



# RULE-MAKING ORDER

**CR-103P (May 2009)**  
(Implements RCW 34.05.360)

**Agency: Administrative Order #11-01 – Health Care Authority  
Basic Health Plan (BHP)**

**Permanent Rule Only**

**Effective date of rule:**

**Permanent Rules**

31 days after filing.

Other (specify) \_\_\_\_\_ (If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)

**Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?**

Yes  No If Yes, explain:

**Purpose:**

To amend 182-22 and 182-24 WAC to comply with federal rules concerning eligibility and a fair hearings process.

**Citation of existing rules affected by this order:**

Repealed:

Amended: Chapter 182-22 and 182-24 WAC

Suspended:

**Statutory authority for adoption: 70.47 RCW**

**Other authority :**

**PERMANENT RULE (Including Expedited Rule Making)**

Adopted under notice filed as WSR 11-12-083 on June 1, 2011

Describe any changes other than editing from proposed to adopted version: None

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name: \_\_\_\_\_ phone ( ) \_\_\_\_\_

Address: \_\_\_\_\_ fax ( ) \_\_\_\_\_

e-mail \_\_\_\_\_

**Date adopted:** July 8, 2011

**NAME (TYPE OR PRINT)**

Jason Siems

**SIGNATURE**

**TITLE**

Rules Coordinator

**CODE REVISER USE ONLY**

OFFICE OF THE CODE REVISER  
STATE OF WASHINGTON  
FILED

**DATE: July 08, 2011**

**TIME: 11:05 AM**

**WSR 11-15-020**

**Note: If any category is left blank, it will be calculated as zero.  
No descriptive text.**

**Count by whole WAC sections only, from the WAC number through the history note.  
A section may be counted in more than one category.**

**The number of sections adopted in order to comply with:**

<b>Federal statute:</b>	New	_____	Amended	_____	Repealed	_____
<b>Federal rules or standards:</b>	New	_____	Amended	_____	Repealed	_____
<b>Recently enacted state statutes:</b>	New	_____	Amended	_____	Repealed	_____

**The number of sections adopted at the request of a nongovernmental entity:**

New	_____	Amended	_____	Repealed	_____
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**The number of sections adopted in the agency's own initiative:**

New	1	Amended	5	Repealed	_____
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**The number of sections adopted in order to clarify, streamline, or reform agency procedures:**

New	<u>1</u>	Amended	5	Repealed	_____
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**The number of sections adopted using:**

<b>Negotiated rule making:</b>	New	<u>1</u>	Amended	<u>5</u>	Repealed	_____
<b>Pilot rule making:</b>	New	_____	Amended	_____	Repealed	_____
<b>Other alternative rule making:</b>	New	_____	Amended	_____	Repealed	_____

AMENDATORY SECTION (Amending Order 10-03, filed 11/30/10, effective 12/31/10)

**WAC 182-22-110 Definitions.** The definitions in this section apply throughout chapters 182-22, 182-23, 182-24, and 182-25 WAC.

"Administrator" means the administrator of the Washington state health care authority (HCA) or designee.

"Appeal procedure" means a formal written procedure for resolution of problems or concerns raised by enrollees or applicants which cannot be resolved in an informal manner to the appellant's satisfaction.

"Basic health plan" or "BHP" means the system of enrollment and payment for subsidized basic health care services administered by the HCA through managed health care systems.

"BHP Plus" means the program of expanded benefits available to children through coordination between the department of social and health services (DSHS) and BHP. Eligibility for BHP Plus is determined by the department of social and health services, based on medicaid eligibility criteria. To be eligible for the program children must be under age nineteen, with a family income at or below two hundred percent of federal poverty level, as defined by the United States Department of Health and Human Services. They must be Washington state residents, not eligible for medicare, and may be required to meet additional DSHS eligibility requirements.

"Copayment" means a payment indicated in the schedule of benefits which is made by an enrollee to a health care provider or to the managed health care system.

"Covered services" means those services and benefits in the applicable BHP or WHP schedule of benefits (as outlined in the member handbook), which an enrollee shall be entitled to receive from a managed health care system in exchange for payment of premium and applicable copayments, coinsurance and deductible.

"Dependent," as it applies to BHP or WHP, means:

(a) The subscriber's lawful spouse, not legally separated, who resides with the subscriber; or

(b) The child of the subscriber or the subscriber's dependent spouse, whether by birth, adoption, legal guardianship, or placement pending adoption, who is younger than age twenty-six, and who has not been relinquished for adoption by the subscriber or the subscriber's dependent spouse; or

(c) A person of any age who is incapable of self-support due to disability, and who is the unmarried child of the subscriber or the subscriber's dependent spouse, whether by birth, adoption, or legal guardianship; or

(d) A child younger than age twenty-six who is residing with the subscriber under an informal guardianship agreement. For a child to be considered a dependent of the subscriber under this provision:

(i) The guardianship agreement must be signed by the child's parent;

(ii) The guardianship agreement must authorize the subscriber to obtain medical care for the child;

(iii) The subscriber must be providing at least fifty percent of the child's support(~~(, and~~

~~(iv) The child must be on the account for coverage)).~~

"Disenrollment" means the termination of coverage for an enrollee.

"Effective date of enrollment" means the first date, as established by BHP or WHP, on which an enrollee is entitled to receive covered services from the enrollee's respective managed health care system.

"Eligible full-time employee" means an employee who meets all applicable eligibility requirements and who is regularly scheduled to work thirty or more hours per week for an employer. The term includes a self-employed individual (including a sole proprietor or a partner of a partnership, and may include an independent contractor) if the individual:

(a) Is regularly scheduled to work thirty hours or more per week; and

(b) Derives at least seventy-five percent of his or her income from a trade or business that is licensed to do business in Washington state.

Persons covered under a health benefit plan pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 shall not be considered eligible employees for purposes of minimum participation requirements.

"Eligible part-time employee" means an employee who meets all the criteria in definition "eligible full-time employee" of this section, but who is regularly scheduled to work fewer than thirty hours per week for an employer.

"Employee" means one who is in the employment of an employer, as defined under RCW 50.04.080.

"Employer" means an enterprise licensed to do business in Washington state, as defined under RCW 50.04.080, with employees in addition to the employer, whose wages or salaries are paid by the employer.

"Enrollee" means a person who meets all applicable eligibility requirements, who is enrolled in BHP or WHP, and for whom applicable premium payments have been made.

"Family" means an individual or an individual and eligible spouse and dependents. For purposes of eligibility determination and enrollment, an individual cannot be a member of more than one family.

"Financial sponsor" means a person, organization or other entity, approved by the administrator, that is responsible for payment of all or a designated portion of the monthly premiums on behalf of a subscriber and any dependents.

"Health care authority" or "HCA" means the Washington state health care authority.

"Home care agency" means a private or public agency or organization that administers or provides home care services

directly or through a contract arrangement to ill, disabled, or infirm persons in places of temporary or permanent residence, and is licensed by the department of social and health services (DSHS) as a home care agency. In order to qualify, the agency must be under contract with one of the following DSHS programs: Chore, medicaid personal care, community options program entry system (COPEs) or respite care (up to level three).

"Institution" means a federal, state, county, city or other government correctional or detention facility or government-funded facility where health care historically has been provided and funded through the budget of the operating agency, and includes, but is not limited to: Washington state department of corrections institutions; federal, county and municipal government jail and detention institutions; Washington state department of veterans affairs soldiers' and veterans' homes; department of social and health services state hospitals and facilities and juvenile rehabilitation institutions and group homes. An institution does not include: Educational institutions, government-funded acute health care or mental health facilities except as provided above, chemical dependency facilities, and nursing homes.

"Institutionalized" means to be confined, voluntarily or involuntarily, by court order or health status, in an institution, as defined in this section. This does not include persons on work release or who are residents of higher education institutions, acute health care facilities, alcohol and chemical dependency facilities, or nursing homes.

"Insurance broker" or "agent" means a person who is currently licensed as a disability insurance broker or agent, according to the laws administered by the office of the insurance commissioner under chapter 48.17 RCW.

"Managed health care system" or "MHCS" means:

(a) Any health care organization (including health care providers, insurers, health care service contractors, health maintenance organizations, or any combination thereof) which has entered into a contract with the HCA to provide health care services; or

(b) A self-funded or self-insured method of providing insurance coverage to subsidized enrollees provided under RCW 41.05.140 and subject to the limitations under RCW 70.47.100(7).

"Maternity benefits through medical assistance," also known as S-Medical, means the coordinated program between BHP and DSHS for eligible pregnant women. This program includes all medicaid benefits, including maternity coverage. Eligible members must be at or below one hundred eighty-five percent of the federal poverty level. Eligibility for this program is determined by DSHS, based on medicaid eligibility criteria.

"Medicaid" means the Title XIX medicaid program administered by the department of social and health services, and includes the medical care programs provided to the "categorically needy" and the "medically needy" as defined in chapter 388-503 WAC.

"Medicare" means programs established by Title XVIII of Public Law 89-97, as amended, "Health Insurance for the Aged and Disabled."

"Nonparticipating provider" means a person, health care provider, practitioner, facility, or entity, acting within their scope of practice, that does not have a written contract to participate in a managed health care system's provider network, but provides health care services to enrollees of programs authorized under this chapter whose health care services are provided by the managed health care system.

"Open enrollment" means a time period designated by the administrator during which enrollees may enroll additional dependents or apply to transfer their enrollment from one managed health care system to another.

"Participating employee" means an employee of a participating employer or home care agency who has met all the eligibility requirements and has been enrolled for coverage.

"Participating employer" means an employer who has been approved for enrollment as an employer group.

"Participating provider" means a person, health care provider, practitioner, facility, or entity, acting within their scope of practice, that has a written contract to participate in a managed health care system's provider network.

"Preexisting condition" means any illness, injury or condition for which, in the six months immediately preceding an enrollee's effective date of enrollment:

(a) Treatment, consultation or a diagnostic test was recommended for or received by the enrollee; or

(b) Medication was prescribed or recommended for the enrollee;  
or

(c) Symptoms existed which would ordinarily cause a reasonably prudent individual to seek medical diagnosis, care or treatment.

"Premium" means a periodic payment, determined under RCW 70.47.060(2), which an individual, an employer, a financial sponsor, or other entity makes for enrollment in BHP or WHP.

"Program" means BHP, WHP, BHP Plus, maternity benefits through medical assistance, or other such category of enrollment specified within chapters 182-22 through 182-24 WAC.

"Provider" or "health care provider" means a health care professional or institution duly licensed and accredited to provide covered services in the state of Washington.

"Rate" means the amount, including administrative charges and any applicable premium and prepayment tax imposed under RCW 48.14.0201, negotiated by the administrator with and paid to a managed health care system, to provide BHP or WHP health care benefits to enrollees.

"Schedule of benefits" means the health care services adopted and from time to time amended by the administrator for BHP or WHP, as applicable, which an enrollee shall be entitled to receive from a managed health care system in exchange for payment of premium and applicable copayments, as described in the member handbook.

"Service area" means the geographic area served by a managed health care system as defined in its contract with HCA.

"Subscriber" is a person who applies for coverage on his/her own behalf or on behalf of his/her dependents, if any, who is responsible for payment of premiums and to whom the administrator

sends notices and communications. The subscriber may be an enrollee or the spouse, parent, or guardian of an enrolled dependent and may or may not be enrolled for coverage. Notices to a subscriber and, if applicable, a financial sponsor or employer shall be considered notice to the subscriber and his/her enrolled dependents.

"Washington health program" means the system of enrollment and payment for nonsubsidized basic health care services administered by the HCA through managed health care systems.

"Washington state resident" or "resident" means a person who physically resides and maintains a residence in the state of Washington.

(a) To be considered a Washington resident, enrollees who are temporarily out of Washington state for any reason:

(i) May be required to demonstrate their intent to return to Washington state; and

(ii) May not be out of Washington state for more than three consecutive calendar months.

(b) Dependent children who are attending school out-of-state may be considered to be residents if they are out-of-state during the school year, provided their primary residence is in Washington state and they return to Washington state during holidays and scheduled breaks. Dependent children attending school out-of-state may also be required to provide proof that they pay out-of-state tuition at an accredited secondary school, college, university, technical college, or school of nursing, vote in Washington state and file their federal income taxes using a Washington state address.

(c) "Residence" may include, but is not limited to:

(i) A home the person owns or is purchasing or renting;

(ii) A shelter or other physical location where the person is staying in lieu of a home; or

(iii) Another person's home.

AMENDATORY SECTION (Amending Order 10-03, filed 11/30/10, effective 12/31/10)

**WAC 182-22-330 How to appeal a managed health care system (MHCS) decision nonsubsidized enrollees.**

(1) Nonsubsidized enrollees who are appealing an MHCS decision, including decisions related to coverage disputes; denial of claims; benefits interpretation; or resolution of complaints must follow their MHCS's complaint/appeals process.

(2) Each MHCS must maintain a complaint/appeals process for enrollees and must provide enrollees with instructions for filing a complaint and/or appeal. This complaint/appeals process must comply with the requirements of chapters 48.43 RCW and 284-43 WAC.

(3) On the request of the enrollee, the HCA may assist an

enrollee by:

- (a) Attempting to informally resolve complaints against the enrollee's MHCS;
- (b) Investigating and resolving MHCS contractual issues; and
- (c) Providing information and assistance to facilitate review of the decision by an independent review organization.

NEW SECTION

**WAC 182-22-340 How to appeal a managed health care system (MHCS) decision--Subsidized enrollees and federal Health Coverage Tax Credit enrollees.** (1) Subsidized enrollees or federal Health Coverage Tax Credit enrollees who are appealing an MHCS decision, including decisions related to coverage disputes; denial of claims; benefits interpretation; or resolution of complaints; may voice a grievance or appeal an action by an MHCS to the MHCS either orally or in writing. For the purposes of this section "managed care organization" (MCO) has the same meaning as "managed health care system" (MHCS).

(2) Each MHCS must maintain a complaint/appeals process for enrollees and must provide enrollees with instructions for filing a complaint and/or appeal. This complaint/appeals process must comply with the requirements of chapters 48.43 RCW and 284-43 WAC.

(3) On the request of the enrollee, the HCA may assist an enrollee by:

- (a) Attempting to informally resolve complaints against the enrollee's MHCS;
- (b) Investigating and resolving MHCS contractual issues; and
- (c) Providing information and assistance to facilitate review of the decision by an independent review organization.

(4) MHCSs must maintain records of subsidized enrollees' grievances and appeals and must review the information as part of the MHCS's quality strategy.

(5) MHCSs must provide information describing the MHCS's grievance system to all providers and subcontractors.

(6) Each MHCS must have a grievance system in place for subsidized 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 MHCS 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 (7) of this section for this process;

(b) An appeal process for an action, as defined in WAC 388-538-050. See subsection (8) of this section for the standard appeal process and subsection (9) of this section for the expedited

appeal process;

(c) Access to the HCA's hearing process for actions as defined in WAC 388-538-050. The HCA'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 HCA's hearing process for subsidized enrollees;

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

(e) Access to the board of appeals (BOA) for actions as defined in WAC 388-538-050.

(7) The MHCS grievance process:

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

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

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

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

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

(f) The MHCS 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 health care 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 MHCS must complete the disposition of a grievance and notice to the affected parties within ninety days of receiving the grievance.

(8) The MHCS appeal process:

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

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

(c) MHCSs must inform enrollees in writing within fifteen days of enrollment about enrollees' rights and how to use the MHCS's appeal process and the HCA's hearing process. The MHCSs must have HCA approval for all written information the MHCS 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 MHCS'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 MHCS mailing the notice of action. Otherwise, the time frames in (d) of this subsection apply.

(f) The MHCS'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 CFR 438.10(c) and (d);

(iii) Explain the action the MHCS 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 MHCS 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 (9) 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 (10) 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 MHCS 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 CFR 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 MHCS 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 MHCS must give enrollees any assistance necessary in taking procedural steps for an appeal (e.g., interpreter services and toll-free numbers).

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

(i) The MHCS 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 health care 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 (9) of this section 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 MHCS 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) MHCSs 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 MHCS 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 MHCS 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 MHCS receives the appeal.

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

(i) Be in writing. For notice of an expedited resolution, the MHCS must also make reasonable efforts to provide oral notice (also see subsection (9) 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 an HCA 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 (10) 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 MHCS's action (also see subsection (11) of this section).

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

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

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

(9) The MHCS expedited appeal process:

(a) Each MHCS must establish and maintain an expedited appeal review process for appeals when the MHCS 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 MHCS 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 MHCS 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 MHCS 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.

(10) Continuation of previously authorized services:

(a) The MHCS 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 CFR 431.213 and 431.214 are met, within ten calendar days of the MHCS 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 MHCS'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 MHCS 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 MHCS mails the notice of the resolution of the appeal and the enrollee has not requested an HCA hearing (with continuation of services until the HCA 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 MHCS's action, the MHCS 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.

(11) Effect of reversed resolutions of appeals:

(a) If the MHCS or OAH reverses a decision to deny, limit, or delay services that were not provided while the appeal was pending, the MHCS must authorize or provide the disputed services promptly, and as expeditiously as the enrollee's health condition requires.

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

AMENDATORY SECTION (Amending Order 10-03, filed 11/30/10, effective 12/31/10)

**WAC 182-22-450 MHCS duties.** (1) When an MHCS assists applicants in the enrollment process, it must provide them with the

toll-free number for BHP or WHP and information on all MHCS available within the applicant's county of residence and the estimated premiums for each available MHCS.

(2) An MHCS shall pay a nonparticipating provider no more than the lowest amount paid for that service under the MHCS's contracts with similar providers in the state.

(a) For services provided to plan enrollees on or after the effective date of this section, nonparticipating providers must accept as payment in full the amount paid by the managed health care system under RCW 70.47.100(2) in addition to any deductible, coinsurance, or copayment that is due from the enrollee under the terms and conditions set forth in the MHCS contract with the administrator.

(b) A plan enrollee is not liable to any nonparticipating provider for covered services, except for amounts due for any deductible, coinsurance, or copayment under the terms and conditions set forth in the managed health care system contract with the administrator.

(3) Pursuant to federal managed care access standards, 42 CFR Sec. 438, MHCS's must maintain a network of appropriate providers that is supported by written agreements sufficient to provide adequate access to all services covered under the contract with the authority, including hospital-based physician services.

AMENDATORY SECTION (Amending Order 10-03, filed 11/30/10, effective 12/31/10)

**WAC 182-24-010 Definitions.** The following definitions apply throughout this chapter.

"BHP enrollee," "subsidized enrollee," or "reduced premium enrollee" means: An individual who is not a full-time student who has received a temporary visa to study in the United States and who otherwise meets the criteria in (a), (b), or (c) of this subsection.

(a) An individual who enrolls in BHP, either as the subscriber or an eligible dependent, whose current gross family income does not exceed (~~twice~~) two hundred percent the federal poverty level as adjusted for family size and determined annually by the federal Department of Health and Human Services, (~~and~~) who receives a premium subsidy from the HCA, and who is transition eligible, as determined by the administrator in coordination with the Center for Medicaid Service, with countable income at or below one hundred thirty-three percent of the federal poverty level as adjusted for family size and determined annually by the federal Department of Health and Human Services.

(b) An individual who enrolls in BHP, either as the subscriber or an eligible dependent, and who is a foster parent licensed under chapter 74.15 RCW and whose current gross family income does not exceed three hundred percent of the federal poverty level as adjusted for family size and determined annually by the federal Department of Health and Human Services, and who receives a premium subsidy from the HCA.

(c) To the extent that state funds are specifically appropriated for this purpose, with a corresponding federal match, "subsidized enrollee" also means an individual who enrolls in BHP, either as the subscriber or an eligible dependent, whose current gross family income is more than two hundred percent, but less than two hundred fifty-one percent, of the federal poverty level as adjusted for family size and determined annually by the federal Department of Health and Human Services, and who receives a premium subsidy from the HCA.

"Subsidy" means the difference between the amount of periodic payment the HCA makes to a managed health care system on behalf of a subsidized enrollee, and the amount determined to be the subsidized enrollee's responsibility under RCW 70.47.060(2).

AMENDATORY SECTION (Amending Order 10-03, filed 11/30/10, effective 12/31/10)

**WAC 182-24-020 Eligibility.** (1) To be eligible for enrollment in BHP, unless otherwise specified elsewhere in this chapter, an individual must be a Washington state resident, age nineteen to sixty-four, who:

- (a) Is not eligible for free or purchased medicare;
- (b) Is not eligible for or receiving medical assistance from the department of social and health services (DSHS);
- (c) Is not enrolled in WHP;
- (d) Is not confined or residing in a government-operated institution, unless he or she meets eligibility criteria adopted by the administrator;
- (e) Is not a full-time student who has received a temporary visa to study in the United States;
- (f) Is a U.S. citizen; or a qualified alien who meets the eligibility requirements in Title 8 United States Code (USC), Chapter 14, Subchapter I, Section 1613, five-year limited eligibility of qualified aliens for federal means-tested public benefit;

(g) Resides in an area of the state served by a managed health care system participating in the plan;

~~((g))~~ (h) Chooses to obtain coverage from a particular managed health care system;

~~((h))~~ (i) Pays or has paid on their behalf their portion of the costs for participation in the plan; and

~~((i))~~ (j) Whose gross family income at the time of enrollment meets the definition of a subsidized enrollee.

(2) Persons not meeting these criteria, as evidenced by information submitted on the application for enrollment or otherwise obtained by BHP, will not be enrolled. An enrollee who is no longer a Washington resident or who is later determined to have failed to meet BHP's eligibility criteria at the time of enrollment, will be disenrolled.

(3) Eligibility for BHP Plus and maternity benefits through medical assistance is determined by DSHS, based on medicaid eligibility criteria.

(4)(a) An individual otherwise eligible for enrollment in BHP may be denied enrollment if the administrator has determined that acceptance of additional enrollment would exceed limits established by the legislature, would jeopardize the orderly development of BHP, or would result in an overexpenditure of BHP funds. An individual otherwise eligible for enrollment in BHP also may be denied enrollment if no managed health care system(s) is accepting new enrollment in that program or from the geographic area where the applicant lives.

(b) If the administrator closes or limits enrollment, to the extent funding is available, BHP will continue to accept and process applications for enrollment from:

(i) Children eligible for BHP, who were referred to DSHS for BHP Plus coverage, but were found ineligible for BHP Plus for reasons other than noncompliance;

(ii) Employees of a home care agency group enrolled or applying for coverage under WAC 182-22-220;

(iii) Eligible individual home care providers;

(iv) Licensed foster care workers;

(v) Persons who disenrolled from BHP in order to enroll in medicaid, and subsequently became ineligible for medicaid;

(vi) Limited enrollment of new employer groups;

(vii) Members of the Washington National Guard and Reserves who served in Operation Enduring Freedom, Operation Iraqi Freedom, or Operation Noble Eagle, and their spouses and dependents; and

(viii) Subject to availability of funding, additional space for enrollment may be reserved for other applicants as determined by the administrator, in order to ensure continuous coverage and service for current individual and group accounts. (For example: Within established guidelines, processing routine income changes that may affect subsidy eligibility for current enrollees; adding new family members to an existing account; transferring enrollees between group and individual accounts; restoring coverage for enrollees who are otherwise eligible for continued enrollment under WAC 182-24-070 (7)(b) after a limited suspension of coverage due to late payment or other health care coverage; adding newly hired employees to an existing employer group; or adding new or returning members of federally recognized Native American tribes to that tribe's currently approved financial sponsor group.)

(c) If the administrator has closed or limited enrollment, applicants for BHP who are not in any of the categories in (b) of this subsection may reserve space on a waiting list to be processed according to the date the waiting list request or application is received by BHP. When enrollment is reopened by the administrator, applicants whose names appear on the waiting list will be notified by BHP of the opportunity to enroll. BHP may require new application forms and documentation from applicants on the waiting list, or may contact applicants to verify continued interest in applying, before determining their eligibility.