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State/Territory Name: Washington

State Plan Amendment (SPA) #: 15-0008

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
701 Fifth Avenue, Suite 1600, MS/RX-200
Seattle, WA 98104
Centers of Medicaid and CHIP Services

APR 2 8 2015

Dorothy Frost Teeter, Director
MaryAnne Lindeblad, Medicaid Director
Health Care Authority
Post Office Box 45502
Olympia, Washington 98504-5010

RE: Washington State Plan Amendment (SPA) Transmittal Number 15-0008.

Dear Ms. Teeter and Ms. Lindeblad:

The Centers for Medicare & Medicaid Services (CMS) Seattle Regional Office has completed its review of State Plan Amendment (SPA) Transmittal Number WA 15-0008. This SPA clarified the policy for Federal Qualified Health Centers (FQHC's) to request a rate adjustment for a change of scope of services.

This SPA is approved with an effective date of March 12, 2015.

If you have any additional questions or require any further assistance, please contact me, or have your staff contact James Moreth at (360) 943-0469 or James.Moreth@cms.hhs.gov.

Sincerely,

[redacted]

Frank A. Schneider
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc:
Ann Myers, SPA Coordinator

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Seattle Regional Office
701 Fifth Avenue, Suite 1600, MS/RX-200
Seattle, Washington 98104

Division of Medicaid & Children's Health Operations

APR 2 8 2015

Dorothy Frost Teeter, Director
MaryAnne Lindeblad, Medicaid Director
Health Care Authority
Post Office Box 45502
Olympia, Washington 98504-5010

RE: Washington State Plan Amendment (SPA) Transmittal Number WA 15-0008.

Dear Ms. Teeter and Ms. Lindeblad:

This letter is being sent as a companion to the Centers for Medicare & Medicaid (CMS) approval of Washington State Plan Amendment (SPA) Transmittal Number 15-0008, which clarified reimbursement policy for Federal Qualified Health Centers (FQHC's) by requesting a rate adjustment necessitated by a change in scope of FQHC's services. This amendment was submitted on February 4, 2015, with an effective date of March 12, 2015.

Regulations at 42 Code of Federal Regulations (CFR) 430.10 require that the State Plan be a comprehensive written statement describing the nature and scope of the State's Medicaid program. It should contain all information necessary for CMS to determine whether the Plan can be approved and whether the State program is eligible for Federal Financial Participation (FFP). The CMS' analysis of SPA 15-0008 identified that additional changes are needed in the Washington Medicaid State Plan related to the coverage and reimbursement of FQHC benefits as specified below.

1. In State Plan Attachment 3.1-A, the FQHC benefit is described as "unlimited" yet the state's implementing regulations describe a limitation: one service per day (with two exceptions). WAC 182-548-1400(8). Please change Attachment 3.1-A page 1, item 2.c from "no limitations" to "with limitations" then add the state's existing service limitation to the Attachment 3.1-A limitation pages (starting on page 11).

2. WA has a benefit limitation that only one FQHC service can be reimbursed each day, with two exceptions. See page 26 of the FQHC provider manual. However, the State Plan represents that FQHC services are "unlimited" (see State Plan at Attachment 3.1-A item 2.c). The State Plan should acknowledge the state's service limitation. Please

change Attachment 3.1-A, item 2.c from "no limitations" to "with limitations" and the one-per-day limit to the Attachment 3.1-A limitations pages (starting on page 11).

3. The State Plan pages for FQHCs do not authorize the FQHCs to provide "other ambulatory services" either by service listing or by cross-reference to other parts of the State Plan. See SSA section 1902(a)(2)(C). Please submit a new Attachment 3.1-A pages addressing "other ambulatory services" descriptions.

4. The State Plan pages for FQHCs do not describe the "core providers" eligible to provide services through the FQHC (e.g. physicians, nurse practitioners, clinical psychologists, etc.; see generally 42 CFR 405.2446) nor do the State Plan pages describe the additional provider types that Washington authorizes (e.g. naturopaths and various mental health service providers) to provide services through FQHCs. In addition to the absence of provider types, the State Plan also fails to identify minimum qualifications (e.g. education, experience, training, certification, registration, licensure and supervisory requirements) that an individual practitioner must have in order to deliver State Plan FQHC services. Please submit a new Attachment 3.1-A pages addressing FQHC provider types and qualifications.

The State has 90 days from the date of this letter to respond to the issues described above. Within that period the State may submit a SPA to address the inconsistencies and/or submit a corrective action plan describing in detail how the State will resolve the issues identified above in a timely manner.

Failure to respond may result in the initiation of a formal compliance process. During the 90 days, CMS will provide technical assistance, as needed or required.

If you have questions concerning this letter, please contact me, or have your staff contact James Moreth at (360) 943-0469 or James.Moreth@cms.hhs.gov.

Sincerely,

[redacted]

Frank A. Schneider
Acting Associate Regional Administrator
Division of Medicaid and Children's Health Operations

cc:
Ann Myers

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: ~~14-0033~~ 15-0008 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 ~~January 1, 2015~~ ~~March 1, 2015 P&I~~ March 12, 2015 (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:
1902(bb) of the Social Security Act

7. FEDERAL BUDGET IMPACT:
a. FFY 2015 $0
b. FFY 2016 $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
~~Att. 4.19-B page 4~~ (P&I)
Att. 4.19 Page(s) 34-35

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
~~Att. 4.19-B page 4~~ (P&I)
Att. 4.19 Page(s) 34-35

10. SUBJECT OF AMENDMENT:

RHC Change of Scope Provisions

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:
[redacted]

13. TYPED NAME:
MARYANNE LINDEBLAD

14. TITLE:
MEDICAID DIRECTOR

15. DATE SUBMITTED:
2-4-15

16. RETURN TO:
Ann Myers
Office of Rules and Publications
Legal and Administrative Services
Health Care Authority
626 8th Ave SE MS: 42716
Olympia, WA 98504-2716

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: 2/04/15

18. DATE APPROVED: 4/28/15

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
March 12 2015

20. SIGNATURE OF REGIONAL OFFICIAL:
[redacted]

21. TYPED NAME: Frank A. Schneider

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

23. REMARKS:

2/04/15: State authorizes P&I change to box 1 and 4
4/28/15: State authorizes P&I change to box 4 8,9

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.)

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 it has experienced a valid change in scope of service. An FQHC may file a change in scope of services rate adjustment application only when:

- The cost to the FQHC of providing covered healthcare services to eligible clients has increased or decreased due to the following: change in the type, intensity (total quantity of labor and materials consumed by an individual client during an average encounter), duration (length of an average encounter) and/or amount of services; and
- The cost change equals or exceeds an increase of 1.75% in the rate per encounter over one year; a decrease of 2.5% in the rate per encounter over one year; or a cumulative increase or decrease of 5% in the rate per encounter as compared to the current year's cost per encounter; and
- The costs reported to the State to support the proposed change in scope rate adjustment are reasonable under OMB circular A-122 or its successor,and other applicable state and federal law; and
- The service meets the definition of an FQHC service as defined in section 1905(a)(2)(C) of the Social Security Act; and
- The service is included as a covered Medicaid service as defined in the State Plan.

An FQHC may apply for a prospective or retrospective change in scope rate adjustment.

For prospective change in scope, an FQHC submits projected costs sufficient to establish an interim rate. Once the center can demonstrate its true costs of providing the services, it must submit required 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 final rate within 90 days of receiving complete information from the center. The final rate will take effect on the date the State issues the adjustment.

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)

For retrospective change in scope, an FQHC submits actual data of twelve months 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. If approved, a retrospective rate adjustment takes effect on the date the FQHC filed the application with the agency. The State will notify the center of a decision within 90 days of receiving completed application.

For clients enrolled with a managed care contractor, and effective April 1, 2014, the State anticipates that the managed care contractor will pay each center an encounter rate that is at least equal to the PPS rate specific to each center. To ensure that the appropriate amounts are being paid to each center, the State will perform an analysis of the managed care contractor's data at least quarterly and verify that the payments made by the managed care contractor in the previous quarter were in compliance with Section 1902(bb)(5)(A) of the SSA. This process will apply to centers reimbursed under the APM rate methodology and to centers reimbursed under the PPS rate methodology.

At no time will a managed care organization be at risk for or have any claim to the supplemental payment portion of the rate which will be reconciled to ensure accurate payment of the obligated funds.

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