WAC 182-538-050 Definitions. The following definitions and abbreviations and those found in chapter 182-500 WAC apply to this chapter. If conflict exists, this chapter takes precedence.

"Administrative hearing" means an evidentiary adjudicative proceeding before an administrative law judge or presiding officer that is available to an enrollee under chapter 182-526 WAC 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.

"Child or youth with special health care needs" means a client under age 19 who is:

(a) Eligible for supplemental security income under Title XVI of the Social Security Act;

(b) Eligible for medicaid under section 1902 (e)(3) of the Social Security Act;

(c) In foster care or other out-of-home placement;

(d) Receiving foster care or adoption assistance; or

(e) Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501 (a)(1)(D) of Title V of the Social Security Act.

"Client" - 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 90 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 20 or younger with complex behavioral health needs; and

(b) Their families.

[Statutory Authority: RCW 41.05.021, 41.05.160 and 42 C.F.R. 438.50. WSR 22-07-107, § 182-538-050, filed 3/23/22, effective 4/23/22. Statutory Authority: RCW 41.05.021, 41.05.160, 2019 c 325, 2014 c 225, and 2018 c 201. WSR 19-24-063, § 182-538-050, filed 11/27/19, effective 1/1/20. Statutory Authority: RCW 41.05.021, 41.05.160 and 42 C.F.R. Parts 431, 433, 438, 440, 457, and 495. WSR 17-23-199, § 182-538-050, filed 11/22/17, effective 12/23/17. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-24-098, § 182-538-050, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-050, filed 12/19/12, effective 2/1/13. WSR 11-14-075, recodified as § 182-538-050, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. WSR 08-15-110, § 388-538-050, filed 7/18/08, effective 8/18/08; WSR 06-03-081, § 388-538-050, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.522, 2003 E1 c 25 § 201(4), 2004 c 276 § 201(4), 42 U.S.C. 1396N (section 1915 (b) and (c) of the Social Security Act of 1924). WSR 05-01-066, § 388-538-050, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.522. WSR 03-18-109, § 388-538-050, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.09.080, 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. WSR 02-01-075, § 388-538-050, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090, 74.09.510 and [74.09.]522 and 1115 Federal Waiver, 42 U.S.C. 1396 (a), (e), (p), 42 U.S.C. 1396r-6(b), 42 U.S.C. 1396u-2. WSR 00-04-080, § 388-538-050, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. WSR 95-18-046 (Order 3886), § 388-538-050, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. WSR 93-17-039 (Order 3621), § 388-538-050, filed 8/11/93, effective 9/11/93.]