Chapter 182-538 WAC
MANAGED CARE

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WAC

182-538-040 Introduction.
182-538-050 Definitions.
182-538-060 Managed care choice and assignment.
182-538-067 Qualifications to become a managed care organization (MCO) in integrated managed care.
182-538-068 Qualifications to become a primary care case management (PCCM) provider in integrated managed care regional service areas.
182-538-070 Payments, corrective action, and sanctions for managed care organizations (MCOs).
182-538-071 Payments for primary care case management (PCCM) providers in the integrated managed care for regional service areas.
182-538-095 Scope of care for integrated managed care enrollees and managed care organization benefit administration requirements.
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).
182-538-120 Enrollee request for a second medical opinion.
182-538-130 Exemptions and ending enrollment in managed care.
182-538-140 Quality of care.
182-538-150 Apple health foster care program.
182-538-170 Notice requirements.
182-538-180 Rights and protections.
182-538-190 Behavioral health services only (BHSO).
182-538-195 Telemedicine and store and forward technology.

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

182-538-061 Voluntary enrollment into managed care—Washington medicaid integration partnership (WMIP). [Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-061, filed 12/19/12, effective 2/1/13. WSR 11-14-075, recodified as § 182-538-061, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. WSR 08-15-110, § 388-538-061, filed 7/18/08, effective 8/18/08; WSR 06-03-081, § 388-538-061, 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, § 388-538-061, filed 12/8/04, effective 1/8/05.] Repealed by WSR 15-24-098, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021 and 41.05.160.

182-538-063 Managed care for medical care services clients. [Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-063, filed 12/19/12, effective 2/1/13. Statutory Authority: RCW 41.05.021, 74.09.035, and 2011 1st sp.s. c 36. WSR 12-19-051, § 182-538-063, filed 9/13/12, effective 10/14/12. WSR 11-14-075, recodified as § 182-538-063, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 2007 c 522 § 209 (13)-(14). WSR 08-10-048, § 388-538-063, filed 5/1/08, effective 6/1/08. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. WSR 06-24-036, § 388-538-063, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090 and 74.09.522. WSR 06-03-081, § 388-538-063, filed 1/12/06, effective 2/12/06. Statutory Authority: RCW 74.08.090, 74.09.035, 74.09.522, and 2003 1st sp.s. c 25 § 209(15). WSR 04-15-003, § 388-538-063, filed 7/7/04, effective 8/7/04.] Repealed by WSR 15-24-098, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021 and 41.05.160.

182-538-065 Medicaid-eligible basic health (BH) enrollees. [Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-065, filed 12/19/12, effective 2/1/13. WSR 11-14-075, recodified as § 182-538-065, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. WSR 06-03-081, § 388-538-065, 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, § 388-538-065, filed 12/8/04, effective 1/8/05. 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, § 388-538-065, 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, § 388-538-065, filed 2/1/00, effective 3/3/00.] Repealed by WSR 15-24-098, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021 and 41.05.160.

182-538-112 The department of social and health services' (DSHS) hearing process for enrollee appeals of managed care organization (MCO) actions. [WSR 11-14-075, recodified as § 182-538-112, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. WSR 08-15-110, § 388-538-112, filed 7/18/08, effective 8/18/08; WSR 06-03-081, § 388-538-112, 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, § 388-538-112, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.522, and 74.09.450. WSR 04-13-002, § 388-538-112, filed 6/2/04, effective 7/3/04. Statutory Authority: RCW 74.08.090, 74.09.522. WSR 03-18-110, § 388-538-112, filed 9/2/03, effective 10/3/03.] Repealed by WSR 13-02-010, filed 12/19/12, effective 2/1/13. Statutory Authority: RCW 41.05.021, 42 C.F.R. 438.

WAC 182-538-040 Introduction. (1) This chapter governs services provided under the Washington apple health integrated managed care (IMC) contract.

(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.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2019 c 325, 2014 c 225, and 2018 c 201. WSR 19-24-063, § 182-538-040, 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, § 182-538-040, filed 11/22/17, effective 12/23/17. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-24-098, § 182-538-040, 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 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 multi-county 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.]

WAC 182-538-060 Managed care choice and assignment. (1) 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 IMC enrollment 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.

(4) An enrollee in IMC must enroll with an MCO available in the regional service area where the 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) An enrollee may be placed into the PRC program by the MCO or the agency. 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:

(i) Assigns the client according to agency policy, or this rule, or both;

(ii) Does not assign clients to any MCO that has a total statewide market share of forty percent or more of clients who are enrolled in apple health IMC. On a quarterly basis, the agency reviews enrollment data to determine each MCO's statewide market share in apple health IMC;

(iii) Applies performance measures associated with increasing or reducing assignment consistent with this rule and agency policy or its contracts with MCOs.

(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/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.

(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).

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 20-20-011, § 182-538-060, filed 9/24/20, effective 10/25/20. Statutory Authority: RCW 41.05.021, 41.05.160, 2019 c 325, 2014 c 225, and 2018 c 201. WSR 19-24-063, § 182-538-060, filed 11/27/19, effective 1/1/20. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-24-098, § 182-538-060, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-060, filed 12/19/12, effective 2/1/13. WSR 11-14-075, recodified as § 182-538-060, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. WSR 08-15-110, § 388-538-060, filed 7/18/08, effective 8/18/08; WSR 06-03-081, § 388-538-060, 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, § 388-538-060, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.522. WSR 03-18-109, § 388-538-060, 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, § 388-538-060, 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, § 388-538-060, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. WSR 98-16-044, § 388-538-060, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. WSR 95-18-046 (Order 3886), § 388-538-060, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. WSR 93-17-039 (Order 3621), § 388-538-060, filed 8/11/93, effective 9/11/93.]

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 apple health IMC contract, a managed care organization (MCO) must:

(a) Contract with the agency; and

(b) 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) An MCO must meet the following qualifications to be eligible to contract with the 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) 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.

(3)(a) The agency may from time to time conduct a procurement for new apple health MCOs or to reduce or expand the use of existing apple health MCOs.

(b) The agency may conduct a procurement when the agency determines in its sole discretion there is a need to:

(i) Expand or reduce current MCO contracts;

(ii) Enhance current MCO provider networks; or

(iii) Establish new contracts for integrated managed care in one or more regional services areas; or

(iv) Adjust the program to ensure adherence to state and federal law.

(c) In accordance with RCW 74.09.522 and 74.09.871, the agency will give significant weight to the following factors in any procurement process:

(i) Demonstrated commitment to, and experience in, serving low-income populations;

(ii) Demonstrated commitment to, and experience in, serving persons who have mental illness, substance use disorders, or co-occurring disorders;

(iii) Demonstrated commitment to, and experience with, partnerships with county and municipal criminal justice systems, housing services, and other critical support services necessary to achieve the outcomes established in RCW 70.320.020, 71.24.435, and 71.36.025;

(iv) Recognition that meeting enrollees' physical and behavioral health care needs is a shared responsibility of contracted behavioral health administrative services organizations, MCOs, service providers, the state, and communities;

(v) Consideration of past and current performance and participation in other state or federal behavioral health programs as a contractor;

(vi) Quality of services provided to enrollees under previous contracts with the state of Washington or other states;

(vii) Accessibility, including appropriate utilization, of services offered to enrollees;

(viii) Demonstrated capability to perform contracted services, including the ability to supply an adequate provider network; and

(ix) The ability to meet any other requirements established by the agency.

(d) The agency may define and consider additional factors as part of any procurement including, but not limited to:

(i) Timely processing of, and payments to, providers in the MCO networks, including reconciliation of outstanding payments; and

(ii) The optimal number of MCOs per regional services area, based on population and in the manner that the agency determines most beneficial for the program, clients, and providers.

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

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 20-20-011, § 182-538-067, filed 9/24/20, effective 10/25/20. Statutory Authority: RCW 41.05.021, 41.05.160, 2019 c 325, 2014 c 225, and 2018 c 201. WSR 19-24-063, § 182-538-067, filed 11/27/19, effective 1/1/20. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-24-098, § 182-538-067, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-067, filed 12/19/12, effective 2/1/13. WSR 11-14-075, recodified as § 182-538-067, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. WSR 08-15-110, § 388-538-067, filed 7/18/08, effective 8/18/08; WSR 06-03-081, § 388-538-067, 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, § 388-538-067, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.522. WSR 03-18-112, § 388-538-067, filed 9/2/03, effective 10/3/03. Statutory Authority: RCW 74.09.080, RCW 74.08.510, [74.08.]522, 74.09.450, 1115 Waiver, 42 U.S.C. 1396. WSR 02-01-075, § 388-538-067, filed 12/14/01, effective 1/14/02.]

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.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2019 c 325, 2014 c 225, and 2018 c 201. WSR 19-24-063, § 182-538-068, filed 11/27/19, effective 1/1/20. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-24-098, § 182-538-068, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-068, filed 12/19/12, effective 2/1/13. WSR 11-14-075, recodified as § 182-538-068, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. WSR 08-15-110, § 388-538-068, filed 7/18/08, effective 8/18/08; WSR 06-03-081, § 388-538-068, filed 1/12/06, effective 2/12/06. 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, § 388-538-068, filed 12/14/01, effective 1/14/02.]

WAC 182-538-070 Payments, corrective action, and sanctions for managed care organizations (MCOs). (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) Home health services delivered through MCOs involving an in-home visit by a provider require the provider to comply with electronic visit verification requirements. See WAC 182-551-2220.

(4) 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.

(5) 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.

(6) The agency may require corrective action for:

(a) Substandard rates of clinical performance measures;

(b) Deficiencies found in audits and on-site visits; or

(c) Findings of noncompliance with any contractual, state, or federal requirements.

(7) The agency may:

(a) Impose sanctions for an MCO's noncompliance with any contractual, state, or federal requirements including, but not limited to,

intermediate sanctions as described in 42 C.F.R. Sec. 438.700 and 42 C.F.R. Sec. 438.702; and

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

(8) As authorized by 42 C.F.R. Sec. 438.702(b), if an MCO fails to meet any material obligation under the MCO contract including, but not limited to, the items listed in 42 C.F.R. Sec. 438.700 (b), (c), or (d), the agency may impose the maximum allowable sanction on a per-occurrence, per-day basis until the agency determines the MCO has:

(a) Corrected the violation; and

(b) Remedied any harm caused by the noncompliance.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 24-08-060, § 182-538-070, filed 3/29/24, effective 4/29/24. Statutory Authority: RCW 41.05.021, 41.05.160, and P.L. 114-255. WSR 23-24-026, § 182-538-070, filed 11/29/23, effective 1/1/24. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 23-03-063, § 182-538-070, filed 1/12/23, effective 2/12/23. Statutory Authority: RCW 41.05.021, 41.05.160, 2019 c 325, 2014 c 225, and 2018 c 201. WSR 19-24-063, § 182-538-070, filed 11/27/19, effective 1/1/20. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 18-08-035, § 182-538-070, filed 3/27/18, effective 4/27/18; WSR 15-24-098, § 182-538-070, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-070, filed 12/19/12, effective 2/1/13. WSR 11-14-075, recodified as § 182-538-070, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. WSR 08-15-110, § 388-538-070, filed 7/18/08, effective 8/18/08; WSR 06-03-081, § 388-538-070, 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, § 388-538-070, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.522. WSR 03-18-109, § 388-538-070, 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, § 388-538-070, 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, § 388-538-070, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090. WSR 96-24-073, § 388-538-070, filed 12/2/96, effective 1/2/97. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. WSR 95-18-046 (Order 3886), § 388-538-070, filed 8/29/95 effective 9/1/95. Statutory Authority: RCW 74.08.090. WSR 93-17-039 (Order 3621), § 388-538-070, filed 8/11/93, effective 9/11/93.]

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.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2019 c 325, 2014 c 225, and 2018 c 201. WSR 19-24-063, § 182-538-071, filed 11/27/19, effective 1/1/20. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-24-098, § 182-538-071, 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) An enrollee in integrated managed care (IMC) is eligible only for the scope of services 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 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 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.

(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 are determined to be not medically necessary as defined in WAC 182-500-0070.

(b) 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.

MCO Benefit Administration Requirements.

(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;

(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, 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); or

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

(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;

(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;

(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;

(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.

(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.

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

(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.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2019 c 325, 2014 c 225, and 2018 c 201. WSR 19-24-063, § 182-538-095, filed 11/27/19, effective 1/1/20. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-24-098, § 182-538-095, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-095, filed 12/19/12, effective 2/1/13. WSR 11-14-075, recodified as § 182-538-095, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. WSR 08-15-110, § 388-538-095, filed 7/18/08, effective 8/18/08. Statutory Authority: RCW 74.04.050, 74.08.090, 74.09.530, and 74.09.700. WSR 06-24-036, § 388-538-095, filed 11/30/06, effective 1/1/07. Statutory Authority: RCW 74.08.090 and

74.09.522. WSR 06-03-081, § 388-538-095, 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, § 388-538-095, filed 12/8/04, effective 1/8/05. Statutory Authority: RCW 74.08.090, 74.09.522. WSR 03-18-109, § 388-538-095, 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, § 388-538-095, filed 12/14/01, effective 1/14/02. Statutory Authority: RCW 74.08.090. WSR 01-02-076, § 388-538-095, filed 12/29/00, effective 1/29/01. 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, § 388-538-095, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. WSR 98-16-044, § 388-538-095, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. WSR 95-18-046 (Order 3886), § 388-538-095, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. WSR 93-17-039 (Order 3621), § 388-538-095, filed 8/11/93, effective 9/11/93.]

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 that are covered based on the enrollee's apple health eligibility program. See WAC 182-501-0060 and 182-501-0065 for categories of services that are covered and program rules for specific services that are covered.

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

(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.

(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.

(4) The agency will not authorize or pay for the following services:

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

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

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

[Statutory Authority: RCW 41.05.021, 41.05.160, 2019 c 325, 2014 c 225, and 2018 c 201. WSR 19-24-063, § 182-538-096, filed 11/27/19, ef-

fective 1/1/20. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-24-098, § 182-538-096, 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, without 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 provider outside the managed care system; and

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

[Statutory Authority: RCW 41.05.021, 41.05.160, 2019 c 325, 2014 c 225, and 2018 c 201. WSR 19-24-063, § 182-538-100, filed 11/27/19, effective 1/1/20. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-24-098, § 182-538-100, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-100, filed 12/19/12, effective 2/1/13. WSR 11-14-075, recodified as § 182-538-100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. WSR 08-15-110, § 388-538-100, filed 7/18/08, effective 8/18/08; WSR 06-03-081, § 388-538-100, filed 1/12/06, effective 2/12/06; WSR 03-18-110, § 388-538-100, 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, § 388-538-100, 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, §

388-538-100, 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), § 388-538-100, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. WSR 95-04-033 (Order 3826), § 388-538-100, filed 1/24/95, effective 2/1/95; WSR 93-17-039 (Order 3621), § 388-538-100, filed 8/11/93, effective 9/11/93.]

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 15 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.

(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 the MCO received orally.

(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.

(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 45 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 10 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 14 calendar days following receipt of the request for service. An extension of up to 14 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 72 hours after receipt of the request for service.

(B) The MCO may extend the 72-hour time frame up to 14 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.

(c) **Acknowledgment letter.** The MCO must acknowledge in writing receipt of each standard 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 a standard appeal filed orally by an enrollee. The MCO must acknowledge receipt of each expedited appeal either orally or in writing within two business days.

(d) **Standard service authorization - 60-day deadline.** For appeals involving standard service authorization decisions, an enrollee must file an appeal within 60 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 - 10-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 10 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 30 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 72 hours after the MCO receives the appeal. The MCO may extend the 72-hour time frame up to 14 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 60 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 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 issue a final decision and provide notice as expeditiously as the enrollee's physical or mental health condition requires, but not later than 72 hours after receiving the appeal. The MCO may extend the time frame for an expedited appeal, up to 14 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.

(d) 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.

(e) 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.

(f) 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 – 120 days.** An enrollee's request for an agency administrative hearing must be filed no later than 120 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 10 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 10 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 60 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 72 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.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 25-05-061, s 182-538-110, filed 2/14/25, effective 3/17/25. Statutory Authority: RCW 41.05.021, 41.05.160, 2019 c 325, 2014 c 225, and 2018 c 201. WSR 19-24-063, § 182-538-110, 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, § 182-538-110, filed 11/22/17, effective 12/23/17. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-24-098, § 182-538-110, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-110, filed 12/19/12, effective 2/1/13. WSR 11-14-075, recodified as § 182-538-110, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. WSR 08-15-110, § 388-538-110, filed 7/18/08, effective 8/18/08; WSR 06-03-081, § 388-538-110, filed 1/12/06, effective 2/12/06; WSR 03-18-110, § 388-538-110, 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, § 388-538-110, 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, § 388-538-110, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.08.090. WSR 97-04-004, § 388-538-110, filed 1/24/97, effective 2/24/97. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. WSR 95-18-046 (Order 3886), § 388-538-110, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. WSR 94-04-038 (Order 3701), § 388-538-110, filed 1/26/94, effective 2/26/94; WSR 93-17-039 (Order 3621), § 388-538-110, filed 8/11/93, effective 9/11/93.]

WAC 182-538-111 The administrative hearing process for primary care case management (PCCM). PCCM enrollees follow the same administrative hearing rules and processes as fee-for-service clients under chapter 182-526 WAC.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2019 c 325, 2014 c 225, and 2018 c 201. WSR 19-24-063, § 182-538-111, filed 11/27/19, effective 1/1/20. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-24-098, § 182-538-111, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-111, filed 12/19/12, effective 2/1/13. WSR 11-14-075, recodified as § 182-538-111, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. WSR 08-15-110, § 388-538-111, filed 7/18/08, effective 8/18/08; WSR 06-03-081, § 388-538-111, filed 1/12/06, effective 2/12/06; WSR 03-18-110, § 388-538-111, filed 9/2/03, effective 10/3/03.]

WAC 182-538-120 Enrollee request for a second medical opinion. (1) A managed care enrollee has the right to a timely referral for a second opinion upon request when:

(a) The enrollee needs more information about treatment recommended by the provider or managed care organization (MCO); or

(b) The enrollee believes the MCO is not authorizing medically necessary care.

(2) A managed care enrollee has a right to a second opinion from a participating provider. At the MCO's discretion, a clinically appropriate nonparticipating provider who is agreed upon by the MCO and the enrollee may provide the second opinion.

(3) Primary care case management (PCCM) enrollees have a right to a timely referral for a second opinion by another provider who has a core provider agreement with the agency.

[Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-120, filed 12/19/12, effective 2/1/13. WSR 11-14-075, recodified as § 182-538-120, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. WSR 08-15-110, § 388-538-120, filed 7/18/08, effective 8/18/08; WSR 06-03-081, § 388-538-120, 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, § 388-538-120, filed 12/8/04, effective 1/8/05. 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, § 388-538-120, 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, § 388-538-120, 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), § 388-538-120, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. WSR 93-17-039 (Order 3621), § 388-538-120, filed 8/11/93, effective 9/11/93.]

WAC 182-538-130 Exemptions and ending enrollment in managed care. 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 exempts or ends enrollment from mandatory managed care when any of the following apply:

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

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

(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;

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

(iv) Is a child or youth with special health care needs as defined in WAC 182-538-050.

(3) **Case-by-case clinical criteria.** 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) 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.

(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:

(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.

(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.

(8) **MCO request.** The agency will grant a request from an MCO to end enrollment of an enrollee 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 10 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.

(e) The MCO will continue to provide services to the enrollee until the date the person is no longer enrolled.

(f) The agency may exempt the client for the period of time the circumstances are expected to exist. The agency may periodically review those circumstances to determine if they continue to exist. Any authorized exemption will continue only until the client can be enrolled in IMC.

[Statutory Authority: RCW 41.05.021, 41.05.160 and 42 C.F.R. 438.50. WSR 22-07-107, § 182-538-130, 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, § 182-538-130, filed 11/27/19, effective 1/1/20. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 16-23-021, § 182-538-130, filed 11/4/16, effective 1/1/17; WSR 15-24-098, § 182-538-130, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-130, filed 12/19/12, effective 2/1/13. WSR 11-14-075, recodified as § 182-538-130, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. WSR 08-15-110, § 388-538-130, filed 7/18/08, effective 8/18/08; WSR 06-03-081, § 388-538-130, filed 1/12/06, effective 2/12/06; WSR 03-18-111, § 388-538-130, 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, § 388-538-130, 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, § 388-538-130, filed 2/1/00, effective 3/3/00. Statutory Authority: RCW 74.04.050, 74.04.055, 74.04.057 and 74.08.090. WSR 98-16-044, § 388-538-130, filed 7/31/98, effective 9/1/98. Statutory Authority: RCW 74.08.090 and 1995 2nd sp.s. c 18. WSR 95-18-046 (Order 3886), § 388-538-130, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. WSR 93-17-039 (Order 3621), § 388-538-130, filed 8/11/93, effective 9/11/93.]

WAC 182-538-140 Quality of care. 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:

(1) Have a clearly defined quality organizational structure and operation, including a fully operational quality assessment, measurement, and improvement program;

(2) Have effective means to detect overutilization and underutilization of services;

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

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

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

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

(b) Evaluation of the entity before delegation;

(c) An annual evaluation of the entity; and

(d) 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;

(6) 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;

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

(8) 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;

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

(10) Maintain a health information system that:

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

(b) 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;

(c) 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 10 years;

(d) 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

(e) 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;

(11) Conduct performance improvement projects designed to achieve significant improvement, sustained over time, in clinical care outcomes and services, and that involve the following:

(a) Measuring performance using objective quality indicators;

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

(c) Evaluating the effectiveness of system changes;

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

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

(f) Completing each performance improvement project timely so as to generally allow aggregate information to produce new quality of care information every year;

(12) Ensure enrollee access to health care services;

(13) Ensure continuity and coordination of enrollee care;

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

(15) Perform client satisfaction surveys; and

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

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 23-03-063, § 182-538-140, filed 1/12/23, effective 2/12/23. Statutory Authority: RCW 41.05.021, 41.05.160, 2019 c 325, 2014 c 225, and 2018 c 201. WSR 19-24-063, § 182-538-140, 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, § 182-538-140, filed 11/22/17, effective 12/23/17. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-24-098, § 182-538-140, filed 12/1/15, effective 1/1/16. Statutory Authority: RCW 41.05.021, 42 C.F.R. 438. WSR 13-02-010, § 182-538-140, filed 12/19/12, effective 2/1/13. WSR 11-14-075, recodified as § 182-538-140, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090 and 74.09.522. WSR 08-15-110, § 388-538-140, filed 7/18/08, effective 8/18/08; WSR 06-03-081, § 388-538-140, filed 1/12/06, effective 2/12/06; WSR 03-18-111, § 388-538-140, 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, § 388-538-140, 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, § 388-538-140, 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), § 388-538-140, filed 8/29/95, effective 9/1/95. Statutory Authority: RCW 74.08.090. WSR 93-17-039 (Order 3621), § 388-538-140, filed 8/11/93, effective 9/11/93.]

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 people.

(b) The agency will enroll eligible 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.

(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) 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 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.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2019 c 325, 2014 c 225, and 2018 c 201. WSR 19-24-063, § 182-538-150, filed 11/27/19, effective 1/1/20. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 16-23-021, § 182-538-150, filed 11/4/16, effective 1/1/17; WSR 15-24-098, § 182-538-150, filed 12/1/15, effective 1/1/16.]

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

[Statutory Authority: RCW 41.05.021, 41.05.160, 2019 c 325, 2014 c 225, and 2018 c 201. WSR 19-24-063, § 182-538-170, filed 11/27/19, effective 1/1/20.]

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.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2019 c 325, 2014 c 225, and 2018 c 201. WSR 19-24-063, § 182-538-180, filed 11/27/19, effective 1/1/20.]

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.

[Statutory Authority: RCW 41.05.021, 41.05.160, 2019 c 325, 2014 c 225, and 2018 c 201. WSR 19-24-063, § 182-538-190, filed 11/27/19, effective 1/1/20.]

WAC 182-538-195 Telemedicine and store and forward technology. The medicaid agency's rules related to the authorized use of telemedicine and store and forward technology are found in WAC 182-501-0300 and are applicable to the benefits (including behavioral health services) administered by agency-contracted managed care entities (managed care organizations and behavioral health administrative service organizations) and fee-for-service programs.

[Statutory Authority: RCW 41.05.021, 41.05.160, and 2021 c 157. WSR 23-04-048, § 182-538-195, filed 1/26/23, effective 2/26/23.]