PROPOSED RULE MAKING

CR-102 (December 2017)
(Implements RCW 34.05.320)
Do **NOT** use for expedited rule making

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STATE OF WASHINGTON
FILED

DATE: November 20, 2019
TIME: 11:38 AM

WSR 19-23-096

Agency: Health Care Authority

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

☒ **Preproposal Statement of Inquiry was filed as WSR** 19-08-089 **; or**
☐ **Expedited Rule Making--Proposed notice was filed as WSR _____; or**
☐ **Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1); or**
☐ **Proposal is exempt under RCW _____.**

Title of rule and other identifying information: (describe subject) Chapter 182-502A - Program Integrity

Hearing location(s):

Date:	**Time:**	**Location:** (be specific)	**Comment:**
December 24, 2019	10:00 AM	Health Care Authority Cherry Street Plaza Sue Crystal Conference Room 626 8th Ave, Olympia WA 98504	Metered public parking is available street side around building. A map is available at: https://www.hca.wa.gov/assets/program/Driving-parking-checkin-instructions.pdf or directions can be obtained by calling: (360) 725-1000

Date of intended adoption: Not sooner than December 26, 2019 (Note: This is **NOT** the **effective** date)

Submit written comments to:
Name: HCA Rules Coordinator
Address: PO Box 42716, Olympia WA 98504-2716
Email: arc@hca.wa.gov
Fax: (360) 586-9727
Other:
By (date) December 24, 2019

Assistance for persons with disabilities:
Contact Amber Lougheed
Phone: (360) 725-1349
Fax: (360) 586-9727
TTY: Telecommunication Relay Services (TRS): 711
Email: amber.lougheed@hca.wa.gov
Other:
By (date) December 13, 2019

Purpose of the proposal and its anticipated effects, including any changes in existing rules: This amendment removes unnecessary definitions, shortens definitions for terms defined elsewhere, and uses the terms “preliminary finding” and “final notice,” consistent with all types of program integrity (PI) activities.

WAC 182-502A-0401 provides detail about PI activity methods and specifies that the agency may request and evaluate records or other information. This rule also sets out requirements for the electronic or facsimile submission of records and states that the agency destroys hardcopies submitted without prior approval. The rule provides that entities must not adjust or rebill a claim subject to a PI activity until the activity and all appeals are exhausted. Subsection (8) requires that entities allow the agency access to its premises and provide requested records.

WAC 182-502A-0801 clarifies that the dispute resolution process is informal.

WAC 182-502A-0901 uses the term administrative hearing, consistent with Chapter 182-526 WAC, and clarifies that there is no hearing right for a denied claim payment.

WAC 182-502A-1001 clarifies that the agency must publish metrics for contractors' audits, and it may publish metrics for the agency's own PI activities.

WAC 182-502A-1101 is a new section added for managed care organizations (MCOs).

- These rules require MCOs to: enforce all PI contract terms and regulations; conduct and enforce PI activities; and establish an appeals process for subcontractors and providers to contest overpayments.
- This rule also states that subcontractors and providers do not have the right to an administrative hearing on the results of the appeals process.
- Overpayment assessments that are not appealed must be recovered within 60 days of: 1) the overpayment being identified and assessed; or 2) the completion of the appeals process regarding a disputed overpayment assessment.
- MCOs must report to the agency overpayments and related appeals and results.
- The agency may identify MCO overpayments to subcontractors and providers and may sanction an MCO or assess liquidated damages for MCO provider fraud, waste, and abuse, or as outlined in the parties' contract.

Reasons supporting proposal: The revisions make the chapter easier to understand and align with federal and state regulations.

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Statute being implemented: RCW 41.05.021, 41.05.160

Is rule necessary because of a:

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

If yes, CITATION: C.F.R. Sections 438.608- 438.610

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

Name of proponent: (person or organization) Health Care Authority

☐ Private
☐ Public
☒ Governmental

Name of agency personnel responsible for:

	Name	Office Location	Phone
Drafting:	Melinda Froud	PO Box 42716, Olympia WA 98504-2716	360-725-1408
Implementation:	Scott Best	PO Box 45503, Olympia WA 98504-5503	360-725-1396
Enforcement:	Scott Best	PO Box 45503, Olympia WA 98504-5503	360-725-1396

Is a school district fiscal impact statement required under RCW 28A.305.135? ☐ Yes ☒ No

If yes, insert statement here:
N/A

The public may obtain a copy of the school district fiscal impact statement by contacting:
Name:
Address:

Phone:
Fax:
TTY:
Email:
Other:

Is a cost-benefit analysis required under RCW 34.05.328?

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

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

☒ No: Please explain: RCW 34.05.328 does not apply to Health Care Authority rules unless requested by the Joint Administrative Rules Review Committee or applied voluntarily.

Regulatory Fairness Act Cost Considerations for a Small Business Economic Impact Statement:

This rule proposal, or portions of the proposal, **may be exempt** from requirements of the Regulatory Fairness Act (see chapter 19.85 RCW). Please check the box for any applicable exemption(s):

☐ This rule proposal, or portions of the proposal, is exempt under RCW 19.85.061 because this rule making is being adopted solely to conform and/or comply with federal statute or regulations. Please cite the specific federal statute or regulation this rule is being adopted to conform or comply with, and describe the consequences to the state if the rule is not adopted.

Citation and description:

☐ This rule proposal, or portions of the proposal, is exempt because the agency has completed the pilot rule process defined by RCW 34.05.313 before filing the notice of this proposed rule.

☐ This rule proposal, or portions of the proposal, is exempt under the provisions of RCW 15.65.570(2) because it was adopted by a referendum.

☐ This rule proposal, or portions of the proposal, is exempt under RCW 19.85.025(3). Check all that apply:

- ☐ RCW 34.05.310 (4)(b) (Internal government operations)
- ☐ RCW 34.05.310 (4)(c) (Incorporation by reference)
- ☐ RCW 34.05.310 (4)(d) (Correct or clarify language)
- ☐ RCW 34.05.310 (4)(e) (Dictated by statute)
- ☐ RCW 34.05.310 (4)(f) (Set or adjust fees)
- ☐ RCW 34.05.310 (4)(g) ((i) Relating to agency hearings; or (ii) process requirements for applying to an agency for a license or permit)

☐ This rule proposal, or portions of the proposal, is exempt under RCW _____.

Explanation of exemptions, if necessary:

COMPLETE THIS SECTION ONLY IF NO EXEMPTION APPLIES

If the proposed rule is **not exempt**, does it impose more-than-minor costs (as defined by RCW 19.85.020(2)) on businesses?

☒ No Briefly summarize the agency's analysis showing how costs were calculated. The new section, 182-502A-1101 – Managed care organizations, does not apply to small businesses. The amended sections of this Chapter clarify other entities' responsibilities, but does not impose new costs.

☐ Yes Calculations show the rule proposal likely imposes more-than-minor cost to businesses, and a small business economic impact statement is required. Insert statement here:

The public may obtain a copy of the small business economic impact statement or the detailed cost calculations by contacting:

Name:
Address:
Phone:

Fax:
TTY:
Email:
Other:

Date: November 20, 2019	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

AMENDATORY SECTION (Amending WSR 15-01-129, filed 12/19/14, effective 1/19/15)

WAC 182-502A-0101 ((~~Program integrity —~~))Purpose. (1) Program integrity means a system of reasonable and consistent oversight of the medicaid program.

(2) The medicaid agency conducts program integrity activities to ((~~identify and prevent or recover~~)) detect and prevent potential fraud, waste, and abuse. These activities include identifying improper ((~~agency~~)) payments and recovering overpayments.

AMENDATORY SECTION (Amending WSR 18-07-050, filed 3/14/18, effective 4/14/18)

WAC 182-502A-0201 ((~~Program integrity —~~))Definitions. The definitions in this section and those found in chapter 182-500 WAC apply throughout this chapter.

Adverse determination means a finding of an overpayment identified in a program integrity activity.

((**Agency** ~~means the Washington state health care authority and includes the agency's designees.~~))

Algorithm means the set of rules applied to claim or encounter data to identify overpayments.

Audit means an examination of claims data, an entity's records, or both, to determine whether the entity has complied with applicable laws, rules, regulations, and agreements.

Audit, on-site means an audit conducted partially at an entity's place of business.

Audit, self means an audit conducted by the entity and reviewed by the agency.

((**Contractor** ~~is any person contracted by the agency to oversee how health benefits are provided or to administer health benefits to clients on the agency's behalf. A contractor includes, but is not limited to:~~

~~• A behavioral health organization (BHO) as defined in WAC 182-500-0015;~~

~~• A behavioral health administrative service organization (BH-ASO) as defined in WAC 182-538C-050;~~

~~• A managed care organization (MCO) as defined in WAC 182-538-050; or~~

~~• An accountable community of health.~~))

Credible allegation of fraud ((~~means the agency has investigated an allegation of fraud and concluded that the existence of fraud is more probable than not~~)) - See 42 C.F.R. 455.2.

Data mining means using software to detect patterns or aberrancies in a data set.

((**Designee** ~~means a person the agency has designated to perform program integrity activities on its behalf.~~))

Educational intervention means agency-provided education to an entity prior to or following an agency-initiated program integrity activity that has identified an adverse determination. Educational intervention includes, but is not limited to, any notice of adverse de-

terminations issued by the agency or any agency training that has failed to correct the level of payment error.

Encounter includes any service provided by a federally qualified health center, rural health clinic, or tribe, which is paid an enhanced rate; and any service provided to a Washington apple health client who is covered by an MCO or other contractor, and reported to the agency.

Entity includes current and former contractors, providers, and their subcontractors.

Extrapolation means a method of estimating an unknown value by projecting the results of a sample to the universe from which the sample was drawn.

Fraud ((~~means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to oneself or some other person. This includes any act that constitutes fraud under applicable federal or state law.~~)) - See 42 C.F.R. 455.2.

Improper payment means any payment by the agency that was more than or less than the sum to which the payee was legally entitled.

Metrics mean the quantifiable measures used to track and assess the status of program integrity activities and entity performance. ((~~Metrics include, but are not limited to:~~

~~• Adverse determinations;~~

~~• Identified improper payments;~~

~~• Cost avoidance;~~

~~• Payments; and~~

~~• Recoveries.~~))

Net payment error rate means the calculated percentage of the improper payment amount identified in the sample of claims for the audit period divided by the total payment amount sampled claims for the audit period.

Overpayment see RCW 41.05A.010, including any subsequent amendments.

((~~**Payee** includes providers who are reimbursed by agency-contracted managed care organizations.~~

~~**Person** means an individual, corporation, business trust, estate, trust, partnership, limited liability company, association, joint venture, government, governmental subdivision, agency, public corporation, or any other legal or commercial entity.~~

~~**Program integrity activities** means those activities conducted by the agency or the agency's designees to determine compliance with applicable laws, rules, regulations, and agreements.~~))

Program integrity compliance plan means a document issued by the agency outlining the importance of ethical behavior on the part of the agency's contracted entities, as well as identified monitoring, auditing, and educational obligations an entity must comply with to remain an agency-contracted entity.

Record means any document or electronically stored information including writings, drawings, graphs, charts, photographs, sound recordings, images, and other data or data compilations, stored in any medium from which information can be obtained either directly or, if necessary, after translation by the entity into a reasonably usable form. This includes documentation relating to claims, encounters, and payments.

Relevant - See Federal Rule of Evidence 401.

Risk assessment means to identify potential risk of fraud, waste and abuse, and improper payments within all Washington apple health programs.

Sustained high level of payment error means the net payment error rate is equal to or exceeds five percent for the audit period.

Universe means a defined population of claims or encounters or both.

AMENDATORY SECTION (Amending WSR 18-07-050, filed 3/14/18, effective 4/14/18)

WAC 182-502A-0301 ((~~Program integrity —~~))Authority to conduct program integrity activities. The medicaid agency ((~~may~~)) conducts program integrity activities ((~~and designate agents to do so on its behalf,~~)) on all Title XIX, Title XXI, and state-only-funded expenditures. See 42 C.F.R. 2.54, 431, 433, 438, 447, 455, 456, 457, 495, and 1001; 45 C.F.R. 92; 42 U.S.C. 1396a; and chapters 41.05, 41.05A, and 74.09 RCW.

AMENDATORY SECTION (Amending WSR 18-07-050, filed 3/14/18, effective 4/14/18)

WAC 182-502A-0401 Program integrity activities. ((~~(1) **Form.**~~)) The medicaid agency verifies entities' compliance with applicable laws, rules, regulations, and agreements through program integrity activities ((~~include:~~

~~(a) Conducting audits;~~

~~(b) Conducting reviews;~~

~~(c) Conducting investigations;~~

~~(d)~~)).

(1) **Methods.** Program integrity activity methods include, but are not limited to:

(a) Data mining to identify possible fraud, waste, and abuse (FWA) for further examination;

(b) Audits and reviews to determine compliance with federal, state, and agency rules and regulations, or to identify FWA;

(c) Investigations of suspected fraud and abuse;

(d) Algorithms to identify payment, program, and system irregularities leading to improper payments;

(e) On-site reviews and inspections of an entity's premises to ensure compliance with federal, state, and agency rules and regulations;

(f) Referral of enforcement actions against entities that have committed fraud or abuse to law enforcement agencies, or licensing agencies, or both;

(g) Technical assistance and education to prevent and identify potential FWA;

(h) Outreach to and education for entities and client communities, including how to report suspected fraud, explaining federal,

state, and agency rules and requirements, conducting entity self-audits and implementing compliance programs; and

(i) Initiating and reviewing entity self-audits under WAC 182-502A-0501((~~:~~

~~(e) Applying algorithms to claim or encounter data;~~

~~(f) Conducting on-site inspections of entity locations (see subsection (4) of this section); and~~

~~(g) Verifying entity compliance with applicable laws, rules, regulations, and agreements~~)).

(2) **Location.** Program integrity activities ((~~may~~)) occur((~~:~~

~~(a) On the premises of the medicaid agency;~~

~~(b) On the premises of the entity~~)) at the agency, an entity's premises, or at both locations.

(3) **Timing.** The agency may ((~~commence~~)) begin program integrity activities concerning any current or former agency-contracted entity or that entity's agent ((~~thereof~~)) at any time up to six years after the date of service.

(4) **Notice.**

(a) The agency provides ((~~a~~)) thirty-calendar-days' notice to entities ((~~prior to~~)) before an on-site visit, except in those instances identified in (c) of this subsection.

(b) Hospitals are entitled to notice as described in RCW 70.41.045(4).

(c) The agency is not required to give notice of an on-site visit if evidence exists of danger to public health and safety or fraudulent activities.

(5) **Scope.** The agency determines the scope of a program integrity activity.

(6) **Selecting information to evaluate.**

(a) The agency may evaluate any records or other information relevant to validating that the ((~~payee~~)) entity received only those funds to which it is legally entitled. ((~~In this chapter, "relevant" has a meaning identical to Federal Rule of Evidence 401.~~))

(b) The agency may select information to evaluate by:

(i) Conducting a risk assessment of claim or encounter data;

(ii) Applying algorithms;

(iii) Data mining;

(iv) Claim-by-claim review;

(v) Encounter-by-encounter review;

(vi) Stratified random sampling;

(vii) Nonstratified random sampling; or

(viii) Applying any other method, or combination of methods, designed to identify relevant information.

(7) **Collecting records and other information to evaluate.** ((~~The entity must submit a copy of all records requested by the agency.~~))

(a) ((~~The~~)) After the agency serves notice, an entity must submit ((~~requested~~)) a copy of all records and other information requested to the agency ((~~within~~)) by the ((~~time frame~~)) date stated in the request.

(b) The entity must submit records electronically or by facsimile and must follow the instructions for records submission included in the agency's notice, unless the agency gives the entity permission to submit a hard copy of the records.

(c) If sent electronically, records must be:

(i) Copied to secured media (e.g., CD or DVD) and sent to the address stated in the notice; or

(ii) Uploaded to the agency's secure file transfer protocol (SFTP) site.

(d) If an entity submits hard copy records without prior approval, the agency destroys the records and requires the entity to resubmit them in an electronic format.

(e) If an entity fails to timely comply with the request, the agency may:

(i) Deny the entity's claim under a prepay review process;

(ii) Issue a ((~~draft audit report or~~)) preliminary ((~~review notice~~)) finding; or

(iii) Issue a final ((~~audit report or~~)) notice ((~~of improper payment.~~

~~(c) An entity that fails to timely comply with a request under (a) of this subsection has no right to contest at an administrative hearing an agency action taken under (b)(i) of this subsection.~~

~~(d) The entity must submit records electronically, or by facsimile, unless the agency has given the entity written permission to submit the records in hard copy.~~

~~(e)~~)).

(f) Once a program integrity activity ((~~has commenced~~)) begins, the entity must retain all original records and supportive materials until the program integrity activity is completed and all issues resolved, even if the retention period for those records and materials extends beyond the period otherwise required by law.

((~~(8)~~)) (g) Unless instructed to do so by the agency, the entity must not adjust or rebill a claim or encounter that is within the scope of a program integrity activity until that activity ends and any resulting appeals are exhausted.

(8) **Cooperation with on-site visits, audits, and investigations.** For an on-site visit, audit, or investigation, the entity must allow the agency access to its premises and provide any records or other information requested while on-site.

(9) **Evaluating information.**

(a) The agency may evaluate relevant information by applying any method or combination of methods reasonably calculated to determine whether an entity has complied with an applicable law, regulation, or agreement.

(b) A health care provider's bill for services, appointment books, accounting records, or other similar documents alone do not qualify as appropriate documentation of services rendered.

(c) The agency provides the entity a description of the method or combination of methods used by the agency ((~~under subsection (6) of this section~~)) to select information to evaluate.

((~~(9)~~)) (10) **Nonbilled services.** Nonbilled services include any item, drug, code, or payment group that a provider does not submit on the provider's claim to the agency or contractor. When calculating improper payments, the agency does not include nonbilled services in its calculations.

((~~(10)~~)) (11) **Paid-at-zero services.** The agency considers paid-at-zero services or supplies only when conducting program integrity activities involving payment groups or encounters.

((~~(11)~~)) (12) **Conducting on-site audits.** The agency may conduct on-site audits at any entity location.

(a) During an on-site audit, the agency may create a copy of an entity's records that are potentially relevant to the audit.

(b) Failure to grant the agency access to the entity's records or premises constitutes failure to comply with a program integrity activity.

((~~(12)~~)) (13) **Conducting interviews.** The agency may interview any person it reasonably believes has relevant information ((~~under subsection (6) of this section~~)) regarding a program integrity activity. Interviews may consist of one or more sessions.

((~~(13)~~)) (14) **Costs.** The agency does not reimburse the costs an entity incurs complying with program integrity activities.

((~~(14)~~)) (15) **Conducting ((~~site~~)) on-site visits.** The agency may conduct on-site inspections of any entity location to determine whether the entity is complying with all applicable laws, rules, regulations, and agreements. ((~~See subsection (4) of this section.~~))

AMENDATORY SECTION (Amending WSR 15-01-129, filed 12/19/14, effective 1/19/15)

WAC 182-502A-0501 ((~~Program integrity—~~))Entity self-audits. (1) The medicaid agency may require an entity to self-audit.

(a) The agency ((~~will~~)) gives written notice of the instruction to self-audit.

(b) The entity must acknowledge receipt of the notice within thirty calendar days of receiving it.

(c) The entity must comply with all terms included in the notice; failure to timely comply with the notice constitutes failure to comply with a program integrity activity.

(d) The agency ((~~will~~)) does not require an entity to self-audit any services or encounters that are included in an active state or federal program integrity activity, rate adjustment, cost settlement, or other payment adjustment.

(e) The agency ((~~will~~)) reviews the self-audit and states in writing whether it accepts or rejects the results of the self-audit. If the agency rejects the results it may:

(i) Instruct the entity to repeat the self-audit; or

(ii) Audit the entity.

(2) ((~~An entity may initiate a self-audit at any time to verify payments made by the agency. When the entity's self-audit and identifies an overpayment~~)) When an entity self-discloses overpayments, it must:

(a) Submit to the agency written notice of the self-audit and identify each claim included in the self-audit.

(b) Report and repay the overpayment to the agency within sixty calendar days of identifying the overpayment, unless the overpayment is ((~~one of the following~~)):

(i) Included in an active state or federal program integrity activity((~~.~~)); or

(ii) Related to a state-initiated rate adjustment, cost settlement, or other payment adjustment.

(c) The entity's overpayment report must include:

(i) The reason for the overpayment;

(ii) How the entity calculated the overpayment; and

(iii) A list of claims associated with the overpayment.

(d) The agency ((~~will~~)) reviews the self-audit and states in writing whether it accepts or rejects the methodology and findings. If the agency rejects the findings it may:

(i) Instruct the entity to repeat the self-audit; or

(ii) Audit the entity.

(e) The agency ((~~will~~)) does not accept any identified overpayment as full or final repayment before the completion of its review of the entity's self-audit findings.

(3) The entity's dispute and appeal rights under this section are identical to its rights during an audit conducted by the office of program integrity.

AMENDATORY SECTION (Amending WSR 18-07-050, filed 3/14/18, effective 4/14/18)

WAC 182-502A-0601 ((~~Program integrity —~~))Extrapolation. (1) To determine an improper payment from a sample, the medicaid agency may extrapolate to the universe from which the sample was drawn:

(a) If the audit identifies a sustained high level of payment error involving the provider; or

(b) When the agency has documented educational intervention to the provider and the education has failed to correct the provider's level of payment error.

(2) If during the course of the audit, an entity adjusts or rebills a claim or encounter that is part of the audit sample or universe, the original claim or encounter amount remains in the audit sample or universe.

(3) When the agency uses the results of an audit sample to extrapolate the amount to be recovered, the agency provides the entity with the following information:

(a) The sample size.

(b) The method used to select the sample.

(c) The universe from which the sample was drawn.

(d) Any formulas or calculations used to determine the amount of the improper payment.

AMENDATORY SECTION (Amending WSR 18-07-050, filed 3/14/18, effective 4/14/18)

WAC 182-502A-0701 ((~~Program integrity activity —~~))Agency outcomes. (1) Following the medicaid agency's evaluation of an entity's records including, but not limited to, claims, encounter data, or payments, the agency may do any combination of the following:

(a) Deny a claim or claim line.

(b) ((~~Adjust or~~)) Recover an improperly paid claim.

(c) Instruct the entity to submit:

(i) Additional documentation((~~.~~)); or

(ii) A ((~~claim adjustment or a~~)) new claim. ((~~The entity must submit a claim adjustment or a new claim within sixty calendar days from the date of the agency's instruction or~~)) If the entity fails to

submit a new claim within sixty calendar days, the agency ((~~will deny the claim adjustment or~~)) denies the new claim((~~. An entity has no right to an adjudicative hearing for denial under this subsection~~)) as untimely.

(d) Request a refund of an improper payment to the agency by check.

(e) Refer an overpayment to the office of financial recovery for collection.

(f) Issue a ((~~draft audit report or preliminary review notice that lists~~)) preliminary finding((~~s and alleged improper payments~~)), which the entity may dispute under WAC 182-502A-0801.

(i) If an entity agrees with the preliminary ((~~findings and alleged improper payments~~)) finding before the deadline ((~~noted~~)) stated in the ((~~report or~~)) notice, the entity must notify the agency in writing. The agency then issues a final ((~~audit report or~~)) notice ((~~of improper payment~~)).

(ii) If an entity does not respond by the agency's deadline ((~~noted in the report or notice, the agency issues a final audit report or notice of improper payment, unless the agency extends the deadline~~)), the agency issues a final notice.

(g) Issue ((~~a final audit report,~~)) an overpayment notice((~~,~~)) or final notice ((~~of improper payment~~)), which the entity may appeal under WAC 182-502A-0901.

(i) The final ((~~audit report, overpayment notice, or~~)) notice ((~~of improper payment~~)) includes:

(A) The asserted overpayment or improper payment amount;

(B) The reason for an adverse determination;

(C) The specific criteria and citation of legal authority used to make the adverse determination;

(D) An explanation of the entity's appeal rights;

(E) The appropriate procedure to submit a claims adjustment, if applicable; and

(F) One or more of the following:

(I) Directives;

(II) Educational intervention; or

(III) A program integrity compliance plan.

(ii) Upon request, the agency ((~~will~~)) allows an entity with an adverse determination the option of repaying the amount owed according to a negotiated repayment plan of up to twelve months. Interest may be calculated and charged on the remaining balance each month.

(h) Recover interest under RCW 41.05A.220.

(i) Impose civil penalties under RCW 74.09.210.

(j) Refer the entity to appropriate licensing authorities for disciplinary action.

(k) Refer the entity to the agency's medical dental advisory committee for review and potential termination of the contract or core provider agreement.

(l) Determine it has sufficient evidence to make a credible allegation of fraud. The agency ((~~will~~)) then:

(i) Refers the case to the medicaid fraud control ((~~unit~~)) division and any other appropriate prosecuting authority for further action; and

(ii) Suspends some or all Washington apple health payments to the entity unless the agency determines there is good cause not to suspend payments under 42 C.F.R. 455.23.

(2) The agency may assess an overpayment and terminate the core provider agreement if an entity fails to retain adequate documentation for services billed to the agency.

(3) At any time during a program integrity activity, the agency may issue a final ((~~audit report or a~~)) notice ((~~of improper payment~~)) if the entity:

(a) Stops doing business with the agency;

(b) Transfers control of the business;

(c) Makes a suspicious asset transfer;

(d) Files for bankruptcy; or

(e) Fails to comply with program integrity activities.

(4) The entity must repay any overpayment identified by the agency within sixty calendar days of being notified of the overpayment, except when a repayment plan is negotiated with the agency under subsection (1)(g)(ii) of this section.

AMENDATORY SECTION (Amending WSR 18-07-050, filed 3/14/18, effective 4/14/18)

WAC 182-502A-0801 ((~~Program integrity~~))Dispute resolution process. (1) An entity may informally dispute a ((~~draft audit report or~~)) preliminary ((~~review notice~~)) finding. The medicaid agency must receive any request for dispute resolution within thirty calendar days of the date the entity received the ((~~draft audit report or~~)) preliminary ((~~review notice~~)) finding. The request for dispute resolution must be in writing and include the following:

(a) The supporting evidence for each disputed ((~~adverse determination~~)) preliminary finding; and

(b) The relief sought for each disputed ((~~adverse determination~~)) preliminary finding.

(2) The dispute may include a request for a dispute resolution conference (DRC).

(a) If the agency grants the entity's request for a DRC, the DRC ((~~must~~)) occurs within sixty calendar days of the date the entity received the agency's written acceptance of the request for a DRC.

(b) At least five business days before the DRC, the entity must notify the agency of who will attend the DRC on the entity's behalf.

(3) Following the timely submission of a written request for dispute resolution under subsection (1) of this section and completion of any DRC, the agency ((~~will address~~)) addresses in writing each written ((~~dispute~~)) disputed preliminary finding raised by the entity.

(4) The agency may terminate the dispute resolution process and issue a final ((~~audit report or~~)) notice ((~~of improper payment~~)) if the entity fails to ((~~submit a timely dispute or~~)) comply with the requirements ((~~under subsection (1)~~)) of this section.

AMENDATORY SECTION (Amending WSR 18-07-050, filed 3/14/18, effective 4/14/18)

WAC 182-502A-0901 ((~~Program integrity activity—Adjudicative proceedings.~~)) Administrative hearing (formal appeal) right. (1) ((~~If an entity objects to any report or notice assessing an overpayment, the entity may request an adjudicative proceeding by following the procedure set out in RCW 41.05A.170.~~

~~(2)~~)) An entity has a right to an administrative hearing (formal appeal), and any resulting appeals process under RCW 41.05A.170 and chapter 182-526 WAC, if the agency assesses an overpayment against the entity.

(2) An entity does not have an administrative hearing right for the denial of payment of a claim.

(3) At the ((~~adjudicative proceeding~~)) administrative hearing and on appeal, the entity bears the burden of proving by a preponderance of the evidence that it has complied with applicable laws, rules, regulations, and agreements.

((~~(3)~~)) (4) The ((~~adjudicative proceeding~~)) administrative hearing process is governed by chapter 34.05 RCW and chapter 182-526 WAC.

((~~(4)~~)) (5) The medicaid agency ((~~will~~)) does not recoup overpayments until a decision in the ((~~adjudicative proceeding~~)) administrative hearing is issued and all appeals, if any, have been exhausted.

((~~(5)~~)) (6) Interest on overpayments continues to accrue, but it is not collected until a decision in the ((~~adjudicative proceeding~~)) administrative hearing is issued and all appeals, if any, have been exhausted. See RCW 74.09.220.

AMENDATORY SECTION (Amending WSR 18-07-050, filed 3/14/18, effective 4/14/18)

WAC 182-502A-1001 ((~~Program integrity activity~~))Metrics. ((~~Under RCW 74.09.195 (2)(b), the medicaid agency will, on an annual basis:~~

~~(1) Compile metrics of program integrity activities conducted by the agency and its entities; and~~

~~(2) Publish the metrics on the agency's web site.~~)) (1) The medicaid agency annually, compiles and publishes metrics for any contractor that conducts audits on the agency's behalf under RCW 74.09.195 (2)(b).

(2) The agency may publish metrics of the program integrity activities it conducts. Metrics include, but are not limited to:

(a) Adverse determinations;

(b) Identified improper payments;

(c) Cost avoidance;

(d) Payments; and

(e) Recoveries.

NEW SECTION

WAC 182-502A-1101 Managed care organizations. This section applies to entities that contract with the medicaid agency to provide services in exchange for a capitated rate.

(1) Managed care organizations (MCOs) must comply with and enforce all applicable program integrity:

(a) Federal and state laws and regulations;

(b) Terms of their contracts with the agency; and

(c) Terms of their contracts with subcontractors and providers.

(2) MCOs must:

(a) Adopt and enforce program integrity policies and procedures that guide the contractor's officers, employees, agents, and subcontractors;

(b) Include and enforce federal and state program integrity requirements in their subcontracts and in their provider application, credentialing, and recredentialing processes;

(c) Adopt and implement methods for detecting and preventing fraud, waste, and abuse to ensure payments to subcontractors and providers are proper and comply with medicaid regulations and billing instructions;

(d) Perform ongoing analyses of their authorization, utilization, claims, providers' billing patterns, and encounter data to detect improper payments;

(e) Conduct reviews, audits, and investigations of subcontractors and providers;

(f) Report to the agency any:

(i) Fraud, waste, or abuse; and

(ii) Overpayments and recoveries.

(g) Recover overpayments to any subcontractor or provider; and

(h) Refer any suspected or potential fraud to the agency and to the medicaid fraud control division or other law enforcement agency.

(3) MCOs must establish an appeals process, similar to the dispute resolution process in WAC 182-502A-801, for their subcontractors or providers to contest an assessment of an overpayment by a managed care entity.

(4) MCOs' subcontractors or providers do not have a right to an administrative hearing under chapter 34.05 RCW or chapter 182-526 WAC to contest the results of the appeals process. The MCO will provide notice and will state in the notice that there is no right to an administrative hearing.

(5) Overpayment assessments by an MCO to its subcontractor or provider that are not appealed or that are upheld after appeal must be recovered from its subcontractors or providers within:

(a) Sixty calendar days of the overpayment being identified and assessed against the subcontractor or provider; or

(b) Sixty calendar days of completion of an appeals process for the subcontractor or provider who disputes the overpayment assessment.

(6) An MCO must report to the agency:

(a) Identification of an overpayment assessed against a subcontractor or provider.

(b) Notification of a subcontractor's or provider's appeal of an overpayment assessment.

(c) Results of an appeal of an overpayment assessment from the subcontractor or provider.

(d) Recovery of the identified overpayment assessed or settlement information as a result of the appeal.

(7) The agency may sanction an MCO or assess liquidated damages when:

(a) The agency identifies fraud, waste, or abuse by an MCO provider;

(b) The MCO fails to report MCO provider overpayments; or

(c) Other situations arise as identified in the contract.