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.

[Statutory Authority: RCW 41.05.021, 41.05.160 and 42 U.S.C. Sec. 1396 (a)(68). WSR 19-20-060, § 182-502-0017, filed 9/26/19, effective 10/27/19.]