Chapter 182-548 WAC
FEDERALLY QUALIFIED HEALTH CENTERS

WAC

WAC 182-548-1000 Federally qualified health centers—Purpose. This chapter establishes the medicaid agency's:

(1) Requirements for enrollment as a federally qualified health center (FQHC) provider; and

(2) Reimbursement methodology for services provided by an FQHC to a Washington apple health client.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-11-008, § 182-548-1000, filed 5/7/15, effective 6/7/15. 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 chapter 182-500 WAC, 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 medicaid agency 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 agency 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 agency 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 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 organization 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 agency uses to pay providers for covered medical services provided to Washington apple health clients, except those services provided under the agency's prepaid managed care organizations or those services that qualify for an encounter rate.

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

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

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-11-008, § 182-548-1100, filed 5/7/15, effective 6/7/15. WSR 11-14-075, recodified as § 182-548-1100, 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, § 388-548-1100, filed 4/7/10, effective 5/8/10.]

WAC 182-548-1200 Federally qualified health centers—Enrollment. (1) To enroll as a Washington apple health 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 medicaid agency uses one of two timeliness standards for determining the effective date of a medicaid-certified FQHC.

(a) The agency 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 agency 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.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-11-008, § 182-548-1200, filed 5/7/15, effective 6/7/15. 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 medicaid agency pays for FQHC services when they are:

(a) Within the scope of an eligible client's Washington apple health program. Refer to WAC 182-501-0060 scope of services; and

(b) Medically necessary as defined in WAC 182-500-0070.

(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.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 15-11-008, § 182-548-1300, filed 5/7/15, effective 6/7/15. 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.]

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 medicaid 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:

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

(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.

(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 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 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. Rebasing 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 15-11-008, § 182-548-1400, filed 5/7/15, effective 6/7/15; 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 rate adjustment. In accordance with 42 U.S.C. 1396a (bb)(3)(B), the agency will adjust its payment rate to a federally qualified health center (FQHC) to take into account any increase or decrease in the scope of the FQHC's services. The procedures and requirements for any such rate adjustment are described below.

(1) **Triggering events.**

(a) An FQHC may file a change in scope of services rate adjustment application on its own initiative only when:

(i) The cost to the FQHC of providing covered health care services to eligible clients has increased due to one or more of the following:

(A) A change in the type of health care services the FQHC provides;

(B) A change in the intensity of health care services the FQHC provides. Intensity means the total quantity of labor and materials consumed by an individual client during an average encounter has increased;

(C) A change in the duration of health care services the FQHC provides. Duration means the length of an average encounter has increased;

(D) A change in the amount of health care services the FQHC provides in an average encounter;

(E) Any change comparable to (a)(i)(A) through (D) of this subsection in which the type, intensity, duration or amount of services has decreased and the cost of an average encounter has decreased; and

(ii) The cost change equals or exceeds:

(A) An increase of one and three-quarters percent in the prospective payment system (PPS) rate per encounter over one year as measured by comparing the cost per encounter to the then current PPS rate;

(B) A decrease of two and one-half percent in the PPS rate per encounter over one year as measured by comparing the cost per encounter to the then current PPS rate; or

(C) A cumulative increase or decrease of five percent in the PPS rate per encounter as compared to the current year's cost per encounter; and

(iii) The costs reported to the agency to support the proposed change in scope rate adjustment are reasonable under OMB *Circular A-122* or successor (the *Uniform Grants Guidance*) and other applicable state and federal law.

(b) At any time, the agency may instruct the FQHC to file a medicaid cost report with a statement of whether the FQHC asserts that its PPS rate should be increased or decreased due to a change in the scope of services (the FQHC "position statement").

(i) The FQHC must file a completed cost report and position statement no later than ninety calendar days after receiving the instruction from the agency to file same; provided, however, if the FQHC has recently completed its fiscal year at the time of the agency's request but has not received its annual audit by the time of the request, the FQHC may at its option wait and respond to the agency's request ninety days after the FQHC receives its annual audit or it may submit a cost report based on the prior year's audit.

(ii) The FQHC's cost report and position statement will be reviewed under the same criteria listed above for an application for a change in scope adjustment.

(iii) The agency will not request more than one change in scope in a calendar year.

(2) **Filing requirements.**

(a) The FQHC may apply for a prospective change in scope of service rate adjustment, a retrospective change in scope of service rate adjustment, or both, in a single application.

(i) Unless instructed to file an application by the agency, the FQHC may file no more than one change in scope of service application per calendar year; however, more than one type of change in scope may be included in a single application.

(ii) The FQHC must file for a change in scope of service rate adjustment no later than ninety days after the end of the calendar year in which the FQHC believes the change in scope occurred or in which the FQHC learned based on its annual audit that the cost threshold in subsection (1)(a)(ii) of this section was met, whichever is later.

(b) Prospective change in scope.

(i) To file a prospective change in scope of service rate adjustment application, the FQHC must submit projected costs sufficient to establish an interim rate. A prospective change is a change the FQHC plans to implement in the future. The interim rate adjustment will go into effect after the change takes effect.

(ii) The interim rate is subject to the post change in scope review and rate adjustment process defined in subsection (5) of this section.

(iii) If the change in scope occurs fewer than ninety days after the FQHC submitted a complete application to the agency, the interim rate must take effect no later than ninety days after the complete application was submitted to the agency.

(iv) The change in scope occurs more than ninety days but fewer than one hundred eighty days after the FQHC submitted a complete application to the agency, the interim rate takes effect when the change in scope occurs.

(v) If the FQHC fails to implement a change in service identified in its prospective change in scope of service rate adjustment application within one hundred eighty days, the application is void and the FQHC may resubmit the application to the agency, in which case, (a)(i) of this subsection does not apply.

(c) Retrospective change in scope.

(i) A retrospective change in scope of service rate adjustment application must state each qualifying event listed in subsection (1)(a)(i) of this section that supports its application and include twelve months of data documenting the cost change caused by the qualifying event. A retrospective change in scope is a change that took place in the past and the FQHC is seeking to adjust its rate based on that change.

(ii) If approved, a retrospective rate adjustment takes effect on the date the FQHC filed the application with the agency.

(3) **Supporting documentation.**

(a) To apply for a change in scope of service rate adjustment, the FQHC must include the following documentation in the application:

(i) A narrative description of the proposed change in scope;

(ii) A description of each cost center on the cost report that was or will be affected by the change in scope;

(iii) The FQHC's most recent audited financial statements, if audit is required by federal law;

(iv) The implementation date for the proposed change in scope; and

(v) Any additional documentation requested by the agency.

(b) A prospective change in scope of service rate adjustment application must also include projected medicaid cost report or projected medicare cost report with supplemental schedules necessary to identify the medicaid cost per visit for the twelve-month period following implementation of the change in scope.

(c) A retrospective change in scope of service rate adjustment application must also include the medicaid cost report or medicare cost report with supplemental schedules necessary to identify the medicaid cost per visit and encounter data for twelve months or the fiscal year following implementation of the proposed change in scope.

(4) **Review of the application.**

(a) Application processing.

(i) The agency must review the application for completeness, accuracy, and compliance with program rules.

(ii) Within sixty days of receiving the application, the agency must notify the FQHC of any deficient documentation or request any additional information that is necessary to process the application.

(iii) Within ninety days of receiving a complete application, the agency must send the FQHC:

(A) A decision stating whether it will implement a PPS rate change; and

(B) A rate-setting statement.

(iv) Failure to act within ninety days will mean that the change is considered denied by the agency and the FQHC may appeal the decision as provided for in subsection (6) of this section.

(b) Determining rate for change in scope.

(i) The agency must set an interim rate for prospective changes in scope by adjusting the FQHC's existing rate by the projected average cost per encounter of any approved change. The agency will review the costs to determine if they are reasonable, and set a new interim rate based on the determined cost per encounter.

(ii) The agency must set an adjusted encounter rate for retrospective changes in scope by adjusting the FQHC's existing rate by the documented average cost per encounter of the approved change. Projected costs per encounter may be used if there are insufficient historical data to establish the rate. The agency will review the costs to determine whether they are reasonable, and set a new rate based on the determined cost per encounter.

(c) If the FQHC is paid under an alternative payment methodology (APM), any change in scope of service rate adjustment requested by the FQHC will modify the PPS rate in addition to the APM.

(d) The agency may delegate the duties related to application processing and rate setting to a third party. The agency retains final authority for making decisions related to changes in scope.

(5) **Post change in scope of services rate adjustment review.**

(a) If the change in scope application was retrospective (i.e., based on a year or more of actual encounter data), the agency may conduct a post change in scope rate adjustment review.

(b) If the change in scope application was prospective (i.e., based on less than a full year of actual encounter data), the FQHC must submit the following information to the agency within eighteen months of the effective date of the rate adjustment:

(i) Medicaid cost report or medicare cost report with supplemental schedules necessary to identify the medicaid cost per visit and encounter data for twelve consecutive months of experience following implementation of the change in scope; and

(ii) Any additional documentation requested by the agency.

(c) The agency will conduct the post change in scope review within ninety days of receiving the cost report and encounter data from the FQHC.

(d) If necessary, the agency will adjust the encounter rate within ninety days to ensure that the rate reflects the reasonable cost of the change in scope of services.

(e) A rate adjustment based on a post change in scope review will take effect on the date the agency issues its adjustment. The new rate will be prospective.

(f) If the FQHC fails to submit the post change in scope cost report or related encounter data, the agency must provide written notice to the center or clinic of the deficiency within thirty days.

(g) If the FQHC fails to submit required documentation within five months of this deficiency notice, the agency may reinstate the prechange in scope encounter rate going forward from the date the interim rate was established. Any overpayment to the FQHC may be recouped by the agency.

(6) **Appeals.** Appeals of agency action under this section are governed by WAC 182-502-0220, except that any rate change begins on the date the agency received the change in scope of services rate adjustment application.

[Statutory Authority: RCW 41.05.021, 41.05.160. WSR 15-05-023, § 182-548-1500, filed 2/9/15, effective 3/12/15. 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.]