Chapter 182-548 WAC
FEDERALLY QUALIFIED HEALTH CENTERS

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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, the definitions found in chapter 182-500 WAC apply.

"APM index" - The agency uses the alternative payment methodology (APM) 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 an FQHC's total reasonable costs for establishing base encounter rates.

"Cost center" - A category of service approved to be provided by the FQHC under WAC 182-548-1200 and reported in the medicaid cost report. The categories of services provided by the FQHC may include medical, mental health, dental, maternity support services, and substance use disorder.

"Cost report" - A statement of costs and provider utilization that occurred during the time period covered by the cost report. FQHCs complete a cost report when there is a request for a change in scope rate adjustment, there is a rebasing of the encounter rate, or the agency sets a base rate.

"Encounter" - A face-to-face or telemedicine (including audio-only telemedicine) visit between an encounter-eligible client and an FQHC provider who exercises independent judgment when providing services that qualify for encounter rate reimbursement.

"Encounter-eligible client" - A client who receives benefits under Title XIX (medicaid) or Title XXI (CHIP).

"Encounter rate" - A cost-based, facility-specific rate for covered FQHC services.

"Enhancements (also called managed care enhancements)" - A monthly amount the agency pays to FQHCs for each client enrolled with a managed care organization (MCO). FQHCs may contract with MCOs 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:

(a) Is receiving a grant under section 329, 330, or 340 of the federal 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 PHS Act;

(b) Based on the recommendation of the PHS, is determined by CMS to meet the requirements for receiving such a grant;

(c) Was treated by CMS, for purposes of medicare part B, as a comprehensive federally funded health center (FFHC) as of January 1, 1990; or

(d) Is an outpatient health program or facility operated by a tribe or tribal organization under the federal Indian Self-Determination and Education Assistance Act of 1975 or an Urban Indian organization receiving funding under Title V of the federal Indian Health Care Improvement Act of 1976.

"Fee-for-service" - A payment method the agency uses to pay providers for covered medical services provided to Washington apple health clients, which excludes services provided by the agency's contracted managed care organizations and services that qualify for an encounter rate.

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

"Medicare economic index (MEI)" - An index published in the Federal Register used in the calculation of changes to determine allowed charges for physician services. The agency adjusts FQHC encounter rates and enhancement rates by the MEI each year on January 1st.

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

[Statutory Authority: 42 U.S.C. 1396a(bb), 42 U.S.C. 1396d (2)(A), RCW 41.05.021, and 41.05.160. WSR 22-22-049, § 182-548-1100, filed 10/27/22, effective 1/1/23. 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 with the medicaid agency; 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 a properly completed FQHC enrollment packet within 60 calendar days from the date of CMS's written notification to the FQHC of the medicare certification.

(b) The agency uses the date when both the properly completed FQHC enrollment packet and properly completed core provider agreement have been received if either of the required documentation is submitted 61 or more calendar days after the date of medicare's letter notifying the clinic of the medicare certification.

[Statutory Authority: 42 U.S.C. 1396a(bb), 42 U.S.C. 1396d (2)(A), RCW 41.05.021, and 41.05.160. WSR 22-22-049, § 182-548-1200, filed 10/27/22, effective 1/1/23. 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 encounter rate 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 encounter-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: 42 U.S.C. 1396a(bb), 42 U.S.C. 1396d (2)(A), RCW 41.05.021, and 41.05.160. WSR 22-22-049, § 182-548-1300, filed 10/27/22, effective 1/1/23. 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—Payment methodologies. (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 are 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 100 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 adjusted 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 100 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) The agency determines PPS base encounter rates 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 adjusted 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 recoups 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, known as APM-3, 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 are 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 recoups 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 periodically rebases the encounter rates using the FQHC cost reports and other relevant data. Rebasing is done only for FQHCs that are reimbursed under the APM.

(e) The agency ensures that the payments made under the APM are at least equal to the payments that would be made under the PPS.

(8) This subsection describes the payment methodology that the agency uses to pay participating FQHCs for services provided beginning July 1, 2017, and ending December 31, 2022.

(a) Each FQHC may receive payments under the APM described in subsection (7) of this section, or receive payments under the revised APM described in this subsection.

(b) The revised APM, known as APM-4, is as follows:

(i) The revised APM establishes a budget-neutral, baseline per member per month (PMPM) rate for each FQHC. The PMPM rate accounts for enhancement payments in accordance with the definition of enhancements in WAC 182-548-1100. For the purposes of this section, "budget-neutral" means the cost of the revised APM to the agency will not exceed what would have otherwise been spent not including the revised APM on a per member per year basis.

(ii) The agency pays the FQHC a PMPM payment each month for each managed care client assigned to them by an MCO.

(iii) The agency pays the FQHC a PMPM rate in addition to the amounts the MCO pays the FQHC. The agency may prospectively adjust the FQHC's PMPM rate for any of the following reasons:

(A) Quality and access metrics performance.

(B) FQHC encounter rate changes.

(iv) In accordance with 42 U.S.C. 1396a (bb)(5)(A), the agency performs an annual reconciliation.

(A) If the FQHC was underpaid, the agency pays the difference, and the PMPM rate may be subject to prospective adjustment under (b)(iii) of this subsection.

(B) If the FQHC was overpaid, the PMPM rate may be subject to prospective adjustment under (b)(iii) of this subsection.

[Statutory Authority: 42 U.S.C. 1396a(bb), 42 U.S.C. 1396d (2)(A), RCW 41.05.021, and 41.05.160. WSR 22-22-049, § 182-548-1400, filed 10/27/22, effective 1/1/23. Statutory Authority: RCW 41.05.021, 41.05.160 and 42 U.S.C. 1396a (bb)(5)(A). WSR 20-24-083, § 182-548-1400, filed 11/25/20, effective 1/1/21. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-12-016, § 182-548-1400, filed 5/30/17, effective 7/1/17; 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 182-548-1450 Federally qualified health centers—General payment information. (1) The agency limits FQHC encounter rate reimbursement to one per client, per day except in the following circumstances:

(a) There is a subsequent visit in the same cost center that requires separate evaluation and treatment on the same day for unrelated diagnoses; or

(b) There are separate visits in different types of cost centers that occur with different health care professionals. (For example, a client with a separate medical and dental visit on the same day.)

(2) All services provided within the same cost center performed on the same day must be included in the same encounter, except for in the circumstance outlined in subsection (1)(a) of this section.

(3) Services and supplies incidental to an encounter are included in the encounter rate payment and must be billed on the same claim.

(4) FQHCs must provide services in a single encounter that are typically rendered in a single visit based on clinical guidance and standards of care.

(a) FQHCs must not split services into multiple encounters unless there is clinical justification. (For example, fluoride treatment must be provided on the same day as an encounter-eligible service.)

(b) Clinical justification must be based on medical necessity and documented in the client's record.

(5) Services provided in an FQHC that are not encounter-eligible are paid on a fee-for-service basis according to agency rules, billing guides and fee schedules.

(6) Managed care organization (MCO) contracted services provided in an FQHC for clients enrolled in an MCO are paid for by the MCO.

(7) 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.

(i) For each FQHC, the agency compares the amount paid in enhancement payments to the amount determined by the following formula:

(Managed care encounters x encounter rate) - MCO payments for FQHC services

(ii) If the agency determines that the FQHC was overpaid, the agency recoups the appropriate amount. If the agency determines that the FQHC was underpaid, the agency pays the difference.

(iii) The agency may prospectively adjust the FQHC's monthly enhancement payments if the agency determines the FQHC has been overpaid or underpaid in the annual reconciliation.

(A) The agency uses the FQHC's most current reconciliation data, and any supplemental information provided by the FQHC to determine if any adjustment to the enhancement rate is necessary.

(B) If the agency determines a prospective adjustment to enhancement payments is necessary, the agency notifies the FQHC in writing at least 30 calendar days prior to the enhancement payment adjustment.

(8) The agency pays the encounter rate and the enhancement payments with respect to services provided to encounter-eligible clients. Services provided to clients who are enrolled in medical programs that are paid only in state funds are not encounter-eligible; these claims are paid on a fee-for-service basis regardless of the type of service performed.

[Statutory Authority: 42 U.S.C. 1396a(bb), 42 U.S.C. 1396d (2)(A), RCW 41.05.021, and 41.05.160. WSR 22-22-049, § 182-548-1450, filed 10/27/22, effective 1/1/23. Statutory Authority: RCW 41.05.021,

41.05.160 and 42 U.S.C. 1396a (bb)(5)(A). WSR 20-24-083, § 182-548-1450, filed 11/25/20, effective 1/1/21. Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 17-12-016, § 182-548-1450, filed 5/30/17, effective 7/1/17.]

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 adjusts 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 with the agency on its own initiative only when the FQHC satisfies the criteria described in (a)(i), (ii), and (iii) of this subsection.

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

(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.

(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.

(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 position statement indicating whether the FQHC asserts that its PPS rate should be increased or decreased due to a change in the scope of services.

(i) The FQHC files a completed cost report and position statement no later than 90 calendar days after receiving the instruction from the agency. If the FQHC has not received the annual audit report at

the time of the agency's request, the FQHC informs the agency, in writing, that it will submit one of the following alternatives:

(A) The cost report and position statement within 90 calendar days of receiving its annual audit report; or

(B) The cost report and position statement based on the prior year's audit.

(ii) The agency reviews the FQHC's cost report and position statement 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.

(b) 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.

(c) The FQHC files for a change in scope of service rate adjustment based on the following deadlines, whichever is later:

(i) Ninety calendar days after the end of the FQHC's fiscal year, demonstrating that the change in scope occurred as documented in the medicaid cost report.

(ii) Ninety calendar days after the FQHC learned, based on its annual audit, that the cost threshold in subsection (1)(a)(ii) of this section was met during the fiscal year.

(d) Prospective change in scope.

(i) A prospective change in scope of service rate adjustment application must state each triggering event listed in subsection (1)(a)(i) of this section that supports the FQHC's application.

(ii) A prospective change in scope of service rate adjustment application must be based on one of the following:

(A) A change the FQHC plans to implement in the future. The FQHC submits 12 months of projected data and costs sufficient to establish an interim rate; or

(B) A change which occurred in the FQHC's most recent fiscal year with less than 12 months of experience to support the change reflected in the medicaid cost report. The FQHC submits a combination of historical data and projected costs sufficient to establish an interim rate.

(iii) The interim rate adjustment goes into effect after the change takes effect.

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

(v) If the change in scope occurs less than 90 calendar days after the FQHC submitted a complete application to the agency, the interim rate takes effect no later than 90 calendar days after the complete application was submitted to the agency.

(vi) If the change in scope occurs more than 90 calendar days but less than 180 calendar days after the FQHC submitted a complete application to the agency, the interim rate takes effect when the change in scope occurs.

(vii) If the FQHC fails to implement a change in service identified in its prospective change in scope of service rate adjustment application within 180 calendar days, the application is void and the

FQHC may resubmit the application to the agency, in such a circumstance, (b) of this subsection does not apply.

(viii) If the change in scope is based on a triggering event that already occurred but is supported by less than 12 months of data in the filed cost report, the interim rate takes effect on the date the FQHC submitted the completed application to the agency.

(e) Retrospective change in scope.

(i) A retrospective change in scope of service rate adjustment application must state each triggering event listed in subsection (1)(a)(i) of this section that supports its application and include 12 months of data documenting the cost change caused by the triggering 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 submitted a complete application to the agency, as determined by the agency.

(3) **Supporting documentation.**

(a) To apply for a change in scope of service rate adjustment, the FQHC submits the following supporting documentation to the agency in electronic format by email to fqhcrhc@hca.wa.gov:

(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 the projected medicaid cost report and the projected medicare cost report with supplemental schedules necessary to identify the medicaid cost per visit for the 12-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 and the medicare cost report with supplemental schedules necessary to identify the medicaid cost per visit and encounter data for one of the following:

(i) The 12-month period following the implementation of the triggering event; or

(ii) The fiscal year following implementation of the proposed change in scope.

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

(a) Application processing.

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

(ii) Within 60 calendar days of receiving the application, the agency notifies the FQHC of any deficient documentation or request any additional information that is necessary to process the application. If the FQHC does not provide the agency with the documentation or information within 30 calendar days of the request, the agency may deny the application.

(iii) Within 90 calendar days of receiving a complete application, including any additional documentation or information that the agency might request, the agency sends the FQHC:

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

(B) A rate-setting statement if the rate change is implemented.

(iv) The FQHC may appeal the decision on the application as provided for in WAC 182-548-1650.

(b) Determining rate for change in scope.

(i) The agency sets 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 reviews the costs to determine if they are reasonable, and set a new interim rate based on the determined cost per encounter.

(ii) The agency sets 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. The agency reviews 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 approved by the agency modifies 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 responsibility and authority for making decisions related to changes in scope.

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

(a) If the approved change in scope rate adjustment was based on a retrospective change in scope application (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 approved change in scope rate adjustment was based on a prospective change in scope application (i.e., based on less than a full year of actual encounter data), the FQHC submits the following information to the agency within 18 months of the effective date of the rate adjustment:

(i) Medicaid cost report and medicare cost report with supplemental schedules necessary to identify the medicaid cost per visit and encounter data for 12 consecutive months of experience following implementation of the change in scope;

(ii) A narrative description of the request;

(iii) A description of each cost center on the cost report that was affected by the change in scope;

(iv) The FQHC's most recent audited financial statements, if audit is required by applicable law; and

(v) Any additional documentation requested by the agency.

(c) The agency conducts the post change in scope review within 90 calendar days of receiving the cost report and encounter data from the FQHC.

(d) If necessary, the agency adjusts the encounter rate within 90 calendar 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 takes effect on the date the agency issues its adjustment. The new rate is prospective.

(f) If the FQHC fails to submit the post change in scope cost report or related encounter data, the agency provides written notice to the center or clinic within 30 calendar days.

(g) If the FQHC fails to submit required documentation within five months of the notice identified in (f) of this subsection, the agency may reinstate the prechange in scope encounter rate going for-

ward from the date the interim rate was established. The agency may recoup any overpayment to the FQHC.

[Statutory Authority: 42 U.S.C. 1396a(bb), 42 U.S.C. 1396d (2)(A), RCW 41.05.021, and 41.05.160. WSR 22-22-049, § 182-548-1500, filed 10/27/22, effective 1/1/23. Statutory Authority: RCW 41.05.021 and 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.]

WAC 182-548-1600 Federally qualified health centers—Appeals related to overpayments. An overpayment assessment by the agency against an FQHC identified in the annual managed care reconciliation (see WAC 182-548-1450) may be appealed based on WAC 182-502-0230 and RCW 41.05A.170. Administrative hearing appeals are governed by chapter 34.05 RCW (Administrative Procedure Act) and chapter 182-526 WAC (HCA administrative hearing rules).

[Statutory Authority: 42 U.S.C. 1396a(bb), 42 U.S.C. 1396d (2)(A), RCW 41.05.021, and 41.05.160. WSR 22-22-049, § 182-548-1600, filed 10/27/22, effective 1/1/23.]

WAC 182-548-1650 Federally qualified health centers—Appeals related to rate setting. (1) An FQHC provider has a right to an administrative appeal of agency action related to rate setting under this chapter based on the rules in this section.

(a) The rules in WAC 182-502-0220 do not apply to appeals of agency action related to rate setting under this chapter.

(b) Appeals related to rate setting under this section are not governed by the Administrative Procedure Act, chapter 34.05 RCW.

(c) Any rate change that the agency grants that is the result of fraudulent practices on the part of the FQHC, including as described under RCW 74.09.210, is exempt from the appeal provisions in this chapter.

(d) An FQHC who fails to submit requested information as outlined in this chapter will be determined to have abandoned their appeal.

(2) The first level of appeal.

(a) An FQHC provider who wants to contest an agency action concerning the reimbursement rate must file a written appeal with the agency. Written appeals must be sent to the address provided in the rate notification letter.

(b) The FQHC must file the appeal within 60 calendar days of the date of the rate notification letter from the agency, unless an extension has been granted.

(i) The agency may grant a time extension for the appeal period if the FQHC makes such a request before the expiration of the 60-day period.

(ii) The agency does not consider an appeal filed after the 60-day period unless an extension is granted by the agency.

(c) The appeal must include the following:

(i) A statement of the specific issue being appealed;

(ii) Supporting documentation; and

(iii) A request for the agency to recalculate the rate.

(d) When an FQHC appeals a portion of a rate, the agency may review all components of the reimbursement rate.

(e) To complete a review of the appeal, the agency may do one or both of the following:

(i) Request additional information;

(ii) Conduct an audit of the documentation provided.

(f) The agency issues a decision or requests additional information within 60 calendar days of receiving the rate appeal request. When the agency requests additional information:

(i) The FQHC has 45 calendar days from the date of the request to submit the additional information to the agency; and

(ii) The agency issues a decision within 30 calendar days of receipt of the additional information.

(g) Any rate increase or decrease resulting from an appeal is effective retroactively to the rate effective date in the notification letter. The exception is identified in (h) of this subsection.

(h) If an appeal is related to the denial of a change in scope rate adjustment application, any rate adjustment effective date is established by the following rules:

(i) For prospective change in scope, the effective date of the rate adjustment is established by WAC 182-548-1500 (2)(d);

(ii) For retrospective change in scope, the effective date of the rate adjustment is established by WAC 182-548-1500 (2)(e);

(iii) For a post change in scope of services, the effective date of the rate adjustment is established by WAC 182-548-1500 (5)(e).

(3) The second level of appeal.

(a) When an FQHC disagrees with a rate review decision from the first level of appeal, it may file a request along with supporting documentation for a dispute conference with the agency. For this section, "dispute conference" means an informal administrative appeal to resolve FQHC disagreements with an agency action not resolved at the first level of appeal.

(b) If an FQHC files a request for a dispute conference, it must submit the request to the agency within 30 calendar days after the date of the rate review decision.

(i) Any request for a dispute conference must be sent to the address indicated in the rate review decision.

(ii) The agency does not consider dispute conference requests submitted after the 30-day period for the first level decision.

(c) The agency conducts the dispute conference within 90 calendar days of receiving the request.

(d) The agency-director designee issues the final decision within 30 calendar days of the conference. Extensions of time for extenuating circumstances may be granted by the agency-director designee.

(e) Any rate increase or decrease resulting from a dispute conference decision is effective on the date specified in the dispute conference decision.

(f) The dispute conference is the final level of administrative appeal within the agency and precedes judicial action.

(4) The agency considers an FQHC who fails to attempt to resolve disputed rates as provided in this section has abandoned the dispute.

[Statutory Authority: 42 U.S.C. 1396a(bb), 42 U.S.C. 1396d (2)(A), RCW 41.05.021, and 41.05.160. WSR 22-22-049, § 182-548-1650, filed 10/27/22, effective 1/1/23.]