



Region 10  
2201 Sixth Avenue, MS/RX 43  
Seattle, Washington 98121

JAN 11 2012

Douglas Porter, Director  
Health Care Authority  
Post Office Box 45502  
Olympia, Washington 98504-5010

**RE: Washington State Plan Amendment (SPA) Transmittal Number 11-015B**

Dear Mr. Porter:

The Centers for Medicare & Medicaid Services (CMS) Seattle Regional Office has completed its review of State Plan Amendment (SPA) Transmittal Number 11-015B. This amendment modifies the alternative payment methodology for Federally Qualified Health Centers (FQHCs) and updates the reimbursement methodology for new FQHCs and FQHCs that have merged.

This SPA is approved effective July 7, 2011.

If you have any additional questions or require any further assistance, please contact me, or have your staff contact Joe Fico at (206) 615-2380 or [Joseph.Fico@cms.hhs.gov](mailto:Joseph.Fico@cms.hhs.gov)

Sincerely,

A handwritten signature in black ink that reads "Carol J.C. Peverly".

Carol J.C. Peverly  
Associate Regional Administrator  
Division of Medicaid and Children's Health  
Operations

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

1. TRANSMITTAL NUMBER:  
**11-15B (P&I)**

2. STATE  
Washington

FOR: HEALTH CARE FINANCING ADMINISTRATION

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE  
SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE  
~~April 7, 2011~~ **July 7, 2011 (P&I)**

5. TYPE OF PLAN MATERIAL (Check One):

- NEW STATE PLAN
- AMENDMENT TO BE CONSIDERED AS NEW PLAN
- AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT  
a. FFY 2011 (\$4,225,000) **(\$2,877,000) (P&I)**  
b. FFY 2012 (\$18,064,000) **(\$15,939,000) (P&I)**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B pgs 33, 34, 35 (P&I)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (If Applicable):

Attachment 4.19-B pgs 33, 34, 35 (P&I)

10. SUBJECT OF AMENDMENT:

Federally Qualified Health Center (FQHC) Rates

11. GOVERNOR'S REVIEW (Check One):

- GOVERNOR'S OFFICE REPORTED NO COMMENT
- COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
- NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
- OTHER, AS SPECIFIED: Exempt

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

Susan N. Dreyfus

14. TITLE:

Secretary

15. DATE SUBMITTED:

6/8/11

16. RETURN TO:

Ann Myers  
Department of Social and Health Services  
Medicaid Purchasing Administration  
626 8<sup>th</sup> Ave SE MS: 45504  
POB 5504  
Olympia, WA 98504-5504

**FOR REGIONAL OFFICE USE ONLY**

17. DATE RECEIVED: **June 8, 2011**

18. DATE APPROVED: **JAN 11 2012**

**PLAN APPROVED - ONE COPY ATTACHED**

19. EFFECTIVE DATE OF APPROVAL MATERIAL: ~~APR 07 2011~~ **JUL 07 2011**

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:

**Carol J.C. Reverly**

22. TITLE: **Associate Regional Administrator  
Division of Medicaid &  
Children's Health**

23. REMARKS:

8/18/2011 - Pen & Ink Changes Authorized by the State.

10/13/2011 - Pen & Ink Changes Authorized by the State.

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

XVI. Federally Qualified Health Centers

Effective January 1, 2001, through December 31, 2008, the payment methodology for Federally Qualified Health Centers (FQHCs) conforms to Section 1902(bb) of the Social Security Act (SSA). As set forth in Section 1902(bb)(2) and (3), all FQHCs that provide services on January 1, 2001, and through December 31, 2008, are reimbursed on a prospective payment system (PPS). The reconciliation for calendar year 2009 will be done starting in calendar year 2010 and every year thereafter.

Effective January 1, 2009, fee-for-service (FFS) and managed care organization (MCO) payments to FQHCs will be determined using an alternative payment methodology (APM) as authorized in Section 1902(bb)(6) of the SSA. Those FQHCs that do not choose the APM will continue to be paid under the PPS.

For the period beginning January 1, 2009, the PPS and APM will utilize the centers' base encounter rates, using the PPS methodology in place at the time. Because the FQHC cost reports reflected the centers' fiscal year, the base rates were adjusted to a calendar year, as illustrated by the following formula (the example reflects a center with a fiscal year ending March 31):

$$\frac{(((FY99 R * FY99 E) / 12) * 3) + (FY00 R * FY00 E) + (((FY01 R * FY01 E) / 12) * 9)}{((FY99 E / 12) * 3) + (FY00 E) + ((FY01 E / 12) * 9)}$$

R = Rate  
E = Encounters

For FQHCs receiving their initial designation after January 1, 2001, their base rates were established using an average encounter rate of other FQHCs located in the same or adjacent area with similar caseloads, on an interim basis until their permanent rates were determined.

Effective January 1, 2009, and each January 1 thereafter, PPS rates will be increased by the percentage change in the Medicare Economic Index (MEI) for that period.

Effective January 1, 2009, and each January 1 thereafter, APM rates will be increased by a Washington-specific health care index developed by IHS Global Insight. To ensure that the APM pays an amount at least equal to the PPS, the greater of the Washington-specific index or the MEI will be used. The greater of the Washington-specific index or the MEI will also be applied retroactively to the centers' base encounter rates.

For services provided on and after July 7, 2011, each center will have the choice of receiving either (1) its PPS rate, as determined under the method described above or (2) a rate determined under a revised APM. The revised APM will be as follows: for centers that rebased their rate effective January 1, 2010, their 2008 allowed cost per visit inflated by the cumulative percentage increase in the MEI between 2009 and 2011. For centers that did not rebase in 2010, their rate is based on their PPS base rate from 2002 (or subsequent year to the extent the 2002 rate was updated to account for the addition of a new site or type of service) inflated by the cumulative percentage increase in the IHS Global Insight index from the base year through calendar year 2008 and the cumulative increase in the MEI from 2009 through 2011. The rates will be inflated by MEI effective January 1, 2012 and each January 1 thereafter. The State will compare each year's APM rate to the rate that would have been paid under PPS to ensure the APM payments are at least equal to the payments that would have been made under PPS.

## STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE: WASHINGTON

POLICY AND METHODS USED IN ESTABLISHING PAYMENT RATES FOR EACH OF THE OTHER TYPES OF CARE OR SERVICE LISTED IN SECTION 1905 (A) OF THE ACT THAT IS INCLUDED IN THE PROGRAM UNDER THE PLAN (cont.)

## XVI. Federally Qualified Health Centers (continued)

The State will periodically rebase the FQHC encounter rates using the FQHC cost reports and other relevant data. Rebasing will be done only for centers that choose the APM.

FQHCs receiving their initial designation after January 1, 2001, will be paid an average encounter rate of other FQHCs located in the same or adjacent area with similar caseloads, on an interim basis. Within two years of receiving its initial designation, the FQHC must demonstrate its true costs using standard cost reporting methods, to establish its base encounter rate. The State will audit the new center's cost report to ensure the costs are reasonable and necessary.

The new FQHC will receive this rate for the remainder of the calendar year in which it is established and will receive annual increases thereafter consistent with the payment methodology (PPS or APM) chosen by the center.

If two or more FQHCs merge, a weighted average of the centers' encounter rates is used as the encounter rate for the new center.

An adjustment will be made to a center's encounter rate if the center can show that they have experienced a valid change in scope of service.

A change in scope of service is defined as a change in the type, intensity, duration and/or amount of services. A change in the scope of service will occur if: (1) the center adds or drops any service that meets the definition of FQHC service as defined in section 1905(a)(2)(C) of the Social Security Act; and, (2) the service is included as a covered Medicaid service as defined in the State Plan Amendment.

The center is responsible for notifying the FQHC Program Manager in writing of any changes during the calendar year, no later than 60 days after the effective date of the change. Within 60 days of notification, the State will verify the change meets the definition of change in scope of service.

If the change represents a decrease in scope of service, the State will recalculate the base encounter rate by decreasing it by the average cost-per-encounter detailed in the center's most recent rebasing. If the change represents an increase in scope of service, the State will recalculate the base encounter rate on an interim basis by increasing it by the average statewide cost-per-encounter as detailed in the most recent rebasing of other centers that provide the service. Once the center can demonstrate its true costs of providing the service, it must submit adequate documentation of the costs to the State. The State will perform a desk review of the costs to determine if the costs are reasonable and necessary, and adjust the interim rate by the accepted cost-per-encounter to establish a final encounter rate. The new encounter rate(s) will be effective on the date the new service was fully implemented and available.