RULE-MAKING ORDER
PERMANENT RULE ONLY

CR-103P (December 2017)
(Implements RCW 34.05.360)

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STATE OF WASHINGTON
FILED

DATE: November 27, 2019
TIME: 11:27 AM

WSR 19-24-063

Agency: Health Care Authority

Effective date of rule:

Permanent Rules

☐ 31 days after filing.

☒ Other (specify) January 1, 2020 **(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: This rulemaking is required to comply with the requirements in 2ESHB 1388 which changed the designation of the state Behavioral Health Authority from the Department of Social and Health Services to the Health Care Authority, effective July 1, 2018. These rules currently operate under emergency filing WSR 19-13-057.

This rulemaking is also required to implement Engrossed Second Substitute Senate Bill 5432 which directs the agency to fully implement behavioral health integration for January 1, 2020, by: 1) removing behavioral health organizations from law; 2) clarifying the roles and responsibilities among the Health Care Authority, the Department of Social and Health Services, and the Department of Health; and 3) clarifying the roles and responsibilities of behavioral health administrative services organizations and the Medicaid managed care organizations; and 4) making technical corrections related to the behavioral health system.

This rulemaking is also needed to implement Second Substitute Senate Bill 6312 concerning state purchasing of mental health and chemical dependency treatment services and the full integration of medical and behavioral health services by January 1, 2020.

Citation of rules affected by this order:

New:

182-538-170 Notice requirements
182-538-180 Rights and protections
182-538-190 Behavioral health services only (BHSO)
182-538C-252 Behavioral Health Administrative services Organizations – Advisory board membership
Chapter 182-100 WAC Problem Gambling
Chapter 182-538D WAC Behavioral Health Services

Repealed:

182-538A-040 Washington apple health fully integrated managed care
182-538A-050 Definitions
182-538A-060 Fully integrated managed care and choice
182-538A-067 Qualifications to become a managed care organization (MCO) in fully integrated managed care (FIMC) regional service areas
182-538A-068 Qualifications to become a primary care case management (PCCM) provider in fully integrated managed care (FIMC) regional service areas
182-538A-070 Payments to managed care organizations (MCOs) in fully integrated managed care (FIMC) regional service areas)
182-538A-071 Payments to primary care case management (PCCM) providers in fully integrated managed care (FIMC) regional service areas
182-538A-095 Scope of care for fully integrated managed care (FIMC) and behavioral health services only (BHSO) enrollees
182-538A-100 Managed care emergency services for fully integrated managed care (FIMC) and enrollees
182-538A-110 The grievance and appeal system, and agency administrative hearing for fully integrated managed care (FIMC) managed care organization (MCO) enrollees
182-538A-111 The administrative hearing process for primary care case management (PCCM) enrollees in FIMC regional service areas,
182-538A-120 Fully integrated managed care (FIMC) enrollee request for a second medical opinion

182-538A-130 Exemptions and ending enrollment in fully integrated managed care (FIMC)
182-538A-140 Fully integrated managed care (FIMC) quality of care
182-538A-150 Apple health foster care program in fully integrated managed care regional service areas
182-538A-170 Notice requirements
182-538A-180 Rights and protections
182-538A-190 Behavioral health services only (BHSO)

Amended:
182-538-040 Introduction
182-538-050 Definitions
182-538-060 Managed care choice and assignment
182-538-067 Qualification to become a managed care organization (MCO)
182-538-068 Qualifications to become a primary care case management (PCCM) provider
182-538-070 Payments to managed care organization (MCOs)
182-538-071 Payments for primary care case management (PCCM) providers
182-538-095 Scope of care for managed care enrollees
182-538-096 Scope of service for PCCM enrollees
182-538-100 Managed care emergency services
182-538-110 The grievance and appeal system and agency administrative hearing for managed care organization (MCO) enrollees
182-538-111 The administrative hearing process for primary care case management (PCCM)
182-538-130 Exemptions and ending enrollment in managed care
182-538-140 Quality of care
182-538-150 Apple health foster care program
Chapter 182-538B WAC Behavioral Health Wraparound Services
182-538C-040 Behavioral Health Services
182-538C-050 Definitions
182-538C-070 Payment
182-538C-110 Grievance and appeal system and agency administrative hearing for behavioral health administrative services organizations (BH-ASOs),
182-538C-220 Covered crisis mental health services
182-538C-230 Covered substance use disorder detoxification services

Suspended: N/A

Statutory authority for adoption: RCW 41.05.021, 41.05.160, Engrossed Second Substitute Senate Bill 5432, 66th Legislature, 2019 Regular Session; Second Substitute Senate Bill 6312, 63rd Legislature, 2104 Regular Session, 2ESBH 1388 (Chapter 201, Laws of 2018)

Other authority: N/A

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 19-20-125 on October 2, 2019 (date).

Describe any changes other than editing from proposed to adopted version:

Proposed/Adopted	WAC Subsection	Reason
WAC 182-538-070 Payments		
Proposed	(5) The MCO pays a reimbursement for each patient day of care that exceeds the MCO daily allocation of state hospital beds based on a quarterly calculation of the bed usage. (a) The agency bills the MCO quarterly for state hospital patient days of care exceeding the MCO daily allocation of state hospital beds and the established rate of reimbursement. (b) An MCO using fewer patient days of care than its quarterly allocation of state hospital beds receives a portion of the reimbursement collected proportional to its share of the total number of patient days	The agency removed the bed allocation process because related fees ended in the summer of 2019. Specifically, the agency removed 182-538-070(5).

	of care that were not used at the appropriate state hospital.	
Adopted	~~(5) The MCO pays a reimbursement for each patient day of care that exceeds the MCO daily allocation of state hospital beds based on a quarterly calculation of the bed usage.~~ ~~(a) The agency bills the MCO quarterly for state hospital patient days of care exceeding the MCO daily allocation of state hospital beds and the established rate of reimbursement.~~ ~~(b) An MCO using fewer patient days of care than its quarterly allocation of state hospital beds receives a portion of the reimbursement collected proportional to its share of the total number of patient days of care that were not used at the appropriate state hospital.~~	
WAC 182-538-110 The grievance and appeal system and agency administrative hearing for managed care organization (MCO) enrollees.		
Proposed	(3)(g) Methods to file either a grievance or appeal include, but are not limited to, U.S. mail, commercial delivery services, hand delivery, fax, and email.	The agency added "telephone" to the list of additional methods to file either a grievance or appeal. This is to more closely match federal provisions in 42 CFR 438.406(b)(3).
Adopted	(3)(g) Methods to file either a grievance or appeal include, but are not limited to, U.S. mail, commercial delivery services, hand delivery, fax, telephone, and email.	
WAC 182-538-130 Exemptions and ending enrollment in managed care		
Proposed	(2)(b) The agency grants a request to exempt or to end enrollment in managed care when the client or enrollee:	This change was made to clarify when a request for exemption from managed care becomes effective for clients who have a right to be exempted.
Adopted	(2)(b) The agency grants a request to exempt or to end enrollment in managed care, with the change effective the earliest possible date given the requirements of the agency's enrollment system, when the client or enrollee:	
WAC 182-538-190 Behavioral health services only (BHSO).		
Proposed	(5) A BHSO enrollee may change MCOs for any reason with the change becoming effective according to the agency's managed care policy.	The agency made this change to match the agency's online Behavioral Health Organization (BHO) fact

Adopted	(5) A BHSO enrollee may change MCOs at any time for any reason with the change becoming effective the earliest possible date given the requirements of the agency's enrollment system.	sheet, which states that clients can change managed care organizations (MCOs) at "any time." The agency also added a more specific statement about the agency's policy for the effective date of MCO choices.

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

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

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:

Federal statute:	New		Amended		Repealed	
Federal rules or standards:	New		Amended		Repealed	
Recently enacted state statutes:	New		Amended		Repealed	

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

New		Amended		Repealed	

The number of sections adopted on the agency's own initiative:

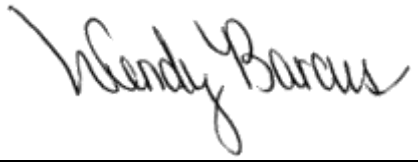
New		Amended		Repealed	

The number of sections adopted in order to clarify, streamline, or reform agency procedures:

New	17	Amended	23	Repealed	18

The number of sections adopted using:

Negotiated rule making:	New		Amended		Repealed	
Pilot rule making:	New		Amended		Repealed	
Other alternative rule making:	New	17	Amended	23	Repealed	18

Date Adopted: November 27, 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. (1) This chapter governs services provided under the Washington apple health integrated managed care (IMC) contract((~~s. If a conflict exists between the requirements of this chapter and other rules, the requirements of this chapter take precedence~~)).

(2) IMC provides physical and behavioral health services to medicaid beneficiaries through managed care.

(3) IMC includes enrollees receiving behavioral health services only (BHSO).

(4) IMC medicaid services are available only through a contracted managed care organization (MCO) and its provider network, except as identified in this chapter.

(5) For nonmedicaid funded behavioral health wraparound services, see chapter 182-538B WAC.

(6) For crisis and crisis related behavioral health services, see chapter 182-538C WAC.

(7) For behavioral health services, also see chapter 182-538D WAC.

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. If conflict exists, this chapter takes precedence.

"Administrative hearing" means ((~~the agency's administrative hearing process~~)) an evidentiary adjudicative proceeding before an administrative law judge or presiding officer that is available to an enrollee under chapter 182-526 WAC ((~~for review of an adverse benefit determination in accordance with~~)) according to 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) 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, 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 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 to serve a client who has not selected an MCO.

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

"Behavioral health" - See WAC 182-538D-0200.

"Behavioral health administrative service organization (BH-ASO)" means an entity selected by the medicaid agency to administer behavioral health services and programs, including crisis services for all people in an integrated managed care regional service area. The BH-ASO administers crisis services for all people in its defined regional service area, regardless of a person's ability to pay.

"Behavioral health services only (BHSO)" means the program in which enrollees only receive behavioral health benefits through a managed care delivery system.

"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 or PCCM provider~~)) - See WAC 182-500-0020.

"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 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.

"Fully integrated managed care (FIMC)" - See integrated managed care.

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

"Grievance and appeal system" means the processes the MCO 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.

"Integrated managed care (IMC)" means the program under which a managed care organization provides:

(a) Physical health services funded by medicaid; and

(b) Behavioral health services funded by medicaid, and other available resources provided for in chapters 182-538B, 182-538C, and 182-538D WAC.

"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 or PCCM provider.

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

"Managed care organization" or **"MCO"** means an organization having a certificate of authority or certificate of registration from the office of insurance commissioner that contracts with the 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.

"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) to participate in the MCO'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 MCO to provide services to enrollees.

"Patient days of care" means all voluntary patients and involuntarily committed patients under chapter 71.05 RCW, regardless of where in the state hospital the patients reside. Patients who are committed to the state hospital under chapter 10.77 RCW are not included in the patient days of care. Patients who are committed under RCW 10.77.088 by municipal or district courts after failed competency restoration and dismissal of misdemeanor charges are not counted in the patient days of care until a petition for ninety days of civil commitment under chapter 71.05 RCW has been filed in court. Patients who are committed under RCW 10.77.086 by a superior court after failed competency restoration and dismissal of felony charges are not counted in the patient days of care until the patient is civilly committed under chapter 71.05 RCW.

"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 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.

"Regional service area (RSA)" means a single county or multicounty grouping formed for the purpose of health care purchasing and designated by the agency and the department of social and health services.

"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.

"Wraparound with intensive services (WISe)" is a program that provides comprehensive behavioral health services and support to:

(a) Medicaid-eligible people age twenty or younger with complex behavioral health needs; and

(b) Their families.

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 integrated managed care (IMC) when that client:

(a) Is eligible for one of the Washington apple health programs for which enrollment is mandatory;

(b) Resides in an area where enrollment is mandatory; and

(c) Is not exempt from ((~~managed care~~)) IMC enrollment ((~~or~~)) and 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 one of the following:

(a) Enrollment with a managed care organization (MCO) available in their regional service 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 for physical health or behavioral health or both.

(3) 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) ((~~A client~~)) An enrollee in IMC must enroll with an MCO available in the regional service area where the ((~~client~~)) enrollee resides.

(5) All family members will be enrolled with the same MCO, 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 as the family member placed in the PRC program.

(6) ((~~A client~~)) An enrollee may be placed into the PRC program by the ((~~client's~~)) MCO or the agency. ((~~The client~~)) An enrollee placed in the PRC program must follow the enrollment requirements of the program as stated in WAC 182-501-0135.

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

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

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

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

(c) The client is reenrolled within the previous six months with their prior MCO plan if:

(i) The agency identifies the prior MCO and the program is available; and

(ii) The client does not have a family member enrolled with an agency-contracted MCO or PCCM provider.

(d) If the client has a break in eligibility of less than two months, the client will be automatically reenrolled with his or her previous MCO or PCCM provider and no notice will be sent; or

(e) If the client cannot be assigned according to (a), (b), (c), or (d) of this subsection, the agency assigns the client according to agency policy.

(f) 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~~)) AI/AN does not choose an MCO, the agency assigns the client to an MCO available in the area where the client resides. The MCO is responsible for primary care provider (PCP) choice and assignment.

(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. The assigned client has ten calendar days to contact the agency to change the MCO 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 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 previous MCO and no notice will be sent.~~

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

~~(10)~~)) (9) An MCO enrollee's selection of a PCP or assignment to a PCP occurs as follows:

(a) An MCO enrollee may choose:

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

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

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

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

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

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

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) in integrated managed care. (1) To provide physical or behavioral health services under the IMC medicaid contract:

(a) An MCO must contract with the agency.

(b) MCO must also contract with an agency-contracted behavioral health administrative service organization (BH-ASO) that maintains an adequate provider network to deliver services to clients in IMC regional service areas.

(2) A managed care organization (MCO) 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 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)~~)) (3) At its discretion, the agency awards a contract to an MCO through a competitive process or an application process available to all qualified providers.

((~~(3)~~)) (4) The agency reserves the right not to contract with any otherwise qualified MCO.

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

WAC 182-538-068 Qualifications to become a primary care case management (PCCM) provider in integrated managed care regional service areas. A primary care case management (PCCM) provider or the individual providers in a PCCM group or clinic must:

(1) Have a core provider agreement with the medicaid agency;

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

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

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

(5) Accept the case management rate paid by the agency.

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

WAC 182-538-070 Payments ((to)) and sanctions for managed care organizations (MCOs) in integrated managed care regional service areas. (1) The medicaid agency pays apple health managed care organizations (MCOs) 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 contract;

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

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

(e) Are paid based on legislative allocations.

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

(3) The agency pays MCOs a service-based enhancement rate for wraparound with intensive services (WISe) administered by a certified WISe provider who holds a current behavioral health agency license issued by the department of health under chapter 246-341 WAC.

(4) For crisis services, the MCO must determine whether the person receiving the services is eligible for Washington apple health or if the person has other insurance coverage.

(5) 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;

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

(d) Apply a monthly penalty assessment associated with poor performance on selected behavioral health performance measures.

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

((~~(4)~~)) (7) 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 182-538-071 Payments for primary care case management (PCCM) providers in the integrated managed care for regional service areas. (1) The medicaid agency pays PCCM providers a monthly case management fee according to contracted terms and conditions.

(2) The agency pays PCCM providers for health care services under the fee-for-service health care delivery system.

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

WAC 182-538-095 Scope of care for integrated managed care enrollees and managed care organization benefit administration requirements.

Scope of Care.

(1) ((~~A managed care~~)) An enrollee in integrated managed care (IMC) is eligible only for the scope of services ((~~in WAC 182-501-0060 for categorically needy clients.~~

~~(a)~~)) that are covered based on the apple health program (eligibility program) in which they are enrolled.

(a) See the chart in WAC 182-501-0060 for category of covered services that are covered based on enrollee's apple health eligibility program, and the program rules to determine which specific services are covered. See WAC 182-501-0065 for a description of the category of covered services.

(b) The apple health eligibility programs for IMC includes the alternative benefit plan (ABP), categorically needy (CN), and medically needy (MN) programs.

(2) The managed care organization (MCO) covers the services included ((~~in the contract for its enrollees.~~

~~(i) MCOs may, at their discretion, cover services not required under the MCO contract.~~

~~(ii)~~)) under the IMC medicaid contract for IMC enrollees based on their apple health eligibility program.

(3) If an IMC enrollee is enrolled in behavioral health services only (BHSO):

(a) The MCO will only cover the behavioral health benefit included in the IMC medicaid contract.

(b) The MCO is not responsible for coverage of the physical health benefit in the IMC contract.

(c) See WAC 182-538-190 regarding additional rules related to BHSO.

(4) The agency ((~~cannot~~)) does not require the MCO to cover any services outside the scope of covered services in the MCO's contract with the agency. At its discretion, an MCO may cover services not required under the IMC medicaid contract.

((~~(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 contract.~~

~~(2) The following services are not covered by the MCO:~~)) (5) Services included in enrollees' medicaid eligibility program, and identified as covered based on program rules, may be excluded from coverage by the agency under the managed care contract. These excluded services that are covered based on program rules are available on a fee-for-service basis.

(6) The MCO is not required to authorize or pay for covered services if:

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

(b) Services ((~~not included in the categorically needy scope of services~~)) are excluded from coverage under the managed care contract.

(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, but were not authorized by the MCO.

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

((~~(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.~~))

MCO Benefit Administration Requirements.

((~~(4)~~)) (7) For services covered by the agency through contracts with MCOs:

(a) The agency requires the MCO to subcontract with enough providers to deliver the scope of contracted services in a timely manner((~~. Except for emergency services,~~));

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

(c) MCOs provide covered services to enrollees through their participating providers((~~;~~

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

~~(c)~~)), unless an exception applies. An MCO covers services from a nonparticipating provider when an enrollee obtains:

(i) Emergency services; or

(ii) Authorization from the MCO to receive services from a nonparticipating provider.

(d) For nonemergency services, MCOs may require:

(i) The enrollee to obtain a referral from the primary care provider (PCP)((~~, and/or~~)); or

(ii) The provider to obtain authorization from the MCO, according to the requirements of the MCO contract;

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

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

((~~(f)~~)) (g) 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)~~)) (h) For enrollees outside their MCO services area, the MCO must cover enrollees for emergency care and medically necessary covered benefits that cannot wait until the enrollees return to their MCO services area.

((~~(5)~~)) (8)(a) An MCO enrollee may obtain specific services described in the managed care contract from either an MCO-contracted provider or a provider with a separate agreement with the agency without a referral from the PCP or MCO. These services are communicated to enrollees by the agency and MCOs as described in (b) of this subsection.

(b) The agency sends each enrollee 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 to provide new enrollees with written information about covered services.

((~~(6)~~)) (9) An enrollee is entitled to timely access to covered services that are medically necessary as defined in WAC 182-500-0070.

((~~(7)~~)) (10) All nonemergency services covered under the MCO contract and received from nonparticipating providers require prior authorization from the MCO.

(11) A provider may bill an enrollee for services only if the requirements of WAC 182-502-0160 are met.

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

WAC 182-538-096 Scope of service for PCCM enrollees. (1) An enrollee is entitled to timely access to covered services that are medically necessary.

(2) A primary care case management (PCCM) enrollee is eligible for the scope of services ((~~in~~)) that are covered based on the enrollee's apple health eligibility program. See WAC 182-501-0060 and 182-501-0065((~~. An enrollee is entitled to timely access to covered services that are medically necessary~~)) for categories of services that are covered and program rules for specific services that are covered.

((~~(a)~~)) (3) The agency covers services through the fee-for-service system for enrollees with a primary care case management (PCCM) provider. ((~~Except for emergencies,~~))

(a) The PCCM provider must either provide the covered services or refer the enrollee to other providers who are contracted with the agency for covered services, except for emergency services.

(b) The PCCM provider is responsible for explaining to the enrollee how to obtain the services for which the PCCM provider is referring the enrollee.

(c) Services that require PCCM provider referral are described in the PCCM contract.

((~~(b)~~)) (d) The agency sends each enrollee written information about covered services when the client enrolls in managed care and when there is a change in covered services. This information describes covered services, which services are covered by the agency, and how to access services through the PCCM provider.

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

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

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

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

~~(d) Services referred by the PCCM provider require an authorization number to receive payment from the agency; and~~

~~(e) An enrollee may request a hearing for review of PCCM provider or agency coverage decisions (see WAC 182-538-110).~~

~~(3)~~)) (4) The agency will not authorize or pay for the following services ((~~are not covered~~)):

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

(b) Services not included in the ((~~categorically needy~~)) scope of covered services for the client's apple health eligibility program.

(c) Services((~~, other than a screening exam as described in WAC 182-538-100(3),~~)) received in a hospital emergency department for nonemergency medical conditions((~~.~~

~~(d) Services that require a referral from the PCCM provider as described in the PCCM contract, but were not referred by the PCCM provider~~)), other than a screening exam as described in WAC 182-538-100(3).

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

WAC 182-538-100 Managed care emergency services. (1) A managed care enrollee may obtain emergency services for emergency medical conditions from any qualified medicaid provider.

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

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

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

(3) MCOs must cover all emergency services provided to an enrollee by a provider who is qualified to furnish medicaid services, with-

out regard to whether the provider is a participating or nonparticipating provider.

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

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

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

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

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

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

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

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

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 enrollees. See WAC 182-538-111 for information about PCCM enrollees.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) For termination, suspension, or reduction of previously authorized services, at least ten 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 determines and justifies to the agency upon request, a need for additional information and that the extension is in the enrollee's interest.

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

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

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

(v) For expedited authorization decisions:

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

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

(I) The enrollee requests the extension; or

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

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

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

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

(c) **Acknowledgment letter.** The MCO must acknowledge in writing receipt of each 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 - Sixty-day deadline.** For appeals involving standard service authorization decisions, an enrollee must file an appeal within sixty calendar days of the date on the MCO's notice of adverse benefit determination. This time frame also applies to a request for an expedited appeal.

(e) **Previously authorized service - Ten-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 mailing notice of the adverse benefit determination.

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

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

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

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

(iii) Include as parties to the appeal:

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

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

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

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

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

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

(A) The enrollee requests the extension; or

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

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

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

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

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

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

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

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

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

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

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

(C) That the enrollee may be held liable for the cost of those benefits received for the first sixty days after the agency or the office of administrative hearings (OAH) receives an agency administra-

tive hearing request, if the hearing decision upholds the MCO's adverse benefit determination. See RCW 74.09.741 (5)(g).

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

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

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

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

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

(i) The enrollee requests the extension; or

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

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

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

(i) The enrollee requests the extension; or

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

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

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

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

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

(iii) Provide written notice within two calendar days.

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

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

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

(b) **Right to agency administrative hearing.** If an enrollee has completed the MCO appeal process and does not agree with the MCO's

resolution of the appeal, the enrollee may file a request for an agency administrative hearing based on the rules in this section and the agency administrative hearing rules in chapter 182-526 WAC.

(c) **Deadline – One hundred twenty 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.

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

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

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

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

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

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

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

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

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

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

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

(i) The enrollee withdraws the MCO appeal;

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

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

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

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

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

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

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

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

WAC 182-538-111 The administrative hearing process for primary care case management (PCCM). ((~~(1) This section contains information about the administrative hearing process for primary care case management (PCCM) enrollees. See WAC 182-538-110 for information about the grievance system for managed care organization (MCO) enrollees.~~

~~(2)~~)) PCCM enrollees follow the same administrative hearing rules and processes as fee-for-service clients under chapter 182-526 WAC.

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 medicaid agency enrolls clients into integrated managed care (IMC) based on the rules in WAC 182-538-060. IMC is mandatory in all regional service areas.

(1) **Authority to request.** The following people may request that the agency approve an exemption or end enrollment in managed care:

(a) A client or enrollee;

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

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

(2) **Standards to exempt or end enrollment.**

(a) The agency ((~~approves a request to exempt a client from enrollment or to~~)) exempts or ends enrollment from mandatory managed care when any of the following apply:

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

((~~(b)~~)) (ii) 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, with the change effective the earliest possible date given the requirements of the agency's enrollment system, when the client or enrollee:

(i) Is American Indian or Alaska native or is a descendant of an AI/AN client and requests not to be in managed care;

(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.

(3) **Case-by-case clinical criteria** ((~~to authorize an exemption or to~~)). Clinical criteria for an enrollee or client to be exempted or end enrollment in IMC.

(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~~)) The medically necessary care at issue is covered under the agency's managed care contracts and is not a benefit under the behavioral health services only (BHSO) program;

(iii) The client is receiving the medically necessary care at issue from an established provider or providers who are not available through any contracted MCO; and

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

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

(c) If an enrollee request to end enrollment is received after the enrollment effective date, the enrollee remains enrolled pending the agency's decision.

(4) **Approved request.**

(a) 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.

(b) For clients who are not AI/AN, the following rules apply:

(i) 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)~~)) (ii) The agency limits the period of time based on the circumstances or how long the conditions described are expected to exist.

(iii) The agency may periodically review those circumstances or conditions to determine if they continue to exist.

(iv) Any authorized exemption will continue only until the client can be enrolled in managed care.

(5) **BHSO.**

(a) When a client is exempt from mandatory IMC or their enrollment in the mandatory IMC program ends, the exemption is for the physical health benefit only. The client remains enrolled in behavioral health services only (BHSO) for the behavioral health benefit.

(b) AI/AN clients are an exception in that they can choose to receive their behavioral health benefit on a fee-for-service basis.

(6) **Denied request.** When the agency denies a request for exemption or to end enrollment((~~, the~~)):

(a) The agency will notify the client or enrollee of its decision by telephone or in writing and confirms a telephone notification in writing.

(b) 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.

(c) 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)~~)) (7) **Administrative hearing request.** 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)~~)) (8) **MCO request.** The agency will grant a request from an MCO 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.

(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 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 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 seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees.

(c) The agency will not approve a request to end enrollment of an enrollee's behavioral health services. The agency may determine to transition the enrollee to behavioral health services only (BHSO).

(d) When the agency receives a request from an MCO to end enrollment of an enrollee, the agency reviews each request on a case-by-case basis. The agency will respond to the MCO in writing with the decision. If the agency grants the request to end enrollment:

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

(A) The enrollee's right to use the MCO's 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)~~)) (e) The MCO will continue to provide services to the enrollee until the date the ((~~individual~~)) person is no longer enrolled.

((~~(6)~~)) (f) 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~~)) IMC.

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) to comply with quality improvement standards detailed in the agency's managed care contract. MCOs 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~~)) overutilization and underutilization of services;

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

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

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

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

(ii) Evaluation of the entity 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 outcomes and services, and that involve the following:

(i) Measuring performance using objective quality indicators;

(ii) Implementing system changes to achieve improvement in service quality;

(iii) Evaluating the effectiveness of system changes;

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

(v) Reporting each project status and the results as requested by the 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;

(o) Perform client satisfaction surveys; and

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

(2) 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~~)) people.

(b) The agency will enroll eligible ((~~individuals~~)) people 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)~~)) (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 as enrollment in AHFC is voluntary.

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

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

(a) Covered services;

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

(c) Hearings through the agency.

NEW SECTION

WAC 182-538-170 Notice requirements. The notice requirements in chapter 182-518 WAC apply to integrated managed care (IMC).

NEW SECTION

WAC 182-538-180 Rights and protections. (1) People have medicaid-specific rights when applying for, eligible for, or receiving medicaid-funded health care services.

(2) All applicable statutory and constitutional rights apply to all medicaid people including, but not limited to:

(a) The participant rights under WAC 246-341-0600;

(b) Applicable necessary supplemental accommodation services including, but not limited to:

(i) Arranging for or providing help to complete and submit forms to the agency;

(ii) Helping people give or get the information the agency needs to decide or continue eligibility;

(iii) Helping to request continuing benefits;

(iv) Explaining the reduction in or ending of benefits;

(v) Assisting with requests for administrative hearings; and

(vi) On request, reviewing the agency's decision to terminate, suspend, or reduce benefits.

(c) Receiving the name, address, telephone number, and any languages offered other than English of providers in a managed care organization (MCO);

(d) Receiving information about the structure and operation of the MCO and how health care services are delivered;

(e) Receiving emergency care, urgent care, or crisis services;

(f) Receiving poststabilization services after receiving emergency care, urgent care, or crisis services that result in admittance to a hospital;

(g) Receiving age-appropriate and culturally appropriate services;

(h) Being provided a qualified interpreter and translated material at no cost to the person;

(i) Receiving requested information and help in the language or format of choice;

(j) Having available treatment options and explanation of alternatives;

(k) Refusing any proposed treatment;

(l) Receiving care that does not discriminate against a person;

(m) Being free of any sexual exploitation or harassment;

(n) Making an advance directive that states the person's choices and preferences for health care services under 42 C.F.R. Sec. 489 Subpart I;

(o) Choosing a contracted health care provider;

(p) Requesting and receiving a copy of health care records;

(q) Being informed the cost for copying, if any;

(r) Being free from retaliation;

(s) Requesting and receiving policies and procedures of the MCO as they relate to health care rights;

(t) Receiving services in an accessible location;

(u) Receiving medically necessary services in accordance with the early and periodic screening, diagnosis, and treatment (EPSDT) program under WAC 182-534-0100, if the person is age twenty or younger;

(v) Being treated with dignity, privacy, and respect;

(w) Receiving treatment options and alternatives in a manner that is appropriate to a person's condition;

(x) Being free from seclusion and restraint;

(y) Receiving a second opinion from a qualified health care professional within an MCO provider network at no cost or having one arranged outside the network at no cost, as provided in 42 C.F.R. Sec. 438.206(b)(3);

(z) Receiving medically necessary health care services outside of the MCO if those services cannot be provided adequately and timely within the MCO;

(aa) Filing a grievance with the MCO if the person is not satisfied with a service;

(bb) Receiving a notice of action so that a person may appeal any decision by the MCO that:

(i) Denies or limits authorization of a requested service;

(ii) Reduces, suspends, or terminates a previously authorized service; or

(iii) Denies payment for a service, in whole or in part.

(cc) Filing an appeal if the MCO fails to provide health care services in a timely manner as defined by the state or act within the time frames in 42 C.F.R. Sec. 438.408(b); and

(dd) Requesting an administrative hearing if an appeal is not resolved in a person's favor.

NEW SECTION

WAC 182-538-190 Behavioral health services only (BHSO). This section applies to enrollees receiving behavioral health services only (BHSO) under the integrated managed care (IMC) medicaid contract.

(1) IMC is mandatory for clients in eligible programs, but the agency may end enrollment or exempt clients from IMC based on WAC 182-538-130.

(2) If the agency ends enrollment or exempts a client from IMC, the client is required to enroll in behavioral health services only (BHSO). An exception to this requirement exists for American Indian and Alaskan native (AI/AN) clients. IMC including BHSO is optional for AI/AN clients.

(3) For BHSO enrollees, the MCO covers the behavioral health benefits included in the IMC medicaid contract, and the agency covers physical health services on a fee-for-service basis.

(4) The agency assigns the BHSO enrollee to an MCO available in the area where the client resides.

(5) A BHSO enrollee may change MCOs at any time for any reason with the change becoming effective the earliest possible date given the requirements of the agency's enrollment system.

REPEALER

The following chapter of the Washington Administrative Code is repealed:

WAC 182-538A-040	Washington apple health fully integrated managed care.
WAC 182-538A-050	Definitions.
WAC 182-538A-060	Fully integrated managed care and choice.
WAC 182-538A-067	Qualifications to become a managed care organization (MCO) in fully integrated managed care (FIMC) regional service areas.
WAC 182-538A-068	Qualifications to become a primary care case management (PCCM) provider in fully integrated managed care (FIMC) regional service areas.
WAC 182-538A-070	Payments to managed care organizations (MCOs) in fully integrated managed care (FIMC) regional service areas.
WAC 182-538A-071	Payments to primary care case management (PCCM) providers in fully integrated managed care (FIMC) regional service areas.
WAC 182-538A-095	Scope of care for fully integrated managed care (FIMC) and behavioral health services only (BHSO) enrollees.
WAC 182-538A-100	Managed care emergency services for fully integrated managed care (FIMC) enrollees.
WAC 182-538A-110	The grievance and appeal system, and agency administrative hearing for fully integrated managed care (FIMC) managed care organization (MCO) enrollees.
WAC 182-538A-111	The administrative hearing process for primary care case management (PCCM) enrollees in FIMC regional service areas.
WAC 182-538A-120	Fully integrated managed care (FIMC) enrollee request for a second medical opinion.
WAC 182-538A-130	Exemptions and ending enrollment in fully integrated managed care (FIMC).
WAC 182-538A-140	Fully integrated managed care (FIMC) quality of care.
WAC 182-538A-150	Apple health foster care program in fully integrated managed care regional service areas.
WAC 182-538A-170	Notice requirements.
WAC 182-538A-180	Rights and protections.

WAC 182-538A-190 Behavioral health services only (BHSO).

AMENDATORY SECTION (Amending WSR 16-05-051, filed 2/11/16, effective 4/1/16)

WAC 182-538B-040 Behavioral health wraparound services. (1) This chapter governs nonmedicaid funded behavioral health services provided under the medicaid agency's behavioral health services wraparound contract. See also chapter 182-538D WAC for rules applicable to nonmedicaid behavioral health services.

(2) Washington apple health ((~~fully~~)) integrated managed care ((~~(FIMC)~~)) (IMC) behavioral health wraparound services are available only through a managed care organization (MCO) contracted to provide ((~~FIMC~~)) IMC services ((~~or behavioral health services only (BHSO)~~)).

(3) The MCO provides contracted nonmedicaid funded behavioral health wraparound services to medicaid enrollees in an ((~~FIMC~~)) IMC regional service area:

(a) Within available resources;

(b) Based on medical necessity; and

(c) In order of priority to populations as identified by state and federal authorities.

(4) When nonmedicaid funding is exhausted, behavioral health wraparound services are no longer paid for and cannot be authorized regardless of medical necessity.

AMENDATORY SECTION (Amending WSR 16-05-051, filed 2/11/16, effective 4/1/16)

WAC 182-538B-050 Definitions. The following definitions and those found in chapters 182-500((~~,~~)) and 182-538((~~, and 182-538A~~)) WAC apply to this chapter, unless otherwise stated.

"Action" means the denial or limited authorization of a service covered under the behavioral health services wraparound contract based on medical necessity.

"Available resources" means funds appropriated for the purpose of providing behavioral health wraparound services.

(a) This includes:

(i) Federal funds, except those provided according to Title XIX of the Social Security Act; and

(ii) State funds appropriated by the legislature for the purpose of providing services under the behavioral health administrative services organization contract.

(b) This does not include funds appropriated for the purpose of operating and administering the state psychiatric hospitals.

"Integrated managed care (IMC)" See WAC 182-538-050.

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

WAC 182-538B-110 Grievance and appeal system and agency administrative hearing. (1) **Introduction.** This section contains information about the managed care organization (MCO) grievance and appeal system

and the agency's administrative hearing process for enrollees under the behavioral health services wraparound contract in ((~~fully~~)) integrated managed care ((~~(FIMC)~~)) (IMC) regional service areas.

(a) The MCO must have a grievance and appeal system and access to an agency administrative hearing to allow enrollees to file grievances and seek review of an MCO action as defined in this chapter.

(b) The agency's administrative hearing rules in chapter 182-526 WAC apply to agency administrative hearings requested by an enrollee to review the resolution of an enrollee's appeal of an MCO action.

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

(d) The MCO's policies and procedures regarding the grievance system must be approved by the agency.

(2) **MCO grievance and appeal system.** The MCO grievance and appeal system includes:

(a) A grievance process for addressing complaints about any matter that is not an action;

(b) An appeals process to address an enrollee's request for review of an MCO action;

(c) Access to an independent review by an independent review organization (IRO) under RCW 48.43.535 and WAC 182-526-0200;

(d) Access to the agency's administrative hearing process for review of an MCO's resolution of an appeal; and

(e) Allowing enrollees and the enrollee's authorized representatives to file grievances and appeals orally or in writing. An MCO cannot require enrollees to provide written follow-up for a grievance or an appeal the MCO received orally.

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

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

(b) An enrollee does not have a right to an agency administrative hearing in regards to the resolution of a grievance.

(c) The MCO must acknowledge receipt of each grievance either orally or in writing within two business days.

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

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

(a) An enrollee, the enrollee's authorized representative, or a provider acting on behalf of the enrollee with the enrollee's written consent may appeal an MCO action.

(b) An MCO treats oral inquiries about appealing an action as an appeal to establish the earliest possible filing date for the appeal. The MCO confirms the oral appeal in writing.

(c) An MCO 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) The enrollee must file an appeal of an MCO action within sixty calendar days of the date on the MCO's notice of action.

(e) The MCO is not obligated to continue services pending the results of an appeal or subsequent agency administrative hearing.

(f) The MCO appeal process:

(i) Provides the enrollee a reasonable opportunity to present evidence and allegations of fact or law, both in person and in writing;

(ii) Provides the enrollee and the enrollee's representative the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the action. 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) Includes as parties to the appeal:

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

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

(g) The MCO ensures that the people making decisions on appeals:

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

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

(A) An appeal of an action involving medical necessity; or

(B) An appeal that involves any clinical issues.

(h) Time frames for resolution of appeals.

(i) An MCO resolves each appeal and provides notice as expeditiously as the enrollee's health condition requires and no longer than seventy-two hours after the day the MCO receives the appeal.

(ii) The MCO may extend the time frame by an additional fourteen calendar days if:

(A) The enrollee requests the extension; or

(B) The MCO determines additional information is needed and delay is in the interests of the enrollee.

(i) Notice of resolution of appeal. The notice of the resolution of the appeal must:

(i) Be in writing and be sent to the enrollee and the requesting provider;

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

(iii) Include information on the enrollee's right to request an agency administrative hearing and how to do so as provided in the agency hearing rules in WAC 182-526-0200, if the appeal is not resolved wholly in favor of the enrollee.

(j) **Deemed completion of the appeals process.** If the MCO fails to adhere to the notice and timing requirements for appeals, the enrollee is deemed to have completed the MCO's appeals process and may request an agency administrative hearing under WAC 182-526-0200.

(5) **Agency administrative hearing.**

(a) Only an enrollee or enrollee's authorized representative may request an agency administrative hearing. A provider may not request a hearing on behalf of an enrollee.

(b) If an enrollee does not agree with the MCO's resolution of an appeal and has completed the MCO appeal process, the enrollee may file a request for an agency administrative hearing based on the rules in this section and the agency hearing rules in WAC 182-526-0200. The enrollee must request an agency administrative hearing within ninety calendar days of the notice of resolution of appeal.

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

(6) **Effect of reversed resolutions of appeals.** If an MCO, a final order as defined in chapter 182-526 WAC, or an independent review organization (IRO) reverses a decision to deny or limit services, the MCO must authorize or provide the disputed services promptly and as expeditiously as the enrollee's health condition requires.

(7) **Available resources exhausted.** When available resources are exhausted, any appeals process, independent review, or agency administrative hearing process related to a request to authorize a service will be terminated, since services cannot be authorized without funding regardless of medical necessity.

AMENDATORY SECTION (Amending WSR 16-05-051, filed 2/11/16, effective 4/1/16)

WAC 182-538B-170 Notice requirements. Chapter 182-518 WAC applies to notice requirements in ((~~fully~~)) integrated managed care ((~~(FIMC)~~)) (IMC) regional service areas.

AMENDATORY SECTION (Amending WSR 17-23-200, filed 11/22/17, effective 12/23/17)

WAC 182-538C-040 Behavioral health services. (1) This chapter governs crisis-related and other behavioral health services provided under the medicaid agency's behavioral health administrative services organization (BH-ASO) contract. See also chapter 182-538D WAC for rules applicable to nonmedicaid behavioral health services.

(2) The BH-ASO contracts with the agency to provide behavioral health services within ((~~a fully~~)) an integrated managed care ((~~(FIMC)~~)) (IMC) regional service area.

(a) The BH-ASO provides the following services to all people, regardless of insurance status, income level, ability to pay, and county of residence:

(i) Mental health crisis services; ((~~and~~))

(ii) Operation of a behavioral health ombuds (ombudsman); and

(iii) Implementation of the Involuntary Treatment Act for both mental health and substance use disorders.

(b) The BH-ASO may provide substance use disorder crisis services within available resources to all people, regardless of the person's insurance status, income level, ability to pay, and county of residence.

(c) The BH-ASO provides the following services to people who are not eligible for medicaid coverage and are involuntarily or voluntarily detained under chapter 71.05, 71.24, or 71.34 RCW, ((~~RCW 70.96A.140,~~)) or a less restrictive alternative (LRA) court order:

(i) Evaluation and treatment services;

(ii) Substance use disorder residential treatment services; and

(iii) Outpatient behavioral services, under an LRA court order.

(d) To be eligible to contract with the agency, the BH-ASO must:

(i) Accept the terms and conditions of the agency's contracts; and

(ii) Be able to meet the network and quality standards established by the agency.

(e) Services related to the administration of chapters 71.05, 71.24, and 71.34 RCW ((~~and RCW 70.96A.140~~)).

(3) The BH-ASO may provide contracted noncrisis behavioral health services to people in an ((~~FIMC~~)) IMC regional service area:

(a) Within available resources;

(b) Based on medical necessity; and

(c) In order of priority to populations as identified by state and federal authorities.

(4) Within an ((~~FIMC~~)) IMC regional service area, the BH-ASO is a subcontractor with all ((~~FIMC~~)) IMC managed care organizations (MCOs) to provide crisis services for medicaid enrollees and the administration of involuntary treatment acts under ((~~RCW 70.96A.140 or~~)) chapter 71.05, 71.24, or 71.34 RCW.

(5) For medicaid-funded services subcontracted for by ((~~FIMC~~)) IMC managed care organizations (MCOs) to the BH-ASO:

(a) Grievances and appeals must be filed with the ((~~FIMC~~)) IMC MCO; and

(b) The grievance and appeal system and the agency's administrative hearing rules in chapter 182-538 WAC apply instead of the grievance and appeal system and hearing rules in this chapter.

AMENDATORY SECTION (Amending WSR 16-05-051, filed 2/11/16, effective 4/1/16)

WAC 182-538C-050 Definitions. The definitions ((~~and abbreviations~~)) in this section and those found in chapters 182-500 and 182-538 WAC apply to this chapter. ((~~If conflict exists, this chapter takes precedence.~~))

"Action" means the denial or limited authorization of a service covered under the behavioral health administrative services organization (BH-ASO) contract based on medical necessity.

"Available resources" means funds appropriated for the purpose of providing community behavioral health programs.

(a) This includes:

(i) Federal funds, except those provided according to Title XIX of the Social Security Act; and

(ii) State funds appropriated by the legislature for the purpose of providing services under the BH-ASO contract.

(b) This does not include funds appropriated for the purpose of operating and administering the state psychiatric hospitals.

"Behavioral health" ((~~means mental health and substance use disorder conditions and related benefits~~)) - See WAC 182-538-050.

"Behavioral health administrative services organization (BH-ASO)" ((~~means an entity selected by the medicaid agency to administer behavioral health programs, including crisis services for individuals in a fully integrated managed care regional service area. The BH-ASO administers crisis services for all individuals in its defined regional service area, regardless of an individual's ability to pay~~)) - See WAC 182-538-050.

"Complaint" - See "grievance."

"Crisis" ((~~means an actual or perceived urgent or emergent situation that occurs when:~~

~~(a) An individual's stability or functioning is disrupted; and~~

~~(b) There is an immediate need to resolve the situation to prevent:~~

~~(i) A serious deterioration in the individual's mental or physical health; or~~

~~(ii) The need for referral to a significantly higher level of care.~~

~~**"Fully integrated managed care (FIMC)"** means the program under which a managed care organization provides:~~

~~(a) Physical health services funded by medicaid; and~~

~~(b) Behavioral health services funded by other available resources as defined in this chapter.~~

~~**"Grievance"** means an expression of dissatisfaction made by or on behalf of an individual and referred to a behavioral health administrative services organization (BH-ASO) about any matter other than an action~~)) - See WAC 182-538D-0200.

"Grievance" - See WAC 182-538-050.

"Integrated managed care (IMC)" - See WAC 182-538-050.

"Less restrictive alternative (LRA)" means court-ordered outpatient treatment in a setting less restrictive than total confinement.

"Noncrisis services" means services funded by nonmedicaid funding sources that are provided to ((~~individuals~~)) people who are not enrolled in Washington apple health or otherwise eligible for medicaid. These services may be provided at the discretion of the behavioral

health administrative services organization (BH-ASO) within available resources, such as:

(a) Crisis stabilization;

(b) Outpatient mental health or substance use disorder services; and

(c) Withdrawal management.

"Patient days of care" ((~~means all voluntary patients and involuntarily committed patients under chapter 71.05 RCW, regardless of where in the state hospital the patients reside. Patients who are committed to the state hospital under chapter 10.77 RCW are not included in the patient days of care. Patients who are committed under RCW 10.77.088 by municipal or district courts after failed competency restoration and dismissal of misdemeanor charges are not counted in the patient days of care until a petition for ninety days of civil commitment under chapter 71.05 RCW has been filed in court. Patients who are committed under RCW 10.77.086 by a superior court after failed competency restoration and dismissal of felony charges are not counted in the patient days of care until the patient is civilly committed under chapter 71.05 RCW.~~

~~**"Regional service area"** means a single county or multi-county grouping formed for the purpose of health care purchasing and designated by the agency and the department of social and health services~~)) - See WAC 182-538-050.

"Regional service area" - See WAC 182-538-050.

AMENDATORY SECTION (Amending WSR 16-05-051, filed 2/11/16, effective 4/1/16)

WAC 182-538C-070 Payment. (1) For crisis services, the behavioral health administrative services organization (BH-ASO) must determine whether the ((~~individual~~)) person receiving the services is eligible for Washington apple health or if the ((~~individual~~)) person has any other form of insurance coverage.

(2) For ((~~individuals~~)) people receiving crisis services who do not have other insurance coverage, the BH-ASO is responsible for the cost of those services.

(3) The BH-ASO administers and pays for the evaluation of involuntary detention or involuntary treatment under chapters 71.05, 71.24, and 71.34 RCW ((~~and RCW 70.96A.140~~)).

(4) The BH-ASO pays a reimbursement for each state hospital patient day of care that exceeds the BH-ASO daily allocation of state hospital beds based on a quarterly calculation of the bed usage by the BH-ASO.

(a) The medicaid agency bills the BH-ASO quarterly for state hospital patient days of care exceeding the BH-ASO daily allocation of state hospital beds and the established rate of reimbursement.

(b) The BH-ASO using fewer patient days of care than its quarterly allocation of state hospital beds will receive a portion of the reimbursement collected proportional to its share of the total number of patient days of care that were not used at the appropriate state hospital.

AMENDATORY SECTION (Amending WSR 17-23-200, filed 11/22/17, effective 12/23/17)

WAC 182-538C-110 Grievance and appeal system and agency administrative hearing for behavioral health administrative services organizations (BH-ASOs). (1) **General.** This section applies to the behavioral health administrative service organization (BH-ASO) grievance system for people within ((~~fully~~)) integrated managed care ((~~(FIMC)~~)) (IMC) regional service areas.

(a) The BH-ASO must have a grievance and appeal system to allow a person to file a grievance and request a review of a BH-ASO action as defined in this chapter.

(b) The agency's administrative hearing rules in chapter 182-526 WAC apply to agency administrative hearings requested by a person to review the resolution of an appeal of a BH-ASO action.

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

(d) The BH-ASO must maintain records of grievances and appeals.

(e) The BH-ASO is not obligated to continue services pending the results of an appeal or subsequent agency administrative hearing.

(2) **The BH-ASO grievance and appeal system.** The BH-ASO grievance system includes:

(a) A process for addressing complaints about any matter that is not an action;

(b) An appeal process to address a person's request for a review of a BH-ASO action as defined in this chapter; and

(c) Access to the agency's administrative hearing process for a person to request a review of a BH-ASO's resolution of an appeal.

(3) **The BH-ASO grievance process.**

(a) A person or a person's authorized representative may file a grievance with a BH-ASO. A provider may not file a grievance on behalf of a person without the written consent of the person or the person's authorized representative.

(b) There is no right to an agency administrative hearing regarding the BH-ASO's decision on a grievance, since a grievance is not an action.

(c) The BH-ASO must notify a person of the decision regarding the person's grievance within five business days of the decision.

(4) **The BH-ASO appeal process.**

(a) Parties to the appeal include:

(i) The person and the person's authorized or legal representative; or

(ii) The authorized representative of the deceased person's estate.

(b) A person, the person's authorized representative, or the provider acting with the person's written consent may appeal a BH-ASO action.

(c) A BH-ASO must treat oral inquiries about appealing an action as an appeal in order to establish the earliest possible filing date for the appeal.

(d) The BH-ASO must confirm any oral appeal in writing to the person or provider acting on behalf of the person.

(e) The person or provider acting on behalf of the person must file an appeal, either orally or in writing, within sixty calendar days of the date on the BH-ASO's notice of action.

(f) The BH-ASO must acknowledge receipt of each appeal to both the person and the provider requesting the service within three calendar days of receipt. ((~~The appeal acknowledgment letter sent by the BH-ASO serves as written confirmation of an appeal filed orally by a person.~~))

(g) If the person requests an expedited appeal for a crisis-related service, the BH-ASO must make a decision on whether to grant the person's request for expedited appeal and provide written notice as expeditiously as the person's health condition requires, within three calendar days after the BH-ASO receives the appeal. The BH-ASO must make reasonable efforts to provide oral notice.

(h) The BH-ASO appeal process:

(i) Provides the person a reasonable opportunity to present evidence and allegations of fact or law in writing.

(ii) Provides the person and the person's authorized representative opportunity before and during the appeals process to examine the person's case file, including medical records and any other documents and records considered during the appeal process free of charge.

(iii) If the person requests an expedited appeal, the BH-ASO must inform the person that it may result in the person having limited time to review records and prepare for the appeal.

(i) The BH-ASO ensures the staff making decisions on appeals:

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

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

(A) An appeal of an action; or

(B) An appeal that involves any clinical issues.

(j) Time frames for standard resolution of appeals.

(i) For appeals involving termination, suspension, or reduction of previously authorized noncrisis services, the BH-ASO must make a decision within fourteen calendar days after receipt of the appeal.

(ii) If the BH-ASO cannot resolve an appeal within fourteen calendar days, the BH-ASO must notify the person that an extension is necessary to complete the appeal.

(k) Time frames for expedited appeals for crisis-related services ((~~or behavioral health prescription drug authorization decisions~~)).

(i) The BH-ASO must resolve the expedited appeal and provide notice of the decision no later than three calendar days after the BH-ASO receives the appeal.

(ii) The BH-ASO may extend the time frame by fourteen additional calendar days if:

(A) The person requests the extension; or

(B) The BH-ASO determines additional information is needed and the delay is in the interests of the person.

(iii) If the BH-ASO denies a request for expedited resolution of a noncrisis related service appeal, it must:

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

(B) Make reasonable efforts to give the person prompt oral notice of the denial; and

(C) Follow-up within two calendar days of the oral notice with a written notice of denial.

(l) Extension of a standard resolution or expedited appeal not requested by the person.

(i) The BH-ASO must notify the person in writing of the reason for the delay, if not requested by that person.

(ii) The extension cannot delay the decision beyond twenty-eight calendar days of the request for appeal, without the informed written consent of the person.

(m) Notice of resolution of appeal. The notice of the resolution of the appeal must:

(i) Be in writing and be sent to the person and the provider requesting the services;

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

(iii) Include notice of the right to request an agency administrative hearing and how to do so as provided in the agency hearing rules in chapter 182-526 WAC, if the appeal is not resolved wholly in favor of the person.

(5) **Agency administrative hearings.**

(a) Only a person or a person's authorized representative may request an agency administrative hearing. A provider may not request a hearing on behalf of a person.

(b) If a person does not agree with the BH-ASO's resolution of an appeal, the person may file a request for an agency administrative hearing based on this section and the agency hearing rules in chapter 182-526 WAC.

(c) The BH-ASO 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.

(6) **Effect of reversed resolutions of appeals.** If the BH-ASO's decision not to provide services is reversed on appeal by the BH-ASO or through a final order from the agency administrative hearing process, the BH-ASO must authorize or provide the disputed services promptly and as expeditiously as the person's health condition requires.

(7) **Available resources exhausted.** When available resources are exhausted, any appeals or administrative hearing process related to a request for authorization of a noncrisis service will be terminated, since noncrisis services cannot be authorized without funding, regardless of medical necessity.

AMENDATORY SECTION (Amending WSR 16-05-051, filed 2/11/16, effective 4/1/16)

WAC 182-538C-220 Covered crisis mental health services. (1) Crisis mental health services are intended to stabilize ((~~an individual~~)) a person in crisis to:

(a) Prevent further deterioration;

(b) Provide immediate treatment and intervention in a location best suited to meet the needs of the ((~~individual~~)) person; and

(c) Provide treatment services in the least restrictive environment available.

(2) Crisis mental health services include:

(a) Crisis telephone support ((~~under WAC 388-877A-0230~~));

(b) Crisis outreach services ((~~under WAC 388-877A-0240~~));

(c) Crisis stabilization services ((~~under WAC 388-877A-0260~~));

(d) Crisis peer support services ((~~under WAC 388-877A-0270~~)); and

(e) Emergency involuntary detention services ((~~under WAC 388-877A-0280~~)).

(3) A facility providing any crisis mental health service to ((~~an individual~~)) a person must:

(a) Be licensed by the department of ((~~social and~~)) health ((~~services~~)) as a behavioral health agency;

(b) Be certified by the department of ((~~social and~~)) health ((~~services~~)) to provide crisis mental health services;

(c) Have policies and procedures to support and implement the:

(i) Program-specific requirements ((~~in WAC 388-877A-0230 through 388-877A-0280~~)) for each crisis mental health service provided; and

(ii) Department of corrections access to confidential mental health information requirements in WAC ((~~388-865-0600 through 388-865-0640~~)) 182-538D-0600 through 182-538D-0640.

(4) A BH-ASO or its subcontractor providing crisis mental health services only is not required to meet the initial assessment, individual service plan, and clinical record requirements in WAC ((~~388-877-0610, 388-877-0620, and 388-877-0640~~)) 246-341-0610, 246-341-0620, and 246-341-0640.

(5) A BH-ASO or its subcontractor must ensure crisis mental health services:

(a) Are, with the exception of stabilization services, available twenty-four hours a day, seven days a week;

(b) Include family members, significant others, and other relevant treatment providers, as necessary, to provide support to the ((~~individual~~)) person in crisis; and

(c) Are provided in a setting that is safe for the ((~~individual~~)) person and staff members of the BH-ASO and its subcontractor.

AMENDATORY SECTION (Amending WSR 16-05-051, filed 2/11/16, effective 4/1/16)

WAC 182-538C-230 Covered substance use disorder detoxification services. (1) Chemical dependency detoxification services are provided to ((~~an individual~~)) a person to assist in the process of withdrawal from psychoactive substances in a safe and effective manner.

(2) A facility providing detoxification services to ((~~an individual~~)) a person must:

(a) Be a facility licensed by the department of health under one of the following:

(i) Chapter 246-320 WAC;

(ii) Chapter 246-322 WAC;

(iii) Chapter 246-324 WAC; or

(iv) Chapter 246-337 WAC.

(b) Be licensed by the department of ((~~social and~~)) health ((~~services~~)) as a behavioral health agency;

(c) Meet the applicable behavioral health agency licensure, certification, administration, personnel, clinical requirements, and behavioral health services administrative requirements; and

(d) Have policies and procedures to support and implement the applicable requirements in WAC ((~~388-877B-0110 through 388-877B-0130~~)) 246-341-1100 and 246-341-1102.

(3) A BH-ASO or its subcontractor agency must:

(a) Provide counseling to each ((~~individual~~)) person that addresses the ((~~individual's~~)) person's:

(i) Chemical dependency and motivation; and

(ii) Continuing care needs and need for referral to other services.

(b) Maintain a list of resources and referral options that can be used by staff members to refer ((~~an individual~~)) a person to appropriate services.

(c) Post any rules and responsibilities for ((~~individuals~~)) people receiving treatment, including information on potential use of increased motivation interventions or sanctions, in a public place in the facility.

(d) Provide tuberculosis screenings to ((~~individuals~~)) people for the prevention and control of tuberculosis.

(e) Provide HIV/AIDS information and include a brief risk intervention and referral as indicated.

NEW SECTION

WAC 182-538C-252 Behavioral health administrative services organizations—Advisory board membership. (1) A behavioral health administrative services organization (BH-ASO) must appoint advisory board members and maintain an advisory board in order to:

(a) Promote active engagement with people with behavioral health disorders, their families, and behavioral health agencies; and

(b) Solicit and use the advisory board members input to improve service delivery and outcome.

(2) The BH-ASO must appoint advisory board members and maintain an advisory board that:

(a) Broadly represents the demographic character of the service area;

(b) Is composed of at least fifty-one percent representation of one or more of the following:

(i) People with lived experience;

(ii) Parents or legal guardians of people with lived experience; or

(iii) Self-identified as people in recovery from a behavioral health disorder.

(c) Includes law enforcement representation; and

(d) Includes tribal representation, upon request of a tribe.

(3) When the BH-ASO is not a function of county government, the advisory board must include no more than four county elected officials.

(4) The advisory board:

(a) May have members who are employees of subcontracted agencies, as long as there are written rules that address potential conflicts of interest.

(b) Has the discretion to set rules in order to meet the requirements of this section.

(c) Membership is limited to three years per term for time served, per each advisory board member. Multiple terms may be served by a member if the advisory board rules allow it.

(5) The advisory board independently reviews and provides comments to the BH-ASO, on plans, budgets, and policies developed by the BH-ASO to implement the requirements of this section, chapters 71.05, 71.24, 71.34 RCW, and applicable federal laws.

Chapter 182-538D WAC
BEHAVIORAL HEALTH SERVICES

NEW SECTION

WAC 182-538D-0200 Behavioral health services—Definitions. The following definitions and those found in chapters 182-500, 182-538, and 182-538C WAC apply to this chapter. If conflict exists, this chapter takes precedence.

"Adult" means a person age eighteen or older. For purposes of the medicaid program, people age eighteen through age twenty have the early and periodic screening, diagnostic and treatment (EPSDT) benefit described in chapter 182-534 WAC. In the medicaid program, EPSDT is available until a person reaches age twenty-one.

"Assessment" means the process of obtaining all pertinent biopsychosocial information, as identified by the person, and family and collateral sources, for determining a diagnosis and to plan individualized services and supports.

"Behavioral health" means the prevention, treatment of, and recovery from substance use disorders, mental health disorders or problem and pathological gambling disorders.

"Behavioral health administrative service organization (BH-ASO)" See WAC 182-538-050.

"Behavioral health agency" means an entity licensed by the department of health to provide behavioral health services, including services for mental health disorders and substance use disorders.

"Chemical dependency professional" or **"CDP"** means a person credentialed by the department of health as a chemical dependency professional (CDP) with primary responsibility for implementing an individualized service plan for substance use disorder services.

"Child" means a person under the age of eighteen. For the purposes of the medicaid program, people age eighteen through age twenty have the early and periodic screening, diagnostic and treatment (EPSDT) benefit described in chapter 182-534 WAC. In the medicaid program, EPSDT is available until a person reaches age twenty-one.

"Clinical record" means a paper or electronic file that is maintained by the provider and contains pertinent psychological, medical, and clinical information for each person served.

"Community support services" means services authorized, planned, and coordinated through resource management services including, at a minimum, assessment, diagnosis, emergency crisis intervention available twenty-four hours, seven days a week; prescreening determinations for people who are mentally ill being considered for placement in nursing homes as required by federal law; screening for patients being considered for admission to residential services; diagnosis and treatment for children who are mentally or severely emotionally disturbed discovered under screening through the federal Title XIX early and periodic screening, diagnosis, and treatment (EPSDT) program; investigation, legal, and other nonresidential services under chapter 71.05 RCW; case management services; psychiatric treatment including medication supervision; counseling; psychotherapy; assuring transfer of relevant patient information between service providers; recovery serv-

ices; and other services determined by behavioral health administrative service organizations and managed care organizations.

"Complaint" See "grievance" in WAC 182-538-050.

"Consent" means agreement given by a person after the person is provided with a description of the nature, character, anticipated results of proposed treatments and the recognized serious possible risks, complications, and anticipated benefits, including alternatives and nontreatment. Informed consent must be provided in a terminology that the person can reasonably be expected to understand.

"Consultation" means the clinical review and development of recommendations regarding activities, or decisions of, clinical staff, contracted employees, volunteers, or students by people with appropriate knowledge and experience to make recommendations.

"Crisis" means an actual or perceived urgent or emergent situation that occurs when a person's stability or functioning is disrupted and there is an immediate need to resolve the situation to prevent a serious deterioration in the person's mental or physical health, or to prevent the need for referral to a significantly higher level of care.

"Cultural competence" or **"culturally competent"** means the ability to recognize and respond to health-related beliefs and cultural values, disease incidence and prevalence, and treatment efficacy. Examples of culturally competent care include striving to overcome cultural, language, and communications barriers, providing an environment in which people from diverse cultural backgrounds feel comfortable discussing their cultural health beliefs and practices in the context of negotiating treatment options, encouraging people to express their spiritual beliefs and cultural practices, and being familiar with and respectful of various traditional healing systems and beliefs and, where appropriate, integrating these approaches into treatment plans.

"Designated crisis responder (DCR)" means a mental health professional appointed by the county, or an entity appointed by the county, to perform the duties described in chapter 71.05 RCW.

"Disability" means a physical or mental impairment that substantially limits one or more major life activities of a person and the person:

(a) Has a record of such an impairment; or

(b) Is regarded as having such impairment.

"Ethnic minority" or **"racial/ethnic groups"** means, for the purposes of this chapter, any of the following general population groups:

(a) African American;

(b) An American Indian or Alaskan native, which includes:

(i) A person who is a member or considered to be a member in a federally recognized tribe;

(ii) A person determined eligible to be found Indian by the secretary of interior;

(iii) An Eskimo, Aleut, or other Alaskan native; and

(iv) An unenrolled Indian meaning a person considered Indian by a federally or nonfederally recognized Indian tribe or off-reservation Indian/Alaskan native community organization.

(c) Asian/Pacific Islander; or

(d) Hispanic.

"Housing services" means the active search and promotion of individual access to, and choice in, safe and affordable housing that is appropriate to the person's age, culture, and needs.

"Integrated managed care (IMC)" See WAC 182-538-050.

"Less restrictive alternative (LRA)" See WAC 182-538C-050.

"Mental health professional" means a person who meets the following:

(a) A psychiatrist, psychologist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner (ARNP), psychiatric nurse, or social worker as defined in chapters 71.05 and 71.34 RCW;

(b) A person who is licensed by the department of health as a mental health counselor, mental health counselor associate, marriage and family therapist, or marriage and family therapist associate; or

(c) A person with a master's degree or further advanced degree in counseling or one of the social sciences from an accredited college or university who has at least two years of experience in direct treatment of people with mental illness or emotional disturbance, experience that was gained under the supervision of a mental health professional recognized by the department of health or attested to by the licensed behavioral health agency.

"Mental health specialist" means:

(a) A **"child mental health specialist"** is defined as a mental health professional with the following education and experience:

(i) A minimum of one hundred actual hours (not quarter or semester hours) of special training in child development and the treatment of children and youth with serious emotional disturbance and their families; and

(ii) The equivalent of one year of full-time experience in the treatment of seriously emotionally disturbed children and youth and their families under the supervision of a child mental health specialist.

(b) A **"geriatric mental health specialist"** is defined as a mental health professional who has the following education and experience:

(i) A minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to the mental health problems and treatment of people age sixty and older; and

(ii) The equivalent of one year of full-time experience in the treatment of people age sixty and older, under the supervision of a geriatric mental health specialist.

(c) An **"ethnic minority mental health specialist"** is defined as a mental health professional who has demonstrated cultural competence attained through major commitment, ongoing training, experience and/or specialization in serving ethnic minorities, including evidence of one year of service specializing in serving the ethnic minority group under the supervision of an ethnic minority mental health specialist; and

(i) Evidence of support from the ethnic minority community attesting to the person's commitment to that community; or

(ii) A minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to ethnic minority issues and treatment of ethnic minorities.

(d) A **"disability mental health specialist"** is defined as a mental health professional with special expertise in working with an identified disability group. For purposes of this chapter only, "disabled" means a person with a disability other than a mental illness, including a developmental disability, serious physical handicap, or sensory impairment.

(i) If the consumer is deaf, the specialist must be a mental health professional with:

(A) Knowledge about the deaf culture and psychosocial problems faced by people who are deaf; and

(B) Ability to communicate fluently in the preferred language system of the consumer.

(ii) The specialist for people with developmental disabilities must be a mental health professional who:

(A) Has at least one year experience working with people with developmental disabilities; or

(B) Is a developmental disabilities professional as defined in RCW 71.05.020.

"Peer counselor" means a person recognized by medicaid agency as a person who:

(a) Is a self-identified consumer of behavioral health services who:

(i) Has applied for, is eligible for, or has received behavioral health services; or

(ii) Is the parent or legal guardian of a person who has applied for, is eligible for, or has received behavioral health services;

(b) Is a counselor credentialed under chapter 18.19 RCW;

(c) Has completed specialized training provided by or contracted through the medicaid agency. If the person was trained by trainers approved by the department of social and health services before October 1, 2004, and has met the requirements in (a), (b) and (d) of this subsection by January 31, 2005, the person is exempt from completing this specialized training;

(d) Has successfully passed an examination administered by the medicaid agency or an authorized contractor; and

(e) Has received a written notification letter from the medicaid agency stating that the medicaid agency recognizes the person as a "peer counselor."

"Quality plan" means an overarching system and/or process whereby quality assurance and quality improvement activities are incorporated and infused into all aspects of a behavioral health administrative service organization's (BH-ASO's) or managed care organization's (MCO's) operations.

"Residential services" means a complete range of residences and supports authorized by resource management services and which may involve a facility, a distinct part thereof, or services which support community living, for people who are acutely mentally ill, adults who are chronically mentally ill, children who are severely emotionally disturbed, or adults who are seriously disturbed and determined by the behavioral health organization to be at risk of becoming acutely or chronically mentally ill.

"Resource management services" means the planning, coordination, and authorization of residential services and community support services for people who are:

(a) Adults and children who are acutely mentally ill;

(b) Adults who are chronically mentally ill;

(c) Children who are severely emotionally disturbed; or

(d) Adults who are seriously disturbed and determined solely by a behavioral health organization to be at risk of becoming acutely or chronically mentally ill.

"Substance use disorder" means a cluster of cognitive, behavioral, and physiological symptoms indicating that a person continues using the substance despite significant substance-related problems. The diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to the use of the substances.

"Supervision" means the regular monitoring of the administrative, clinical, or clerical work performance of a staff member, trainee,

student, volunteer, or employee on contract by a person with the authority to give direction and require change.

"Youth" means a person who is age seventeen or younger.

NEW SECTION

WAC 182-538D-0234 Behavioral health administrative service organizations—When the medicaid agency administers regional behavioral health services. (1) If a currently operating behavioral health administrative service organization (BH-ASO) chooses to stop functioning as a BH-ASO, fails to perform contract requirements and fails to correct the issue to the medicaid agency's satisfaction when corrective action is issued, or does not meet the requirements under RCW 71.24.045, the following is implemented:

(a) Under RCW 71.24.035(16), the director of the medicaid agency:

(i) Is designated as the BH-ASO until a new BH-ASO is designated; and

(ii) Assumes the duties assigned to the region without a participating BH-ASO.

(b) The medicaid agency:

(i) Administers behavioral health services within the region without a participating BH-ASO; and

(ii) Continues to apply the BH-ASO requirements in chapter 182-538C WAC.

(2) A person who resides within the service area of a region without a participating BH-ASO may receive services, within available resources as defined in RCW 71.24.025(2), from any provider of behavioral health services that is contracted with the medicaid agency and licensed by the department of health.

NEW SECTION

WAC 182-538D-0246 Behavioral health administrative service organizations and managed care organizations—Public awareness of behavioral health services. A behavioral health administrative service organization (BH-ASO), or a managed care organization (MCO), or a BH-ASO's or MCO's designee must provide public information on the availability of mental health and substance use disorder services. The BH-ASO or MCO must:

(1) Maintain information on available services, including crisis services and the recovery help line in telephone directories, public web sites, and other public places in easily accessible formats; and

(2) Publish and disseminate brochures and other materials or methods for describing services and hours of operation that are appropriate for all people, including those who may be visually impaired, limited-English proficient, or unable to read.

NEW SECTION

WAC 182-538D-0254 Behavioral health administrative service organizations and managed care organizations—Voluntary and involuntary inpatient evaluation and treatment services. (1) A behavioral health administrative service organization (BH-ASO) and managed care organization (MCO) must develop and implement age and culturally competent behavioral health services that are consistent with chapters 71.24, 71.05, and 71.34 RCW.

(2) For involuntary evaluation and treatment services, the BH-ASO or MCO:

(a) Must ensure that people in their regional service area have access to involuntary inpatient care; and

(b) Is responsible for coordinating discharge planning with the treating inpatient facility.

NEW SECTION

WAC 182-538D-0258 Behavioral health administrative service organizations—Administration of the Mental Health Involuntary Treatment Act and Substance Use Disorders Involuntary Treatment Act. Behavioral health administrative service organizations (BH-ASOs) are responsible for administration of the Mental Health Involuntary Treatment Act and Substance Use Disorders Involuntary Treatment Act, including investigation, detention, transportation for people not eligible for medicaid, due process and other court-related services, and other services required by chapters 71.05, 71.24, and 71.34 RCW. This includes:

(1) BH-ASOs ensuring that designated crisis responders (DCRs) perform the duties of involuntary investigation and detention in accordance with the requirements of chapters 71.05, 71.24, and 71.34 RCW.

(2) BH-ASOs and managed care organizations documenting the person's compliance with the conditions of mental health less restrictive alternative court orders by:

(a) Ensuring periodic evaluation of each committed person for release from or continuation of an involuntary treatment order. Evaluations must be recorded in the clinical record, and must occur at least monthly for ninety-day commitments and one hundred eighty-day commitments.

(b) Notifying the DCR if noncompliance with the less restrictive alternative order impairs the person sufficiently to warrant detention or evaluation for detention and petitioning for revocation of the less restrictive alternative court order.

NEW SECTION

WAC 182-538D-0262 Behavioral health administrative service organizations and managed care organizations—Behavioral health ombuds office. (1) A behavioral health administrative service organization

(BH-ASO) must provide unencumbered access to and maintain the independence of the behavioral health ombuds. Managed care organizations (MCOs) must ensure the BH-ASO provides access to omsbuds for medicaid managed care enrollees.

(2) Behavioral health ombuds must be current consumers of the mental health or substance use disorder system, or past consumers or family members of past consumers.

(3) The BH-ASO must maintain a behavioral health ombuds office that:

(a) Is reflective of the age and demographic character of the region and assists and advocates for people with resolving issues at the lowest possible level;

(b) Is independent of the BH-ASO, MCO, medicaid agency, and the provider network, unless by written exception from the medicaid agency;

(c) Supports people, family members, and other interested parties regarding issues, grievances, and appeals;

(d) Is accessible to people, including having a toll-free, independent phone line for access;

(e) Is able to access provider sites and records relating to people with appropriate releases so that it can reach out to people and help to resolve issues, grievances, and appeals;

(f) Receives training and adheres to confidentiality consistent with this chapter and chapters 71.05, 71.24, and 71.34 RCW;

(g) Involves other people, at the person's request;

(h) Supports people in the pursuit of a formal resolution;

(i) If necessary, continues to assist the person through the administrative hearing process;

(j) Coordinates and collaborates with allied services to improve the effectiveness of advocacy and to reduce duplication when serving the same person;

(k) Provides information on grievances to the BH-ASO;

(l) Provides reports and formalized recommendations at least biennially to the BH-ASO and local consumer and family advocacy groups; and

(m) Posts and makes information available to people regarding the behavioral health ombuds office consistent with WAC 182-538D-0262, and local advocacy organizations that may assist people in understanding their rights.

NEW SECTION

WAC 182-538D-0264 Behavioral health administrative service organizations and managed care organizations—Quality plan. A behavioral health administrative service organization (BH-ASO) and managed care organization (MCO) must have a quality plan for continuous quality improvement in the delivery of culturally competent behavioral health services. See WAC 182-538-140 for MCOs and WAC 182-538C-040 for BH-ASOs.

NEW SECTION

WAC 182-538D-0380 Managed care organization—Choice of primary behavioral health provider. The managed care organization (MCO) must:

(1) Ensure that each person receiving nonemergency behavioral health rehabilitation services has a primary behavioral health provider who is responsible to carry out the individual service plan; and

(2) Allow people, parents of people age twelve and younger, and guardians of people of all ages to select a primary behavioral health provider from the available primary behavioral health provider staff within the MCO.

(3) Assign a primary behavioral health provider not later than fifteen working days after the person requests services if the person does not select a primary behavioral health provider.

(4) Allow a person to change primary behavioral health providers at any time for any reason. The person must notify the MCO or its designee of the request for a change, and inform the MCO or designee of the name of the new primary behavioral health provider.

DEPARTMENT OF CORRECTIONS ACCESS TO CONFIDENTIAL MENTAL HEALTH INFORMATION

NEW SECTION

WAC 182-538D-0600 Purpose. In order to enhance and facilitate the department of corrections' ability to carry out its responsibility of planning and ensuring community protection, mental health records and information, as defined in this section, that are otherwise confidential shall be released by any mental health service provider to the department of corrections personnel for whom the information is necessary to carry out the responsibilities of their office as authorized in RCW 71.05.445. Department of corrections personnel must use records only for the stated purpose and must assure that records remain confidential and subject to the limitations on disclosure outlined in chapter 71.05 RCW, except as provided in RCW 72.09.585.

NEW SECTION

WAC 182-538D-0620 Scope. Many records and reports are updated on a regular or as needed basis. The scope of the records and reports to be released to the department of corrections are dependent upon the reason for the request.

(1) For the purpose of a presentence investigation release only the most recently completed or received records of those completed or received within the twenty-four-month period before the date of the request; or

(2) For all other purposes including risk assessments release all versions of records and reports that were completed or received within the ten year period prior to the date of the request that are still available.

NEW SECTION

WAC 182-538D-0630 Time frame. The mental health service provider will provide the requested relevant records, reports and information to the authorized department of corrections person in a timely manner, according to the purpose of the request:

(1) Presentence investigation - Within seven days of the receipt of the request. If some or all of the requested relevant records, reports and information are not available within that time period the mental health service provider shall notify the authorized department of corrections person prior to the end of the seven-day-period and provide the requested relevant records, reports or information within a mutually agreed to time period; or

(2) All other purposes - Within thirty days of the receipt of the request. If some or all of the requested relevant records, reports and information are not available within that time period the mental health service provider shall notify the authorized department of corrections person prior to the end of the thirty-day period and provide the requested relevant records, reports or information within a mutually agreed to time period; or

(3) Emergent situation requests - When an offender subject has failed to report for department of corrections supervision or in an emergent situation that poses a significant risk to the public, the mental health provider shall upon request, release information related to mental health services delivered to the offender and, if known, information regarding the whereabouts of the offender. Requests if oral must be subsequently confirmed in writing the next working day, which includes email or facsimile so long as the requesting person at the department of corrections is clearly defined. The request must specify the information being requested. Disclosure of the information requested does not require the consent of consumer.

Information that can be released is limited to:

(a) A statement as to whether the offender is or is not being treated by the mental health services provider; and

(b) Address or information about the location or whereabouts of the offender.

NEW SECTION

WAC 182-538D-0640 Written requests. The written request for relevant records, reports and information must include:

(1) Verification that the person for whom records, reports and information are being requested is under the authority of the department of corrections, per chapter 9.94A RCW, and the expiration date of that authority;

(2) Sufficient information to identify the person for whom records, reports and information are being requested including name and other identifying data;

(3) Specification as to which records and reports are being requested and the purpose for the request;

(4) Specification as to what relevant information is requested and the purpose for the request;

(5) Identification of the department of corrections person to whom the records, reports and information shall be sent, including the person's name, title and address;

(6) Name, title and signature of the requestor and date of the request.

Chapter 182-100 WAC
PROBLEM GAMBLING

NEW SECTION

WAC 182-100-0100 Problem gambling and gambling disorder treatment services. (1) Under RCW 41.05.750, the Washington state health care authority (HCA) administers a program to:

(a) Prevent and treat problem gambling and gambling disorder; and

(b) Train professionals to identify and treat problem gambling issues and gambling disorders. Training must be administered by a qualified person who has training and experience in treatment services for people experiencing a problem gambling issue or gambling disorder.

(2) To be eligible to receive treatment under this program, a person must participate in a behavioral health assessment process under WAC 246-341-0610 to determine that the person:

(a) Has a problem gambling issue or gambling disorder;

(b) Wants treatment and is willing to do the work necessary to undergo treatment; and

(c) Is unable to afford treatment.

(3) Family members of a person who has a problem gambling issue or gambling disorder may be eligible to receive treatment if they are unable to afford treatment.

(4) Treatment under this section is available only to the extent of the funds appropriated or otherwise made available to HCA for this purpose.

(5) Problem gambling and gambling disorder treatment services include diagnostic screening and assessment, and individual, group, couples, and family counseling and case management.

(6) An agency providing problem gambling and gambling disorder services must meet the behavioral health agency licensure, certification, administration, personnel, clinical, and outpatient requirements in WAC 246-341-0754 and 246-341-0300 through 246-341-0650.

(7) Definitions for the purposes of this section only.

(a) **"Gambling disorder"** means a mental disorder as defined in the most current edition of the *Diagnostic and Statistical Manual of Mental Disorders* and is characterized by loss of control over gambling, progression in preoccupation with gambling and in obtaining money to gamble, and continuation of gambling despite adverse consequences;

(b) **"Problem gambling"** means at-risk behavior that compromises, disrupts, or damages family or personal relationships, or vocational pursuits.