PROPOSED RULE MAKING

CR-102 (June 2012)
(Implements RCW 34.05.320)
Do **NOT** use for expedited rule making

Agency: Health Care Authority, Washington Apple Health

☒ **Preproposal Statement of Inquiry was filed as WSR** 16-08-050**; or**
☐ **Expedited Rule Making--Proposed notice was filed as WSR _____; or**
☐ **Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1).**

☒ **Original Notice**
☐ **Supplemental Notice to WSR _____**
☐ **Continuance of WSR _____**

Title of rule and other identifying information:

182-538-130, Exemptions and ending enrollment in managed care.
182-538-150, Apple health foster care program.
182-501-0200, Third-party resources.

Hearing location:
Health Care Authority
Cherry Street Plaza Building; Sue Crystal Conf Rm 106A
626 - 8th Avenue, Olympia WA 98504

Metered public parking is available street side around building. A map is available at:
http://www.hca.wa.gov/documents/directions_to_csp.pdf
or directions can be obtained by calling: (360) 725-1000

Date: **July 5, 2016** Time: **10:00 a.m.**

Submit written comments to:
Name: HCA Rules Coordinator
Address: PO Box 45504, Olympia WA, 98504-5504
Delivery: 626 – 8th Avenue, Olympia WA 98504
e-mail arc@hca.wa.gov
fax (360) 586-9727

by **5:00 pm on July 5, 2016**

Date of intended adoption: Not sooner than July 6, 2016
(Note: This is **NOT** the **effective** date)

Assistance for persons with disabilities: Contact Amber Lougheed by July 1, 2016
e-mail: amber.lougheed@hca.wa.gov or (360) 725-1349
TTY (800) 848-5429 or 711

Purpose of the proposal and its anticipated effects, including any changes in existing rules:

- Revised these sections to reflect that HCA is now delegating third-party activities to managed care organizations.
- Revised citation in WAC 182-538-150(3)(b) to reflect that adoption support and foster care alumni can opt out of the Apple Health Foster Care program for any reason.
- Made housekeeping changes.

Reasons supporting proposal: See Purpose.

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Statute being implemented: RCW 41.05.021, 41.05.160

Is rule necessary because of a:

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

If yes, CITATION:

DATE
May 31, 2016

NAME
Wendy Barcus

SIGNATURE
Wendy Barcus

TITLE
HCA Rules Coordinator

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: May 31, 2016
TIME: 1:46 PM

WSR 16-12-089

(COMPLETE REVERSE SIDE)

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

Name of proponent: Health Care Authority

☐ Private
☐ Public
☒ Governmental

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting.....	Sean Sullivan	PO Box 42716, Olympia WA, 98504-2716	(360) 725-1344
Implementation....	Evelyn Cantrell	PO Box 42716, Olympia WA, 98504-5504	(360) 725-9970
Enforcement.....	Evelyn Cantrell	PO Box 42716, Olympia WA, 98504-5504	(360) 725-9970

Has a small business economic impact statement been prepared under chapter 19.85 RCW or has a school district fiscal impact statement been prepared under section 1, chapter 210, Laws of 2012?

☐ Yes. Attach copy of small business economic impact statement or school district fiscal impact statement.

A copy of the statement may be obtained by contacting:
Name:
Address:

phone ( )
fax ( )
e-mail

☒ No. Explain why no statement was prepared.

The agency has determined that the proposed filing does not impose a disproportionate cost impact on small businesses or nonprofits.

Is a cost-benefit analysis required under RCW 34.05.328?

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

phone ( )
fax ( )
e-mail

☒ No: Please explain:

RCW 34.05.328 does not apply to Health Care Authority rules unless requested by the Joint Administrative Rules Review Committee or applied voluntarily.

AMENDATORY SECTION (Amending WSR 15-15-053, filed 7/9/15, effective 8/9/15)

WAC 182-501-0200 Third-party resources. (1) The medicaid agency requires a provider to seek timely reimbursement from a third party when a client has available third-party resources, except as described under subsections (2) and (3) of this section.

(2) The agency pays for medical services and seeks reimbursement from a liable third party when the claim is for any of the following:

(a) Prenatal care;

(b) Labor, delivery, and postpartum care (except inpatient hospital costs) for a pregnant woman; or

(c) Preventive pediatric services as covered under the early and periodic screening, diagnosis and treatment program.

(3) The agency pays for medical services and seeks reimbursement from any liable third party when both of the following apply:

(a) The provider submits to the agency documentation of billing the third party and the provider has not received payment after thirty days from the date of services; and

(b) The claim is for a covered service provided to a client on whose behalf the office of support enforcement is enforcing an absent parent to pay support. For the purpose of this section, "is enforcing" means the absent parent either:

(i) Is not complying with an existing court order; or

(ii) Received payment directly from the third party and did not pay for the medical services.

(4) The provider may not bill the agency or the client for a covered service when a third party pays a provider the same amount as or more than the agency rate.

(5) When the provider receives payment from a third party after receiving reimbursement from the agency, the provider must refund to the agency the amount of the:

(a) Third-party payment when the payment is less than the agency's maximum allowable rate; or

(b) ((~~The~~)) Agency payment when the third-party payment is equal to or more than the agency's maximum allowable rate.

(6) The agency does not pay for medical services if third-party benefits are available to pay for the client's medical services when the provider bills the agency, except under subsections (2) and (3) of this section.

(7) The client is liable for charges for covered medical services that would be paid by the third-party payment when the client either:

(a) Receives direct third-party reimbursement for the services; or

(b) Fails to execute legal signatures on insurance forms, billing documents, or other forms necessary to receive insurance payments for services rendered. See WAC 182-503-0540 for assignment of rights.

(8) The agency considers an adoptive family to be a third-party resource for the medical expenses of the birth mother and child only when there is a written contract between the adopting family and either the birth mother, the attorney, the provider, or the adoption service. The contract must specify that the adopting family will pay for the medical care associated with the pregnancy.

(9) A provider cannot refuse to furnish covered services to a client because of a third-party's potential liability for the services.

(10) For third-party liability on personal injury litigation claims, the agency or managed care organization (MCO) is responsible for providing medical services under WAC 182-501-0100.

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

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

(a) The client ((~~has or the enrollee becomes~~)) or enrollee is eligible for medicare((~~, TRICARE, or any other third-party health care coverage comparable to the agency's managed care coverage~~));

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

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

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

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

(2)(a) The following people may request ((~~that~~)) the agency ((~~exempt~~)) to approve an exemption or end enrollment in managed care ((~~as described in this section~~)):

(i) A client or enrollee;

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

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

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

(i) Is American Indian or Alaska native;

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

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

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

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

(i) The care must be medically necessary;

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

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

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

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

(c) When the agency denies a request for exemption or ((~~ending~~)) to end enrollment, the agency will notify the client or enrollee of its decision by telephone or in writing and confirms a telephone notification in writing. When a client or enrollee is limited-English proficient, the written notice must be available in the client's or enrollee's primary language under 42 C.F.R. 438.10. The written notice must contain all the following information:

(i) The agency's decision;

(ii) The reason for the decision;

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

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

(4)((~~(a)~~)) 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.

((~~(b) A client seeking to remain unenrolled who appeals an agency denial retains that status pending the appeal if the appeal is filed within the time frames required in WAC 182-504-0130.~~))

(5) The agency will grant a request from an MCO to ((~~remove~~)) end enrollment of an enrollee ((~~from enrollment~~)) 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 ((~~for ending~~)) 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 ((~~the enrollee's termination of~~)) 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 ((~~the enrollee's~~)) 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) When the agency receives a request from an MCO to ((~~remove an enrollee from~~)) end enrollment ((~~in managed care~~)) 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) The MCO will continue to provide services to the enrollee until the date the individual is no longer enrolled.

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

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

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

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

(a) WAC 182-538-068;

(b) WAC 182-538-071;

(c) WAC 182-538-096; and

(d) WAC 182-538-111.

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

((~~(a) The agency will not enroll a client in AHFC or will end an enrollee's enrollment in AHFC when the client has, or becomes eligible for, TRICARE or any other third-party health care coverage that would:~~

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

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

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

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

(5) The agency sends written information about covered services when the individual becomes eligible to enroll in AHFC and at any time

there is a change in covered services. In addition, the agency requires MCOs 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.