Chapter 182-548 WAC
FEDERALLY QUALIFIED HEALTH CENTERS

WAC

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.

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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.

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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.

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WAC 182-548-1300 Federally qualified health centers—Services. (1) The following outpatient services qualify for FQHC reimbursement:

(a) Physician services specified in 42 CFR 405.2412.

(b) Nurse practitioner or physician assistant services specified in 42 CFR 405.2414.

(c) Clinical psychologist and clinical social worker services specified in 42 CFR 405.2450.

(d) Visiting nurse services specified in 42 CFR 405.2416.

(e) Nurse-midwife services specified in 42 CFR 405.2401.

(f) Preventive primary services specified in 42 CFR 405.2448.

(2) The department pays for FQHC services when they are:

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

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

(3) FQHC services may be provided by any of the following individuals in accordance with 42 CFR 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.

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WAC 182-548-1400 Federally qualified health centers—Reimbursement and limitations. (1) Effective January 1, 2001, the payment methodology for federally qualified health centers (FQHC) conforms to 42 U.S.C. 1396a(bb). As set forth in 42 U.S.C. 1396a (bb)(2) and (3), all FQHCs that provide services on January 1, 2001, and through December 31, 2008, are reimbursed on a prospective payment system (PPS).

(2) Effective January 1, 2009, FQHCs have the choice to continue being 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), payments made under the APM must be at least as much as payments that would have been made under the PPS.

(3) The department calculates the FQHC's PPS encounter rate as follows:

(a) Until the FQHC's first audited cost report is available, the department 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 department sets the clinic's encounter rate at one hundred percent of its total reasonable costs as defined in the cost report. The FQHC receives this rate for the remainder of the calendar year during which the audited cost report became available. Thereafter, the encounter rate is then inflated each January 1 by the medicare economic index (MEI) for primary care services.

(4) For FQHCs in existence during calendar years 1999 and 2000, the department sets the payment prospectively using a weighted average of one hundred percent of the center'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 department adjusts a PPS base encounter rate to account for an increase or decrease in the scope of services provided during calendar year 2001 in accordance with WAC 388-548-1500.

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

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

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

(5) The department calculates the FQHC's APM encounter rate as follows:

(a) Beginning January 1, 2009, the APM utilizes the FQHC base encounter rates, as described in WAC 388-548-1400 (4)(b).

(i) The base rates are adjusted to reflect any valid changes in scope of service between years 2002 and 2009.

(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.

(b) The department will ensure that the APM pays an amount that is at least equal to the PPS, the annual inflator used to increase the APM rates is the greater of the APM index or the MEI.

(c) 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 nonFQHC services provided in an FQHC are made on a fee-for-service basis using the department's published fee schedules. NonFQHC 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.

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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 federally qualified health centers 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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