RULE-MAKING ORDER
PERMANENT RULE ONLY

CR-103P (December 2017)
(Implements RCW 34.05.360)

CODE REVISER USE ONLY

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: September 26, 2019
TIME: 11:29 AM

WSR 19-20-060

Agency: Health Care Authority

Effective date of rule:

Permanent Rules

☒ 31 days after filing.

☐ Other (specify) _____ **(If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)**

Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?

☐ Yes ☒ No If Yes, explain:

Purpose: The agency is updating this section to provide notice to providers and support enforcement of compliance with state and federal requirements related to the operations of entities receiving more than $5 million in Medicaid payments annually, including but not limited to such entities providing information about the False Claims Act and establishing written policies for employees.

Citation of rules affected by this order:

New: 182-502-0017
Repealed:
Amended: 182-502-0016
Suspended:

Statutory authority for adoption: RCW 41.05.021, RCW 41.05.160, 42 USC Sec. 1396(a)(68)

Other authority:

PERMANENT RULE (Including Expedited Rule Making)

Adopted under notice filed as WSR 19-17-056 on August 19, 2019 (date).

Describe any changes other than editing from proposed to adopted version:

Proposed/Adopted	WAC Subsection	Reason
Original WAC # 182-502-0017		
Proposed	(5)(a) **Annual monitoring**. At the conclusion of each federal fiscal year, the agency identifies who qualifies as an entity subject to the requirements in Section 1902(a)(68) of the Social Security Act. (b) If the agency determines that an entity is subject to and must comply with Section 1902(a)(68) of the act: (i) The agency provides written notice to the entity that it must comply; (ii) The entity must submit an attestation to the agency under penalty of perjury to verify the entity has adopted and disseminated compliant written policies as required; and (iii) The agency may request copies of the written policies and proof of dissemination to verify compliance with the requirements. (c) If the agency does not receive the required documentation by the due date, the agency sends a warning to the entity to become compliant by a specified deadline. (d) If the entity remains noncompliant after the deadline, the agency ceases medical assistance payments until the entity is compliant.	Typographical and formatting corrections.
Adopted	(5)~~(a)~~ **Annual monitoring**. At the conclusion of each federal fiscal year, the agency identifies who qualifies as an	

	entity subject to the requirements in Section 1902(a)(68) of the Social Security Act. ~~(b)~~ (a) If the agency determines that an entity is subject to and must comply with Section 1902(a)(68) of the act: (i) The agency provides written notice to the entity that it must comply; (ii) The entity must submit an attestation to the agency under penalty of perjury to verify the entity has adopted and disseminated compliant, written policies as required; and (iii) The agency may request copies of the written policies and proof of dissemination to verify compliance with the requirements. ~~(c)~~ (b) If the agency does not receive the required documentation by the due date, the agency sends a warning to the entity to become compliant by a specified deadline. ~~(d)~~ (c) If the entity remains noncompliant after the deadline, the agency ceases medical assistance payments until the entity is compliant.	

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

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

Note: If any category is left blank, it will be calculated as zero. No descriptive text.

Count by whole WAC sections only, from the WAC number through the history note. A section may be counted in more than one category.

The number of sections adopted in order to comply with:

Federal statute:	New	1	Amended	1	Repealed	____
Federal rules or standards:	New	____	Amended	____	Repealed	____
Recently enacted state statutes:	New	____	Amended	____	Repealed	____

The number of sections adopted at the request of a nongovernmental entity:

New ____ Amended ____ Repealed ____

The number of sections adopted on the agency's own initiative:

New ____ Amended ____ Repealed ____

The number of sections adopted in order to clarify, streamline, or reform agency procedures:

New ____ Amended ____ Repealed ____

The number of sections adopted using:

Negotiated rule making:	New	____	Amended	____	Repealed	____
Pilot rule making:	New	____	Amended	____	Repealed	____
Other alternative rule making:	New	1	Amended	1	Repealed	____

Date Adopted: September 26, 2019

Name: Wendy Barcus

Title: HCA Rules Coordinator

Signature:

AMENDATORY SECTION (Amending WSR 15-10-003, filed 4/22/15, effective 5/23/15)

WAC 182-502-0016 Continuing requirements. (1) To continue to provide services for eligible clients and be paid for those services, a provider must:

(a) Provide all services without discriminating on the grounds of race, creed, color, age, sex, sexual orientation, religion, national origin, marital status, the presence of any sensory, mental or physical handicap, or the use of a trained dog guide or service animal by a person with a disability;

(b) Provide all services according to federal and state laws and rules, medicaid agency billing instructions, ((~~numbered memoranda~~)) provider alerts issued by the agency, and other written directives from the agency;

(c) Inform the agency of any changes to the provider's application or contract((~~,~~)) including, but not limited to, changes in:

(i) Ownership (see WAC 182-502-0018);

(ii) Address or telephone number;

(iii) Professional practicing under the billing provider number; or

(iv) Business name.

(d) Retain a current professional state license, registration, certification ((~~and~~)) or applicable business license for the service being provided, and update the agency of all changes;

(e) Inform the agency in writing within seven calendar days of changes applicable to the provider's clinical privileges;

(f) Inform the agency in writing within seven business days of receiving any informal or formal disciplinary order, disciplinary decision, disciplinary action or other action(s)((~~,~~)) including, but not limited to, restrictions, limitations, conditions and suspensions resulting from the practitioner's acts, omissions, or conduct against the provider's license, registration, or certification in any state;

(g) Screen employees and contractors with whom they do business prior to hiring or contracting, and on a monthly ongoing basis thereafter, to assure that employees and contractors are not excluded from receiving federal funds as required by 42 U.S.C. 1320a-7 and 42 U.S.C. 1320c-5;

(h) Report immediately to the agency any information discovered regarding an employee's or contractor's exclusion from receiving federal funds in accordance with 42 U.S.C. 1320a-7 and 42 U.S.C. 1320c-5. See WAC 182-502-0010 (2)(j) for information on the agency's screening process;

(i) Pass any portion of the agency's screening process as specified in WAC 182-502-0010 (2)(j) when the agency requires such information to reassess a provider;

(j) Maintain professional and general liability coverage to the extent the provider is not covered:

(i) Under agency, center, or facility professional and general liability coverage; or

(ii) By the Federal Tort Claims Act, including related rules and regulations((~~;~~)).

(k) Not surrender, voluntarily or involuntarily, ((~~his or her~~)) the provider's professional state license, registration, or certification in any state while under investigation by that state or due to

findings by that state resulting from the practitioner's acts, omissions, or conduct;

(l) Furnish documentation or other assurances as determined by the agency in cases where a provider has an alcohol or chemical dependency problem, to adequately safeguard the health and safety of medical assistance clients that the provider:

(i) Is complying with all conditions, limitations, or restrictions to the provider's practice both public and private; and

(ii) Is receiving treatment adequate to ensure that the dependency problem will not affect the quality of the provider's practice((~~; and~~)).

(m) Submit to a revalidation process at least every five years. This process includes, but is not limited to:

(i) Updating provider information including, but not limited to, disclosures;

(ii) Submitting forms as required by the agency including, but not limited to, a new core provider agreement; and

(iii) Passing the agency's screening process as specified in WAC 182-502-0010 (2)(j).

(n) Comply with the employee education requirements regarding the federal and the state false claims recovery laws, the rights and protections afforded to whistleblowers, and related provisions in Section 1902 of the Social Security Act (42 U.S.C. 1396a(68)) and chapter 74.66 RCW when applicable. See WAC 182-502-0017 for information regarding the agency's requirements for employee education about false claims recovery.

(2) A provider may contact the agency with questions regarding its programs. However, the agency's response is based solely on the information provided to the agency's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern the agency's programs.

(3) The agency may refer the provider to the appropriate state health professions quality assurance commission.

NEW SECTION

WAC 182-502-0017 Employee education about false claims recovery. (1) The medicaid agency (agency) requires any entity (including providers) that makes or receives medical assistance payments from the agency or the agency designee of at least $5,000,000 annually under the state plan to meet the requirements of Section 1902(a)(68) of the Social Security Act in order to receive payments.

(2) **Entity policies and procedures.** Entities must adopt and disseminate policies and procedures for their employees, contractors, and agents regarding federal and state false claims and whistleblower protection laws.

(a) Written policies and procedures may be in paper or electronic form, but must be readily available to all employees, contractors, and agents.

(b) If the entity has an employee handbook, it must include a specific discussion of the laws described in written policies regarding the rights of employees to be protected as whistleblowers, and a specific discussion of the entity's policies and procedures for detecting and preventing fraud, waste, and abuse.

(3) **Entity.** An "entity" may include, but is not limited to, individual providers, a governmental agency, organization, unit, corporation, partnership, or other business arrangement irrespective of the form of business structure by which it exists or whether for-profit or not-for-profit.

(a) An organization may have multiple subsidiaries, locations, federal employer identification numbers (FEIN), or provider numbers and still be combined for the purposes of meeting the definition of an entity.

(b) Whether subsidiaries would be aggregated or viewed as separate entities depends on the corporate structure and assessment of the largest separate organizational unit that furnishes medicaid health care items or services.

(c) The agency and its designee administering the medicaid program, or any agent performing an administrative function, are not considered entities.

(4) **Payments received.** For any entity that receives medical assistance payments under the state plan of at least $5,000,000 annually, the total amount includes:

(a) All payments received by an entity who furnishes items or services at one or more location(s);

(b) All payments received by an entity who furnishes items or services under one or more contractual or other payment arrangement(s);

(c) Only the amounts received from the agency or the agency designee. The amounts paid by a managed care organization (MCO) to the entity are only counted against the MCO, not the entity, when calculating the $5,000,000 threshold; and

(d) Only payments received from Washington state. Payments from multiple states are not aggregated to reach the $5,000,000 annual threshold.

(5) **Annual monitoring.** At the conclusion of each federal fiscal year, the agency identifies who qualifies as an entity subject to the requirements in Section 1902(a)(68) of the Social Security Act.

(a) If the agency determines that an entity is subject to and must comply with Section 1902(a)(68) of the act:

(i) The agency provides written notice to the entity that it must comply;

(ii) The entity must submit an attestation to the agency under penalty of perjury to verify the entity has adopted and disseminated compliant, written policies as required; and

(iii) The agency may request copies of the written policies and proof of dissemination to verify compliance with the requirements.

(b) If the agency does not receive the required documentation by the due date, the agency sends a warning to the entity to become compliant by a specified deadline.

(c) If the entity remains noncompliant after the deadline, the agency ceases medical assistance payments until the entity is compliant.