



PROPOSED RULE MAKING

CR-102 (June 2024) (Implements RCW 34.05.320) Do NOT use for expedited rule making

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: September 30, 2025

TIME: 7:28 AM

WSR 25-20-081

Agency: Health Care Authority

☒ Original Notice

☐ Supplemental Notice to WSR _____

☐ Continuance of WSR _____

☒ Preproposal Statement of Inquiry was filed as WSR 25-12-098 ; 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 182-40 WAC, PEBB/SEBB reimbursement methodology requirements

Hearing location(s):

Date:	Time:	Location: (be specific)	Comment:
November 4, 2025	10:00 AM	The Health Care Authority holds public hearings virtually without a physical meeting place	To attend the virtual public hearing, you must register in advance: https://us02web.zoom.us/webinar/register/WN_klyJXQreTC2C-q7UNWCPOg If the link above opens with an error message, please try using a different browser. After registering, you will receive a confirmation email containing information about joining the public hearing

Date of intended adoption: Not sooner than November 5, 2025 (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

Beginning (date and time) October 1, 2025, 8:00 AM

By (date and time) November 4, 2025, by 11:59 PM

Assistance for persons with disabilities:

Contact HCA Rules Coordinator

Phone 360-725-1174

Fax 360-586-9727

TTY Telecommunication Relay Service (TRS): 711

Email arc@hca.wa.gov

Other

By (date) October 17, 2025

Purpose of the proposal and its anticipated effects, including any changes in existing rules: To help ensure access to primary care, behavioral health, and affordable hospital services, HCA is developing new rules as required under RCW 41.05.028.

Reasons supporting proposal: See Purpose.

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Statute being implemented: RCW 41.05.021, 41.05.160, and RCW 41.05.028

Is rule necessary because of a:

Federal Law?

☐ Yes ☒ No

Federal Court Decision?

☐ Yes ☒ No

State Court Decision?

☐ Yes ☒ No

If yes, CITATION:

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 Type of proponent: ☐ Private. ☐ Public. ☒ Governmental.			
Name of agency personnel responsible for:			
	Name	Office Location	Phone
Drafting	Jason Crabbe	PO Box 42716, Olympia, WA 98504-2716	360-725-9563
Implementation	Cade Walker	PO Box 42684, Olympia, WA 98504-2684	360-725-0830
Enforcement	Cade Walker	PO Box 42684, Olympia, WA 98504-2684	360-725-0830
Is a school district fiscal impact statement required under RCW 28A.305.135?			☐ Yes ☒ No
If yes, insert statement here:			
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 and Small Business Economic Impact Statement			
Note: The Governor's Office for Regulatory Innovation and Assistance (ORIA) provides support in completing this part.			
(1) Identification of exemptions:			
This rule proposal, or portions of the proposal, may be exempt from requirements of the Regulatory Fairness Act (see chapter 19.85 RCW). For additional information on exemptions, consult the exemption guide published by ORIA . 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)(e) (Dictated by statute)
☐ RCW 34.05.310 (4)(c) (Incorporation by reference)	☐ RCW 34.05.310 (4)(f) (Set or adjust fees)
☐ RCW 34.05.310 (4)(d) (Correct or clarify language)	☐ 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 19.85.025(4) . (Does not affect small businesses).	
☐ This rule proposal, or portions of the proposal, is exempt under RCW _____.	
Explanation of how the above exemption(s) applies to the proposed rule: The legislation only regulates health plans administered under the PEBB and SEBB programs. There are no direct impacts to the regulation of small employer health insurance coverage. Any market impacts on small employer health coverage costs would be tertiary to the direct regulation in RCW 41.05.028 and only speculative at this time.	
(2) Scope of exemptions: Check one.	
☒ The rule proposal: Is fully exempt. (<i>Skip section 3.</i>) Exemptions identified above apply to all portions of the rule proposal.	
☐ The rule proposal: Is partially exempt. (<i>Complete section 3.</i>) The exemptions identified above apply to portions of the rule proposal, but less than the entire rule proposal. Provide details here (consider using this template from ORIA):	
☐ The rule proposal: Is not exempt. (<i>Complete section 3.</i>) No exemptions were identified above.	
(3) Small business economic impact statement: Complete this section if any portion is not exempt.	
If any portion of 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 minor cost analysis and how the agency determined the proposed rule did not impose more-than-minor 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 the required small business economic impact 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: September 30, 2025	Signature:
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

Chapter 182-40 WAC
PEBB/SEBB REIMBURSEMENT METHODOLOGY REQUIREMENTS

GENERAL

NEW SECTION

WAC 182-40-0100 Purpose. The rules in this chapter are effective January 1, 2027, and implement the requirements and limitations in RCW 41.05.028.

NEW SECTION

WAC 182-40-0200 Definitions. The following definitions and those found in chapter 41.05 RCW apply to this chapter. If a definition in this chapter conflicts with a definition in chapter 41.05 RCW, the definition in chapter 41.05 RCW prevails:

"Authority" - See RCW 41.05.011.

"Allowed amount" means the maximum portion of a billed charge a contractor will pay, including any applicable enrollee cost-sharing responsibility, for a covered health care service.

"Benchmark reimbursement" means the applicable payment standard against which a contractor's allowed amounts paid to providers and facilities are assessed for compliance measurement.

"Benchmark weight" means a numerical assignment of required resources to provide care for a specific medicare diagnosis-related group (DRG) relative to average resources across all DRGs.

"Centers for Medicare and Medicaid Services" or **"CMS"** - See WAC 182-500-0020.

"Compliance measurement" means the authority's review of contractor-submitted data for each plan year to determine compliance under this chapter.

"Contractor" means a health carrier that provides medical insurance offered to public employees and their covered dependents under chapter 41.05 RCW, or a third-party administrator contracted by the authority to provide medical coverage to public employees under chapter 41.05 RCW.

"Diagnosis-related group" or **"DRG"** - See WAC 182-550-1050.

"Hospital" means a hospital licensed under chapter 70.41 RCW and located in Washington state that receives payment for services provided to enrollees in the public employees' benefits board (PEBB) program, as defined in WAC 182-08-015, or enrollees in the school employees' benefits board (SEBB) program, as defined in WAC 182-30-020.

"Percent of medicare" means the percent of the equivalent amount of medicare or other reimbursement benchmarking as determined by the reimbursement benchmarking methodology in WAC 182-40-0600.

"Plan year" means the 12-month period beginning on January 1st of each year and ending on December 31st of the same year.

"Premium" means all sums charged, received, or deposited by a health carrier as consideration for a health plan or the continuance of a health plan. Any assessment or any "membership," "policy," "contract," "service," or similar fee or charge made by a health carrier in consideration for a health plan is deemed part of the premium. "Premium" does not include amounts paid as enrollee point-of-service cost-sharing.

"Public employee" - See RCW 41.05.011.

"Ratio of costs-to-charges" or **"RCC"** - See WAC 182-550-1050.

REIMBURSEMENT REQUIREMENTS AND REPORTING

NEW SECTION

WAC 182-40-0300 Hospital reimbursement requirements. (1) **In-network hospitals.** The maximum reimbursement paid to an in-network hospital for inpatient and outpatient hospital services, including contractor payments and any applicable member cost-sharing, must be the lesser of:

- (a) The billed charges;
- (b) The contractor's contracted rate with a hospital; or
- (c) One of the following:

(i) For hospitals not primarily engaged in the care and treatment of children located in King or Pierce counties, 200 percent of what medicare would have reimbursed for the same or similar service; or

(ii) For a hospital primarily engaged in the care and treatment of children located in either of the following:

(A) **King County** - 150 percent of the hospital-specific medicaid inpatient ratio of costs-to-charges (RCC) published by the authority; or

(B) **Pierce County** - 190 percent of the hospital-specific medicaid inpatient RCC published by the authority.

(2) **Out-of-network hospitals.** The maximum reimbursement amount paid by a contractor, including any applicable enrollee cost-sharing responsibility, to an in-state, out-of-network hospital for inpatient and outpatient hospital services must be the lesser of:

- (a) The billed charges; or
- (b) One of the following:

(i) For hospitals not primarily engaged in the care and treatment of children located in King or Pierce counties, 185 percent of what medicare would have reimbursed for the same or similar service; or

(ii) For a hospital primarily engaged in the care and treatment of children located in either of the following:

(A) **King County** - 135 percent of the hospital-specific medicaid inpatient RCC published by the authority; or

(B) **Pierce County** - 175 percent of the hospital-specific medicaid inpatient RCC published by the authority.

(3) Contractor reimbursement for services provided by rural hospitals certified by the Centers for Medicare and Medicaid Services (CMS) as critical access hospitals may not be less than 101 percent of allowable costs as defined by CMS for the purpose of medicare cost reporting.

(4) By September 1st of every calendar year, the authority notifies contractors of the published medicaid RCC that applies to reimbursements under subsections (1) and (2) of this section for the following plan year.

(5) A contractor must determine any applicable member cost-sharing based on the reimbursement amount authorized to be paid to hospitals for claims under this section.

(6) If the authority determines a contractor has provided total payments that exceed the maximum reimbursement established in subsections (1) and (2) of this section, or is less than the minimum reimbursement established in subsection (3) of this section, the authority will send the contractor a written notice of noncompliance according to WAC 182-40-1400.

(7) The authority determines compliance under this section separately for contractor payments made under the public employees' benefits board program and school employees' benefits board program established under chapter 41.05 RCW.

(8) Annual premiums established by a contractor must take into account projected changes in reimbursement for hospital services anticipated to result from the application of reimbursement caps applied in subsections (1) and (2) of this section.

(9) For purposes of this section:

(a) Reimbursement for inpatient and outpatient services does not include charges for professional services; and

(b) **"The contractor's contracted rate"** means the allowed amount established by the contractor to each in-network hospital for each inpatient and outpatient service in effect when the service was provided.

(10) Except for subsection (3) of this section, this section does not apply to:

(a) Rural hospitals certified by CMS as sole community hospitals or critical access hospitals, except for hospitals owned or operated by a health system that owns or operates more than two acute care hospitals licensed under chapter 70.41 RCW;

(b) Hospitals located on an island operating within a public hospital district in Skagit County; or

(c) Hospitals that:

(i) Are not currently designated as a critical access hospital;

(ii) Do not meet current federal eligibility requirements for designation as a critical access hospital;

(iii) Have combined medicaid and medicare inpatient days greater than 60 percent of all hospital inpatient days; and

(iv) Are located on the land of a federally recognized Indian tribe.

NEW SECTION

WAC 182-40-0400 Primary care and behavioral health reimbursement requirements. (1) Reimbursement for in-network primary care and in-network nonfacility-based behavioral health services may not be less than 150 percent of the total amount medicare would have reimbursed for the same or similar service, inclusive of contractor payments and any member cost-sharing.

(2) If the authority determines total payments, inclusive of contractor payments and any member cost-sharing, is less than the minimum reimbursement established in subsection (1) of this section, the authority will send the contractor a written notice of noncompliance according to WAC 182-40-1400.

(3) The authority determines compliance under this section separately for contractor payments made under the public employees' benefits board program and school employees' benefits board program established under chapter 41.05 RCW.

(4) The authority will publish a list of service codes, provider licensure types, and sites of service to which the reimbursement provisions in this section are applicable no later than April 1st of the year preceding the plan year for which the reimbursement requirements are applicable.

(5) For the purposes of this section, reimbursement for primary care and behavioral health services does not include charges for facility-based services.

NEW SECTION

WAC 182-40-0500 Reimbursement through nonfee-for-service payment methodology. (1) A contractor may reimburse a provider or hospital through a nonfee-for-service payment methodology as long as:

(a) The payments incentivize higher quality or improved outcomes including, but not limited to:

(i) Value-based payments;

(ii) Capitation payments;

(iii) Bundled payments;

(iv) Integrated care payments consistent with the requirements in RCW 74.09.758; and

(v) Shared savings payments; and

(b) The contractor complies with the reimbursement requirements in WAC 182-40-0300 and 182-40-0400.

(2) Failure to comply with the reimbursement requirements in this chapter will result in a written notice of noncompliance as identified in WAC 182-40-1400.

NEW SECTION

WAC 182-40-0600 Reimbursement benchmarking. (1) Except for hospitals primarily engaged in the care and treatment of children in King

or Pierce counties, for the purpose of calculating any payment thresholds set in this chapter:

(a) The authority calculates the amount of benchmark reimbursement for a service as the amount that would have been paid if the Centers for Medicare and Medicaid Services reimbursed a claim under the medicare program, including applicable post claim settlements, except for:

(i) Services for which there is no published medicare rate or payment methodology; or

(ii) Services with a published medicare reimbursement rate or payment methodology with a low volume of medicare experience.

(b) For inpatient services with a low volume of medicare experience, the authority determines the relative benchmark weight for enrollees in the public employees' benefits board program and school employees' benefits board program, established under chapter 41.05 RCW, by using medicare or elements from nationally available fee schedules such as TRICARE.

(2) For hospitals primarily engaged in the care and treatment of children in King and Pierce counties, the authority calculates the amount of benchmark reimbursement for services using the hospital-specific published medicaid inpatient ratio of cost to charges as determined by the authority.

(3) For rural hospitals certified by the Centers for Medicare and Medicaid Services as critical access hospitals, the authority calculates the amount of benchmark reimbursement for a service using allowable cost reporting in the hospital's medicare cost report.

(4) For the purposes of calculating any payment thresholds set in this chapter, the authority annually determines and publishes guidance in January of the year preceding the plan year for which the reimbursement requirements are applicable that includes the following:

(a) Payment thresholds;

(b) A list of hospitals subject to the provisions of WAC 182-40-0300; and

(c) The underlying reimbursement benchmarking methodology used in the annual compliance measurement.

NEW SECTION

WAC 182-40-0700 Reporting requirements. (1) Contractors must provide the authority with the following in the form and manner prescribed by the authority:

(a) Cost and quality of care information; and

(b) Data on all claims and encounters.

(2) Except for hospitals primarily engaged in the care and treatment of children in King and Pierce counties, providers and hospitals submitting any claims to a public employees' benefits board program and school employees' benefits board program health plan must include all the current year modifiers required by the Centers for Medicare and Medicaid Services. This ensures all rebates, incentives, or adjustments that would have applied if the services were reimbursed by medicare apply.

(3) Contractors may not enter into an agreement with a provider, hospital, or third party that would restrict the contractor from providing this information or data.

(4) If a contractor reimburses a hospital or provider on a non-fee-for-service basis or provides payment in addition to a fee-for-service arrangement, the contractor must report to the authority such alternative payment methods and amounts paid in a format determined by the authority, by no later than June 1st of each year for the preceding plan year.

(5) When the authority determines that a contractor failed to meet the requirements in this section, the authority provides the contractor with a written notice of noncompliance and assesses a fine for each failure according to WAC 182-40-1500.

ENFORCEMENT

NEW SECTION

WAC 182-40-0800 Annual compliance measurement. (1) The authority conducts an annual measurement as described in WAC 182-40-0300 and 182-40-0400 following the end of a plan year to ensure compliance with this chapter.

(2) The authority may request additional information or documentation from the contractor.

(a) If the authority sends a written request for additional information or documentation, the contractor has 28 calendar days upon receipt of the request to:

(i) Provide the requested information or documentation; or

(ii) Request additional time to complete the request.

(b) The authority grants additional time on a case-by-case basis, but the request must be received before the expiration of the original 28 calendar days to avoid a fine.

(c) When the authority determines that a contractor has failed to meet the requirements in this section, the authority will provide the contractor with a written notice of noncompliance and assess a fine for each failure according to WAC 182-40-1400.

(3) The authority deposits any amounts collected from the contractor due to overpayments into the public employees' and retirees' insurance accounts or school employees' insurance account established under chapter 41.05 RCW, as applicable.

(4) The authority uses amounts deposited to offset health care costs for the public employees' benefits board and school employees' benefits board program health plan offerings in future plan years.

NEW SECTION

WAC 182-40-0900 Hospital overpayments. (1) When the authority determines a contractor has reimbursed a hospital an amount in excess

of the payment threshold for any plan year, as specified in WAC 182-40-0300, it is an overpayment. When the authority identifies an overpayment, the authority provides to the contractor written notice of noncompliance and assessment of the overpayment owed by the contractor.

(2) When the authority determines a contractor failed to meet the requirements under WAC 182-40-0300 for consecutive plan years due to making overpayments, the authority may also assess a fine according to WAC 182-40-1400.

(3) The authority may also require the contractor to create a corrective action plan or demonstrate corrective action. See WAC 182-40-1200.

NEW SECTION

WAC 182-40-1000 Primary care, behavioral health, and critical access hospital underpayments. (1) When the authority determines a contractor reimbursed primary care, behavioral health providers, or critical access hospitals below the required payment threshold for any plan year, as specified in WAC 182-40-0300 and 182-40-0400, the authority provides written notice of noncompliance to the contractor.

(2) When the authority determines a contractor failed to meet the requirements under WAC 182-40-0300 and 182-40-0400 for consecutive plan years due to making underpayments, the authority may also assess a fine according to WAC 182-40-1400.

(3) The authority may also require the contractor to create a corrective action plan or demonstrate corrective action. See WAC 182-40-1200.

NEW SECTION

WAC 182-40-1100 Contractor responsibility for ensuring reimbursement to providers and provider networks. Contractors are responsible for ensuring any reimbursements to providers and provider networks comply with reimbursement requirements established in WAC 182-40-0300 and 182-40-0400. This includes provider reimbursements resulting from arrangements with any person or organization the contractor uses to develop its provider network. For example, arrangements include, but are not limited to, rental provider networks, subcontracted business partners, subcontracted provider networks, contracted vendor networks, reciprocal claims pricing arrangements, health care benefit managers as defined in RCW 48.200.020, etc.

NEW SECTION

WAC 182-40-1200 Corrective action plan. In addition to any action described in this chapter, the authority may require the contractor to create and comply with a corrective action plan and demonstrate

corrective action. A draft of the corrective action plan must be provided to the authority within the time period specified by the authority in its request and must be approved by the authority.

NEW SECTION

WAC 182-40-1300 Hospital balance billing. (1) An in-state, out-of-network hospital that is reimbursed in accordance with WAC 182-40-0300(2) may not charge to or collect from the patient, or a person who is financially responsible for the patient, an amount in addition to the reimbursement paid by the contractor under WAC 182-40-0300(2) other than cost-sharing amounts authorized by the terms of the public employees' benefits board or school employees' benefits board health plan.

(2) The hospital is prohibited from obtaining a patient's waiver of their rights to protection under this section.

(3) When the authority receives or identifies information indicating that an out-of-network hospital may have violated subsection (1) of this section, the following actions apply:

(a) The authority conducts a balance billing review and provides notice to the hospital and any impacted contractor of the balance billing review.

(i) The notice may require the hospital to provide records and additional information or documentation relevant and necessary for the authority to evaluate and validate that the hospital received only those funds to which it was entitled under this chapter.

(ii) The hospital has 30 calendar days upon receipt of the notice to:

(A) Provide the requested information or documentation; or

(B) Request additional time to complete the request.

(iii) The authority grants additional time on a case-by-case basis, but the request must be received before the expiration of the original 30 calendar days to avoid a fine.

(b) Once a balance billing review begins:

(i) The hospital must retain all original records and supportive materials sent to the authority until the authority sends the balance billing determination notice to the hospital and all issues are resolved; and

(ii) Unless instructed to do so by the authority, the hospital must not adjust or rebill a claim or encounter within the scope of the balance billing activity until the authority has concluded the balance billing determination review.

(c) After the balance billing review, the authority provides a balance billing determination notice to the hospital and impacted health contractor.

(i) If the authority finds that the hospital has not balance billed, the authority issues a notice that the review is closed.

(ii) If the authority finds that the hospital has balance billed:

(A) The authority notifies the hospital it must reimburse the enrollee, if it has collected excess funds, within 30 calendar days from receipt of the balance billing determination notice and provide to the authority proof of payment, if any is owed, to the enrollee; and

(B) The authority may assess a fine on the hospital for balance billing according to WAC 182-40-1400, whether or not the member actually paid the amount inappropriately billed.

(iii) If the hospital has not repaid the enrollee any amount owed within 30 calendar days of the hospital's receipt of the balance billing determination notice from the authority, the authority may assess an additional fine according to WAC 182-40-1400.

NEW SECTION

WAC 182-40-1400 Written notice of noncompliance, overpayments, and fines. (1) When the authority determines that a contractor or hospital failed to comply with a requirement in this chapter, the authority provides written notice of noncompliance to the contractor or hospital explaining the nature of the violation.

(2) The authority may assess overpayments or fines against the contractor or hospital as follows:

(a) **Consecutive plan years of hospital overpayments.** For two or more years of consecutive noncompliance, the authority may fine a contractor up to 500 percent of the overpayment amount for the impacted plan years, in addition to collecting the overpayments from the contractor.

(b) **Consecutive plan years of primary care or behavioral health underpayments.** For two or more years of consecutive noncompliance, the authority may fine a contractor up to 500 percent of the underpayment amount for the impacted plan years.

(c) The authority considers the following factors when determining the amount of the fine that will be assessed for consecutive plan years of hospital overpayments or primary care and behavioral health underpayments:

- (i) The number of facilities or providers over or underpaid;
- (ii) The duration of underpayments or overpayments;
- (iii) The volume of over or underpayments; and
- (iv) The types of contract or payment terms that led to over or underpayment.

(d) **Hospital balance billing.** For failure to meet the requirements in WAC 182-40-1300, the authority may assess the following fines:

Size of hospital	Fine assessed
50 beds or more	\$100,000 per calendar day, inclusive of all failures to meet the requirements on that calendar day
Less than 50 beds	\$50,000 per calendar day, inclusive of all failures to meet the requirements on that calendar day

(e) **Reporting penalties.** For failure to meet the requirements in WAC 182-40-0700, the authority may assess the following fines:

Number of failures	Fine assessed
First	\$10,000
Second	\$25,000

Number of failures	Fine assessed
Third	\$50,000
Fourth and subsequent incidents	\$100,000

(f) **Untimely responses to an authority request.** If the authority determines that a contractor has failed to fully and timely respond to the authority's request for information or documentation, the authority may impose an immediate fine for each failure to comply with the requirements of this section as follows:

Number of failures	Fine assessed
First	\$10,000
Second	\$25,000
Third	\$50,000
Fourth and subsequent incidents	\$100,000

(g) Fines under this section are cumulative.

(3) The authority must receive payment of any assessed fine within 28 calendar days of the date the party received the written notice of noncompliance assessing a fine.

(4) Notices are sent either electronically or in another manner that provides proof of receipt.

(5) Contractors and hospitals may appeal a notice of noncompliance, overpayment, or fine in accordance with WAC 182-40-1500.

(6) Payment of fines or overpayments is stayed through the administrative process only if a contractor or hospital timely files an appeal under this section.

(7) The authority may impose a one percent interest charge for each month fines are unpaid after the due date.

NEW SECTION

WAC 182-40-1500 Appeal of notice of noncompliance. (1) A contractor or hospital may appeal a written notice of noncompliance by timely filing an appeal, and the authority will schedule an administrative hearing.

(2) To file an appeal, the contractor or hospital must send a written request to the authority.

(a) The authority must receive the written request within 28 calendar days of the date the contractor or hospital received the notice of noncompliance.

(b) The written request to appeal must be sent to the address listed on the notice in a manner that provides proof of receipt.

(c) The written request to appeal must provide a copy of the notice of noncompliance being disputed.

(3) The authority conducts hearings and appeals under the Administrative Procedure Act, chapter 34.05 RCW, and the administrative hearing rules in chapter 182-526 WAC.

(4) Under WAC 182-526-0025, the authority, in its sole discretion, may conduct the administrative hearing or may transfer the hearing to the office of administrative hearings (OAH).

(a) If the authority conducts the administrative hearing, it issues the final agency decision.

(b) If OAH conducts the administrative hearing, it issues an initial order with instructions on how either party can request review with the authority's board of appeals.

(5) If the final order upholds the notice of noncompliance, the contractor or hospital must pay the fine within 28 calendar days of the issuance date of the final order.