

Chapter 182-548 WAC

FEDERALLY QUALIFIED HEALTH CENTERS

WAC

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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.

[WSR 11-14-075, recodified as § 182-548-1000, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, BIPA of 2000 Section 702, sections 201 and 209 of 2009-2011 budget bill, and 42 U.S.C. 1396a(bb). WSR 10-09-002, § 388-548-1000, filed 4/7/10, effective 5/8/10.]

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 negoti-

ated 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 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 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.

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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 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 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.

[WSR 11-14-075, recodified as § 182-548-1200, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, BIPA of 2000 Section 702, sections 201 and 209 of 2009-2011 budget bill, and 42 U.S.C. 1396a(bb). WSR 10-09-002, § 388-548-1200, filed 4/7/10, effective 5/8/10.]

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 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 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.

[WSR 11-14-075, recodified as § 182-548-1300, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, BIPA of 2000 Section 702, sections 201 and 209 of 2009-2011 budget bill, and 42 U.S.C. 1396a(bb). WSR 10-09-002, § 388-548-1300, filed 4/7/10, effective 5/8/10.]

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

(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.

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 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 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 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:

(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 Janu-

ary 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. Rebas-ing 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.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 14-14-056, § 182-548-1400, filed 6/26/14, effective 8/1/14. Statutory Authority: RCW 41.05.021. WSR 12-16-060, § 182-548-1400, filed 7/30/12, effective 8/30/12. WSR 11-14-075, recodified as § 182-548-1400, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, BIPA of 2000 Section 702, sections 201 and 209 of 2009-2011 budget bill, and 42 U.S.C. 1396a(bb). WSR 10-09-002, § 388-548-1400, filed 4/7/10, effective 5/8/10.]

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.

[WSR 11-14-075, recodified as § 182-548-1500, filed 6/30/11, effective 7/1/11. Statutory Authority: RCW 74.08.090, BIPA of 2000 Section 702, sections 201 and 209 of 2009-2011 budget bill, and 42 U.S.C. 1396a(bb). WSR 10-09-002, § 388-548-1500, filed 4/7/10, effective 5/8/10.]