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 16-23-149**; 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:

182-538-040 Introduction; 182-538-050 Definitions; 182-538-110 The grievance system for managed care organizations (MCO); 182-538-140 Quality of care; 182-538A-110 The grievance system for fully integrated managed care (FIMC) managed care organizations (MCOs);182-538B-110 Grievance system; and 182-538C-040 Behavioral health services

Hearing location:
Health Care Authority
Cherry Street Plaza Building; Pear Conf Rm 107626 - 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: **May 9, 2017** 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 May 9, 2017**

Date of intended adoption: Not sooner than May 10, 2017
(Note: This is **NOT** the **effective** date)

Assistance for persons with disabilities: Contact Amber Lougheed by May 5, 2017
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:

The agency is amending these rules to comply with the federal rule changes adopted by the Centers for Medicare and Medicaid Services (CMS), which revised 42 CFR Parts 431, 433, 438, 440, 457 and 495. These changes modernize the Medicaid managed care regulations to reflect changes in the use of managed care delivery systems and are primarily related to the grievance and appeals process rules.

Reasons supporting proposal: See purpose above.

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: 42 C.F.R. Parts 431, 433, 438, 440, 457, and 495

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: April 05, 2017
TIME: 9:07 AM

WSR 17-08-092

DATE
April 5, 2017

NAME
Wendy Barcus

SIGNATURE
Wendy Barcus

TITLE
HCA Rules Coordinator

(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.....	Melinda Froud	PO Box 42716, Olympia WA, 98504-2716	(360) 725-1408
Implementation....	Evelyn Cantrell	PO Box 45504, Olympia, WA 98504-5504	(360) 725-9970
Enforcement.....	..Evelyn Cantrell	PO Box 45504, 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 15-24-098, filed 12/1/15, effective 1/1/16)

WAC 182-538-040 Introduction. This chapter governs services provided under the Washington apple health managed care contracts. ((~~Washington apple health managed care services are available through either a managed care organization (MCO) or primary care case management (PCCM) provider.~~)) If a conflict exists between the requirements of this chapter and other rules, the requirements of this chapter take precedence.

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

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

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

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

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

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

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

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

(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 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 ((~~request by an enrollee or provider with written permission~~)) review by an MCO of an ((~~enrollee for reconsideration of an action~~)) 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.

"Client" means, for the purposes of this chapter, ((~~an individual~~)) a person eligible for any Washington apple health program, in-

cluding managed care programs, but who is not enrolled with an MCO or PCCM provider.

"Disenrollment" - See "end enrollment."

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

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

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

"Enrollee" means ((~~an individual~~)) 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.

"Grievance" means an expression of dissatisfaction about any matter other than an ((~~action, as "action" is defined in this section~~)) adverse benefit determination.

"Grievance and appeal system" means the ((~~overall system that includes grievances and appeals handled at the MCO level and access to the agency's hearing process~~)) 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.

"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.

"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.

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

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

WAC 182-538-110 The grievance and appeal system, independent review, and agency administrative hearing for managed care organization((s)) (MCO) enrollees. (1) **Introduction.** This section contains information about the grievance ((~~system for managed care organization (~~)) and appeal system, the right to independent review, 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. ((~~The system must comply with the requirements of 42 C.F.R. 438 Subpart F, medicaid agency rules in Title 182 WAC, and the rules of the state office of insurance commissioner (OIC) in chapter 284-43 WAC.~~

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

~~(2)~~)) (b) Once an MCO enrollee has completed the MCO appeal process, the enrollee has the option of requesting an independent review (IR) (referred to as an external medical review (EMR) in the Code of Federal Regulations (C.F.R.)) by an independent review organization (IRO) regarding any adverse benefit determination upheld by the MCO. See subsection (8) of this section.

(c) Once an MCO enrollee has completed the MCO appeals process, the MCO enrollee also 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 ((~~action~~)) adverse benefit determination, which is ((~~called~~)) a grievance;

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

(iii) Access to an independent review (IR) by an independent review organization (IRO) in accordance with RCW 48.43.535 ((~~and WAC 182-526-0200~~)), chapters 284-43 and 284-43A WAC, and subsection (8) of this section; and

(iv) 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, independent review, and the agency's administrative hearing process.

(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, independent review, 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. MCOs may not require enrollees to provide written follow-up for a grievance or an appeal the MCO received orally.

(g) 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) The MCO must ensure that the ((~~individuals~~)) people who make decisions on grievances and appeals are ((~~individuals~~)) people:

(i) Who were ((~~not~~)) neither involved in any previous level of review or decision making, nor a subordinate of that person; and

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

(A) An appeal of an ((~~action~~)) 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.

((~~(3)~~)) (iii) Who take into account all comments, documents, records, and other information submitted by the enrollee or the enrol-

lee'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 ((~~an~~)) the MCO. A provider may not file a grievance on behalf of an enrollee without the enrollee's written consent.

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

(c) The MCO must complete the ((~~disposition~~)) 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 ((~~disposition~~)) resolution of grievances within five business days of determination.

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

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

(e) Enrollees do not have a right to an agency administrative hearing ((~~in regards~~)) to dispute the ((~~disposition~~)) resolution of a grievance.

((~~(4) The~~)) (5) **MCO's notice of** ((~~action~~)) **adverse benefit determination.**

(a) **Language and format requirements.** The notice of ((~~action~~)) 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** ((~~of action~~)). The notice of MCO ((~~action~~)) adverse benefit determination must explain:

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

(ii) The reasons for the ((~~action~~)) 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, the right to an independent review, and the right to request an agency administrative hearing;

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

((~~(v)~~)) (vi) The circumstances under which an appeal can be expedited ((~~resolution is available~~)) and how to request it;

((~~(vi)~~)) (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** ((~~of action~~)). The MCO must mail the notice of ((~~action~~)) 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 ((~~such action~~))

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 ((~~action~~)) adverse benefit determination affecting the claim. This applies only when the ((~~client~~)) enrollee can be held liable for the costs associated with the ((~~action~~)) 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 ((~~three business days~~)) seventy-two hours after receipt of the request for service.

(B) The MCO may extend the ((~~three business days~~)) 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.

((~~(5)~~)) (6) **The MCO appeal**((~~s~~)) **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 ((~~MCO action~~)) adverse benefit determination from the MCO.

(b) **Oral appeals.** An MCO must treat oral inquiries about appealing an ((~~action~~)) 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 receipt of each appeal to both the enrollee and the requesting provider within ((~~three~~)) five calendar days. 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 ((~~ninety~~)) sixty calendar days of the date on the MCO's notice of ((~~action~~)) 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 ((~~actions~~)) 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 ((~~action~~)) adverse benefit determination.

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

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

(i) Provide the enrollee a reasonable opportunity to present evidence and allegations of fact or law, both in person and 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((~~s~~)) process to examine the enrollee's case file, including medical records and any other documents and records considered during the appeal((~~s~~)) process free of charge; 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 ((~~forty-five~~)) 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, ((~~or appeals of mental health drug authorization decisions,~~)) including notice to the affected parties, no longer than three calendar days after the MCO receives the appeal. ((~~(i)~~)) 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 initiate 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((~~:~~
~~(i) Be in writing and~~)) 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.

((~~(ii) Include~~)) (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((~~.~~

~~(j) Administrative hearing rights. For appeals not resolved wholly in favor of the enrollee, the notice of resolution of the appeal must:~~

~~(i) 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;~~

~~(ii) Include information on the enrollee's right to receive services while the hearing is pending and how to make the request as described in the agency hearing rules in WAC 182-526-0200; and~~

~~(iii) Inform the enrollee that the enrollee may be held liable for the cost of services received for the first sixty days after an administrative hearing request is received by the agency or the office of administrative hearings (OAH), if the hearing decision upholds the MCO's action.~~

~~(6)~~));

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

(A) The right to request an independent review (IR) in accordance with RCW 48.43.535 and subsection (8) of this section;

(B) The right to request an agency administrative hearing in accordance with RCW 74.09.741 and chapter 182-526 WAC, and how to request the hearing;

(C) The right to request and receive benefits while an agency administrative hearing is pending, and how to make the request in accordance with subsection (10) of this section and the agency's administrative hearing rules in chapter 182-526 WAC;

(D) That the enrollee may be held liable for the cost of those benefits received for the first sixty days after the agency or the office of administrative hearings (OAH) receives an agency administrative hearing request, if the hearing decision upholds the MCO's 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 ((~~review~~)) process ((~~for appeals~~)) 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 ((~~or~~)), physical or mental health, or ability to attain, maintain, or regain maximum function.

(b) The enrollee may file an expedited appeal either orally 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 ((~~three~~)) 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 ((~~three business days~~)) 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.

((~~(g)~~)) (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.

((~~(h)~~)) (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.

((~~(7)~~)) (8) **Independent review.**

(a) After completing the MCO's appeal process, an enrollee may request an independent review (IR) by a certified independent review organization (IRO) of an adverse benefit determination by the MCO that resulted in a decision not wholly favorable to the enrollee. See RCW 48.43.535.

(b) The enrollee must submit a request for an IR according to the time frame and process established by the MCO in accordance with RCW 48.43.535, chapter 284-43 WAC, and chapter 284-43A WAC.

(c) The IR is optional for the enrollee and is not required before the enrollee requests an agency administrative hearing.

(d) A request for an IR stays (postpones) any pending agency administrative hearing regarding the adverse benefit determination until the IR process is completed.

(e) The IR option is not available once an agency administrative hearing has been held and an initial or final order has been issued regarding the adverse benefit determination.

(9) **Agency administrative hearing.**

(a) ((~~Only an enrollee or enrollee's authorized representative may request an administrative hearing. A provider may not request a hearing on behalf of an enrollee.~~)) **Authority to file.** See WAC 182-526-0090 and 182-526-0155.

(b) **Right to agency administrative hearing.** If an enrollee does not agree with the MCO's resolution of an appeal and has completed the MCO process, 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 ((~~WAC 182-526-0200~~)) 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. A request for independent review does not stay the deadline for requesting an agency administrative hearing.

(d) **Independent party.** The 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.

((~~(d) An enrollee must exhaust the appeals process within the MCO's grievance system before requesting an administrative hearing with the agency.~~

~~(8)~~)) (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.

(10) **Continuation of previously authorized services** ((~~during the appeal process~~)).

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

(i) The enrollee, or enrollee's authorized representative, or ((~~the~~)) 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 ((~~action involving services previously authorized~~)) adverse benefit determination; or

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

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

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

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

~~(v) The enrollee requests an extension of services~~)).

(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 appeal;

(ii) ((~~Ten calendar days pass after the MCO mails notice of the resolution of the appeal against the enrollee and the enrollee has not requested an agency administrative hearing with continuation of services during the ten day time frame;~~)) 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((~~;~~

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

(c) If the final resolution of the appeal upholds the MCO's ((~~action~~)) 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 ((~~was received by the agency or OAH~~)), to the extent that

services were provided solely because of the requirement for continuation of services.

((~~(9)~~)) (11) **Effect of reversed resolutions of appeals.**

(a) **Services not furnished while an appeal is pending.** If the MCO, or an independent review organization, or a final order 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 or a final order 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 182-538-140 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. ((~~MCO's~~)) 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 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

((~~(iv)~~)) (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 16-05-051, filed 2/11/16, effective 4/1/16)

WAC 182-538A-110 The grievance and appeal system, independent review, and agency administrative hearing for fully integrated managed care (FIMC) managed care organization((s)) (MCO((s))) enrollees. Managed care enrollees in fully integrated managed care (FIMC) regional service areas ((~~may file grievances or appeal actions through the grievance system of managed care organizations (MCOs) as~~)) follow the same rules and process described in WAC 182-538-110.

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

WAC 182-538B-110 Grievance and appeal system, independent review, and agency administrative hearing. (1) **Introduction.** This section contains information about the managed care organization (MCO) grievance and appeal system, independent review, and the agency's administrative hearing process for enrollees under the behavioral health services wraparound contract in fully integrated managed care (FIMC) regional service areas.

(a) The MCO must have a grievance and appeal system and access to independent review and 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.

((~~(e) The MCO must maintain records of grievances and appeals.~~))

(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((~~, which is called a grievance~~));

(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~~)) subsection (5) of this section;

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

(e) Allowing enrollees and ((~~their~~)) 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 ((~~disposition~~)) 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 ((~~disposition~~)) 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 receipt of each appeal to both the enrollee and the requesting provider within three calendar days. 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 ((~~must be filed~~)) within ((~~ninety~~)) sixty calendar days of the date on the MCO's notice of action.

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

(f) The MCO appeal((~~s~~)) 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 authorized representative opportunity before and during the appeal((~~s~~)) process to examine the enrollee's case file, including medical records and any other documents and records considered during the appeal((~~s~~)) process at no charge; 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 ((~~individuals~~)) 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 ((~~three calendar days~~)) 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.

(5) **Independent review.**

(a) After completing the MCO's appeal process, an enrollee may request an independent review (IR) by a certified independent review organization (IRO) of an adverse benefit determination by the MCO that resulted in a decision wholly unfavorable to the enrollee. See RCW 48.43.535.

(b) An enrollee must submit a request for an IR according to the time frames and process established by the MCO in accordance with RCW 48.43.535 and chapter 284-43 WAC.

(c) The IR is optional for the enrollee and not required before the enrollee requests an agency administrative hearing.

(d) A request for an IR stays (postpones) any pending agency administrative hearing regarding the adverse benefit determination until the IR process is completed.

(e) The IR option is not available once an agency administrative hearing has been held and an initial or final order has been issued regarding the adverse benefit determination.

(6) **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 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.

((~~(d) An enrollee must exhaust the appeals process within the MCO's grievance system before requesting an administrative hearing with the agency.~~

~~(6)~~)) (7) **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) Grievance system termination.~~)) (8) **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 182-538C-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.

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

(a) The BH-ASO provides the following services to all ((~~individuals~~)) 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).

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

(c) The BH-ASO provides the following services to ((~~individuals~~)) people who are not eligible for medicaid coverage and are involuntarily or voluntarily detained under chapter 71.05 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 and 71.34 RCW and RCW 70.96A.140.

(3) The BH-ASO may provide contracted noncrisis behavioral health services to ((~~individuals~~)) people in an FIMC 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 regional service area, the BH-ASO is a subcontractor with all FIMC 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 or 71.34 RCW.

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

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

(b) The grievance and appeal system, independent review, 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 16-15-030, filed 7/13/16, effective 8/13/16)

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) 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((~~, which is called a grievance~~));

(b) An appeal((~~s~~)) 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((~~s~~)) 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 ((~~ninety~~)) 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((~~s~~)) 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((~~s~~)) 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.

(iii) The appeal determination must not exceed forty-five calendar days from the day the BH-ASO receives the appeal.

(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.

((~~(d) A person must exhaust the appeals process within the BH-ASO's grievance system before requesting an administrative hearing with the agency.~~))

(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) ((~~Grievance system termination.~~)) **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.