Chapter 182-548 WAC
FEDERALLY QUALIFIED HEALTH CENTERS

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WAC 182-548-1000 Federally qualified health centers—Purpose. This chapter establishes the department's:
(1) Requirements for enrollment as a federally qualified health center (FQHC) provider; and
(2) Reimbursement methodology for services provided by FQHCs to clients of medical assistance.

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 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 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 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 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 CFR 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 organizations 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 uses to pay providers for covered medical services provided to medical assistance clients, except those services provided under the department's prepaid managed care organizations or those services that qualify for an encounter rate.

Interim rate—The rate established by the department to pay an FQHC for covered FQHC services prior to the establishment of a permanent rate for that facility.

Medical assistance—The various healthcare programs administered by the department that provide federal and/or state-funded healthcare benefits to eligible clients.

Rebasing—The process of recalculating encounter rates using actual cost report data.

WAC 182-548-1200 Federally qualified health centers—Enrollment. (1) To enroll as a medical assistance 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 CFR 491;
(b) Sign a core provider agreement; and
(c) Operate in accordance with applicable federal, state, and local laws.
(2) The department uses one of two timeliness standards for determining the effective date of a medicaid-certified FQHC.
(a) The department 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 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.

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

(ii) The adjusted base rates are then inflated by each annual percentage, from years 2002 through 2009, of the APM index. The result is the year 2009 APM rate for each FQHC that chooses to be reimbursed under the APM.

The department will periodically rebase the APM rates. The department will not rebase rates determined under the PPS.
6) The department limits encounters to one per client, per day except in the following circumstances:
(a) The visits occur with different healthcare professionals with different specialties; or
(b) There are separate visits with unrelated diagnoses.
7) FQHC services and supplies incidental to the provider's services are included in the encounter rate payment.
8) Payments for non-FQHC services provided in an FQHC are made on a fee-for-service basis using the department's published fee schedules. Non-FQHC services are subject to the coverage guidelines and limitations listed in chapters 388-500 through 557 WAC.
9) For clients enrolled with a managed care organization, covered FQHC services are paid for by that plan.
10) Only clients enrolled in Title XIX (medicaid) or Title XXI (CHIP) are eligible for encounter or enhancement payments. The department 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.
11) For clients enrolled with a managed care organization (MCO), the department 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 department performs an annual reconciliation of the enhancement payments. For each FQHC, the department will compare the amount actually paid to the amount determined by the following formula: (Managed care encounters times encounter rate) less FFS equivalent of MCO services. If the center has been overpaid, the department will recoup the appropriate amount. If the center has been underpaid, the department will pay the difference.

WAC 182-548-1500 Federally qualified health centers—Change in scope of service. (1) For centers reimbursed under the prospective payment system (PPS), the department considers a federally qualified health center (FQHC) change in scope of service to be a change in the type, intensity, duration, and/or amount of services provided by the FQHC. Changes in scope of service apply only to covered medicaid services.
(2) When the department determines that a change in scope of service has occurred after the base year, the department adjusts the FQHC’s encounter rate to reflect the change.
(3) FQHCs must:
(a) Notify the department’s FQHC program manager in writing, at the address published in the department’s FQHC billing instructions, of any changes in scope of service no later than sixty calendar days after the effective date of the change; and
(b) Provide the department with all relevant and requested documentation pertaining to the change in scope of service.
(4) The department adjusts the encounter rate to reflect the change in scope of service using one or more of the following:
(a) A medicaid comprehensive desk review of the FQHC’s cost report;
(b) Review of a medicare audit of the FQHC’s cost report; or
(c) Other documentation relevant to the change in scope of service.
(5) The adjusted encounter rate will be effective on the date the change of scope of service is effective.
(6) For centers reimbursed under the alternative payment methodology (APM), the department considers an FQHC change in scope of service to be a change in the type of services provided by the FQHC. Changes in intensity, duration, and/or amount of services will be addressed in the next scheduled encounter rate rebase. Changes in scope of service apply only to covered medicaid services.
(7) When the department determines that a change in scope of service has occurred after the base year, the department adjusts the FQHC’s encounter rate to reflect the change.
(8) FQHCs must:
(a) Notify the department’s FQHC program manager in writing, at the address published in the department’s FQHC billing instructions, of any changes in scope of service no later than sixty calendar days after the effective date of the change; and
(b) Provide the department with all relevant and requested documentation pertaining to the change in scope of service.
(9) The department adjusts the encounter rate to reflect the change in scope of service using one or more of the following:
(a) A medicaid comprehensive desk review of the FQHC’s cost report;
(b) Other documentation relevant to the change in scope of service.
(10) The adjusted encounter rate will be effective on the date the change of scope of service is effective.


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