

Chapter 182-549 WAC

RURAL HEALTH CLINICS

WAC

182-549-1000	Rural health clinics—Purpose.
182-549-1100	Rural health clinics—Definitions.
182-549-1200	Rural health clinics—Enrollment.
182-549-1300	Rural health clinics—Services.
182-549-1400	Rural health clinics—Reimbursement and limitations.
182-549-1500	Rural health clinics—Change in scope of service.

WAC 182-549-1000 Rural health clinics—Purpose.

This chapter establishes the department's reimbursement methodology for rural health clinic (RHC) services. RHC conditions for certification are found in 42 C.F.R. part 491.

[11-14-075, recodified as § 182-549-1000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 42 C.F.R. 405.2472, 42 C.F.R. 491.08-05-011, § 388-549-1000, filed 2/7/08, effective 3/9/08.]

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 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 in addition to the negotiated payments they receive from the MCOs for services provided to enrollees.

"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 payment.

"Interim rate" - The rate established by the department 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 clinic 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 Census.

"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 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.

[11-14-075, recodified as § 182-549-1100, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 42 U.S.C. 1396a(bb), 42 C.F.R. 405.2472, and 42 C.F.R. 491.10-09-030, § 388-549-1100, filed 4/13/10, effective 5/14/10. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 42 C.F.R. 405.2472, 42 C.F.R. 491.08-05-011, § 388-549-1100, filed 2/7/08, effective 3/9/08.]

WAC 182-549-1200 Rural health clinics—Enrollment. (1) To participate in the Title XIX (Medicaid) 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 in order to receive reimbursement from the department as an RHC.

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

(a) The department 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 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.

[11-14-075, recodified as § 182-549-1200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 42 C.F.R. 405.2472, 42 C.F.R. 491.08-05-011, § 388-549-1200, filed 2/7/08, effective 3/9/08.]

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 pays for RHC services when they are:

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

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

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

(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.

[11-14-075, recodified as § 182-549-1300, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 42 C.F.R. 405.2472, 42 C.F.R. 491.08-05-011, § 388-549-1300, filed 2/7/08, effective 3/9/08.]

WAC 182-549-1400 Rural health clinics—Reimbursement and limitations. (1) For services provided during

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

(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.

the period beginning January 1, 2001, and ending December 31, 2008, the 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:

(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 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.

[Statutory Authority: RCW 41.05.021, 12-16-060, § 182-549-1400, filed 7/30/12, effective 8/30/12. 11-14-075, recodified as § 182-549-1400, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 42 U.S.C. 1396a(bb), 42 C.F.R. 405.2472, and 42 C.F.R. 491.10-09-030, § 388-549-1400, filed 4/13/10, effective 5/14/10. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 42 C.F.R. 405.2472, 42 C.F.R. 491.08-05-011, § 388-549-1400, filed 2/7/08, effective 3/9/08.]

WAC 182-549-1500 Rural health clinics—Change in scope of service. (1) For clinics reimbursed under the prospective payment system (PPS), the department considers a rural health clinic's (RHC) change in scope of service to be a change in the type, intensity, duration, and/or amount of services provided by the RHC. Changes in scope of service apply only to covered medicaid services.

(a) When the department determines that a change in scope of service has occurred after the base year, the department will adjust the RHC's encounter rate to reflect the change.

(b) RHCs must:

(i) Notify the department's RHC program manager in writing, at the address published in the department's rural health clinic billing instructions, of any changes in scope of service no later than sixty days after the effective date of the change; and

(ii) Provide the department with all relevant and requested documentation pertaining to the change in scope of service.

(c) The department adjusts the encounter rate to reflect the change in scope of service using one or more of the following:

(i) A medicaid comprehensive desk review of the RHC's cost report;

(ii) Review of a medicare audit of the RHC's cost report;
or
(iii) Other documentation relevant to the change in scope of service.

(d) The adjusted encounter rate will be effective on the date the change of scope of service is effective.

(2) For clinics reimbursed under the alternative payment methodology (APM), the department considers an RHC change in scope of service to be a change in the type of services provided by the RHC. The department addresses changes in intensity, duration, and/or amount of services in the next scheduled encounter rate rebase. Changes in scope of service apply only to covered medicaid services.

(a) When the department determines that a change in scope of service has occurred after the base year, the department adjusts the RHC's encounter rate to reflect the change.

(b) RHCs must:

(i) Notify the department's RHC program manager in writing, at the address published in the department's rural health clinic billing instructions, of any changes in scope of service no later than sixty calendar days after the effective date of the change; and

(ii) Provide the department with all relevant and requested documentation pertaining to the change in scope of service.

(c) The department adjusts the encounter rate to reflect the change in scope of service using one or more of the following:

(i) A medicaid comprehensive desk review of the RHC's cost report;

(ii) Review of a medicare audit of the RHC's cost report, if available; or

(iii) Other documentation relevant to the change in scope of service.

(d) The adjusted encounter rate will be effective on the date the change of scope of service is effective.

[11-14-075, recodified as § 182-549-1500, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 42 U.S.C. 1396a(bb), 42 C.F.R. 405.2472, and 42 C.F.R. 491. 10-09-030, § 388-549-1500, filed 4/13/10, effective 5/14/10. Statutory Authority: RCW 74.08.090, 74.09.510, 74.09.522, 42 C.F.R. 405.2472, 42 C.F.R. 491. 08-05-011, § 388-549-1500, filed 2/7/08, effective 3/9/08.]