PROPOSED RULE MAKING

CR-102 (December 2017)
(Implements RCW 34.05.320)
Do **NOT** use for expedited rule making

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FILED

DATE: February 13, 2019
TIME: 9:17 AM

WSR 19-05-032

Agency: Health Care Authority

☒ **Original Notice**

☐ **Supplemental Notice to WSR _____**

☐ **Continuance of WSR _____**

☒ **Preproposal Statement of Inquiry was filed as WSR** 18-09-111 **; or**

☐ **Expedited Rule Making--Proposed notice was filed as WSR _____; or**

☐ **Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1); or**

☐ **Proposal is exempt under RCW _____.**

Title of rule and other identifying information: (describe subject)
182-538-040 Introduction; 182-538-050 Definitions; 182-538-060 Managed care choice and assignment; 182-538-067 Qualifications to become a managed care organization (MCO); 182-538-070 Payments to managed care organizations (MCOs); 182-538-095 Scope of care for managed care enrollees; 182-538-110 The grievance and appeal system and agency administrative hearing for managed care enrollees; 182-538-120 Enrollee request for a second medical opinion; 182-538-130 Exemptions and ending enrollment in managed care; 182-538-140 Quality of care; 182-538-150 Apple health foster care program

Hearing location(s):

Date:	**Time:**	**Location:** (be specific)	**Comment:**
March 26, 2019	10:00 AM	Health Care Authority Cherry Street Plaza **Pear Conference Room #107** 626 8th Ave, Olympia WA 98504	Metered public parking is available street side around building. A map is available at: https://www.hca.wa.gov/assets/program/Driving-parking-checkin-instructions.pdf or directions can be obtained by calling: (360) 725-1000

Date of intended adoption: Not sooner than March 27, 2019 (Note: This is **NOT** the **effective** date)

Submit written comments to:
Name: HCA Rules Coordinator
Address: PO Box 42716, Olympia WA 98504-2716
Email: arc@hca.wa.gov
Fax: (360) 586-9727
Other:
By (date) March 22, 2019

Assistance for persons with disabilities:
Contact Amber Lougheed
Phone: (360) 725-1349
Fax: (360) 586-9727
TTY: (800) 848-5429 or 711
Email: amber.lougheed@hca.wa.gov
Other:
By (date) March 22, 2019

Purpose of the proposal and its anticipated effects, including any changes in existing rules: This rulemaking adds the dental managed care program to the managed care rules and lays out the requirements for participation in the program, including eligibility, enrollment, the grievance and appeals process, and covered benefits. As part of this change, the agency is including managed dental organizations (prepaid ambulatory health plans, known as PAHPs) into its regulatory framework.

The state currently provides dental services under the fee-for-service system, which limits access. The managed care program, which aligns with federal rules addressing guaranteed access to care, quality of care, and network adequacy, will improve access, especially for adults.

WAC 182-538-060 revises and clarifies enrollment requirements, adds dental service enrollment options for American Indian and Alaska native clients, and removes the option to submit enrollment forms by mail or facsimile.

WAC 182-538-110(3)(f) requires that an oral appeal is followed by a written, signed appeal to align with federal regulations.

In WAC 182-538-110(6)(b) and (c), the managed care organization (MCO) or PAHP must accept oral inquiries about appealing an adverse benefit. The agency removed the requirement that an acknowledgment letter services to confirm an oral appeal, as the federal regulations require standard appeals to be filed in writing.

The agency removed the right to hearing process in WAC 182-538-130(5)(c)(i)(B) because enrollees can use the managed care grievance system.

The agency removed 182-538-140(1)(k)(vi) to align with federal regulations and removed 182-538-140(1)(o), and (1)(p), as these provisions are already addressed in the MCO contracts. Subsection (2) of that rule requires MCOs to obtain and maintain accreditation.

WAC 182-538-150 added subsection (3)(b) to explain how the agency enrolls people eligible for the Apple Health Foster Care program into the managed care dental program.

Reasons supporting proposal: The agency is proposing these changes to comply with SSB 5883, Sec. 213(1)(c), 65th Legislature, 2017 Regular Session, which directed the agency to develop and implement this program.

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Statute being implemented: RCW 41.05.021, 41.05.160

Is rule necessary because of a:

Federal Law?	☐ Yes	☒ No
Federal Court Decision?	☐ Yes	☒ No
State Court Decision?	☐ Yes	☒ No

If yes, CITATION:

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters: N/A

Name of proponent: (person or organization) Health Care Authority

☐ Private
☐ Public
☒ Governmental

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting:	Melinda Froud	PO Box 42716, Olympia WA 98504-2716	360-725-1408
Implementation:	Rebecca Carrell	PO Box 45530, Olympia, WA 98504-5530	360-725-1226
Enforcement:	Rebecca Carrell	PO Box 45530, Olympia, WA 98504-5530	360-725-1226

Is a school district fiscal impact statement required under RCW 28A.305.135? ☐ Yes ☒ No

If yes, insert statement here:

The public may obtain a copy of the school district fiscal impact statement by contacting:
Name:
Address:

Phone:
Fax:
TTY:
Email:
Other:

Is a cost-benefit analysis required under RCW 34.05.328?

☐ Yes: A preliminary cost-benefit analysis may be obtained by contacting:

Name:
Address:
Phone:
Fax:
TTY:
Email:
Other:

☒ No: Please explain: RCW 34.05.328 does not apply to Health Care Authority rules unless requested by the Joint Administrative Rules Review Committee or applied voluntarily.

Regulatory Fairness Act Cost Considerations for a Small Business Economic Impact Statement:

This rule proposal, or portions of the proposal, **may be exempt** from requirements of the Regulatory Fairness Act (see chapter 19.85 RCW). Please check the box for any applicable exemption(s):

☐ This rule proposal, or portions of the proposal, is exempt under RCW 19.85.061 because this rule making is being adopted solely to conform and/or comply with federal statute or regulations. Please cite the specific federal statute or regulation this rule is being adopted to conform or comply with, and describe the consequences to the state if the rule is not adopted.

Citation and description:

☐ This rule proposal, or portions of the proposal, is exempt because the agency has completed the pilot rule process defined by RCW 34.05.313 before filing the notice of this proposed rule.

☐ This rule proposal, or portions of the proposal, is exempt under the provisions of RCW 15.65.570(2) because it was adopted by a referendum.

☐ This rule proposal, or portions of the proposal, is exempt under RCW 19.85.025(3). Check all that apply:

- ☐ RCW 34.05.310 (4)(b) (Internal government operations)
- ☐ RCW 34.05.310 (4)(c) (Incorporation by reference)
- ☐ RCW 34.05.310 (4)(d) (Correct or clarify language)
- ☐ RCW 34.05.310 (4)(e) (Dictated by statute)
- ☐ RCW 34.05.310 (4)(f) (Set or adjust fees)
- ☐ RCW 34.05.310 (4)(g) ((i) Relating to agency hearings; or (ii) process requirements for applying to an agency for a license or permit)

☐ This rule proposal, or portions of the proposal, is exempt under RCW _____.

Explanation of exemptions, if necessary:

COMPLETE THIS SECTION ONLY IF NO EXEMPTION APPLIES

If the proposed rule is **not exempt**, does it impose more-than-minor costs (as defined by RCW 19.85.020(2)) on businesses?

☒ No Briefly summarize the agency's analysis showing how costs were calculated. The proposed rules do not impose more than minor costs on small businesses.

☐ Yes Calculations show the rule proposal likely imposes more-than-minor cost to businesses, and a small business economic impact statement is required. Insert statement here:

The public may obtain a copy of the small business economic impact statement or the detailed cost calculations by contacting:

Name:
Address:
Phone:
Fax:

TTY:
Email:
Other:

Date: February 13, 2019	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

AMENDATORY SECTION (Amending WSR 17-23-199, filed 11/22/17, effective 12/23/17)

WAC 182-538-040 Introduction. This chapter governs services provided under the Washington apple health managed care contracts, including the managed dental care program.

If a conflict exists between the requirements of this chapter and other rules, the requirements of this chapter take precedence.

AMENDATORY SECTION (Amending WSR 17-23-199, filed 11/22/17, effective 12/23/17)

WAC 182-538-050 Definitions. The following definitions and abbreviations and those found in chapter 182-500 WAC, Medical definitions, apply to this chapter.

"Administrative hearing" means the agency's administrative hearing process available to an enrollee under chapter 182-526 WAC for review of an adverse benefit determination in accordance with RCW 74.09.741.

"Adverse benefit determination" means one or more of the following:

(a) The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of a covered benefit;

(b) The reduction, suspension, or termination of a previously authorized service;

(c) The denial, in whole or in part, of payment for a service;

(d) The failure to provide services in a timely manner, as defined by the state;

(e) The failure of a managed care organization (MCO) or prepaid ambulatory health plan (PAHP) to act within the time frames provided in 42 C.F.R. Sec. 438.408 (a), (b)(1) and (2) for standard resolution of grievances and appeals; or

(f) For a resident of a rural area with only one MCO or PAHP, the denial of an enrollee's request to exercise the enrollee's right to obtain services outside the network under 42 C.F.R. Sec. 438.52 (b)(2)(ii).

"Agency" - See WAC 182-500-0010.

"Appeal" means a review by an MCO or PAHP of an adverse benefit determination.

"Apple health foster care (AHFC)" means the managed care program developed by the agency and the department of social and health services to serve children and youth in foster care and adoption support and young adult alumni of the foster care program.

"Assign" or **"assignment"** means the agency selects an MCO or PAHP to serve a client who has not selected an MCO or PAHP.

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

"Client" means, for the purposes of this chapter, a person eligible for any Washington apple health program, including managed care programs, but who is not enrolled with an MCO, PAHP, or PCCM provider.

"Disenrollment" - See "end enrollment."

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

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

"End enrollment" means ending the enrollment of an enrollee for one of the reasons outlined in WAC 182-538-130.

"Enrollee" means a person eligible for any Washington apple health program enrolled in managed care with an MCO, PAHP, or PCCM provider that has a contract with the state.

"Enrollee's representative" means a person 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:

(a) Have a biologic, psychologic, or cognitive basis;

(b) Have lasted or are virtually certain to last for at least one year; and

(c) Produce one or more of the following conditions stemming from a disease:

(i) Significant limitation in areas of physical, cognitive, or emotional function;

(ii) Dependency on medical or assistive devices to minimize limitation of function or activities; or

(iii) In addition, for children, any of the following:

(A) Significant limitation in social growth or developmental function;

(B) Need for psychological, educational, medical, or related services over and above the usual for the child's age; or

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

"Exemption" means agency approval of a client's preenrollment request to remain in the fee-for-service delivery system for one of the reasons outlined in WAC 182-538-130.

"Grievance" means an expression of dissatisfaction about any matter other than an adverse benefit determination.

"Grievance and appeal system" means the processes the MCO or PAHP implements to handle appeals of adverse benefit determinations and grievances, as well as the processes to collect and track information about them.

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

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

"Managed care contract" means the agreement between the agency and an MCO or PAHP 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 agency under a comprehensive risk contract to provide prepaid health care services to enrollees under the agency's managed care programs.

"Mandatory enrollment" means the agency'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 or PAHP.

"Nonparticipating provider" means a person, health care provider, practitioner, facility, or entity acting within their scope of practice and licensure that:

(a) Provides health care services to enrollees; and

(b) Does not have a written agreement with the managed care organization (MCO) or prepaid ambulatory health plan (PAHP) to participate in the MCO's or PAHP's provider network.

"Participating provider" means a person, health care provider, practitioner, or entity acting within their scope of practice and licensure with a written agreement with ((~~the~~)) an MCO or PAHP to provide services to enrollees.

"Prepaid ambulatory health plan" or **"PAHP"** means an organization with a certificate of authority or a certificate of registration from the office of the insurance commissioner. These organizations contract with the agency to provide prepaid health care services to enrollees under the agency's managed care programs. PAHPs do not have a comprehensive risk contract and are not responsible for inpatient hospital or institutional services for its enrollees.

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

Primary care case management entity" means an organization that, in addition to providing primary care case management (PCCM) services under contract with the agency, provides any of the following functions:

(a) Provision of intensive telephonic or face-to-face case management, including operation of a nurse triage advice line;

(b) Development of enrollee care plans;

(c) Execution of contracts with and/or oversight responsibilities for the activities of fee-for-service (FFS) providers in the FFS program;

(d) Provision of payments to FFS providers on behalf of the agency;

(e) Provision of enrollee outreach and education activities;

(f) Operation of a customer service call center;

(g) Review of provider claims, utilization and practice patterns to conduct provider profiling and practice improvement;

(h) Implementation of quality improvement activities including administering enrollee satisfaction surveys or collecting data necessary for performance measurement of providers;

(i) Coordination with behavioral health systems/providers; and

(j) Coordination with long-term services and supports systems/providers.

In Washington, only Indian health care providers (IHCPs) can act as PCCM entities.

"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), naturopath, 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.

"Primary dental provider" means a participating provider who has responsibility for supervising, coordinating, and providing primary

dental care to enrollees, initiating referrals for specialist care, and maintaining the continuity of enrollee care.

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

AMENDATORY SECTION (Amending WSR 15-24-098, filed 12/1/15, effective 1/1/16)

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

(a) Is eligible for ((~~one of the~~)) any Washington apple health managed care program((~~s~~)) 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 agency has not ended the client's managed care enrollment, consistent with WAC 182-538-130.

(2) American Indian and Alaska native (AI/AN) clients and their descendants may choose enrollment with one of the following for physical and behavioral health services:

(a) ((~~Enrollment with~~)) A managed care organization (MCO) available in their area;

(b) ((~~Enrollment with~~)) A PCCM provider through a tribal clinic or urban Indian center available in their area; or

(c) The agency's fee-for-service system.

(3) AI or AN clients and their descendants may choose enrollment with one of the following for dental services:

(a) A prepaid ambulatory health plan (PAHP); or

(b) The agency's fee-for-service system.

(4) To enroll with an MCO or PCCM provider, a client may:

(a) Enroll online via the Washington Healthplanfinder at https://www.wahealthplanfinder.org;

(b) Call the agency's toll-free enrollment line at 800-562-3022; or

(c) Go to the ProviderOne client portal at https://www.waproviderone.org/client and follow the instructions((~~:~~

~~(d) Mail a postage-paid completed managed care enrollment form (HCA 13-862) to the agency's unit responsible for managed care enrollment; or~~

~~(e) Fax the managed care enrollment form (HCA 13-862) to the agency at the number located on the enrollment form.~~

~~(4)~~)).

(5) A client must enroll with an MCO or PAHP available in the area where the client resides.

((~~(5)~~)) (6) All family members will be enrolled with the same MCO or PAHP, except family members of an enrollee placed in the patient review and coordination (PRC) program under WAC 182-501-0135 need not enroll in the same MCO or PAHP as the family member placed in the PRC program.

((~~(6)~~)) (7) A client may be placed into the PRC program by the client's MCO, PAHP, or the agency. The client placed in the PRC program must follow the enrollment requirements in WAC 182-501-0135.

((~~(7)~~)) (8) When a client requests enrollment with an MCO, PAHP, or PCCM provider, the agency enrolls a client effective the earliest possible date given the requirements of the agency's enrollment system.

((~~(8)~~)) (9) The agency assigns a client who does not choose an MCO or PAHP as follows:

(a) If the client was enrolled with an MCO, PAHP, or PCCM provider within the previous six months, the client is reenrolled with the same MCO, PAHP, or PCCM;

(b) If (a) of this subsection does not apply and the client has a family member enrolled with an MCO or PAHP, the client is enrolled with that MCO;

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

(i) If a client who is not AI or AN does not choose an MCO or PAHP, the agency assigns the client to ((~~an MCO~~)) a health plan available in the area where the client resides. The ((~~MCO~~)) health plan is responsible for primary care provider (PCP) or primary dental provider choice and assignment.

(ii) For clients who are newly eligible or who have had a break in eligibility of more than six months, the agency sends a written notice to each household of one or more clients who are assigned to an MCO or PAHP. The assigned client has ten calendar days to contact the agency to change the MCO or PAHP assignment before enrollment is effective. The notice includes:

(A) The agency's toll-free number;

(B) The toll-free number and name of the MCO or PAHP to which each client has been assigned;

(C) The effective date of enrollment; and

(D) The date by which the client must respond in order to change the assignment.

(iii) If the client has a break in eligibility of less than six months, the client will be automatically reenrolled with ((~~his or her~~)) the client's previous MCO or PAHP and no notice will be sent.

((~~(9)~~)) (10) Upon request, the agency ((~~will~~)) assists clients in identifying an MCO or PAHP with which their provider participates.

((~~(10) An MCO~~)) (11) An enrollee's selection of a ((~~PCP~~)) primary provider or assignment to a ((~~PCP~~)) primary provider occurs as follows:

(a) An ((~~MCO~~)) enrollee may choose:

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

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

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

(c) An ((~~MCO~~)) enrollee may change ((~~PCPs~~)) primary providers 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~~)) health plan if the ((~~MCO~~)) health plan does not approve an enrollee's request to change ((~~PCPs~~)) primary providers or clinics.

(e) ((~~MCO~~)) Enrollees required to participate in the agency's PRC program may be limited in their right to change ((~~PCPs~~)) primary providers (see WAC 182-501-0135).

(12) To enroll with a PAHP:

(a) Call the agency's toll-free enrollment line at 800-562-3022; or

(b) Go to the ProviderOne client portal at https://www.waproviderone.org/client and follow the instructions.

AMENDATORY SECTION (Amending WSR 15-24-098, filed 12/1/15, effective 1/1/16)

WAC 182-538-067 Qualifications to become a managed care organization (MCO) or prepaid ambulatory health plan (PAHP). (1) A managed care organization (MCO) or prepaid ambulatory health plan (PAHP) must meet the following qualifications to be eligible to contract with the medicaid agency:

(a) Have a certificate of registration from the Washington state office of the insurance commissioner (OIC) that allows the MCO or PAHP to provide health care services under a risk-based contract;

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

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

(d) Pass a readiness review, including an on-site visit conducted by the agency.

(2) At its discretion, the agency awards a contract to an MCO or PAHP through a competitive process or an application process available to all qualified providers.

(3) The agency reserves the right not to contract with any otherwise qualified MCO or PAHP.

AMENDATORY SECTION (Amending WSR 18-08-035, filed 3/27/18, effective 4/27/18)

WAC 182-538-070 Payments to managed care organizations (MCOs) or prepaid ambulatory health plans (PAHPs). (1) The medicaid agency pays apple health managed care organizations (MCOs) or prepaid ambulatory health plans (PAHPs) monthly capitated premiums that:

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

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

(c) Have been certified by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board;

(d) Are based on analysis of historical cost, rate information, or both; and

(e) Are paid based on legislative allocations.

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

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

(4) The agency 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.

AMENDATORY SECTION (Amending WSR 15-24-098, filed 12/1/15, effective 1/1/16)

WAC 182-538-095 Scope of care for managed care enrollees. (1) A managed care enrollee is eligible for the scope of services in WAC 182-501-0060 for categorically needy clients.

(a) The managed care organization (MCO) or prepaid ambulatory health plan (PAHP) covers the services included in the contract for its enrollees.

(i) MCOs or PAHPs may, at their discretion, cover services not required under the ((~~MCO contract~~)) MCO's or PAHP's contract with the agency.

(ii) The agency cannot require the MCO or PAHP to cover any services outside the scope of services in the MCO's or PAHP's contract with the agency.

(b) The agency covers services identified as covered for categorically needy clients in WAC 182-501-0060 and described in WAC 182-501-0065 that are excluded from coverage in the ((~~MCO~~)) managed care contract.

(2) The following services are not covered by the MCO or PAHP:

(a) Services that are not medically necessary as defined in WAC 182-500-0070.

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

(c) Services received in a hospital emergency department for nonemergency medical conditions, except for a screening exam as described in WAC 182-538-100.

(d) Services received from a participating provider that require prior authorization from the MCO or PAHP, but were not authorized by the MCO or PAHP.

(e) All nonemergency services covered under the ((~~MCO~~)) managed care contract and received from nonparticipating providers that were not prior authorized by the MCO or PAHP.

(3) A provider may bill an enrollee for noncovered services as described in subsection (2) of this section, if the requirements of WAC 182-502-0160 are met.

(4) For services covered by the agency through contracts with MCOs or PAHPs:

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

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

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

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

(e) The agency requires the MCO or PAHP 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 health care services, as described in RCW 48.42.100, from any women's health care provider participating with the MCO. Any covered services ordered or prescribed by a women's health care provider must meet the MCO's service authorization requirements for the specific service;

(g) For enrollees outside their MCO or PAHP service((~~s~~)) areas, the MCO or PAHP must cover enrollees for emergency care and medically necessary covered benefits that cannot wait until the enrollees return to their MCO or PAHP service((~~s~~)) areas.

(5)(a) ((~~An MCO~~)) A managed care enrollee may obtain specific services described in the managed care contract from either an MCO- or PAHP-contracted provider or a provider with a separate agreement with the agency without a referral from the PCP or MCO or PAHP. These services are communicated to enrollees by the agency and MCOs or PAHPs as described in (b) of this subsection.

(b) The agency ((~~sends~~)) provides each ((~~enrollee~~)) client written information about covered services when the client must enroll in managed care and any time there is a change in covered services. The agency requires MCOs or PAHPs to provide new enrollees with ((~~written~~)) information about covered services and how to access them.

(6) An enrollee is entitled to timely access to covered services that are medically necessary as defined in WAC 182-500-0070.

(7) All nonemergency services covered under the ((~~MCO~~)) managed care contract and received from nonparticipating providers require prior authorization from the MCO or PAHP.

AMENDATORY SECTION (Amending WSR 17-23-199, filed 11/22/17, effective 12/23/17)

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

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

(a) Each managed care organization (MCO) or prepaid ambulatory health plan (PAHP) must have a grievance and appeal system in place for enrollees.

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

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

(a) The MCO and PAHP grievance and appeal systems must include:

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

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

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

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

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

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

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

(f) An MCO or PAHP must allow enrollees and their authorized representatives to file grievances and appeals orally as well as in writing including, but not limited to, U.S. mail, commercial delivery services, hand delivery, fax, and email. ((~~MCOs may not require enrollees to provide written follow-up for a grievance or an appeal the MCO received orally.~~)) An oral appeal must be followed by a written, signed, appeal unless an expedited resolution is requested.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) For termination, suspension, or reduction of previously authorized services, at least ten calendar days prior to the effective

date of the adverse benefit determination in accordance with 42 C.F.R. Sec. 438.404 and 431.211. This time period does not apply if the criteria in 42 C.F.R. Sec. 431.213 or 431.214 are met. This notice must be mailed by a method that certifies receipt and assures delivery within three calendar days.

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

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

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

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

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

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

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

(v) For expedited authorization decisions:

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

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

(I) The enrollee requests the extension; or

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

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

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

(b) **Oral appeals.** An MCO or PAHP must ((~~treat~~)) accept oral inquiries about appealing an adverse benefit determination ((~~as an appeal to establish the earliest possible filing date for the appeal. The oral appeal must be confirmed in writing by the MCO, unless the enrollee or provider requests an expedited resolution~~)).

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

(d) **((~~Standard service authorization~~)) Timeline to file appeal - Sixty-day deadline.** ((~~For appeals involving standard service authori-~~

~~zation decisions,~~)) An enrollee must file an appeal within sixty calendar days of the date on the MCO's or PAHP's notice of adverse benefit determination. This time frame also applies to a request for an expedited appeal.

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

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

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

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

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

(iii) Include as parties to the appeal:

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

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

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

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

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

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

(A) The enrollee requests the extension; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) The enrollee requests the extension; or

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

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

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

(i) The enrollee requests the extension; or

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

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

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

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

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

(iii) Provide written notice within two calendar days.

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

(8) **The right to an agency administrative hearing for managed care organization (MCO) or prepaid ambulatory health plan (PAHP) enrollees.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) The enrollee withdraws the MCO or PAHP appeal;

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

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

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

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

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

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

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

AMENDATORY SECTION (Amending WSR 13-02-010, filed 12/19/12, effective 2/1/13)

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 prepaid ambulatory health plan (PAHP); or

(b) The enrollee believes the MCO or PAHP 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 or PAHP'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 agency.

AMENDATORY SECTION (Amending WSR 16-23-021, filed 11/4/16, effective 1/1/17)

WAC 182-538-130 Exemptions and ending enrollment in managed care. (1) The agency approves a request to exempt a client from enrollment or to end enrollment from mandatory managed care when any of the following apply:

(a) The client or enrollee is eligible for medicare;

(b) The client or enrollee is not eligible for managed care enrollment, for Washington apple health programs, or both; or

(c) A request for exemption or to end enrollment is received and approved by the agency as described in this section.

(i) If a client requests exemption within the notice period stated in WAC 182-538-060, the client is not enrolled until the agency approves or denies the request.

(ii) If an enrollee request to end enrollment is received after the enrollment effective date, the enrollee remains enrolled pending the agency's decision, unless continued enrollment creates loss of access to providers for medically necessary care.

(2)(a) The following people may request the agency to approve an exemption or end enrollment in managed care:

(i) A client or enrollee;

(ii) A client or enrollee's authorized representative under WAC 182-503-0130; or

(iii) A client or enrollee's representative as defined in RCW 7.70.065.

(b) The agency grants a request to exempt or to end enrollment in managed care when the client or enrollee:

(i) Is American Indian or Alaska native;

(ii) Lives in an area or is enrolled in a Washington apple health program in which participation in managed care is voluntary; or

(iii) Requires care that meets the criteria in subsection (3) of this section for case-by-case clinical exemptions or to end enrollment in the MCO or PAHP program.

(3) Case-by-case clinical criteria to authorize an exemption or to end enrollment.

(a) The agency may approve a request for exemption or to end enrollment when the following criteria are met:

(i) The care must be medically necessary;

(ii) That medically necessary care is covered under the agency's managed care contracts;

(iii) The client is receiving the medically necessary care from an established provider or providers who are not available through any contracted MCO or PAHP, as applicable to the request; and

(iv) It is medically necessary to continue that care from the established provider or providers.

(b) When the agency approves a request for exemption or to end enrollment, the agency will notify the client or enrollee of its decision by telephone or in writing. If the agency approves the request for a limited time, the client or enrollee is notified of the time limitation and the process for renewing the exemption.

(c) When the agency denies a request for exemption or to end enrollment, the agency will notify the client or enrollee of its decision by telephone or in writing and confirms a telephone notification in writing. When a client or enrollee is limited-English proficient, the written notice must be available in the client's or enrollee's

primary language under 42 C.F.R. 438.10. The written notice must contain all the following information:

(i) The agency's decision;

(ii) The reason for the decision;

(iii) The specific rule or regulation supporting the decision; and

(iv) The right to request an agency administrative hearing.

(4) If a client or enrollee does not agree with the agency's decision regarding a request for exemption or to end enrollment, the client or enrollee may file a request for an agency administrative hearing based on RCW 74.09.741, the rules in this chapter, and the agency hearing rules in chapter 182-526 WAC.

(5) The agency will grant a request from an MCO or PAHP to end enrollment of an enrollee on a case-by-case basis when the request is submitted to the agency in writing and includes sufficient documentation for the agency to determine that the criteria to end enrollment in this subsection is met, except for enrollees described in (c) of this subsection.

(a) All of the following criteria must be met to end enrollment:

(i) The enrollee puts the safety or property of the contractor or the contractor's staff, providers, patients, or visitors at risk and the enrollee's conduct presents the threat of imminent harm to others((~~, except for enrollees described in (c) of this subsection~~));

(ii) A clinically appropriate evaluation was conducted to determine whether there was a treatable problem contributing to the enrollee's behavior and there was not a treatable problem or the enrollee refused to participate;

(iii) The enrollee's health care needs have been coordinated as contractually required and the safety concerns cannot be addressed; and

(iv) The enrollee has received written notice from the MCO or PAHP of its intent to request to end enrollment of the enrollee, unless the requirement for notification has been waived by the agency because the enrollee's conduct presents the threat of imminent harm to others. The ((~~MCO's~~)) notice to the enrollee includes the enrollee's right to use the ((~~MCO's~~)) managed care grievance process to review the request to end enrollment.

(b) The agency will not approve a request to end enrollment when the request is solely due to any of the following:

(i) An adverse change in the enrollee's health status;

(ii) The cost of meeting the enrollee's health care needs or because of the enrollee's utilization of services;

(iii) The enrollee's diminished mental capacity; or

(iv) Uncooperative or disruptive behavior resulting from the enrollee's special needs or behavioral health condition, except when continued enrollment in the MCO or ((~~PCCM~~)) PAHP seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees.

(c) When the agency receives a request from an MCO or PAHP to end enrollment of an enrollee that does not meet the criteria described in (a) of this subsection, the agency reviews each request on a case-by-case basis. The agency will respond to the MCO or PAHP in writing with the decision. If the agency grants the request to end enrollment:

(i) The MCO or PAHP will notify the enrollee in writing of the decision. The notice must include((~~:~~

~~(A)~~)) the enrollee's right to use the ((~~MCO's~~)) managed care grievance system as described in WAC 182-538-110((~~; and~~

~~(B) The enrollee's right to use the agency's hearing process (see WAC 182-526-0200 for the hearing process for enrollees)~~)).

(ii) The agency will send a written notice to the enrollee at least ten calendar days in advance of the effective date that enrollment will end. The notice to the enrollee includes the information in subsection (3)(c) of this section.

(d) The MCO or PAHP will continue to provide services to the enrollee until the date the individual is no longer enrolled.

(6) The agency may exempt the client for the period of time the circumstances or conditions described in this section are expected to exist. The agency may periodically review those circumstances or conditions to determine if they continue to exist. Any authorized exemption will continue only until the client can be enrolled in managed care.

AMENDATORY SECTION (Amending WSR 17-23-199, filed 11/22/17, effective 12/23/17)

WAC 182-538-140 Quality of care. (1) To assure that managed care enrollees receive quality health care services, the agency requires managed care organizations (MCOs) and prepaid ambulatory health plan (PAHP) to comply with quality improvement standards detailed in the agency's managed care contract. MCOs and PAHPs 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 underutilization of services;

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

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

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

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

(ii) Evaluation of the entity before delegation;

(iii) An annual evaluation of the entity; and

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

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

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

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

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

(j) Maintain a health information system that:

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

(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 agency;

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

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

(v) 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~~)) health outcomes and ((~~services~~)) enrollee satisfaction, and that involve the following:

(i) Measuring performance using objective quality indicators;

(ii) Implementing ((~~system changes~~)) interventions to achieve improvement in ((~~service quality~~)) the access to and quality of care;

(iii) Evaluating the effectiveness of ((~~system changes~~)) the interventions based on the performance measures;

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

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

(m) Ensure continuity and coordination of enrollee care;

(n) Maintain and monitor availability of health care services for enrollees; and

(o) ((~~Perform client satisfaction surveys; and~~

~~(p)~~)) Obtain and maintain national committee on quality assurance (NCQA) accreditation.

(2) MCOs must also obtain and maintain national committee on quality assurance (NCQA) accreditation.

(3) The agency may:

(a) Impose intermediate sanctions under 42 C.F.R. Sec. 438.700 and corrective action for substandard rates of clinical performance measures and for deficiencies found in audits and on-site visits;

(b) Require corrective action for findings for noncompliance with any contractual state or federal requirements; and

(c) Impose sanctions for noncompliance with any contractual, state, or federal requirements not corrected.

AMENDATORY SECTION (Amending WSR 16-23-021, filed 11/4/16, effective 1/1/17)

WAC 182-538-150 Apple health foster care program. (1) Unless otherwise stated in this section, all of the provisions of chapter 182-538 WAC apply to apple health foster care (AHFC).

(2) The following sections of chapter 182-538 WAC do not apply to AHFC:

(a) WAC 182-538-068;

(b) WAC 182-538-071;

(c) WAC 182-538-096; and

(d) WAC 182-538-111.

(3)(a) Enrollment in AHFC is voluntary for eligible individuals. The agency will enroll eligible individuals in the single MCO that serves children and youth in foster care and adoption support, and young adult alumni of the foster care system.

(b) The agency enrolls individuals eligible for the AHFC program into the managed dental care program under the same enrollment and assignment methodology as used for other eligible individuals, with the exception of those individuals with third-party liability. Enrollment in the managed dental care program is voluntary for AHFC-eligible clients.

(c) An AHFC enrollee may request to end enrollment in AHFC without cause if the client is in the adoption support or young adult alumni programs. WAC 182-538-130 does not apply to these requests.

(4) In addition to the scope of medical care services in WAC 182-538-095, AHFC coordinates health care services for enrollees with the ((~~department of social and health services~~)) community mental health system and other health care systems as needed.

(5) The agency ((~~sends~~)) provides written information about covered services when the individual becomes eligible to enroll in AHFC and at any time there is a change in covered services. In addition, the agency requires MCOs or PAHPs to provide new enrollees with written information about:

(a) Covered services;

(b) The right to grievances and appeals through the MCO or PAHP; and

(c) Hearings through the agency.