DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

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

JAN 1 1 2012

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

RE: Washington State Plan Amendment (SPA) Transmittal Number 11-016A

Dear Mr. Porter:

The Centers for Medicare & Medicaid Services (CMS) Seattle Regional Office has completed its review of State Plan Amendment (SPA) Transmittal Number 11-016A. This amendment modifies the alternative payment methodology for services provided at Rural Health Clinics.

This SPA is approved effective April 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.

Sincerely,

Carol Peverly

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: **11-16** A (P&I)

2. STATE: Washington

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

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 ~~($648,000)~~ ($2,941,000) (P&I)
b. FFY 2012 ~~($2,753,000)~~ ($6,348,000) (P&I)

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attachment 4.19-B pgs 3, 4, 5

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 PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attachment 4.19-B pgs 3, 4, 5

10. SUBJECT OF AMENDMENT:

Rural Health Center (RHC) 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:
Susan N Dreyfus

13. TYPED NAME:
Susan N. Dreyfus

14. TITLE:
Secretary

15. DATE SUBMITTED:
6-13-11

16. RETURN TO:
Ann Myers
Department of Social and Health Services
Medicaid Purchasing Administration
626 8th Ave SE MS: 45504
POB 5504
Olympia, WA 98504-5504

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: June 13, 2011

18. DATE APPROVED: JAN 11 2012

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: APR 07 2011

20. SIGNATURE OF REGIONAL OFFICIAL:
Carol J.C. Peverly

21. TYPED NAME:
Carol J.C. Peverly

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

23. REMARKS:

8/18/11 - Pen & Ink changes authorized by the State.
10/13/11 - Pen & Ink changes authorized by the State.

FORM HCFA-179 (07-92)

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.)

II. Clinic services (cont.)

Effective January 1, 2001, through December 31, 2008, the payment methodology for Rural Health Clinics (RHCs) conforms to Section 1902(bb) of the Social Security Act (SSA). As set forth in Section 1902(bb)(2) and (3), all RHCs that provide services on January 1, 2001 and through December 31, 2008 are reimbursed on a prospective payment system (PPS). The first reconciliation was for payments made in calendar year 2009 and was done starting in calendar year 2010. Thereafter, a reconciliation will be done for each calendar year in the following calendar year.

Effective January 1, 2009, fee-for-service (FFS) and managed care organization (MCO) payments to RHCs will be determined using an alternative payment methodology (APM) as authorized in Section 1902(bb)(6) of the SSA. Those RHCs 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 clinics' base encounter rates, using the PPS methodology in place at the time. The base rates were calculated as illustrated by the following formula:

$$\frac{(1999\ \text{Rate} * 1999\ \text{Encounters}) + (2000\ \text{Rate} * 2000\ \text{Encounters})}{(1999\ \text{Encounters} + 2000\ \text{Encounters})}$$

For clinics receiving their initial RHC designation after 2001, their base rates were established using the first available Medicare-audited cost report.

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 for services provided through April 6, 2011, 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 clinics' base encounter rates.

For services provided on and after April 7, 2011, each clinic 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 the clinic's PPS rate for calendar year 2011 inflated by 5%. Under the revised APM, each clinic's annual PPS rate will then be inflated by 5% on January 1, 20102, and each January 1 thereafter.

When the APM methodology is in effect, the State will periodically rebase the RHC encounter rates using the RHC cost reports and other relevant data. Rebasing will be done only for clinics that are reimbursed under the APM.

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.)

II. Clinic Services (cont.)

RHCs receiving their initial designation after January 1, 2001, are paid an average encounter rate of other clinics located in the same or adjacent area with a similar case load, on an interim basis until the clinic's first Medicare-audited cost report is available.

Once the audited report for the clinic's first year is available, the new clinic's encounter rate is set at 100 percent of its costs as defined in the cost report. The new RHC will receive this rate for the remainder of the calendar year during which the audited cost report became available, and will receive annual increases thereafter consistent with the payment methodology (PPS or APM) chosen by the clinic.

An adjustment will be made to a clinic's encounter rate if the clinic 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 clinic adds or drops any service that meets the definition of RHC service as defined in section 1905(a)(2)(B) of the Social Security Act; and, (2) the service is included as a covered Medicaid service as described in the State Plan Amendment.

The clinic is responsible for notifying the RHC 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 of scope of service.

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 clinics that provide the service.

This interim rate will be effective the date the new service is implemented and fully available to Medicaid clients. Once the clinic 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.

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 clinic's most recent rebasing.

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.)

II. Clinic Services (cont.)

For clients enrolled with a managed care contractor, the State will pay the clinic a supplemental payment in addition to the amount paid by the managed care contractor. The supplemental payments, called enhancements, will be paid in amounts necessary to ensure compliance with Section 1902(bb)(5)(A) of the SSA. The State will pay the enhancements monthly on a per-member-per-month basis.

To ensure that the appropriate amounts are being paid to each clinic, the State will perform an annual reconciliation and verify that the enhancement payments made in the previous year were in compliance with Section 1902(bb)(5)(A). The reconciliation for calendar year 2009 will start in calendar year 2010. Thereafter, each year's reconciliation will start in the following calendar year. The annual reconciliation will be done as follows:

APM: (managed care encounters x APM encounter rate) less (fee-for-service equivalent) = State's payment amount

PPS: (managed care encounters x PPS encounter rate) less (fee-for-service equivalent) = State's payment amount

Covered services for Medicaid-Medicare patients are reimbursed as detailed in Supplement 1 to Attachment 4.19 (B), pages 1, 2, and 3.

D. Non-hospital-owned Freestanding Ambulatory Surgery Centers

Freestanding ambulatory surgery centers (ASC) are reimbursed a facility fee based on Medicare's Grouper, except for procedures Medicare has not grouped; in which case, DSHS groups the service to a like procedure that Medicare has grouped.

All procedures that the department reimburses to an ASC are assigned a grouper of one through eight (1-8). Each of these groupers is assigned a set fee. The department pays the lesser of the usual and customary charge or the grouper fee based on a department fee schedule.

Except as otherwise noted in the plan, state-developed fee schedule rates are the same for both governmental and private providers of non-hospital-owned freestanding ASC services. The Agency's rates were set as of April 1, 2009 and are effective for services on and after that date. All rates are published on the Agency's website.