

Chapter 182-538 WAC

MANAGED CARE

WAC

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WAC 182-538-050 Definitions. The following definitions and abbreviations and those found in WAC 388-500-0005, Medical definitions, apply to this chapter. References to managed care in this chapter do not apply to mental health managed care administered under chapter 388-865 WAC.

"Action" means one or more of the following:

- (1) The denial or limited authorization of a requested service, including the type or level of service;
- (2) The reduction, suspension, or termination of a previously authorized service;
- (3) The denial, in whole or in part, of payment for a service;
- (4) The failure to provide services in a timely manner, as defined by the state; or
- (5) The failure of a managed care organization (MCO) to act within the time frames provided in 42 C.F.R. 438.408(b).

"Ancillary health services" means healthcare services that are auxiliary, accessory, or secondary to a primary healthcare service.

"Appeal" means a request by an enrollee or provider with written permission of an enrollee for reconsideration of an action.

"Assign" or "assignment" means the department selects an MCO or primary care case management (PCCM) provider to serve a client who has not selected an MCO or PCCM provider.

"Auto enrollment" means the department has automatically enrolled a client into an MCO in the client's area of residence.

"Basic health" or "BH" means the healthcare program authorized by chapter 70.47 RCW and administered by the health care authority (HCA).

"Basic health plus"—Refer to WAC 388-538-065.

"Children with special healthcare needs" means children younger than age nineteen who are identified by the department as having special healthcare needs. This includes:

- (1) Children designated as having special healthcare needs by the department of health (DOH) and receiving services under the Title V program;
- (2) Children eligible for Supplemental Security Income under Title XVI of the Social Security Act (SSA); and
- (3) Children who are in foster care or who are served under subsidized adoption.

"Client" means, for the purposes of this chapter, an individual eligible for any medical assistance program, including managed care programs, but who is not enrolled with an MCO or PCCM provider. In this chapter, "client" refers to a person before he or she is enrolled in managed care, while "enrollee" refers to an individual eligible for any medical assistance program who is enrolled in managed care.

"Department" means the department of social and health services (DSHS).

"Disenrollment"—See "end enrollment."

"Emergency medical condition" means a condition meeting the definition in 42 C.F.R. 438.114(a).

"Emergency services" means services defined in 42 C.F.R. 438.114(a).

"End enrollment" means ending the enrollment of an enrollee for one of the reasons outlined in WAC 388-538-130.

"Enrollee" means an individual eligible for any medical assistance program enrolled in managed care with an MCO or PCCM provider that has a contract with the state.

"Enrollee's representative" means an individual with a legal right or written authorization from the enrollee to act on behalf of the enrollee in making decisions.

"Enrollees with special health care needs" means enrollees having chronic and disabling conditions and the conditions:

- (1) Have a biologic, psychologic, or cognitive basis;
- (2) Have lasted or are virtually certain to last for at least one year; and
- (3) Produce one or more of the following conditions stemming from a disease:
 - (a) Significant limitation in areas of physical, cognitive, or emotional function;
 - (b) Dependency on medical or assistive devices to minimize limitation of function or activities; or
 - (c) In addition, for children, any of the following:
 - (i) Significant limitation in social growth or developmental function;
 - (ii) Need for psychological, educational, medical, or related services over and above the usual for the child's age; or

(iii) Special ongoing treatments, such as medications, special diet, interventions, or accommodations at home or school.

"Exemption" means department approval of a client's preenrollment request to remain in the fee-for-service delivery system for one of the reasons outlined in WAC 388-538-130.

"Grievance" means an expression of dissatisfaction about any matter other than an action, as "action" is defined in this section.

"Grievance system" means the overall system that includes grievances and appeals handled at the MCO level and access to the department's hearing process.

"Healthcare service" or **"service"** means a service or item provided for the prevention, cure, or treatment of an illness, injury, disease, or condition.

"Healthy Options program" or **"HO program"** means the department's prepaid managed care health program for medicaid-eligible clients and clients enrolled in the state children's health insurance program (SCHIP).

"Managed care" means a comprehensive healthcare delivery system that includes preventive, primary, specialty, and ancillary services. These services are provided through either an MCO or PCCM provider.

"Managed care contract" means the agreement between the department and an MCO to provide prepaid contracted services to enrollees.

"Managed care organization" or **"MCO"** means an organization having a certificate of authority or certificate of registration from the office of insurance commissioner that contracts with the department under a comprehensive risk contract to provide prepaid healthcare services to eligible clients under the department's managed care programs.

"Mandatory enrollment" means the department's requirement that a client enroll in managed care.

"Mandatory service area" means a service area in which eligible clients are required to enroll in an MCO.

"Nonparticipating provider" means a healthcare provider that does not have a written agreement with an MCO but that provides MCO-contracted healthcare services to managed care enrollees with the MCO's authorization.

"Participating provider" means a healthcare provider with a written agreement with an MCO to provide healthcare services to the MCO's managed care enrollees. A participating provider must look solely to the MCO for payment for such services.

"Primary care case management" or **"PCCM"** means the healthcare management activities of a provider that contracts with the department to provide primary healthcare services and to arrange and coordinate other preventive, specialty, and ancillary health services.

"Primary care provider" or **"PCP"** means a person licensed or certified under Title 18 RCW including, but not limited to, a physician, an advanced registered nurse practitioner (ARNP), or a physician assistant who supervises, coordinates, and provides health services to a client or an enrollee, initiates referrals for specialist and ancillary care, and maintains the client's or enrollee's continuity of care.

"Prior authorization" or **"PA"** means a process by which enrollees or providers must request and receive department approval for services provided through the department's

fee-for-service system, or MCO approval for services provided through the MCO, for certain medical services, equipment, drugs, and supplies, based on medical necessity, before the services are provided to clients, as a precondition for provider reimbursement.

"Timely" means in relation to the provision of services, an enrollee has the right to receive medically necessary healthcare as expeditiously as the enrollee's health condition requires. In relation to authorization of services and grievances and appeals, "timely" means according to the department's managed care program contracts and the time frames stated in this chapter.

"Washington medicaid integration partnership" or **"WMIP"** means the managed care program that is designed to integrate medical, mental health, chemical dependency treatment, and long-term care services into a single coordinated health plan for eligible aged, blind, or disabled clients.

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WAC 182-538-060 Managed care and choice. (1) Except as provided in subsection (2) of this section, the department requires a client to enroll in managed care when that client:

- (a) Is eligible for one of the medical assistance programs for which enrollment is mandatory;
- (b) Resides in an area where enrollment is mandatory; and
- (c) Is not exempt from managed care enrollment or the department has not ended the client's managed care enrollment, consistent with WAC 388-538-130, and any related hearing has been held and decided.

(2) American Indian/Alaska Native (AI/AN) clients who meet the provisions of 25 U.S.C. 1603 (c)-(d) for federally recognized tribal members and their descendants may choose one of the following:

- (a) Enrollment with a managed care organization (MCO) available in their area;
 - (b) Enrollment with an Indian or tribal primary care case management (PCCM) provider available in their area; or
 - (c) The department's fee-for-service system.
- (3) To enroll with an MCO or PCCM provider, a client may:

- (a) Call the department's toll-free enrollment line at 800-562-3022;
- (b) Mail a postage-paid completed managed care enrollment form (healthy options sign-up form, DSHS 13-664) to the department's unit responsible for managed care enrollment; or

(c) Fax the managed care enrollment form (healthy options sign-up form, DSHS 13-664) to the department at 360-725-2144.

(4) A client must enroll with an MCO provider available in the area where the client resides.

(5) All family members of an enrollee placed in the patient review and coordination (PRC) program under WAC 388-501-0135 must enroll with the same MCO but may enroll in a different MCO than the family member placed in the PRC program.

(6) When a client requests enrollment with an MCO or PCCM provider, the department enrolls a client effective the earliest possible date given the requirements of the department's enrollment system. The department does not enroll clients retrospectively.

(7) The department assigns a client who does not choose an MCO or PCCM provider as follows:

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

(b) If the client does not have a family member or family members enrolled with an MCO that is currently under contract with the department, and the client was previously enrolled with the MCO or PCCM provider, and the department can identify the previous enrollment, the client is reenrolled with the same MCO or PCCM provider;

(c) If the client cannot be assigned according to (a) or (b) of this subsection, the department assigns the client as follows:

(i) If an AI/AN client does not choose an MCO or PCCM provider, the department assigns the client to a tribal PCCM provider if that client resides in a zip code served by a tribal PCCM provider. If there is no tribal PCCM provider in the client's area, the client continues to be served by the department's fee-for-service system. A client assigned under this subsection may request to end enrollment at any time.

(ii) If a non-AI/AN client does not choose an MCO provider, the department assigns the client to an MCO available in the area where the client resides. The MCO is responsible for primary care provider (PCP) choice and assignment.

(iii) For clients who are new recipients or who have had a break in eligibility of greater than two months, the department sends a written notice to each household of one or more clients who are assigned to an MCO or PCCM provider. The assigned client has ten calendar days to contact the department to change the MCO or PCCM provider assignment before enrollment is effective. The notice includes the name of the MCO or PCCM provider to which each client has been assigned, the effective date of enrollment, the date by which the client must respond in order to change the assignment, and the toll-free telephone number of either:

(A) The MCO (for enrollees assigned to an MCO); or

(B) The department (for enrollees assigned to a PCCM provider).

(iv) 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.

(8) The department:

(a) Helps facilitate the choice of a PCP by providing information regarding available providers contracted with the MCOs in the client's service area; and

(b) Upon request, will assist clients in identifying an MCO with which their provider participates.

(9) An MCO enrollee's selection of a PCP or assignment to a PCP occurs as follows:

(a) An MCO enrollee may choose:

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

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

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

(c) An MCO enrollee may change PCPs or clinics in an MCO for any reason, with the change becoming effective no later than the beginning of the month following the enrollee's request.

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

(e) MCO enrollees required to participate in the department's PRC program may be limited in their right to change PCPs (see WAC 388-501-0135).

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WAC 182-538-061 Voluntary enrollment into managed care—Washington medicaid integration partnership (WMIP). (1) The purpose of this section is to describe the managed care requirements for clients eligible for the Washington Medicaid Integration Partnership (WMIP).

(2) Unless otherwise stated in this section, all of the provisions of chapter 388-538 WAC apply to clients enrolled in WMIP.

(3) The following sections of chapter 388-538 WAC do not apply to WMIP enrollees:

(a) WAC 388-538-060. However, WAC 388-538-060(9), describing enrollees' ability to choose their PCP, does apply to WMIP enrollees;

(b) WAC 388-538-063;

(c) WAC 388-538-065;

(d) WAC 388-538-068; and

(e) WAC 388-538-130. However, WAC 388-538-130 (3) and (4), describing the process used when the department receives a request from an MCO to remove an enrollee from enrollment in managed care, do apply to WMIP enrollees. Also, WAC 388-538-130(9), describing the MCO's ability to

refer enrollees to the department's "Patient Review and Coordination" program, does apply to WMIP enrollees.

(4) The process for enrollment of WMIP clients is as follows:

(a) Enrollment in WMIP is voluntary, subject to program limitations in (b) and (d) of this subsection.

(b) For WMIP, the department automatically enrolls clients, with the exception of American Indian/Alaska natives and clients eligible for both Medicare and Medicaid, when they:

- (i) Are aged, blind, or disabled;
- (ii) Are twenty-one years of age or older; and
- (iii) Receive categorically needy medical assistance.

(c) American Indian/Alaska native (AI/AN) clients and clients who are eligible for both Medicare and Medicaid who meet the eligibility criteria in (b) of this subsection may voluntarily enroll or end enrollment in WMIP at any time.

(d) The department will not enroll a client in WMIP, or will end an enrollee's enrollment in WMIP when the client has, or becomes eligible for, CHAMPUS/TRICARE or any other third-party healthcare coverage that would:

(i) Require the department to either exempt the client from enrollment in managed care; or

(ii) End the enrollee's enrollment in managed care.

(e) A client or enrollee in WMIP, or the client's or enrollee's representative, may end enrollment from the MCO at any time without cause. The client may then reenroll at any time with the MCO. The department ends enrollment for clients prospectively to the first day of the month following the request to end enrollment, except as provided in (f) of this subsection.

(f) A client or enrollee may request that the department retroactively end enrollment from WMIP. On a case-by-case basis, the department may retroactively end enrollment from WMIP when, in the department's judgment:

(i) The client or enrollee has a documented and verifiable medical condition; and

(ii) Enrollment in managed care could cause an interruption of on-going treatment that could jeopardize the client's or enrollee's life or health or ability to attain, maintain, or regain maximum function.

(5) In addition to the scope of medical care services described in WAC 388-538-095, WMIP includes mental health, chemical dependency treatment, and long-term care services.

(6) The department sends each client written information about covered services when the client is eligible to enroll in WMIP, and any time there is a change in covered services. In addition, the department requires MCOs to provide new enrollees with written information about covered services. This notice informs the client about the right to end enrollment and how to do so.

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WAC 182-538-063 GAU clients residing in a designated mandatory managed care plan county. (1) In Laws

of 2007, chapter 522, section 209 (13) and (14), the legislature authorized the department to provide coverage of certain medical and mental health benefits to clients who:

(a) Receive medical care services (MCS) under the general assistance unemployable (GAU) program; and

(b) Reside in a county designated by the department as a mandatory managed care plan county.

(2) The only sections of chapter 388-538 WAC that apply to GAU clients described in this section are incorporated by reference into this section.

(3) GAU clients who reside in a county designated by the department as a mandatory managed care plan county must enroll in a managed care plan as required by WAC 388-505-0110(7) to receive department-paid medical care. A GAU client enrolled in an MCO plan under this section is defined as a GAU enrollee.

(4) GAU clients are exempt from mandatory enrollment in managed care if they are American Indian or Alaska Native (AI/AN) and meet the provisions of 25 U.S.C. 1603 (c)-(d) for federally recognized tribal members and their descendants.

(5) The department exempts a GAU client from mandatory enrollment in managed care:

(a) If the GAU client resides in a county that is not designated by the department as a mandatory MCO plan county; or

(b) In accordance with WAC 388-538-130(3).

(6) The department ends a GAU enrollee's enrollment in managed care in accordance with WAC 388-538-130(4).

(7) On a case-by-case basis, the department may grant a GAU client's request for exemption from managed care or a GAU enrollee's request to end enrollment when, in the department's judgment:

(a) The client or enrollee has a documented and verifiable medical condition; and

(b) Enrollment in managed care could cause an interruption of treatment that could jeopardize the client's or enrollee's life or health or ability to attain, maintain, or regain maximum function.

(8) The department enrolls GAU clients in managed care effective on the earliest possible date, given the requirements of the enrollment system. The department does not enroll clients in managed care on a retroactive basis.

(9) Managed care organizations (MCOs) that contract with the department to provide services to GAU clients must meet the qualifications and requirements in WAC 388-538-067 and 388-538-095 (3)(a), (b), (c), and (d).

(10) The department pays MCOs capitated premiums for GAU enrollees based on legislative allocations for the GAU program.

(11) GAU enrollees are eligible for the scope of care as described in WAC 388-501-0060 for medical care services (MCS) programs.

(a) A GAU enrollee is entitled to timely access to medically necessary services as defined in WAC 388-500-0005;

(b) MCOs cover the services included in the managed care contract for GAU enrollees. MCOs may, at their discretion, cover services not required under the MCO's contract for GAU enrollees;

(c) The department pays providers on a fee-for-service basis for the medically necessary, covered medical care ser-

vices not covered under the MCO's contract for GAU enrollees;

(d) A GAU enrollee may obtain:

(i) Emergency services in accordance with WAC 388-538-100; and

(ii) Mental health services in accordance with this section.

(12) The department does not pay providers on a fee-for-service basis for services covered under the MCO's contract for GAU enrollees, even if the MCO has not paid for the service, regardless of the reason. The MCO is solely responsible for payment of MCO-contracted healthcare services that are:

(a) Provided by an MCO-contracted provider; or

(b) Authorized by the MCO and provided by nonparticipating providers.

(13) The following services are not covered for GAU enrollees unless the MCO chooses to cover these services at no additional cost to the department:

(a) Services that are not medically necessary;

(b) Services not included in the medical care services scope of care, unless otherwise specified in this section;

(c) Services, other than a screening exam as described in WAC 388-538-100(3), received in a hospital emergency department for nonemergency medical conditions; and

(d) Services received from a nonparticipating provider requiring prior authorization from the MCO that were not authorized by the MCO.

(14) A provider may bill a GAU enrollee for noncovered services described in subsection (12) of this section, if the requirements of WAC 388-502-0160 and 388-538-095(5) are met.

(15) Mental health services and care coordination are available to GAU enrollees on a limited basis, subject to available funding from the legislature and an appropriate delivery system.

(16) A care coordinator (a person employed by the MCO or one of the MCO's subcontractors) provides care coordination to a GAU enrollee in order to improve access to mental health services. Care coordination may include brief, evidenced-based mental health services.

(17) To ensure a GAU enrollee receives appropriate mental health services and care coordination, the department requires the enrollee to complete at least one of the following assessments:

(a) A physical evaluation;

(b) A psychological evaluation;

(c) A mental health assessment completed through the client's local community mental health agency (CMHA) and/or other mental health agencies;

(d) A brief evaluation completed through the appropriate care coordinator located at a participating community health center (CHC);

(e) An evaluation by the client's primary care provider (PCP); or

(f) An evaluation completed by medical staff during an emergency room visit.

(18) A GAU enrollee who is screened positive for a mental health condition after completing one or more of the assessments described in subsection (17) of this section may receive one of the following levels of care:

(a) **Level 1.** Care provided by a care coordinator when it is determined that the GAU enrollee does not require Level 2 services. The care coordinator will provide the following, as determined appropriate and available:

(i) Evidenced-based behavioral health services and care coordination to facilitate receipt of other needed services.

(ii) Coordination with the PCP to provide medication management.

(iii) Referrals to other services as needed.

(iv) Coordination with consulting psychiatrist as necessary.

(b) **Level 2.** Care provided by a contracted provider when it is determined that the GAU enrollee requires services beyond Level 1 services. A care coordinator refers the GAU enrollee to the appropriate provider for services:

(i) A regional support network (RSN) contracted provider; or

(ii) A contractor-designated entity.

(19) Billing and reporting requirements and payment amounts for mental health services and care coordination provided to GAU enrollees are described in the contract between the MCO and the department.

(20) The total amount the department pays in any biennium for services provided pursuant to this section cannot exceed the amount appropriated by the legislature for that biennium. The department has the authority to take whatever actions necessary to ensure the department stays within the appropriation.

(21) Nothing in this section shall be construed as creating a legal entitlement to any GAU client for the receipt of any medical or mental health service by or through the department.

(22) An MCO may refer enrollees to the department's patient review and coordination (PRC) program according to WAC 388-501-0135.

(23) The grievance and appeal process found in WAC 388-538-110 applies to GAU enrollees described in this section.

(24) The hearing process found in chapter 388-02 WAC and WAC 388-538-112 applies to GAU enrollees described in this section.

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WAC 182-538-065 Medicaid-eligible basic health (BH) enrollees. (1) Certain children and pregnant women who have applied for, or are enrolled in, managed care through basic health (BH) (chapter 70.47 RCW) are eligible for medicaid under pediatric and maternity expansion provisions of the Social Security Act. The department determines medicaid eligibility for children and pregnant women who enroll through BH.

(2) Eligible children are enrolled in the basic health plus program and eligible pregnant women are enrolled in the maternity benefits program.

(3) The administrative rules and regulations that apply to managed care enrollees also apply to medicaid-eligible clients enrolled through BH, except as follows:

(a) The process for enrolling in managed care described in WAC 388-538-060(3) does not apply since enrollment is through the health care authority, the state agency that administers BH;

(b) American Indian/Alaska native (AI/AN) clients cannot choose fee-for-service or PCCM as described in WAC 388-538-060(2). They must enroll in a BH-contracted MCO.

(c) If a medicaid eligible client applying for BH plus does not choose an MCO prior to the department's eligibility determination, the client is transferred from BH plus to the department for assignment to managed care.

(d) The department does not consider the basic health plus and the maternity benefits programs to be third party.

[11-14-075, recodified as § 182-538-065, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. 06-03-081, § 388-538-065, 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 USC 1396N (section 1915 (b) and (c) of the Social Security Act of 1924). 05-01-066, § 388-538-065, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-065, 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. 00-04-080, § 388-538-065, filed 2/1/00, effective 3/3/00.]

WAC 182-538-067 Managed care provided through managed care organizations (MCOs). (1) Managed care organizations (MCOs) may contract with the department to provide prepaid healthcare services to eligible clients. The MCOs must meet the qualifications in this section to be eligible to contract with the department. The MCO must:

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

(b) Accept the terms and conditions of the department's managed care contract;

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

(d) Accept the prepaid rates published by the department.

(2) The department reserves the right not to contract with any otherwise qualified MCO.

[11-14-075, recodified as § 182-538-067, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. 08-15-110, § 388-538-067, filed 7/18/08, effective 8/18/08; 06-03-081, § 388-538-067, 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 USC 1396N (section 1915 (b) and (c) of the Social Security Act of 1924). 05-01-066, § 388-538-067, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.522. 03-18-112, § 388-538-067, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.09.080, RCW 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-067, filed 12/14/01, effective 1/14/02.]

WAC 182-538-068 Managed care provided through primary care case management (PCCM). A provider may contract with the department as a primary care case management (PCCM) provider to coordinate healthcare services to eligible clients under the department's managed care program. The PCCM provider or the individual providers in a PCCM group or clinic must:

(1) Have a core provider agreement with the department;

(2) Be a recognized urban Indian health center or tribal clinic;

(3) Accept the terms and conditions of the department's PCCM contract;

(4) Be able to meet the quality standards established by the department; and

(5) Accept PCCM rates published by the department.

[11-14-075, recodified as § 182-538-068, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. 08-15-110, § 388-538-068, filed 7/18/08, effective 8/18/08; 06-03-081, § 388-538-068, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-068, filed 12/14/01, effective 1/14/02.]

WAC 182-538-070 Managed care payment. (1) The department pays managed care organizations (MCOs) monthly capitated premiums that:

(a) Have been developed in accordance with 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 historical analysis of financial cost and/or rate information; and

(e) Are paid based on legislative allocations.

(2) The department pays primary care case management (PCCM) providers a monthly case management fee according to contracted terms and conditions.

(3) The department does not pay providers under the fee-for-service system for a service that is the MCO's responsibility, even if the MCO has not paid for the service for any reason. The MCO is solely responsible for payment of MCO-contracted healthcare services.

(4) The department pays an enhancement rate to federally qualified healthcare centers (FQHC) and rural health clinics (RHC) for each client enrolled with MCOs through the FQHC or RHC. The enhancement rate from the department is in addition to the negotiated payments FQHCs and RHCs receive from the MCOs for services provided to MCO enrollees.

(5) The department pays MCOs a delivery case rate, separate from the capitation payment, when an enrollee delivers a child(ren) and the MCO pays for any part of labor and delivery.

[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. 08-15-110, § 388-538-070, filed 7/18/08, effective 8/18/08; 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 USC 1396N (section 1915 (b) and (c) of the Social Security Act of 1924). 05-01-066, § 388-538-070, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.522. 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. 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. 00-04-080, § 388-538-070, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090. 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. 95-18-046 (Order 3886), § 388-538-070, filed 8/29/95 effec-

tive 9/1/95. Statutory Authority: RCW 74.08.090, 93-17-039 (Order 3621), § 388-538-070, filed 8/11/93, effective 9/11/93.]

WAC 182-538-095 Scope of care for managed care enrollees. (1) Managed care enrollees are eligible for the scope of medical care services as described in WAC 388-501-0060 for categorically needy clients.

(a) A client is entitled to timely access to medically necessary services as defined in WAC 388-500-0005.

(b) The managed care organization (MCO) covers the services included in the MCO contract for MCO enrollees. MCOs may, at their discretion, cover additional services not required under the MCO contract. However, the department may not require the MCO to cover any additional services outside the scope of services negotiated in the MCO's contract with the department.

(c) The department covers medically necessary services described in WAC 388-501-0060 and 388-501-0065 that are excluded from coverage in the MCO contract.

(d) The department covers services through the fee-for-service system for enrollees with a primary care case management (PCCM) provider. Except for emergencies, the PCCM provider must either provide the covered services needed by the enrollee, or refer the enrollee to other providers who are contracted with the department for covered services. The PCCM provider is responsible for instructing the enrollee regarding how to obtain the services that are referred by the PCCM provider. Services that require PCCM provider referral are described in the PCCM contract. The department informs an enrollee about the enrollee's program coverage, limitations to covered services, and how to obtain covered services.

(e) MCO enrollees may obtain specific services described in the managed care contract from either an MCO provider or from a provider with a separate agreement with the department without needing to obtain a referral from the PCP or MCO. These services are communicated to enrollees by the department and MCOs as described in (f) of this subsection.

(f) The department sends each client written information about covered services when the client is required to enroll in managed care, and any time there is a change in covered services. This information describes covered services, which services are covered by the department, and which services are covered by MCOs. In addition, the department requires MCOs to provide new enrollees with written information about covered services.

(2) For services covered by the department through PCCM contracts for managed care:

(a) The department covers medically necessary services included in the categorically needy scope of care and rendered by providers who have a current core provider agreement with the department to provide the requested service;

(b) The department may require the PCCM provider to obtain authorization from the department for coverage of nonemergency services;

(c) The PCCM provider determines which services are medically necessary;

(d) An enrollee may request a hearing for review of PCCM provider or the department coverage decisions (see WAC 388-538-110); and

(e) Services referred by the PCCM provider require an authorization number in order to receive payment from the department.

(3) For services covered by the department through contracts with MCOs:

(a) The department requires the MCO to subcontract with a sufficient number of providers to deliver the scope of contracted services in a timely manner. Except for emergency services, MCOs provide covered services to enrollees through their participating providers;

(b) The department requires MCOs to provide new enrollees with written information about how enrollees may obtain covered services;

(c) For nonemergency services, MCOs may require the enrollee to obtain a referral from the primary care provider (PCP), or the provider to obtain authorization from the MCO, according to the requirements of the MCO contract;

(d) MCOs and their providers determine which services are medically necessary given the enrollee's condition, according to the requirements included in the MCO contract;

(e) The department requires the MCO to coordinate benefits with other insurers in a manner that does not reduce benefits to the enrollee or result in costs to the enrollee;

(f) A managed care enrollee does not need a PCP referral to receive women's healthcare services, as described in RCW 48.42.100, from any women's healthcare provider participating with the MCO. Any covered services ordered and/or prescribed by the women's healthcare provider must meet the MCO's service authorization requirements for the specific service.

(g) For enrollees temporarily outside their MCO services area, the MCO is required to cover enrollees for up to ninety days for emergency care and medically necessary covered benefits that cannot wait until the enrollees return to their MCO services area.

(4) Unless the MCO chooses to cover these services, or an appeal, independent review, or a hearing decision reverses an MCO or department denial, the following services are not covered:

(a) For all managed care enrollees:

(i) Services that are not medically necessary[.]

(ii) Services not included in the categorically needy scope of services.

(iii) Services, other than a screening exam as described in WAC 388-538-100(3), received in a hospital emergency department for nonemergency medical conditions.

(b) For MCO enrollees:

(i) Services received from a participating specialist that require prior authorization from the MCO, but were not authorized by the MCO.

(ii) Services received from a nonparticipating provider that require prior authorization from the MCO that were not authorized by the MCO. All nonemergency services covered under the MCO contract and received from nonparticipating providers require prior authorization from the MCO.

(c) For PCCM enrollees, services that require a referral from the PCCM provider as described in the PCCM contract, but were not referred by the PCCM provider.

(5) A provider may bill an enrollee for noncovered services as described in subsection (4) of this section, if the requirements of WAC 388-502-0160 are met.

[11-14-075, recodified as § 182-538-095, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. 08-15-110, § 388-538-095, filed 7/18/08, effective 8/18/08. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. 06-24-036, § 388-538-095, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090 and 74.09.522. 06-03-081, § 388-538-095, 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 USC 1396N (section 1915 (b) and (c) of the Social Security Act of 1924). 05-01-066, § 388-538-095, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.522. 03-18-109, § 388-538-095, 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. 02-01-075, § 388-538-095, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090. 01-02-076, § 388-538-095, filed 12/29/00, effective 1/29/01. 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. 00-04-080, § 388-538-095, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-538-095, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-095, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-095, filed 8/11/93, effective 9/11/93.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 182-538-100 Managed care emergency services. (1) A managed care enrollee may obtain emergency services, for emergency medical conditions from any qualified medicaid provider. ("Emergency services" and "emergency medical condition" are defined in WAC 388-538-050.)

(a) The managed care organization (MCO) covers emergency services for MCO enrollees.

(b) The department covers emergency services for primary care case management (PCCM) enrollees.

(2) Emergency services for emergency medical conditions do not require prior authorization by the MCO, primary care provider (PCP), PCCM provider, or the department.

(3) MCOs must cover all emergency services provided to an enrollee by a provider who is qualified to furnish medicaid services, without regard to whether the provider is a participating or nonparticipating provider.

(4) An enrollee who requests emergency services is entitled to receive an exam to determine if the enrollee has an emergency medical condition. What constitutes an emergency medical condition may not be limited on the basis of diagnosis or symptoms.

(5) The MCO must cover emergency services provided to an enrollee when:

(a) The enrollee had an emergency medical condition, including cases in which the absence of immediate medical attention would not have had the outcomes specified in the definition of an emergency medical condition; and

(b) The plan provider or other MCO representative instructs the enrollee to seek emergency services.

(6) In any disagreement between a hospital and the MCO about whether the enrollee is stable enough for discharge or transfer, or whether the medical benefits of an unstabilized transfer outweigh the risks, the judgment of the attending physician(s) actually caring for the enrollee at the treating facility prevails.

(7) Under 42 C.F.R. 438.114, the enrollee's MCO must cover and pay for:

(a) Emergency services provided to enrollees by an emergency room provider, hospital or fiscal agent outside the managed care system; and

(b) Any screening and treatment the enrollee requires subsequent to the provision of the emergency services.

[11-14-075, recodified as § 182-538-100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. 08-15-110, § 388-538-100, filed 7/18/08, effective 8/18/08; 06-03-081, § 388-538-100, filed 1/12/06, effective 2/12/06; 03-18-110, § 388-538-100, 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. 02-01-075, § 388-538-100, 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. 00-04-080, § 388-538-100, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-100, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 95-04-033 (Order 3826), § 388-538-100, filed 1/24/95, effective 2/1/95; 93-17-039 (Order 3621), § 388-538-100, filed 8/11/93, effective 9/11/93.]

WAC 182-538-110 The grievance system for managed care organizations (MCO). (1) This section contains information about the grievance system for managed care organization (MCO) enrollees, which includes grievances and appeals. See WAC 388-538-111 for information about the grievance system for PCCM enrollees, which includes grievances and appeals.

(2) An MCO enrollee may voice a grievance or appeal an action by an MCO to the MCO either orally or in writing.

(3) MCOs must maintain records of grievances and appeals and must review the information as part of the MCO's quality strategy.

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

(5) Each MCO must have a grievance system in place for enrollees. The system must comply with the requirements of this section and the regulations of the state office of the insurance commissioner (OIC). If a conflict exists between the requirements of this chapter and OIC regulations, the requirements of this chapter take precedence. The MCO grievance system must include all of the following:

(a) A grievance process for complaints about any matter other than an action, as defined in WAC 388-538-050. See subsection (6) of this section for this process;

(b) An appeal process for an action, as defined in WAC 388-538-050. See subsection (7) of this section for the standard appeal process and subsection (8) of this section for the expedited appeal process;

(c) Access to the department's hearing process for actions as defined in WAC 388-538-050. The department's hearing process described in chapter 388-02 WAC applies to this chapter. Where conflicts exist, the requirements in this chapter take precedence. See WAC 388-538-112 for the department's hearing process for MCO enrollees;

(d) Access to an independent review (IR) as described in RCW 48.43.535, for actions as defined in WAC 388-538-050 (see WAC 388-538-112 for additional information about the IR); and

(e) Access to the board of appeals (BOA) for actions as defined in WAC 388-538-050 (also see chapter 388-02 WAC and WAC 388-538-112).

(6) The MCO grievance process:

(a) Only an enrollee may file a grievance with an MCO; a provider may not file a grievance on behalf of an enrollee.

(b) To ensure the rights of MCO enrollees are protected, each MCO's grievance process must be approved by the department.

(c) MCOs must inform enrollees in writing within fifteen days of enrollment about enrollees' rights and how to use the MCO's grievance process, including how to use the department's hearing process. The MCOs must have department approval for all written information the MCO sends to enrollees.

(d) The MCO must give enrollees any assistance necessary in taking procedural steps for grievances (e.g., interpreter services and toll-free numbers).

(e) The MCO must acknowledge receipt of each grievance either orally or in writing, and each appeal in writing, within five working days.

(f) The MCO must ensure that the individuals who make decisions on grievances are individuals who:

(i) Were not involved in any previous level of review or decision making; and

(ii) If deciding any of the following, are healthcare professionals who have appropriate clinical expertise in treating the enrollee's condition or disease:

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

(B) A grievance involving clinical issues.

(g) The MCO must complete the disposition of a grievance and notice to the affected parties within ninety days of receiving the grievance.

(7) The MCO appeal process:

(a) An MCO enrollee, or the enrollee's representative with the enrollee's written consent, may appeal an MCO action.

(b) To ensure the rights of MCO enrollees are protected, each MCO's appeal process must be approved by the department.

(c) MCOs must inform enrollees in writing within fifteen days of enrollment about enrollees' rights and how to use the MCO's appeal process and the department's hearing process. The MCOs must have department approval for all written information the MCO sends to enrollees.

(d) For standard service authorization decisions, an enrollee must file an appeal, either orally or in writing, within ninety calendar days of the date on the MCO's notice of action. This also applies to an enrollee's request for an expedited appeal.

(e) For appeals for termination, suspension, or reduction of previously authorized services, if the enrollee is requesting continuation of services, the enrollee must file an appeal within ten calendar days of the date of the MCO mailing the notice of action. Otherwise, the time frames in subsection (7)(d) of this section apply.

(f) The MCO's notice of action must:

(i) Be in writing;

(ii) Be in the enrollee's primary language and be easily understood as required in 42 C.F.R. 438.10 (c) and (d);

(iii) Explain the action the MCO or its contractor has taken or intends to take;

(iv) Explain the reasons for the action;

(v) Explain the enrollee's or the enrollee's representative's right to file an MCO appeal;

(vi) Explain the procedures for exercising the enrollee's rights;

(vii) Explain the circumstances under which expedited resolution is available and how to request it (also see subsection (8) of this section);

(viii) Explain the enrollee's right to have benefits continue 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 (also see subsection (9) of this section); and

(ix) Be mailed as expeditiously as the enrollee's health condition requires, and as follows:

(A) For denial of payment, at the time of any action affecting the claim. This applies only when the client can be held liable for the costs associated with the action.

(B) For standard service authorization decisions that deny or limit services, not to exceed fourteen calendar days following receipt of the request for service, with a possible extension of up to fourteen additional calendar days if the enrollee or provider requests extension. If the request for extension is granted, the MCO must:

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

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

(C) For termination, suspension, or reduction of previously authorized services, ten days prior to such termination, suspension, or reduction, except if the criteria stated in 42 C.F.R. 431.213 and 431.214 are met. The notice must be mailed by a method which certifies receipt and assures delivery within three calendar days.

(D) For expedited authorization decisions, in cases 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, no later than three calendar days after receipt of the request for service.

(g) The MCO must give enrollees any assistance necessary in taking procedural steps for an appeal (e.g., interpreter services and toll-free numbers).

(h) The MCO must acknowledge receipt of each appeal.

(i) The MCO must ensure that the individuals who make decisions on appeals are individuals who:

(i) Were not involved in any previous level of review or decision making; and

(ii) If deciding any of the following, are healthcare professionals who have appropriate clinical expertise in treating the enrollee's condition or disease:

(A) An appeal of a denial that is based on lack of medical necessity; or

(B) An appeal that involves clinical issues.

(j) The process for appeals must:

(i) Provide that oral inquiries seeking to appeal an action are treated as appeals (to establish the earliest possible filing date for the appeal), and must be confirmed in writing, unless the enrollee or provider requests an expedited resolution.

Also see subsection (8) for information on expedited resolutions;

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

(iii) Provide the enrollee and the enrollee's representative opportunity, before and during the appeals process, to examine the enrollee's case file, including medical records, and any other documents and records considered during the appeal process; and

(iv) Include as parties to the appeal, the enrollee and the enrollee's representative, or the legal representative of the deceased enrollee's estate.

(k) MCOs must resolve each appeal and provide notice, as expeditiously as the enrollee's health condition requires, within the following time frames:

(i) For standard resolution of appeals and notice to the affected parties, no longer than forty-five calendar days from the day the MCO receives the appeal. This time frame may not be extended.

(ii) For expedited resolution of appeals, including notice to the affected parties, no longer than three calendar days after the MCO receives the appeal.

(iii) For appeals for termination, suspension, or reduction of previously authorized services, no longer than forty-five calendar days from the day the MCO receives the appeal.

(l) The notice of the resolution of the appeal must:

(i) Be in writing. For notice of an expedited resolution, the MCO must also make reasonable efforts to provide oral notice (also see subsection (8) of this section).

(ii) Include the results of the resolution process and the date it was completed.

(iii) For appeals not resolved wholly in favor of the enrollee:

(A) Include information on the enrollee's right to request a department hearing and how to do so (also see WAC 388-538-112);

(B) Include information on the enrollee's right to receive services while the hearing is pending and how to make the request (also see subsection (9) of this section); and

(C) Inform the enrollee that the enrollee may be held liable for the cost of services received while the hearing is pending, if the hearing decision upholds the MCO's action (also see subsection (10) of this section).

(m) If an MCO enrollee does not agree with the MCO's resolution of the appeal, the enrollee may file a request for a department hearing within the following time frames (see WAC 388-538-112 for the department's hearing process for MCO enrollees):

(i) For hearing requests regarding a standard service, within ninety days of the date of the MCO's notice of the resolution of the appeal.

(ii) For hearing requests regarding termination, suspension, or reduction of a previously authorized service, within ten days of the date on the MCO's notice of the resolution of the appeal.

(n) The MCO enrollee must exhaust all levels of resolution and appeal within the MCO's grievance system prior to requesting a hearing with the department.

(8) The MCO expedited appeal process:

(a) Each MCO must establish and maintain an expedited appeal review process for appeals when the MCO determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request), that taking the time for a standard resolution could seriously jeopardize the enrollee's life or health or ability to attain, maintain, or regain maximum function.

(b) When approving an expedited appeal, the MCO will issue a decision as expeditiously as the enrollee's health condition requires, but not later than three business days after receiving the appeal.

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

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

(i) Transfer the appeal to the time frame for standard resolution; and

(ii) Make reasonable efforts to give the enrollee prompt oral notice of the denial, and follow up within two calendar days with a written notice.

(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 the provider files the appeal on or before the later of the following:

(A) Unless the criteria in 42 C.F.R. 431.213 and 431.214 are met, within ten calendar days of the MCO mailing the notice of action, which for actions involving services previously authorized, must be delivered by a method which certifies receipt and assures delivery within three calendar days; or

(B) The intended effective date of the MCO's proposed action.

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

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

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

(v) The enrollee requests an extension of services.

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

(i) The enrollee withdraws the appeal;

(ii) Ten calendar days pass after the MCO mails the notice of the resolution of the appeal and the enrollee has not requested a department hearing (with continuation of services until the department hearing decision is reached) within the ten days;

(iii) Ten calendar days pass after the state office of administrative hearings (OAH) issues a hearing decision adverse to the enrollee and the enrollee has not requested an independent review (IR) within the ten days (see WAC 388-538-112);

(iv) Ten calendar days pass after the IR mails a decision adverse to the enrollee and the enrollee has not requested a review with the board of appeals within the ten days (see WAC 388-538-112);

(v) The board of appeals issues a decision adverse to the enrollee (see WAC 388-538-112); or

(vi) The time period or service limits of a previously authorized service has been met.

(c) If the final resolution of the appeal upholds the MCO's action, the MCO may recover the amount paid for the services provided to the enrollee while the appeal was pending, to the extent that they were provided solely because of the requirement for continuation of services.

(10) Effect of reversed resolutions of appeals:

(a) If the MCO or OAH 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.

(b) If the MCO or OAH reverses a decision to deny authorization of services, and the enrollee received the disputed services while the appeal was pending, the MCO must pay for those services.

[11-14-075, recodified as § 182-538-110, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. 08-15-110, § 388-538-110, filed 7/18/08, effective 8/18/08; 06-03-081, § 388-538-110, filed 1/12/06, effective 2/12/06; 03-18-110, § 388-538-110, 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. 02-01-075, § 388-538-110, 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. 00-04-080, § 388-538-110, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090. 97-04-004, § 388-538-110, filed 1/24/97, effective 2/24/97. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-110, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 94-04-038 (Order 3701), § 388-538-110, filed 1/26/94, effective 2/26/94; 93-17-039 (Order 3621), § 388-538-110, filed 8/11/93, effective 9/11/93.]

WAC 182-538-111 Primary care case management (PCCM) grievances and appeals. (1) This section contains information about the grievance system for primary care case management (PCCM) enrollees, which includes grievances and appeals. See WAC 388-538-110 for information about the grievance system for managed care organization (MCO) enrollees.

(2) A PCCM enrollee may voice a grievance or file an appeal, either orally or in writing. PCCM enrollees use the department's grievance and appeal processes.

(3) The grievance process for PCCM enrollees;

(a) A PCCM enrollee may file a grievance with the department. A provider may not file a grievance on behalf of a PCCM enrollee.

(b) The department provides PCCM enrollees with information equivalent to that described in WAC 388-538-110 (7)(c).

(c) When a PCCM enrollee files a grievance with the department, the enrollee is entitled to:

(i) Any reasonable assistance in taking procedural steps for grievances (e.g., interpreter services and toll-free numbers);

(ii) Acknowledgment of the department's receipt of the grievance;

(iii) A review of the grievance. The review must be conducted by a department representative who was not involved in the grievance issue; and

(6/30/11)

(iv) Disposition of a grievance and notice to the affected parties within ninety days of the department receiving the grievance.

(4) The appeal process for PCCM enrollees:

(a) A PCCM enrollee may file an appeal of a department action with the department. A provider may not file an appeal on behalf of a PCCM enrollee.

(b) The department provides PCCM enrollees with information equivalent to that described in WAC 388-538-110 (8)(c).

(c) The appeal process for PCCM enrollees follows that described in chapter 388-02 WAC. Where a conflict exists, the requirements in this chapter take precedence.

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WAC 182-538-112 The department of social and health services' (DSHS) hearing process for enrollee appeals of managed care organization (MCO) actions. (1) The hearing process described in chapter 388-02 WAC applies to the hearing process described in this chapter. Where a conflict exists, the requirements in this chapter take precedence.

(2) A managed care organization (MCO) enrollee must exhaust all levels of resolution and appeal within the MCO's grievance system prior to requesting a hearing with the department. See WAC 388-538-110 for the MCO grievance system.

(3) If an MCO enrollee does not agree with the MCO's resolution of the enrollee's appeal, the enrollee may file a request for a department hearing within the following time frames:

(a) For hearing requests regarding a standard service, within ninety calendar days of the date of the MCO's notice of the resolution of the appeal.

(b) For hearing requests regarding termination, suspension, or reduction of a previously authorized service, and the enrollee is requesting continuation of services, within ten calendar days of the date on the MCO's notice of the resolution of the appeal.

(4) The entire appeal and hearing process, including the MCO appeal process, must be completed within ninety calendar days of the date the MCO enrollee filed the appeal with the MCO, not including the number of days the enrollee took to subsequently file for a department hearing.

(5) Expedited hearing process:

(a) The office of administrative hearings (OAH) must establish and maintain an expedited hearing process when the enrollee or the enrollee's representative requests an expedited hearing and OAH indicates that the time taken for a standard resolution of the claim could seriously jeopardize the enrollee's life or health and ability to attain, maintain, or regain maximum function.

(b) When approving an expedited hearing, OAH must issue a hearing decision as expeditiously as the enrollee's health condition requires, but not later than three business days after receiving the case file and information from the MCO regarding the action and MCO appeal.

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(c) When denying an expedited hearing, OAH gives prompt oral notice to the enrollee followed by written notice within two calendar days of request and transfer the hearing to the time frame for a standard service.

(6) Parties to the hearing include the department, the MCO, the enrollee, and the enrollee's representative or the representative of a deceased enrollee's estate.

(7) If an enrollee disagrees with the hearing decision, then the enrollee may request an independent review (IR) in accordance with RCW 48.43.535.

(8) If there is disagreement with the IR decision, any party may request a review by the department's board of appeals (BOA) within twenty-one days of the IR decision. The department's BOA issues the final administrative decision.

[11-14-075, recodified as § 182-538-112, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. 08-15-110, § 388-538-112, filed 7/18/08, effective 8/18/08; 06-03-081, § 388-538-112, 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 USC 1396N (section 1915 (b) and (c) of the Social Security Act of 1924), 05-01-066, § 388-538-112, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.522, and 74.09.450. 04-13-002, § 388-538-112, filed 6/2/04, effective 7/3/04. Statutory Authority: RCW 74.08.090, 74.09.522. 03-18-110, § 388-538-112, filed 9/2/03, effective 10/3/03.]

WAC 182-538-120 Enrollee request for a second medical opinion. (1) A managed care enrollee has the right to a timely referral for a second opinion upon request when:

(a) The enrollee needs more information about treatment recommended by the provider or managed care organization (MCO); or

(b) The enrollee believes the MCO is not authorizing medically necessary care.

(2) A managed care enrollee has a right to a second opinion from a participating provider. At the MCO's discretion, a clinically appropriate nonparticipating provider who is agreed upon by the MCO and the enrollee may provide the second opinion.

(3) Primary care case management (PCCM) enrollees have a right to a timely referral for a second opinion by another provider who has a core provider agreement with the department.

[11-14-075, recodified as § 182-538-120, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. 08-15-110, § 388-538-120, filed 7/18/08, effective 8/18/08; 06-03-081, § 388-538-120, 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 USC 1396N (section 1915 (b) and (c) of the Social Security Act of 1924), 05-01-066, § 388-538-120, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. 02-01-075, § 388-538-120, 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. 00-04-080, § 388-538-120, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-120, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-120, filed 8/11/93, effective 9/11/93.]

WAC 182-538-130 Exemptions and ending enrollment in managed care. (1) The department exempts a client from mandatory enrollment in managed care or ends an enrollee's enrollment in managed care as specified in this section.

(2) A client or enrollee, or the client's or enrollee's representative as defined in RCW 7.70.065, may request the department to exempt or end enrollment in managed care as described in this section.

(a) If a client requests exemption prior to the enrollment effective date, the client is not enrolled until the department approves or denies the request.

(b) If an enrollee requests to end enrollment, the enrollee remains enrolled pending the department's final decision, unless staying in managed care would adversely affect the enrollee's health status.

(c) The client or enrollee receives timely notice by telephone or in writing when the department approves or denies the client's or enrollee's request. The department follows a telephone denial by written notification. The written notice contains all of the following:

- (i) The action the department intends to take;
- (ii) The reason(s) for the intended action;
- (iii) The specific rule or regulation supporting the action;
- (iv) The client's or enrollee's right to request a hearing;

and

(v) A translation into the client's or enrollee's primary language when the client or enrollee has limited English proficiency.

(3) A managed care organization (MCO) or primary care case management (PCCM) provider may request the department to end enrollment. The request must be in writing and be sufficient to satisfy the department that the enrollee's behavior is inconsistent with the MCO's or PCCM provider's rules and regulations (e.g., intentional misconduct). The department does not approve a request to remove an enrollee from managed care when the request is solely due to an adverse change in the enrollee's health or the cost of meeting the enrollee's healthcare needs. The MCO or PCCM provider's request must include documentation that:

(a) The provider furnished clinically appropriate evaluation(s) to determine whether there is a treatable problem contributing to the enrollee's behavior;

(b) Such evaluation either finds no treatable condition to be contributing, or after evaluation and treatment, the enrollee's behavior continues to prevent the provider from safely or prudently providing medical care to the enrollee; and

(c) The enrollee received written notice of the provider's intent to request the enrollee's removal, unless the department has waived the requirement for provider notice because the enrollee's conduct presents the threat of imminent harm to others. The provider's notice must include:

(i) The enrollee's right to use the provider's grievance system as described in WAC 388-538-110 and 388-538-111; and

(ii) The enrollee's right to use the department's hearing process, after the enrollee has exhausted all grievance and appeals available through the provider's grievance system (see WAC 388-538-110 and 388-538-111 for provider grievance systems, and WAC 388-538-112 for the hearing process for enrollees).

(4) When the department receives a request from an MCO or PCCM provider to remove an enrollee from enrollment in managed care, the department attempts to contact the enrollee for the enrollee's perspective. If the department

approves the request, the department sends a notice at least ten days in advance of the effective date that enrollment will end. The notice includes:

(a) The reason the department approved ending enrollment; and

(b) Information about the enrollee's hearing rights.

(5) The department will exempt a client from mandatory enrollment or end an enrollee's enrollment in managed care when any of the following apply:

(a) The client or enrollee is receiving foster care placement services from the division of children and family services (DCFS);

(b) The client has or the enrollee becomes eligible for medicare, basic health (BH), CHAMPUS/TRICARE, or any other third-party healthcare coverage comparable to the department's managed care coverage that would require exemption or involuntarily ending enrollment from:

(i) An MCO, in accordance with the department's managed care contract; or

(ii) A primary care case management (PCCM) provider, according to the department's PCCM contract.

(c) The enrollee is no longer eligible for managed care.

(6) The department will grant a client's request for exemption or an enrollee's request to end enrollment when:

(a) The client or enrollee is American Indian/Alaska native (AI/AN) as specified in WAC 388-538-060(2);

(b) The client or enrollee has been identified by the department as a child who meets the definition of "children with special healthcare needs";

(c) The client or enrollee is homeless or is expected to live in temporary housing for less than one hundred twenty days from the date of the request; or

(d) The client or enrollee speaks limited English or is hearing impaired and the client or enrollee can communicate with a provider who communicates in the client's or enrollee's language or in American sign language and is not available through the MCO and the MCO does not have a provider available who can communicate in the client's language and an interpreter is not available.

(7) On a case-by-case basis, the department may grant a client's request for exemption or an enrollee's request to end enrollment when, in the department's judgment, the client or enrollee has a documented and verifiable medical condition, and enrollment in managed care could cause an interruption of treatment that could jeopardize the client's or enrollee's life or health or ability to attain, maintain, or regain maximum function.

(8) Upon request, the department may exempt the client or end enrollment for the period of time the circumstances or conditions that lead to exemption or ending enrollment are expected to exist. The department may periodically review those circumstances or conditions to determine if they continue to exist. If the department approves the request for a limited time, the client or enrollee is notified in writing or by telephone of the time limitation, the process for renewing the exemption or the ending of enrollment.

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(6/30/11)

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. 00-04-080, § 388-538-130, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. 98-16-044, § 388-538-130, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. 95-18-046 (Order 3886), § 388-538-130, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-130, filed 8/11/93, effective 9/11/93.]

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

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

(b) Have effective means to detect over and under utilization of services;

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

(d) Ensure that MCO subcontracts and the delegation of MCO responsibilities are in accordance with the department standards and regulations;

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

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

(ii) Evaluation of the entity prior to delegation;

(iii) An annual evaluation of the entity; and

(iv) Evaluation or regular reports and follow-up on issues out of compliance with the delegation agreement or the department's managed care contract specifications.

(f) Cooperate with a department-contracted, qualified independent external review organization (EQRO) conducting review activities as described in 42 C.F.R. 438.358;

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

(h) Assess and develop individualized treatment plans for enrollees with special healthcare needs which ensure integration of clinical and nonclinical disciplines and services in the overall plan of care;

(i) Submit annual reports to the department on performance measures as specified by the department;

(j) Maintain a health information system that:

(i) Collects, analyzes, integrates, and reports data as requested by the department;

(ii) 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 department;

(iii) Collects data on enrollees, providers, and services provided to enrollees through an encounter data system, in a standardized format as specified by the department; and

(iv) 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) Conduct performance improvement projects designed to achieve significant improvement, sustained over

time, in clinical care outcomes and services, and that involve the following:

- (i) Measuring performance using objective quality indicators;
 - (ii) Implementing system changes to achieve improvement in service quality;
 - (iii) Evaluating the effectiveness of system changes;
 - (iv) Planning and initiating activities for increasing or sustaining performance improvement;
 - (v) Reporting each project status and the results as requested by the department; and
 - (vi) Completing each performance improvement project timely so as to generally allow aggregate information to produce new quality of care information every year.
- (l) Ensure enrollee access to healthcare services;
- (m) Ensure continuity and coordination of enrollee care; and
- (n) Maintain and monitor availability of healthcare services for enrollees.

(2) The department may:

- (i) Impose intermediate sanctions in accordance with 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;
- (ii) Require corrective action for findings for noncompliance with any contractual state or federal requirements; and
- (iii) Impose sanctions for noncompliance with any contractual, state, or federal requirements not corrected.

[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. 08-15-110, § 388-538-140, filed 7/18/08, effective 8/18/08; 06-03-081, § 388-538-140, filed 1/12/06, effective 2/12/06; 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. 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. 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. 95-18-046 (Order 3886), § 388-538-140, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. 93-17-039 (Order 3621), § 388-538-140, filed 8/11/93, effective 9/11/93.]