

# Chapter 182-549 WAC

## RURAL HEALTH CLINICS

### WAC

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### 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 CFR part 491.

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### 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 healthcare 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 Consensus.

**"Rural health clinic (RHC)"**—A clinic, as defined in 42 CFR 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 CFR 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 CFR part 491.9.

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**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 CFR 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 CFR 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.

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**WAC 182-549-1300 Rural health clinics—Services.**

(1) Rural health clinic (RHC) services are defined under 42 CFR 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 CFR 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.

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**WAC 182-549-1400 Rural health clinics—Reimbursement and limitations.** (1) Effective January 1, 2001,

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

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

(4) The department calculates the RHC's APM encounter rate as follows:

(a) Beginning January 1, 2009, the APM utilizes RHC base encounter rates as described in WAC 388-549-1400 (3)(b). The base rates are inflated by each annual percentage, from years 2002 through 2009, of the APM index. The result is the year 2009 APM rate for each RHC that chooses to be reimbursed under the APM.

the payment methodology for rural health clinics (RHC) conforms to 42 USC 1396a(bb). RHCs that provide services on January 1, 2001 through December 31, 2008 are reimbursed on a prospective payment system (PPS).

Effective January 1, 2009, RHCs have the choice to continue being reimbursed under the PPS or be reimbursed under an alternative payment methodology (APM), as authorized by 42 USC 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.

(2) The department calculates the RHC's PPS encounter rate for RHC core services as follows:

(a) Until the RHC's first audited medicare cost report is available, the department 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 audited medicare cost report, the department sets the clinic's encounter rate at one hundred percent of its costs as defined in the cost report divided by the total number of encounters the clinic has provided during the time period covered in the audited cost report. The RHC will receive this rate for the remainder of the calendar year during which the audited cost report became available. The encounter rate is then inflated each January 1 by the medicare economic index (MEI) for primary care services.

(3) For RHCs in existence during calendar years 1999 and 2000, the department sets the payment prospectively using a weighted average of one hundred percent of the clinic'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 388-549-1500.

(b) The 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 department does not apply a capped amount to these base encounter rates. The formula used to calculate the base encounter rate is as follows:

(b) To ensure that the APM pays an amount that is at least equal to the PPS in accordance with 42 USC 1396a (bb)(6), the annual inflator used to increase the APM rates is the greater of the APM index or the MEI.

(c) The department periodically rebases the APM rates. The department does not rebase rates determined under the PPS.

(d) When rebasing the APM encounter rates, the department applies a productivity standard to the number of visits performed by each practitioner group (physicians and mid-levels) to determine the number of encounters to be used in each RHC's rate calculation. The productivity standards are

determined by reviewing all available RHC cost reports for the rebasing period and setting the standards at the levels necessary to allow ninety-five percent of the RHCs to meet the standards. The encounter rates of the clinics that meet the standards are calculated using each clinic's actual number of encounters. The encounter rates of the other five percent of clinics are calculated using the productivity standards. This process is applied at each rebasing, so the actual productivity standards may change each time encounter rates are rebased.

(5) The department pays for one encounter, 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.

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

(7) Payments for non-RHC services provided in an RHC are made on a fee-for-service basis using the department's published fee schedules. Non-RHC services are subject to the coverage guidelines and limitations listed in chapters 388-500 through 388-557 WAC.

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

(9) The department does not pay the encounter rate or the enhancements for clients in state-only programs. Services provided to clients in state-only programs are considered fee-for-service, regardless of the type of service performed.

(10) For clients enrolled with a managed care organization (MCO), the department 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 USC 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 department performs an annual reconciliation of the enhancement payments. For each RHC, the department 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 clinic has been overpaid, the department will recoup the appropriate amount. If the clinic has been underpaid, the department will pay the difference.

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**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 depart-

(6/30/11)

ment 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.

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