with the enrollee's or authorized representative's written consent may request an administrative hearing. See RCW 74.09.741, WAC 182-526-0090, and 182-526-0155.

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

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

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

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

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

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

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

(A) Within ((~~ten~~)) 10 calendar days of the MCO mailing the notice of adverse benefit determination; or

(B) The intended effective date of the MCO's proposed adverse benefit determination.

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

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

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

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

(i) The enrollee withdraws the MCO appeal;

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

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

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

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

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

(a) **Services not furnished while an appeal is pending.** If the MCO or a final order entered by the HCA board of appeals, as defined in chapter 182-526 WAC, or an independent review organization (IRO) reverses a decision to deny, limit, or delay services that were not provided while the appeal was pending, the MCO must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires, but not later than ((~~seventy-two~~)) 72 hours from the date it receives notice reversing the determination.

(b) **Services furnished while the appeal is pending.** If the MCO reverses a decision to deny authorization of services or the denial is reversed through an IRO or a final order of OAH or the board of appeals and the enrollee received the disputed services while the appeal was pending, the MCO must pay for those services.