



# PROPOSED RULE MAKING

## CR-102 (June 2012)

(Implements RCW 34.05.320)

Do NOT use for expedited rule making

**Agency:** Health Care Authority, Washington Apple Health

- Preproposal Statement of Inquiry was filed as WSR \_\_\_\_\_ ; 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).

- Original Notice  
 Supplemental Notice to WSR \_\_\_\_\_  
 Continuance of WSR \_\_\_\_\_

**Title of rule and other identifying information:**

WAC 182-548-1000 Federally Qualified Health Center - Purpose  
 WAC 182-548-1100 Federally Qualified Health Center - Definitions  
 WAC 182-548-1200 Federally Qualified Health Center - Enrollment  
 WAC 182-548-1300 Federally Qualified Health Center - Services  
 WAC 182-548-1400 Federally Qualified Health Center - Reimbursement and Limitations

WAC 182-549-1000 Rural Health Clinic - Purpose  
 WAC 182-549-1100 Rural Health Clinic - Definitions  
 WAC 182-549-1200 Rural Health Clinic - Enrollment  
 WAC 182-549-1300 Rural Health Clinic - Services  
 WAC 182-549-1400 Rural Health Clinic - Reimbursement and Limitations

**Hearing location(s):**

Health Care Authority  
 Cherry Street Plaza Building; Sue Crystal Conf Rm, CSP 106B  
 626 - 8<sup>th</sup> Avenue, Olympia WA 98504

Metered public parking is available street side around building. A map is available at:  
[http://www.hca.wa.gov/documents/directions\\_to\\_csp.pdf](http://www.hca.wa.gov/documents/directions_to_csp.pdf)  
 or directions can be obtained by calling: 360-725-1000

Date: May 5, 2015 Time: 10:00 a.m.

**Submit written comments to:**

Name: HCA Rules Coordinator  
 Address: PO Box 45504, Olympia WA, 98504-5504  
 Delivery: 626 – 8<sup>th</sup> Avenue, Olympia WA 98504  
 e-mail [arc@hca.wa.gov](mailto:arc@hca.wa.gov)  
 fax (360) 586-9727

by 5:00 p.m. on May 5, 2015

**Assistance for persons with disabilities:** Contact

Kelly Richters by April 27, 2015

TTY (800) 848-5429 or (360) 725-1307 or e-mail:  
[kelly.richters@hca.wa.gov](mailto:kelly.richters@hca.wa.gov)

**Date of intended adoption:** Not sooner than May 6, 2015  
 (Note: This is **NOT** the **effective** date)

**Purpose of the proposal and its anticipated effects, including any changes in existing rules:**

The agency is making routine housekeeping changes to these rules to replace outdated references to DSHS, and to update invalid WAC references to Title 388 WAC.

**Reasons supporting proposal:** See purpose.

**Statutory authority for adoption:** RCW 41.05.021, 41.05.160

**Statute being implemented:**

**Is rule necessary because of a:**

- Federal Law?  Yes  No  
 Federal Court Decision?  Yes  No  
 State Court Decision?  Yes  No  
 If yes, CITATION:

**DATE**

March 27, 2015

**NAME** (type or print)

Jason R. P. Crabbe

**SIGNATURE**

**TITLE**

HCA Rules Coordinator

**CODE REVISER USE ONLY**

**OFFICE OF THE CODE REVISER  
 STATE OF WASHINGTON  
 FILED**

**DATE: March 27, 2015**

**TIME: 10:38 AM**

**WSR 15-08-057**

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

N/A

**Name of proponent:** Health Care Authority

- Private
- Public
- Governmental

**Name of agency personnel responsible for:**

Name	Office Location	Phone
Drafting..... Chantelle Diaz	PO Box 42716, Olympia, WA 98504-2716	(360) 725-1842
Implementation... Chantelle Diaz	PO Box 42716, Olympia, WA 98504-2716	(360) 725-1842
Enforcement..... Chantelle Diaz	PO Box 42716, Olympia, WA 98504-2716	(360) 725-1842

**Has a small business economic impact statement been prepared under chapter 19.85 RCW or has a school district fiscal impact statement been prepared under section 1, chapter 210, Laws of 2012?**

Yes. Attach copy of small business economic impact statement or school district fiscal impact statement.

A copy of the statement may be obtained by contacting:

Name:

Address:

phone ( ) \_\_\_\_\_

fax ( ) \_\_\_\_\_

e-mail \_\_\_\_\_

No. Explain why no statement was prepared.

The Joint Administrative Review Committee has not requested the filing of a small business economic impact statement, and these rules do not impose a disproportionate cost impact on small businesses

**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 ( ) \_\_\_\_\_

e-mail \_\_\_\_\_

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.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

**WAC 182-548-1000 Federally qualified health centers—Purpose.**

This chapter establishes the ~~((department's))~~ medicaid agency's:

(1) Requirements for enrollment as a federally qualified health center (FQHC) provider; and

(2) Reimbursement methodology for services provided by an FQHC~~((s))~~ to a Washington apple health client~~((s of medical assistance))~~.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

**WAC 182-548-1100 Federally qualified health centers—Definitions.** This section contains definitions of words or phrases that apply to this chapter. Unless defined in this chapter or chapter 182-500 WAC ~~((388-500-0005))~~, the definitions found in the Webster's New World Dictionary apply.

**"APM index"** - The alternative payment methodology (APM) is used to update APM encounter payment rates on an annual basis. The APM index is a measure of input price changes experienced by Washington's federally qualified health center (FQHC) and rural health clinic (RHC) providers. The index is derived from the federal medicare economic index (MEI) and Washington-specific variable measures.

**"Base year"** - The year that is used as the benchmark in measuring a center's total reasonable costs for establishing base encounter rates.

**"Cost report"** - A statement of costs and provider utilization that occurred during the time period covered by the cost report. FQHCs must complete a cost report when there is a change in scope, rebasing of the encounter rate, or when the ~~((department))~~ medicaid agency sets a base rate.

**"Encounter"** - A face-to-face visit between a client and a FQHC provider (e.g., a physician, physician's assistant, or advanced registered nurse practitioner) who exercises independent judgment when providing services that qualify for an encounter rate.

**"Encounter rate"** - A cost-based, facility-specific rate for covered FQHC services, paid to an FQHC for each valid encounter it bills.

**"Enhancements (also called managed care enhancements)"** - A monthly amount paid by the ~~((department))~~ agency to FQHCs for each client enrolled with a managed care organization (MCO). MCOs may contract with FQHCs to provide services under managed care programs. FQHCs receive enhancements from the ~~((department))~~ agency in addition to the negotiated payments they receive from the MCOs for services provided to enrollees.

**"Federally qualified health center (FQHC)"** - An entity that has entered into an agreement with the Centers for Medicare and Medicaid Services (CMS) to meet medicare program requirements under 42 C.F.R. 405.2434 and:

(1) Is receiving a grant under section 329, 330, or 340 of the Public Health Service (PHS) Act, or is receiving funding from such a

grant under a contract with the recipient of such a grant and meets the requirements to receive a grant under section 330 of the Public Health Service Act;

(2) Based on the recommendation of the PHS, is determined by CMS to meet the requirements for receiving such a grant;

(3) Was treated by CMS, for purposes of part B, as a comprehensive federally funded health center (FFHC) as of January 1, 1990; or

(4) Is an outpatient health program or facility operated by a tribe or tribal organization((s)) under the Indian Self-Determination Act or by an Urban Indian organization receiving funding under Title V of the Indian Health Care Improvement Act.

**"Fee-for-service"** - A payment method the ((department)) agency uses to pay providers for covered medical services provided to ((~~medical assistance~~)) Washington apple health clients, except those services provided under the ((department's)) agency's prepaid managed care organizations or those services that qualify for an encounter rate.

**"Interim rate"** - The rate established by the ((department)) agency to pay an FQHC for covered FQHC services prior to the establishment of a permanent rate for that facility.

~~((**Medical assistance** - The various health care programs administered by the department that provide federal and/or state funded health care benefits to eligible clients.))~~

**"Rebasing"** - The process of recalculating encounter rates using actual cost report data.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

**WAC 182-548-1200 Federally qualified health centers—Enrollment.**

(1) To enroll as a ((~~medical assistance~~)) Washington apple health provider and receive payment for services, a federally qualified health center (FQHC) must:

(a) Receive FQHC certification for participation in the Title XVIII (medicare) program according to 42 C.F.R. 491;

(b) Sign a core provider agreement; and

(c) Operate in accordance with applicable federal, state, and local laws.

(2) The ((department)) medicaid agency uses one of two timeliness standards for determining the effective date of a medicaid-certified FQHC.

(a) The ((department)) agency uses medicare's effective date if the FQHC returns a properly completed core provider agreement and FQHC enrollment packet within sixty calendar days from the date of medicare's letter notifying the center of the medicare certification.

(b) The ((department)) agency uses the date the signed core provider agreement is received if the FQHC returns the properly completed core provider agreement and FQHC enrollment packet sixty-one or more calendar days after the date of medicare's letter notifying the clinic of the medicare certification.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

**WAC 182-548-1300 Federally qualified health centers—Services.**

- (1) The following outpatient services qualify for FQHC reimbursement:
- (a) Physician services specified in 42 C.F.R. 405.2412.
  - (b) Nurse practitioner or physician assistant services specified in 42 C.F.R. 405.2414.
  - (c) Clinical psychologist and clinical social worker services specified in 42 C.F.R. 405.2450.
  - (d) Visiting nurse services specified in 42 C.F.R. 405.2416.
  - (e) Nurse-midwife services specified in 42 C.F.R. 405.2401.
  - (f) Preventive primary services specified in 42 C.F.R. 405.2448.
- (2) The (~~department~~) medicaid agency pays for FQHC services when they are:
- (a) Within the scope of an eligible client's (~~medical assistance~~) Washington apple health program. Refer to WAC (~~(388-501-0060)~~) 182-501-0060 scope of services; and
  - (b) Medically necessary as defined in WAC (~~(388-500-0005)~~) 182-500-0070.
- (3) FQHC services may be provided by any of the following individuals in accordance with 42 C.F.R. 405.2446:
- (a) Physicians;
  - (b) Physician assistants (PA);
  - (c) Nurse practitioners (NP);
  - (d) Nurse midwives or other specialized nurse practitioners;
  - (e) Certified nurse midwives;
  - (f) Registered nurses or licensed practical nurses; and
  - (g) Psychologists or clinical social workers.

AMENDATORY SECTION (Amending WSR 14-14-056, filed 6/26/14, effective 8/1/14)

**WAC 182-548-1400 Federally qualified health centers—Reimbursement and limitations.**

- (1) For services provided during the period beginning January 1, 2001, and ending December 31, 2008, the medicaid agency's payment methodology for federally qualified health centers (FQHC) was a prospective payment system (PPS) as authorized by 42 U.S.C. 1396a (bb)(2) and (3).
- (2) For services provided beginning January 1, 2009, FQHCs have the choice to be reimbursed under the PPS or to be reimbursed under an alternative payment methodology (APM), as authorized by 42 U.S.C. 1396a (bb)(6). As required by 42 U.S.C. 1396a (bb)(6), payments made under the APM will be at least as much as payments that would have been made under the PPS.
- (3) The agency calculates FQHC PPS encounter rates as follows:
- (a) Until an FQHC's first audited medicaid cost report is available, the agency pays an average encounter rate of other similar FQHCs within the state, otherwise known as an interim rate;
  - (b) Upon availability of the FQHC's first audited medicaid cost report, the agency sets FQHC encounter rates at one hundred percent of its total reasonable costs as defined in the cost report. FQHCs re-

ceive this rate for the remainder of the calendar year during which the audited cost report became available. The encounter rate is then increased each January 1st by the percent change in the medicare economic index (MEI).

(4) For FQHCs in existence during calendar years 1999 and 2000, the agency sets encounter rates prospectively using a weighted average of one hundred percent of the FQHC's total reasonable costs for calendar years 1999 and 2000 and adjusted for any increase or decrease in the scope of services furnished during the calendar year 2001 to establish a base encounter rate.

(a) The agency adjusts PPS base encounter rates to account for an increase or decrease in the scope of services provided during calendar year 2001 in accordance with WAC 182-548-1500.

(b) PPS base encounter rates are determined using audited cost reports, and each year's rate is weighted by the total reported encounters. The agency does not apply a capped amount to these base encounter rates. The formula used to calculate base encounter rates is as follows:

$$\text{Specific FQHC Base Encounter Rate} = \frac{(\text{Year 1999 Rate} \times \text{Year 1999 Encounters}) + (\text{Year 2000 Rate} \times \text{Year 2000 Encounters})}{(\text{Year 1999 Encounters} + \text{Year 2000 Encounters}) \text{ for each FQHC}}$$

(c) Beginning in calendar year 2002 and any year thereafter, encounter rates are increased by the MEI for primary care services, and adjusted for any increase or decrease in the FQHC's scope of services.

(5) The agency calculates the FQHC's APM encounter rate for services provided during the period beginning January 1, 2009, and ending April 6, 2011, as follows:

(a) The APM utilizes the FQHC base encounter rates, as described in subsection (4)(b) of this section.

(b) Base rates are adjusted to reflect any approved changes in scope of service in calendar years 2002 through 2009.

(c) The adjusted base rates are then increased by each annual percentage, from calendar years 2002 through 2009, of the IHS Global Insight index, also called the APM index. The result is the year 2009 APM rate for each FQHC that chooses to be reimbursed under the APM.

(6) This subsection describes the encounter rates that the agency pays FQHCs for services provided during the period beginning April 7, 2011, and ending June 30, 2011. On January 12, 2012, the federal Centers for Medicare and Medicaid Services (CMS) approved a state plan amendment (SPA) containing the methodology outlined in this section.

(a) During the period that CMS approval of the SPA was pending, the agency continued to pay FQHCs at the encounter rates described in subsection (5) of this section.

(b) Each FQHC has the choice of receiving either its PPS rate, as determined under the method described in subsection (3) of this section, or a rate determined under a revised APM, as described in (c) of this subsection.

(c) The revised APM uses each FQHC's PPS rate for the current calendar year, increased by five percent.

(d) For all payments made for services provided during the period beginning April 7, 2011, and ending June 30, 2011, the agency will recoup from FQHCs any amount in excess of the encounter rate established in this section. This process is specified in emergency rules that took effect on October 29, 2011, (WSR 11-22-047) and February 25, 2012 (WSR 12-06-002).

(7) This subsection describes the encounter rates that the agency pays FQHCs for services provided on and after July 1, 2011. On January 12, 2012, CMS approved a SPA containing the methodology outlined in this section.

(a) Each FQHC has the choice of receiving either its PPS rate as determined under the method described in subsection (3) of this section, or a rate determined under a revised APM, as described in (b) of this subsection.

(b) The revised APM is as follows:

(i) For FQHCs that rebased their rate effective January 1, 2010, the revised APM is their allowed cost per visit during the cost report year increased by the cumulative percentage increase in the MEI between the cost report year and January 1, 2011.

(ii) For FQHCs that did not rebase their rate effective January 1, 2010, the revised APM is based on their PPS base rate from 2001 (or subsequent year for FQHCs receiving their initial FQHC designation after 2002) increased by the cumulative percentage increase in the IHS Global Insight index from the base year through calendar year 2008 and by the cumulative percentage increase in the MEI from calendar years 2009 through 2011. The rates were increased by the MEI effective January 1, 2012, and will be increased by the MEI each January 1st thereafter.

(c) For all payments made for services provided during the period beginning July 1, 2011, and ending January 11, 2012, the agency will recoup from FQHCs any amount paid in excess of the encounter rate established in this section. This process is specified in emergency rules that took effect on October 29, 2011, (WSR 11-22-047) and February 25, 2012 (WSR 12-06-022).

(d) For FQHCs that choose to be paid under the revised APM, the agency will periodically rebase the encounter rates using the FQHC cost reports and other relevant data. Rebasing will be done only for FQHCs that are reimbursed under the APM.

(e) The agency will ensure that the payments made under the APM are at least equal to the payments that would be made under the PPS.

(8) The agency limits encounters to one per client, per day except in the following circumstances:

(a) The visits occur with different health care professionals with different specialties; or

(b) There are separate visits with unrelated diagnoses.

(9) FQHC services and supplies incidental to the provider's services are included in the encounter rate payment.

(10) Fluoride treatment and sealants must be provided on the same day as an encounter-eligible service. If provided on another day, the rules for non-FQHC services in subsection (11) of this section apply.

(11) Payments for non-FQHC services provided in an FQHC are made on a fee-for-service basis using the agency's published fee schedules. Non-FQHC services are subject to the coverage guidelines and limitations listed in chapters 182-500 through 182-557 WAC.

(12) For clients enrolled with a managed care organization (MCO), covered FQHC services are paid for by that plan.

(13) For clients enrolled with an MCO, the agency pays each FQHC a supplemental payment in addition to the amounts paid by the MCO. The supplemental payments, called enhancements, are paid in amounts necessary to ensure compliance with 42 U.S.C. 1396a (bb)(5)(A).

(a) The FQHCs receive an enhancement payment each month for each managed care client assigned to them by an MCO.

(b) To ensure that the appropriate amounts are paid to each FQHC, the agency performs an annual reconciliation of the enhancement payments. For each FQHC, the agency will compare the amount actually paid to the amount determined by the following formula: (Managed care encounters times encounter rate) less fee-for-service equivalent of MCO services. If the FQHC has been overpaid, the agency will recoup the appropriate amount. If the FQHC has been underpaid, the agency will pay the difference.

(14) Only clients enrolled in Title XIX (medicaid) or Title XXI (CHIP) are eligible for encounter or enhancement payments. The agency does not pay the encounter rate or the enhancement rate for clients in state-only medical programs. Services provided to clients in state-only medical programs are considered fee-for-service regardless of the type of service performed.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

**WAC 182-549-1000 Rural health clinics—Purpose.** This chapter establishes the ~~((department's))~~ medicaid agency's reimbursement methodology for rural health clinic (RHC) services. RHC conditions for certification are found in 42 C.F.R. Part 491.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

**WAC 182-549-1100 Rural health clinics—Definitions.** This section contains definitions of words and phrases that apply to this chapter. Unless defined in this chapter or chapter 182-500 WAC ((388-500-0005)), the definitions found in the Webster's New World Dictionary apply.

**"APM index"** - The alternative payment methodology (APM) is used to update APM encounter payment rates on an annual basis. The APM index is a measure of input price changes experienced by Washington's federally qualified health center (FQHC) and rural health clinic (RHC) providers.

**"Base year"** - The year that is used as the benchmark in measuring a clinic's total reasonable costs for establishing base encounter rates.

**"Encounter"** - A face-to-face visit between a client and a qualified rural health clinic (RHC) provider (e.g., a physician, physician's assistant, or advanced registered nurse practitioner) who exercises independent judgment when providing services that qualify for an encounter rate.

**"Encounter rate"** - A cost-based, facility-specific rate for covered RHC services, paid to a rural health clinic for each valid encounter it bills.

**"Enhancements(~~(")~~) (also called managed care enhancements)"** - A monthly amount paid to RHCs for each client enrolled with a managed care organization (MCO). MCOs may contract with RHCs to provide services under managed care programs. RHCs receive enhancements from the ~~((department))~~ medicaid agency in addition to the negotiated payments they receive from the MCOs for services provided to enrollees.

**"Fee-for-service"** - A payment method the ~~((department))~~ agency uses to pay providers for covered medical services provided to ~~((medical assistance))~~ clients enrolled in the Title XIX (medicaid) program or the Title XXI (CHIP) program, except those services provided under the ~~((department's))~~ agency's prepaid managed care organizations or those services that qualify for an encounter payment.

**"Interim rate"** - The rate established by the ~~((department))~~ agency to pay a rural health clinic for covered RHC services prior to the establishment of a permanent rate for that facility.

~~((("Medical assistance" - The various health care programs administered by the department that provide federal and/or state-funded benefits to eligible clients.))~~

**"Medicare cost report"** - The cost report is a statement of costs and provider utilization that occurred during the time period covered

by the cost report. RHCs must complete and submit a report annually to medicare.

**"Mobile unit"** - The objects, equipment, and supplies necessary for provision of the services furnished directly by the RHC are housed in a mobile structure.

**"Permanent unit"** - The objects, equipment, and supplies necessary for the provision of the services furnished directly by the ((elinie)) RHC are housed in a permanent structure.

**"Rebasing"** - The process of recalculating encounter rates using actual cost report data.

**"Rural area"** - An area that is not delineated as an urbanized area by the Bureau of the Consensus.

**"Rural health clinic (RHC)"** - A clinic, as defined in 42 C.F.R. 405.2401(b), that is primarily engaged in providing RHC services and is:

- Located in a rural area designated as a shortage area as defined under 42 C.F.R. 491.2;
- Certified by medicare as ((a)) an RHC in accordance with applicable federal requirements; and
- Not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases.

**"Rural health clinic (RHC) services"** - Outpatient or ambulatory care of the nature typically provided in a physician's office or outpatient clinic or similar setting, including specified types of diagnostic examination, laboratory services, and emergency treatments. The specific list of services which must be made available by the clinic can be found under 42 C.F.R. Part 491.9.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

**WAC 182-549-1200 Rural health clinics—Enrollment.** (1) To participate in the Title XIX (medicaid) program or the Title XXI (CHIP) program and receive payment for services, a rural health clinic (RHC) must:

- (a) Receive RHC certification for participation in the Title XVIII (medicare) program according to 42 C.F.R. 491;
- (b) Sign a core provider agreement;
- (c) Comply with the clinical laboratory improvement amendments (CLIA) of 1988 testing for all laboratory sites per 42 C.F.R. Part 493; and
- (d) Operate in accordance with applicable federal, state, and local laws.

(2) An RHC may be a permanent or mobile unit. If an entity owns clinics in multiple locations, each individual site must be certified by the ((department)) medicaid agency in order to receive reimbursement from the ((department)) agency as an RHC.

(3) The ((department)) agency uses one of two timeliness standards for determining the effective date of a medicaid-certified RHC.

(a) The ((department)) agency uses medicare's effective date if the RHC returns a properly completed core provider agreement and RHC enrollment packet within sixty days from the date of medicare's letter notifying the clinic of the medicare certification.

(b) The ((department)) agency uses the date the signed core provider agreement is received if the RHC returns the properly completed core provider agreement and RHC enrollment packet after sixty days of the date of medicare's letter notifying the clinic of the medicare certification.

AMENDATORY SECTION (Amending WSR 11-14-075, filed 6/30/11, effective 7/1/11)

**WAC 182-549-1300 Rural health clinics—Services.** (1) Rural health clinic (RHC) services are defined under 42 C.F.R. 440.20(b).

(2) The ((department)) medicaid agency pays for RHC services when they are:

(a) Within the scope of ((an-eligible)) a client's ((medical-assistance-program)) benefit package. Refer to WAC ((388-501-0060)) 182-501-0060; and

(b) Medically necessary as defined in WAC ((388-500-0005)) 182-500-0070.

(3) RHC services may be provided by any of the following individuals in accordance with 42 C.F.R. 405.2401, 491.7, and 491.8:

- (a) Physicians;
- (b) Physician assistants (PA);
- (c) Nurse practitioners (NP);
- (d) Nurse midwives or other specialized nurse practitioners;
- (e) Certified nurse midwives;
- (f) Registered nurses or licensed practical nurses; and
- (g) Psychologists or clinical social workers.

AMENDATORY SECTION (Amending WSR 12-16-060, filed 7/30/12, effective 8/30/12)

**WAC 182-549-1400 Rural health clinics—Reimbursement and limitations.** (1) For services provided during the period beginning January 1, 2001, and ending December 31, 2008, the medicaid agency's payment methodology for rural health clinics (RHC) was a prospective payment system (PPS) as authorized by 42 U.S.C. 1396a (bb)(2) and (3).

(2) For services provided beginning January 1, 2009, RHCs have the choice to be reimbursed under the PPS or be reimbursed under an alternative payment methodology (APM), as authorized by 42 U.S.C. 1396a (bb)(6). As required by 42 U.S.C. 1396a (bb)(6), payments made under the APM will be at least as much as payments that would have been made under the PPS.

(3) The agency calculates RHC PPS encounter rates for RHC core services as follows:

(a) Until an RHC's first audited medicare cost report is available, the agency pays an average encounter rate of other similar RHCs (whether the RHC is classified as hospital-based or free-standing) within the state, otherwise known as an interim rate.

(b) Upon availability of the RHC's first audited medicare cost report, the agency sets RHC's encounter rates at one hundred percent

of its costs as defined in the cost report divided by the total number of encounters the RHC has provided during the time period covered in the audited cost report. RHCs receive this rate for the remainder of the calendar year during which the audited cost report became available. The encounter rate is then increased each January 1st by the percent change in the medicare economic index (MEI).

(4) For RHCs in existence during calendar years 1999 and 2000, the agency sets the encounter rates prospectively using a weighted average of one hundred percent of the RHC's total reasonable costs for calendar years 1999 and 2000 and adjusted for any increase or decrease in the scope of services furnished during the calendar year 2001 to establish a base encounter rate.

(a) The agency adjusts PPS base encounter rates to account for an increase or decrease in the scope of services provided during calendar year 2001 in accordance with WAC 182-549-1500.

(b) PPS base encounter rates are determined using medicare's audited cost reports, and each year's rate is weighted by the total reported encounters. The agency does not apply a capped amount to these base encounter rates. The formula used to calculate base encounter rates is as follows:

$$\text{Specific RHC Base Encounter Rate} = \frac{(\text{Year 1999 Rate} \times \text{Year 1999 Encounters}) + (\text{Year 2000 Rate} \times \text{Year 2000 Encounters})}{(\text{Year 1999 Encounters} + \text{Year 2000 Encounters}) \text{ for each RHC}}$$

(c) Beginning in calendar year 2002 and any year thereafter, encounter rates are increased by the MEI and adjusted for any increase or decrease in the RHC's scope of services.

(5) The agency calculates RHC's APM encounter rates for services provided during the period beginning January 1, 2009, and ending April 6, 2011, as follows:

(a) The APM utilizes the RHC base encounter rates as described in subsection (4)(b) of this section.

(b) Base rates are increased by each annual percentage, from calendar years 2002 through 2009, of the IHS Global Insight index, also called the APM index.

(c) The result is the year 2009 APM rates for each RHC that chooses to be reimbursed under the APM.

(6) This subsection describes the encounter rates that the agency pays RHCs for services provided during the period beginning April 7, 2011, and ending June 30, 2011. On January 12, 2012, the federal Centers for Medicare and Medicaid Services (CMS) approved a state plan amendment (SPA) containing the methodology outlined in this section.

(a) During the period that CMS approval of the SPA was pending, the agency continued to pay RHCs at the encounter rate described in subsection (5) of this section.

(b) Each RHC has the choice of receiving either its PPS rate, as determined under the method described in subsection (3) of this section, or a rate determined under a revised APM, as described in (c) of this subsection.

(c) The revised APM uses each RHC's PPS rate for the current calendar year, increased by five percent.

(d) For all payments made for services provided during the period beginning April 7, 2011, and ending June 30, 2011, the agency will recoup from RHCs any amount paid in excess of the encounter rate established in this section. This process is specified in emergency rules

that took effect on October 29, 2011, (WSR 11-22-047) and February 25, 2012 (WSR 12-06-002).

(7) This subsection describes the encounter rate that the agency pays RHCs for services provided on and after July 1, 2011. On January 12, 2012, CMS approved a SPA containing the methodology outlined in this section.

(a) Each RHC has the choice of receiving either its PPS rate, as determined under the method described in subsection (3) of this section, or a rate determined under a revised APM, as described in (b) of this subsection.

(b) The revised APM is as follows:

(i) For RHCs that rebased their rate effective January 1, 2010, the revised APM is their allowed cost per visit during the cost report year increased by the cumulative percentage increase in the MEI between the cost report year and January 1, 2011.

(ii) For RHCs that did not rebase their rate effective January 1, 2010, the revised APM is based on their PPS base rate from 2001 (or subsequent year for RHCs receiving their initial RHC designation after 2002) increased by the cumulative percentage increase in the IHS Global Insight index from the base year through calendar year 2008 and the cumulative increase in the MEI from calendar years 2009 through 2011. The rates will be increased by the MEI effective January 1, 2012, and each January 1st thereafter.

(c) For all payments made for services provided during the period beginning July 1, 2011, and ending January 11, 2012, the agency will recoup from RHCs any amount paid in excess of the encounter rate established in this section. This process is specified in emergency rules that took effect on October 29, 2011, (WSR 11-22-047) and February 25, 2012 (WSR 12-06-002).

(d) For RHCs that choose to be paid under the revised APM, the agency will periodically rebase the encounter rates using the RHC cost reports and other relevant data. Rebasing will be done only for RHCs that are reimbursed under the APM.

(e) The agency will ensure that the payments made under the APM are at least equal to the payments that would be made under the PPS.

(8) The agency pays for one encounter, per client, per day except in the following circumstances:

(a) The visits occur with different health care professionals with different specialties; or

(b) There are separate visits with unrelated diagnoses.

(9) RHC services and supplies incidental to the provider's services are included in the encounter rate payment.

(10) Payments for non-RHC services provided in an RHC are made on a fee-for-service basis using the agency's published fee schedules. Non-RHC services are subject to the coverage guidelines and limitations listed in chapters 182-500 through 182-557 WAC.

(11) For clients enrolled with a managed care organization (MCO), covered RHC services are paid for by that plan.

(12) For clients enrolled with an MCO, the agency pays each RHC a supplemental payment in addition to the amounts paid by the MCO. The supplemental payments, called enhancements, are paid in amounts necessary to ensure compliance with 42 U.S.C. 1396a (bb)(5)(A).

(a) The RHCs receive an enhancement payment each month for each managed care client assigned to them by an MCO.

(b) To ensure that the appropriate amounts are paid to each RHC, the agency performs an annual reconciliation of the enhancement payments. For each RHC, the agency will compare the amount actually paid

to the amount determined by the following formula: (Managed care encounters times encounter rate) less fee-for-service equivalent of MCO services. If the RHC has been overpaid, the agency will recoup the appropriate amount. If the RHC has been underpaid, the agency will pay the difference.

(13) Only clients enrolled in the Title XIX (medicaid) program or the Title XXI (CHIP) program are eligible for encounter or enhancement payments. The agency does not pay the encounter rate or the enhancement rate for clients in state-only medical programs. Services provided to clients in state-only medical programs are considered fee-for-service, regardless of the type of service performed.