WSR 26-19-140
PROPOSED RULES
HEALTH CARE AUTHORITY
[Filed September 23, 2026, 9:17 a.m.]

Original Notice.

Preproposal statement of inquiry was filed as WSR 25-13-053.

Title of Rule and Other Identifying Information: Chapter 182-566 WAC, Certified community behavioral health clinics.

Hearing Location(s): On October 27, 2026, at 10:00 a.m. The health care authority (HCA) holds public hearings virtually without a physical meeting place. Virtual public hearings are held via Microsoft Teams webinar. To attend, you must register in advance at https://events.gcc.teams.microsoft.com/event/0d7f053a-648a-4726-9cd6-186bde5cf01d@11d0e217-264e-400a-8ba0-57dcc127d72d.

After registering, you will receive a confirmation email containing information about joining the public hearing. You will be able to join the public hearing through most standard internet browsers; you do not need to install Microsoft Teams.

Date of Intended Adoption: Not sooner than October 28, 2026.

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 24, 2026, 8:00 a.m., by October 27, 2026, 11:59 p.m.

Assistance for Persons with Disabilities: Contact Jessica Nguyen, phone 360-725-1174, fax 360-586-9727, telecommunication relay service 711, email arc@hca.wa.gov, by October 9, 2026.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed rules implement a statewide certified community behavioral health clinic (CCBHC) model as directed by ESSB 5167, section 214(43), 69th legislature, 2025 regular session. The rules also establish cost-based rates and standards for CCBHC certification. CCBHCs are outpatient community-based clinics that provide a comprehensive range of mental health and substance use disorder services to people seeking care.

Reasons Supporting Proposal: See purpose of the proposal.

Statutory Authority for Adoption: RCW 41.05.021 and 41.05.160.

Statute Being Implemented: RCW 41.05.021 and 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: Kendra Cullimore, P.O. Box 42730, Olympia, WA 98504-2730, 360-725-5230.

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 rules apply to outpatient community-based clinics that are not small businesses and are there-

fore exempt from preparation of a small business economic impact statement.

Scope of exemption for rule proposal:

Is fully exempt.

September 23, 2026
Wendy Barcus
Rules Coordinator

RDS-7293.5

Chapter 182-566 WAC
CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS (CCBHC)

NEW SECTION

WAC 182-566-010 General. This chapter contains rules regarding certified community behavioral health clinics (CCBHCs).

(1) CCBHCs are outpatient, community-based clinics that provide a comprehensive range of mental health and substance use disorder services, as described in Section 223 of the Protecting Access to Medicare Act of 2014 (PAMA), to any person who seeks care.

(2) The medicaid agency covers CCBHC services under the CCBHC federal demonstration approved by the Centers for Medicare and Medicaid Services.

(3) This chapter applies to providers selected for certification or certified by the agency as state-certified CCBHCs.

(4) The agency may certify additional providers through a competitive process during the demonstration, subject to available funding. A provider's submission of a certification questionnaire for agency review does not guarantee certification.

(5) CCBHCs are responsible for:

(a) Engaging in whole-person care coordination to ensure a person's health care, behavioral health, and social needs are identified and addressed in a holistic manner; and

(b) Developing formal care coordination partnerships with primary care providers who furnish care in the CCBHC's service area.

(6) A tribal government may attest to certification of a tribal CCBHC using the process described in WAC 182-566-040 or be certified through the process described in WAC 182-566-030.

NEW SECTION

WAC 182-566-020 Definitions. "Certification questionnaire" means the form the medicaid agency uses to verify that a provider meets the core clinical requirements to be a certified community behavioral health clinic.

"Certified community behavioral health clinic (CCBHC)" means a behavioral health provider certified by the medicaid agency to deliver the agency's required scope of services and activities.

"Community needs assessment" or **"CNA"** means a current, data-driven assessment of behavioral health needs, service gaps, and priority populations within the CCBHC service area. Assessments are developed in accordance with the Substance Abuse and Mental Health Services Administration (SAMHSA) Certified Community Behavioral Health Clinic Criteria and Standards Guidance and any subsequent amendments adopted by SAMHSA. (See https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics/ccbhc-certification-criteria.)

"Cost report" means the standardized financial and statistical report that a CCBHC submits to the agency, prepared in accordance with the Centers for Medicare and Medicaid Services (CMS) CCBHC Cost Report Instructions. The report documents the CCBHC's allowable costs and qualifying patient visits for a defined reporting period and is used to establish or rebase the CCBHC's PPS rate.

"Demonstration" means an experimental project approved by the Centers for Medicare and Medicaid Services (CMS) that allows states to test innovative, nontraditional policy approaches in their medicaid programs. A demonstration waives certain federal requirements to allow new service delivery, eligibility, or payment models that aim to improve care, increase efficiency, and remain budget neutral. As referred to in this chapter, the demonstration allows CCBHCs to provide services without a medicaid state plan amendment.

"Designated collaborating organization (DCO)" means an agency-approved organization contracted with the CCBHC to provide one or more services that assist the CCBHC in fulfilling its scope of services.

"Prospective payment system (PPS)" means a reimbursement method that pays CCBHCs a cost-based reimbursement for medicaid services, rather than based on billed charges.

"PPS rate" means a cost-based, provider-specific rate for services based on a PPS model.

"Rebase" means the process of recalculating PPS rates using actual cost report data.

"Substance Abuse and Mental Health Services Administration (SAMHSA)" means the federal agency responsible for defining, funding, and supporting the CCBHC model.

NEW SECTION

WAC 182-566-030 Certification and enrollment. (1) To enroll as a certified community behavioral health clinic (CCBHC), a provider must do all of the following:

(a) Enroll with the medicaid agency;

(b) Be certified as a CCBHC by the state according to Substance Abuse and Mental Health Services Administration (SAMHSA) and Washington state certification criteria. As part of the certification process, CCBHCs must:

(i) Be licensed by the Washington state department of health as a behavioral health agency and certified to provide mental health and substance use disorder services in the state of Washington, as described in chapter 246-341 WAC;

(ii) Demonstrate compliance with staffing, scope of service, and accessibility requirements;

(iii) Report CCBHC services data, clinical outcomes data, quality data, and any other required data; and

(iv) Demonstrate it meets the organizational authority requirements described in the Protecting Access to Medicare Act of 2014, Section 223 (a)(2)(F);

(c) Complete a readiness assessment as described in the certification questionnaire;

(d) Have a site visit completed by the designated certification body. This requirement is not applicable to tribal providers;

(e) Complete a readiness review before beginning to bill for services under the prospective payment system (PPS) described in WAC 182-566-100;

(f) Complete and submit to the agency a federal CCBHC cost report and any other documentation required by the agency to set a PPS rate;

(g) Operate in accordance with applicable federal, state, and local laws; and

(h) Provide a current community needs assessment (CNA). A current CNA must be completed within three years of the CCBHC's due date to submit its certification or recertification materials to the agency.

(2) Tribal providers may follow the certification process described in this section or the tribal CCBHC attestation process described in WAC 182-566-040.

NEW SECTION

WAC 182-566-040 Tribal attestation and enrollment. (1) A tribal provider may become a certified community behavioral health clinic (CCBHC) through the government-to-government process described in this section or through the certification process described in WAC 182-566-030.

(2) Under this process, a tribe must submit:

(a) A tribal attestation or letter confirming the organization meets the CCBHC requirements;

(b) Policies and procedures that meet the requirements in the Protecting Access to Medicare Act of 2014, Section 223, subsection (a);

(c) A signed core provider agreement with the medicaid agency; and

(d) A negotiated sovereign nation agreement (SNA) with the medicaid agency that outlines:

(i) Government-to-government monitoring;

(ii) Denial and decertification procedures for the tribe's CCBHC, which follow the agency's tribal consultation policy and formal communication process;

(A) The medicaid agency sends a dear tribal leader letter (DTLL) for any communication related to denials or decertifications;

(B) The tribe and the tribal CCBHC have 30 calendar days to respond to the medicaid agency; and

(iii) Tribal CCBHC payment structure. Tribes are not obligated to follow the prospective payment system (PPS) payment model described in WAC 182-566-100.

(3) Tribal nations may participate as CCBHCs consistent with applicable federal, tribal, or state law and medicaid requirements.

(4) To renew as a tribal CCBHC, the tribe must submit current copies of the documentation described in subsection (2) of this sec-

tion. The tribe must submit the documents within three years from the beginning date of its current certification. The agency sends the tribal CCBHC a renewal notification 120 calendar days prior to the certification end date.

NEW SECTION

WAC 182-566-050 Designated collaborating organizations (DCO). (1) Designated collaborating organizations (DCO) that have a contract with a certified community behavioral health clinic (CCBHC) must be enrolled as a provider with the medicaid agency.

(2) CCBHCs must notify the medicaid agency of any DCO contract changes, including contract initiation, termination, and addendums, within 30 calendar days of making the contract change.

(3) CCBHC services rendered by DCOs must be included within the CCBHC's bundled daily rate and billed by the CCBHC, not separately by the DCO.

NEW SECTION

WAC 182-566-060 Minimum standards for recertification. (1) A certified community behavioral health clinic (CCBHC) must renew its certification or tribal attestation at least once every three years.

(2) Failure to complete the renewal requirement by the deadline provided in the agency's certification reminder may result in decertification.

(3) Recertification approval is contingent on the CCBHC's submission and the agency's acceptance of:

(a) A community needs assessment (CNA) completed within the last three years that demonstrates alignment between identified community needs and the CCBHC's services and capacity;

(b) An updated cost report; and

(c) Any additional information requested by the agency.

(4) The agency may conduct recertification reviews concurrently with on-site visits or readiness reviews.

(5) Tribal CCBHCs may meet the renewal requirement through the process outlined in this section or through the process described in WAC 182-566-040.

NEW SECTION

WAC 182-566-070 Requirements for certified community behavioral health clinic. (1) A certified community behavioral health clinic (CCBHC) must:

(a) Ensure timely access to care, including crisis services; and

(b) Not deny services based on a person's:

(i) Ability to pay;

(ii) Place of residence; or

(iii) Insurance status.

(2) A CCBHC must directly provide the majority of all required services and may provide the remaining services through formal agreements with other enrolled medicaid providers.

NEW SECTION

WAC 182-566-080 Services. (1) **Required services.** Certified community behavioral health clinics (CCBHCs) must provide the following core services as described in the Protecting Access to Medicare Act of 2014 (PAMA):

(a) Crisis services;
(b) Screening, diagnosis, and risk assessment;
(c) Outpatient mental health and substance use services;
(d) Person and family-centered treatment planning;
(e) Outpatient primary care screening and monitoring;
(f) Targeted case management;
(g) Psychiatric rehabilitation services;
(h) Peer, family support, and counselor services; and
(i) Community-based mental health care for veterans.

(2) **Opioid treatment services.** CCBHCs must provide access to opioid treatment services.

(a) **Designated collaborating organization (DCO) agreements.** A CCBHC not certified as an opioid treatment program (OTP) must maintain a formal designated collaborating organization (DCO) agreement to ensure seamless access to treatment and treatment medications.

(b) **Time-to-service standards.** The CCBHC must implement a triage and screening system to ensure the following response times for opiate treatment program (OTP) services:

(i) **Urgent needs.** For people presenting with urgent, nonemergency medication for opioid use disorders (MOUD) needs, the CCBHC must provide a clinical evaluation and initial service within one business day of the request.

(ii) **Routine needs.** For people with routine MOUD needs, the CCBHC must provide an initial evaluation and service delivery within 10 business days of the initial contact.

(iii) **Emergency/crisis needs.** The CCBHC must take immediate action to address emergency or crisis situations within three hours from the initial contact.

(iv) **Post-emergency follow-up.** For people treated in an emergency department (ED) for an opioid overdose or a substance use crisis, the CCBHC must facilitate an outpatient follow-up visit or pharmacotherapy dispensing within seven calendar days of the ED visit.

(v) **Low-barrier access.** To the extent feasible, the CCBHC must adopt low-threshold treatment models aiming for same-day access to MOUD to reduce barriers to care.

(3) **24/7 crisis response.** The CCBHC must ensure 24-hour access to crisis services, including a mobile crisis response that arrives onsite within three hours from the initial contact when clinically indicated.

(4) **Additional services.** In addition to the required services, CCBHCs may also provide other evidence-based behavioral health services identified in the medicaid agency's CCBHC billing guide.

NEW SECTION

WAC 182-566-090 Quality reporting requirements. (1) Certified community behavioral health clinics (CCBHCs) must:

(a) Report on quality measures defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the medicaid agency; and

(b) Submit quarterly reports to the agency within 60 calendar days of the end of each quarter.

(2) The agency may take corrective action against a CCBHC that fails to report or meet its quarterly quality reporting requirements in a timely manner.

NEW SECTION

WAC 182-566-100 Prospective payment system (PPS). The medicaid agency uses a prospective payment system (PPS) as authorized by the Protecting Access to Medicare Act of 2014, to reimburse certified community behavioral health clinics (CCBHCs).

(1) **Methodology.** The PPS methodology includes:

(a) Cost-based rate development using submitted cost reports;

(b) Clinic-specific PPS rates;

(c) A rebasing of rates at least every three years using new cost reporting materials;

(d) An adjustment using the medicare economic index (MEI) each year between rebasing; and

(e) Supplemental materials requested by the agency.

(2) **PPS updates.** The agency reviews and updates the PPS according to federal demonstration requirements and state fiscal policy.

(3) **Annual MEI updates.**

(a) The agency updates CCBHC PPS rates by the MEI trend on January 1 of each calendar year.

(b) The MEI is updated for CCBHCs using the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary CCBHC MEI calculation tool, which is used solely for the CCBHC program using various payment rates in medicare. The CCBHC MEI tool measures growth specific to the agency's demonstration year for CCBHCs.

(4) **Rebasing CCBHC PPS rates.** A CCBHC must rebase its PPS rates at least once every three years.

(a) When rebasing occurs, the CCBHC must submit its cost report materials using actual data from the previous calendar year.

(b) The CCBHC must submit its cost report materials to the medicaid agency within 120 calendar days from the end of the previous calendar year.

(c) The agency sets final PPS rates within 180 calendar days of receiving the CCBHC's completed cost report materials.

(d) During the rebasing period, the agency pays the CCBHC an interim rate. The interim rate is the previous calendar year's CCBHC PPS rate plus the current year's MEI.

(i) The agency applies CCBHC PPS rates retrospectively to PPS-eligible claims that were paid at the interim rate for dates of service occurring within that calendar year.

(A) If the agency determines a PPS rate adjustment is necessary, the agency notifies the CCBHC in writing at least 30 days prior to the PPS rate adjustment.

(B) If the agency determines the updated CCBHC PPS rate is higher than the interim rate, the agency pays the difference to the CCBHC. If the agency determines the CCBHC PPS rate is lower than the interim rate, the agency recoups the difference from the CCBHC.

(ii) The agency does not retrospectively adjust CCBHC PPS rates for claims with dates of service prior to the calendar year in which the rebase occurs.

NEW SECTION

WAC 182-566-110 CCBHC annual cost report submissions. (1) Certified community behavioral health clinics (CCBHCs) must submit cost reports and any additional required supplemental data to the medicaid agency annually, including the years in which the rates are adjusted by the medicare economic index (MEI) only and not rebased.

(2) CCBHCs must submit cost reports to the agency within 120 calendar days from the end of the previous calendar year, unless otherwise specified, during a year in which a rebase is required.

(3) The agency performs an annual desk audit of the CCBHC's updated cost report materials.

NEW SECTION

WAC 182-566-120 Staffing requirements. The certified community behavioral health clinic (CCBHC) must meet the staffing requirements described in the Substance Abuse and Mental Health Services Administration's (SAMHSA) CCBHC certification criteria. (See https://www.samhsa.gov/communities/certified-community-behavioral-health-clinics/ccbhc-certification-criteria.)

NEW SECTION

WAC 182-566-130 Provider licensing and credentialing. (1) All certified community behavioral health clinic (CCBHC) providers who furnish services directly and any designated collaborating organization (DCO) providers who furnish services under arrangement with the CCBHC must:

(a) Follow all applicable federal, state, and local laws, including all applicable behavioral health agency (BHA) licensing and certification requirements required under chapter 246-341 WAC, as well as any applicable requirements for tribal BHA licensing and certification through attestation; and

(b) Act only within the scope of its respective state licenses, certifications, or registrations and follow all applicable laws and regulations, including any applicable apple health billing regulations or policies.

(2) CCBHC providers must maintain all necessary state-required licenses, certifications, or other credentialing.

(3) The CCBHC must ensure appropriate supervision for providers who are working toward licensure, as required by applicable state law.

NEW SECTION

WAC 182-566-140 Managed care organization payment methodology. (1) Managed care organizations (MCO) or any organizations that manage medicaid payments on behalf of the medicaid agency must pay the full prospective payment system (PPS) rate directly to participating certified community behavioral health clinics (CCBHCs) for eligible claims. This requirement does not apply to tribal CCBHCs.

(2) The agency performs a claim review with the MCO as outlined in the MCO contract to ensure appropriate amounts are paid to each CCBHC.

(3) If the medicaid agency determines that a CCBHC has not received its PPS rate for a claim, the agency notifies the CCBHC and its MCO partners to review identified claims and reprocess as needed.

(4) Claims must be reprocessed within the time period described in WAC 182-502-0150.

NEW SECTION

WAC 182-566-150 General payment information. (1) The agency limits the certified community behavioral health clinic (CCBHC) prospective payment system (PPS) rate reimbursement to one per client, per day.

(2) All CCBHC services provided within the same day must be included in the same claim.

(3) CCBHCs must provide services in a single visit that are typically rendered on the same day based on clinical guidance and standards of care.

(a) CCBHCs must not split services into multiple visits unless there is clinical justification.

(b) Clinical justification must be based on medical necessity and documented in the client's record.

(4) Services provided in a CCBHC that are not within the CCBHC's scope of services are paid according to agency rules, billing guides, and fee schedules.

(5) Services provided to clients who are enrolled in medical programs that are paid only in state funds are not PPS eligible; these claims are paid on a fee-for-service basis regardless of the type of service performed, as described in the agency's provider guides.

NEW SECTION

WAC 182-566-160 Notice of deficiency. (1) The medicaid agency sends a written notice of deficiency if the agency determines that a certified community behavioral health clinic (CCBHC) has demonstrated one or more of the deficiencies described in WAC 182-566-170.

(2) The notice describes the CCBHC's specific deficiencies and the required corrective actions.

(3) The notice may result in a provider's CCBHC decertification.

NEW SECTION

WAC 182-566-170 Grounds for notice of deficiency. The medicaid agency may send a notice of deficiency if a certified community behavioral health clinic (CCBHC):

(1) Fails to provide the services for which the CCBHC is certified;

(2) Fails to ensure timely access to care, including crisis services;

(3) Denies services based on a person's:

(a) Ability to pay;

(b) Place of residence; or

(c) Insurance status;

(4) Engages in practices that pose a risk to client health, safety, or program integrity;

(5) Fails to submit a timely renewal certification;

(6) Submits a renewal certification questionnaire that is materially inaccurate, incomplete, or submits misleading information related to certification, recertification, cost reporting, or quality reporting;

(7) Knowingly, or with reason to know, makes a false statement of fact or fails to submit required information;

(8) Fails to schedule or timely complete the on-site review;

(9) Fails to cooperate or disrupts the agency's representatives during an on-site review or during a behavioral health administrative services organization's (BH-ASO) or managed care organization's (MCO) complaint investigation under the CCBHC's contract;

(10) Fails to implement or successfully complete a required corrective action plan within the agency's time frames;

(11) Fails to meet the terms of its contract with the MCOs; or

(12) No longer meets the certification standards or requirements established under this chapter.

NEW SECTION

WAC 182-566-180 Correction of deficiency. (1) After issuing a notice of deficiency, the medicaid agency allows 30 calendar days from the date on the notice for a certified community behavioral health clinic (CCBHC) to submit and implement a written corrective action plan.

(2) After reviewing the CCBHC's corrective action plan, the agency may:

(a) Accept the corrective action plan;

(b) Require additional corrective action or monitoring pending compliance with the CCBHC's corrective action plan; or

(c) Proceed with decertification.

NEW SECTION

WAC 182-566-190 Process for decertification. The medicaid agency decertifies a certified community behavioral health clinic (CCBHC) as follows:

(1) The agency issues a notice of intent to decertify to the CCBHC. The CCBHC has 30 calendar days from the date on the notice to respond in writing to the agency.

(2) The agency reviews the CCBHC's response and may conduct a verification visit.

(3) If the agency moves forward with decertification, the agency sends a notice of decertification, which includes the decertification date and any applicable transition or wind-down requirements.

NEW SECTION

WAC 182-566-200 Immediate decertification. The medicaid agency may immediately issue a notice of decertification to a certified community behavioral health clinic (CCBHC) without an opportunity for corrective action if the agency determines that the CCBHC:

(1) Presents an immediate threat to client health or safety; or

(2) Committed fraud or abuse under applicable law.

NEW SECTION

WAC 182-566-210 Surrender of certification. A certified community behavioral health clinic (CCBHC) may surrender its certification at any time by sending written notification to the medicaid agency. After the provider surrenders its CCBHC certification:

(1) The provider must not receive payment under the prospective payment system described in this chapter for services provided after the surrender effective date; and

(2) The agency notifies the provider of the surrender effective date and any applicable transition or wind-down requirements.

NEW SECTION

WAC 182-566-220 Rate setting dispute process. (1) **Rate setting disputes of an agency action.** A certified community behavioral health clinic (CCBHC) has a right to dispute an agency action related to rate setting under this chapter based on the rules in this section.

(a) The rules in WAC 182-502-0220 do not apply to disputes of agency action related to rate setting under this chapter.

(b) Disputes related to rate setting under this section are not governed by the Administrative Procedure Act, chapter 34.05 RCW.

(c) Any rate change the agency grants that is the result of fraudulent practices on the part of the CCBHC, including those as described under RCW 74.09.210, is exempt from the dispute provisions in this chapter.

(2) **First level of dispute.** A CCBHC that wants to contest an agency action concerning the reimbursement rate must file a written dispute with the agency. Written dispute notices must be sent to the address provided in the rate notification letter.

(a) The CCBHC must file the dispute within 60 calendar days of the date of the rate notification letter from the agency, unless an extension has been granted.

(b) The agency may grant a time extension for the dispute period if the CCBHC makes such a request before the expiration of the 60-day period.

(c) The agency does not consider a dispute filed after the 60-day period unless the agency grants an extension. The dispute must include the following:

(i) A statement of the specific issue being disputed;

(ii) Supporting documentation; and

(iii) A request for the agency to recalculate the rate.

(d) When a CCBHC disputes a portion of a rate, the agency may review all components of the reimbursement rate.

(e) To complete a review of the dispute, the agency may do one or both of the following:

(i) Request additional information.

(ii) Conduct an audit of the documentation provided.

(f) The agency issues a decision or requests additional information within 60 calendar days of receiving the rate dispute request. When the agency requests additional information:

(i) The CCBHC has 45 calendar days from the date of the request to submit the additional information to the agency; and

(ii) The agency issues a decision within 30 calendar days of receipt of the additional information.

(g) Any rate increase or decrease resulting from a dispute is effective retroactively to the rate effective date in the notification letter.

(3) **Second level of dispute.** When a CCBHC disagrees with a rate review decision from the first level of dispute, it may file a request along with supporting documentation for a dispute conference with the agency. For this section, "dispute conference" means an informal administrative appeal to resolve CCBHC disagreements with an agency action not resolved at the first level dispute.

(a) If a CCBHC files a request for a dispute conference, it must submit the request to the agency within 30 calendar days after the date of the rate review decision.

(b) Any request for a dispute conference must be sent to the address indicated in the rate review decision.

(c) The agency does not consider dispute conference requests submitted after the 30-day period for the first level decision.

(d) The agency conducts the dispute conference within 90 calendar days of receiving the request.

(e) The agency director or designee issues the final decision within 30 calendar days of the conference. Extensions of time for extenuating circumstances may be granted by the agency director or designee.

(f) Any rate increase or decrease resulting from a dispute conference decision is effective on the date specified in the dispute conference decision.

(g) The dispute conference is the final level of administrative appeal within the agency and precedes judicial action.

(4) **Abandoned disputes.** The agency considers a CCBHC to have abandoned its dispute if the CCBHC fails to:

(a) Attempt to resolve disputed rates as provided in this section; or

(b) Submit requested information identified in this chapter.

NEW SECTION

WAC 182-566-230 Decertification dispute process. (1) A certified community behavioral health clinic (CCBHC) has a right to dispute an agency decertification action. The director of the health care authority or designee conducts the review.

(2) A provider may request a review of an agency decertification decision. The request must include:

(a) A statement of the specific reasons the provider is disputing the decertification; and

(b) Any supporting documentation.

(3) The request must be in writing and sent to the address provided on the notice of decertification.

(4) The agency must receive the written dispute review request within 30 calendar days of the date on the agency's written notice of decertification.

(5) When the agency receives a timely dispute review request, the director or designee may schedule a dispute review conference. For this section, "dispute review conference" means an informal conference for the purpose of resolving disagreements between the agency and a provider that disputes a decertification action.

(6) The dispute review conference is not governed by the Administrative Procedure Act, chapter 34.05 RCW.

(7) The director or designee conducts the conference within 30 calendar days of receipt of the dispute review request, unless the director or designee and the provider requesting the review agree to an extension.

(8) The director or designee issues a dispute review decision to the provider who requested the review within 30 calendar days of receiving the dispute review request or within 30 calendar days of the dispute review conference, unless both parties agree to an extension.

(9) The director review is the final level of agency review for disputes to which this section applies.